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Medicaid Managed Care Contract Language: Health Disparities and Health Equity
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This document provides excerpts of health disparities and health equity contract language from Medicaid Managed Care (MMC) contracts from five states—Michigan, Minnesota, North Carolina, Ohio, Oregon—and Washington, D.C. as well as the contract for California's Health Exchange, Covered California. To identify state contracts to include, a select number of Medicaid managed care contracts were reviewed and a Google search was performed. The criteria for inclusion in this compendium were contracts that explicitly addressed health disparities and/or health equity. State contract examples were excluded if the contract only included minimal health disparities language related to federal rules for Medicaid managed care quality strategies[i]. The review was not comprehensive as it did not include every state managed care contract. The following are trends observed across the contracts reviewed:

- The contracts vary significantly from state to state both in terms of the approaches taken and the extent of direction given to MCOs. MMC contractual language related to health equity reflects this overall difference in state managed care approaches.
- The health equity-related language in the MMC contracts reviewed range from Minnesota, which requires that its contractor develop a quality improvement project to address health disparities, to Oregon, which has an entire 26-page Exhibit K dedicated to social determinants of health and equity requirements, and is separately attached.
- While most MMC contracts reference the concept of health equity, the contract requirements are primarily focused on the reduction of heath disparities within the contractor's Medicaid member population. Oregon is an exception and includes requirements that attempt to address social determinants of health and underlying power structures in the pursuit of health equity at a broader, community level.

In this document, each state's contract language is organized in a chart that begins with an overview of the contract language. Website links to the full contracts are included where available. Excerpts from the MMC contract language are organized into specific categories and measures identified by the state as equity or disparities measures. The categories may appear in a different order in the underlying MMC contract but are presented in this table in the following order as applicable to the MMC contract: General Language, Population/Community Health Management, Measurement and Data Analytics, Interventions, Monitoring Performance, Quality Improvement, Specialized Initiatives, and Other.

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Contents

Michigan

Medicaid Health Plan (MHP) contract: https://www.michigan.gov/documents/contract_7696_7.pdf

Overview
Michigan's population health management strategy includes requirements related to disparities reduction and promotion of health equity. The state is using capitation withhold and quality-based auto-assignment programs to reward MHP performance in reducing racial disparities and improving regionally-defined performance. Contractors are required to perform data analytics to identify disparities and implement and report on the effectiveness of evidence-based interventions that are designed to reduce health disparities and to promote health equity. *Michigan Health Plan performance is evaluated on health equity HEDIS measures, among other performance measures. MI Medicaid Managed Care has a special low birth rate initiative related to reducing racial disparities in maternity outcomes.*
General Language
Contractor must provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and wellbeing. Effective utilization of these principles will maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. This includes the management of high-utilizers. Population health management also includes an overarching emphasis on health promotion and disease prevention and will incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities.
Population/Community Health Management
X. Population Health Management **A. Data Aggregation, Analysis, and Dissemination** **1. General** a. Contractor recognizes that Population Health management interventions are designed to address the Social Determinants of Health, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve Health Equity. b. Contractor must develop protocols for providing Population Health management services where telephonic and mail-based care management is not sufficient or appropriate, including the following settings: i. At adult and family shelters for Enrollees who are homeless ii. The Enrollee's home iii. The Enrollee's place of employment or school c. Contractor must implement the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at http://www.thinkculturalhealth.hhs.gov/.

MICHIGAN Continued

Measurement and Data Analytics

X. Population Health Management

A. Data Aggregation, Analysis, and Dissemination

2. Data Analysis to Support Population Health Management

Contract must utilize information such as medical and dental claims data, pharmacy data, and laboratory results, supplemented by UM data, Health Risk Assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including:

- Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level.
- Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.

3. Data Submission and Data Reporting

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

Performance Monitoring

Appendix 4 – Performance Monitoring Standards

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

The Performance Monitoring Standards address the following:

- MDHHS Administrative Measures
- Healthy Michigan Plan (HMP) Measures
- Healthy Michigan Plan Dental Measures
- CMS Core Set Measures / Health Equity HEDIS / HEDIS / Managed Care Quality Measures

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

MICHIGAN Continued

Interventions

D. Providing Care Management Services and Other Targeted Interventions

2. Targeted Interventions for Subpopulations Experiencing Health Disparities:

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

See Appendix for Michigan's Health Equity HEDIS Performance Monitoring Standards for the 2019-2020 contract year.

Specialized Initiatives

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

In June 2017, the Michigan Medicaid Managed Care Plan Division (MCPD) identified Low Birth Weight (LBW) as a target outcome associated with the FY 2018 Pay for Performance (P4P) Initiative for the Medicaid Health Plans (MHPs). The LBW P4P initiative supports and aligns with the Medicaid Health Equity Project, which was initiated by MCPD in 2011 to promote health equity and monitor racial and ethnic disparities within the managed care population...The LBW-CH measure specification will be used to analyze and report state-wide Medicaid managed care data, which will be stratified by prosperity region and race/ethnicity. This breakdown of the date will identify health disparities and methods to improve quality care and services to pregnant women and infants. Project Goal: MCPD is launching this multi-year statewide Pay for Performance (P4P) initiative to align MDHHS efforts to promote health equity in maternity care and infant care.

For FY 2018, the goal is to involve the MHPs, existing home visiting programs, and community health worker programs to design and implement a meaningful P4P project. In order to improve infant health outcomes, the initiative will address documented health disparities and health inequities with particular focus on reducing the LBW-CH rate. The activities in FY18 will include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health. They will also incorporate parties who focus on maternity care to identify and implement models of choice through collaborative processes.

Other

Contractor must fully and completely participate in the Medicaid Health Equity Project and associated initiatives and report all required information to MDHHS within the specified timeline.

Minnesota

Minnesota DHS Contract for Prepaid Medical Assistance and MinnesotaCare:
https://mn.gov/dhs/assets/2020-fc-model-contract_tcm1053-413653.pdf

Overview
Minnesota requires at least one quality improvement project to address health disparities, and that a description of this project be published on the MCO's website. A listing of the MCOs quality improvement websites is included within the Appendix. Healthy disparities focused MCO quality improvement activities include: Blue Cross MN's program to increase colorectal cancer screenings among members of color; HealthPartners program to increase member's with disabilities access to dental care; and Hennepin Health's program to reduce racial disparities in depression management.
Quality Improvement
7.8 Annual Quality Program Update. Annually, the MCO shall demonstrate how the MCO's Quality Improvement Program identifies, monitors and works to improve service and clinical quality issues relevant to the MHCP Enrollees. The MCO shall submit, on or before May 1st of the Contract Year, a web site link to a public web page associated with the MCO describing quality improvement activities that have resulted 2020 Families and Children; MCO 2020 - 139 - 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.

North Carolina

Medicaid Prepaid Health Plan Model Contract (not yet implemented):
https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf

Overview
North Carolina was expected to transition from fee for service to MMC. Their MMC RFP would have moved their Medicaid program to a capitated, full-risk managed care program where the contractors are referred to as Prepaid Health Plans (PHPs). The managed care awards, which included both regional and statewide contracts, were set to go live on 2/1/2020 but have been indefinitely delayed due to the North Carolina General Assembly failing to provide new spending or program authority to transition to managed care[1] as well as Medicaid MCO procurement protests.[2] *Promoting health equity through reduction of health disparities will be a focus within North Carolina's Quality Management and Quality Improvement requirements. PHPs will identify disparities and implement interventions through their population health management programs to reduce disparities.*
Measurement and Data Analytics
E. Quality and Value **1. Quality Management and Quality Improvement** **j. Disparities Reporting and Tracking** • The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures. • The PHP shall address inequalities as determined by the Department during review of the PHP's performance against disparity measures. The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.
Quality Improvement
E. Quality and Value **1. Quality Management and Quality Improvement** .. [NC] will work with the PHP to develop a data-driven, outcomes-based continuous quality improvement process that builds upon this history and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards PHPs and, in turn, providers for advancing quality goals and health outcomes. The PHP shall have a robust Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan. The Quality Management and Improvement Program Plan shall include: • Mechanisms to conduct and assess performance improvement projects (PIPs) specified by the Department; • Mechanisms to assess the quality and appropriateness of care for Members with special health care needs

[1] https://medicaid.ncdhhs.gov/
[2] https://news.bloomberglaw.com/health-law-and-business/insight-its-a-legalpalooza-for-north-carolina-medicaid-managed-care-contracts

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

Ohio

Medicaid Managed Care Plan (MCP) Agreement:
https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/Medicaid-Managed-Care-Generic-PA.pdf

Overview
Ohio's Medicaid Managed Care Plans (MCPs) are required to identify health disparities in health care access, services and outcomes based on member demographic data. MCPs are required to address health disparities through their quality improvement requirements, which include implementing interventions and evaluating their success. Most of the health disparities language is in Appendix K: Quality Care.
General Language
Appendix K Quality Care **k. Addressing Health Disparities** According to the U.S. Department of Health and Human Services' Office of Minority Health, a health disparity is "a particular type of health difference closely linked with social or economic disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location). Support of ODM's health equity efforts includes having MCP health equity representatives actively involved in improvement initiatives, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. These efforts move beyond agenda setting, and instead focus on the work needed for change to occur, and place greater responsibility for improvement on all parties participating in improvement efforts.
Measurement and Data Analytics
Appendix K Quality Care **k. Addressing Health Disparities** In support of ODM's effort to achieve health equity, the MCP shall collect and meaningfully use race, ethnicity and language data to identify and reduce disparities in health care access, services and outcomes. **7. Quality Improvement Program** <u>QI Initiative Staffing</u> i. Quality improvement teams shall be composed of MCP staff dedicated to the Ohio line of business that represent the following areas of expertise: • Continuous quality improvement, • Analytics, • Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts, • Health equity, • Member- and provider-perspectives; and • MCP policies and processes related to the improvement topic.

OHIO Continued

Quality Improvement Continued

Appendix K
Quality Care
ii. Required QI responsibilities include:

- Frequent and ongoing data analysis to quickly determine the effectiveness of interventions;
- Frequent communication with team members and the senior leadership team regarding the status of improvement projects, intervention successes and failures, data used to determine success, lessons learned, opportunities and progress;
- Analyzing data to identify disparities in services and/or care and tailoring interventions to specific populations when needed;

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

QAPI Program Impact and Effectiveness
The MCP shall evaluate the impact and effectiveness of each effort within the QAPI program, including efforts to reduce health disparities. The MCP Medicaid Managed Care Appendix K Quality Care Rev. 1/2019 Page 149 of 218 shall update the QAPI program based on the findings of the self-evaluation and submit both the evaluation results and updates annually to ODM for review and approval following the template provided in the QAPI guidance document. Evaluation should, at a minimum, include:

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

Other

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

Oregon

Medicaid CCO 2.0 Contract: https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf

Overview
Oregon contracts with Coordinated Care Organizations (CCOs) to provide Medicaid managed care services to members in defined regions. In January 2020, 15 CCOs began service to Oregon Health Plan members across the State under its CCO 2.0 contracts. Oregon's CCO 2.0 contract requirements are intended to reduce health disparities, address the social determinants of health, and to promote health equity. The contract dedicates an entire section, Exhibit K, to requirements associated with SDOH and Health Equity. For ease of reading, Exhibit K has been attached in its entirety as an appendix to this document. The other requirements related to disparities or health equity that OR included in different sections of the contract are included in the table below. *The key requirements of the Oregon contract include: the creation of a Community Advisor Council to advise the Contractor on serving the health care needs of the entire community, working in partnership with public and community partners, the collection of demographic and health data and the creation of a community health improvement plan for not just members but for all of the communities within the contractor's service area, the development of a spending proposal to address housing and other SDOH-E priorities, the sharing of any quality incentive dollars received with the Contractor's community partners, and requirement to consider disparities in evaluations.*
General Language
Exhibit B –Statement of Work - Part 3 Patient Rights and Responsibilities, Engagement and Choice 1. **Member and Member Representative Engagement in Member Health Care and Treatment Plans.** Contractor shall actively engage Members, Member Representatives, and their families as partners in the design and implementation of Member's individual treatment and care plans, with ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Contractor shall ensure that Member choices are reflected in the development of Treatment Plans and Member dignity is respected… Contractor shall demonstrate how it: • Engages Members to participate in development of holistic approaches to patient engagement and responsibility that account for SDOH and health disparities;
Measurement and Data Analytics
Exhibit B –Statement of Work - Part 8 Accountability and Transparency of Operations c. Contractor shall assist OHA with development and distribution of survey instruments and participate in other evaluation procedures established by OHA for evaluating Contractor's progress on payment reform and delivery system change including the achievement of benchmarks, progress toward eliminating health disparities, results of evaluations, customer satisfaction, use of Patient-Centered Primary Care Homes (PCPCHs), the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA its external review organizations, or any of its other designees, agents, or subcontractors (or any combination, or all, of them).

OREGON Continued

Quality Improvement

Exhibit B –Statement of Work - Part 10
Transformation Reporting, Performance Measures and External Quality Review

2. Transformation and Quality Strategy (TQS) Requirements

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

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

(1) In accordance with the State's 1115 Waiver, strategies and related activities to improve Quality and appropriateness of care and Health Equity with respect to REAL+D, Cultural Competency, and CLAS standards and criteria.

4. Performance Measures: Quality Pool Incentive Payments

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

b. Contractor will, if it meets certain metrics related to performance or improvement in a Measurement Year, receive a monetary Payment from the Quality Pool. Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings.

The distribution plan must include: An overview of the methodology and/or strategy used to distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Equity and public health partners, that provides information related to the Contractor's process of evaluating the contributions of Participating Providers and connecting those evaluations to distribution of funds;

5. Performance Measure Incentive Payments for Participating Providers

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

6. Performance Improvement Projects

b. Contractor shall undertake PIPs that address at least four of the eight focus areas listed below... One of the four shall be the Statewide PIP…. In order to satisfy the requirements set forth in 42 CFR §438.358 and 438.330(a)(2) Contractor shall select an additional three (3) PIPs from the list as follows:

(8) Social Determinants of Health and Equity.

OREGON Continued

Performance Monitoring

Exhibit H – Value Based Payment

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

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

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

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

Other

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

10. Delivery System Dependencies

Intensive Care Coordination for Prioritized Populations and Members with Special Health Care Needs (1) Contractor shall prioritize working with Members who are eligible for ICC Services and communities experiencing health disparities (as identified in the Community Health Assessment). Contractor shall actively engage such Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable Emergency Department visits and Hospital admissions.

Definitions

"**Health Equity**" means a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all sectors across Oregon, including Tribal governments, to address the equitable distribution or redistributing of resources and power and recognizing, reconciling and rectifying historical and contemporary injustices. **"Health Equity Plan"** means the Health Equity plan required to be drafted by Contractor and provided to OHA in accordance with Ex. K

"Social Determinants of Health and Equity" and **"SHOH-E"** each means the social, economic, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Social Determinants of Health fall into the following domains: neighborhood and built environment, economic stability, education, and social and Community health [3].

"Learning Collaborative" means a program in which CCOs, State agencies, and PCPCHs that provide or perform the activities that serve Health System Transformation objectives, achieve, the purposes of the Contract, and share: (iii) best practices and emerging practices that increase access to Culturally and Linguistically Appropriate care and reduce health disparities;

[3] 410-141-3735

Washington, D.C.

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

Overview
Washington, DC's Medicaid Managed Care Organizations (MCOs) are required to identify health disparities in health care utilization and in health outcomes based on member demographic data including race/ethnicity, language, by DC ward and social determinants of health. MCOs are required to address health disparities through their quality improvement requirements, which include implementing interventions and evaluating their success.
General Language
SECTION C: Specifications/Work Statement C.1.2 The goal of the Medicaid Managed Care Program (MMCP) through this RFP is to promote healthy outcomes of the enrolled populations in the most cost-effective manner possible. The District's Medicaid population is diverse, including individuals with existing complex medical and social needs and those at high-risk or increasing risk for health care disparities. The low-income population may be impacted by a range of social factors, including homelessness that must be recognized within effective plans of care. The MMCP shall have a clear focus on achieving better health outcomes, health care innovation and cost-effective quality healthcare. It is the intent of this RFP to significantly strengthen the managed care delivery system for eligible DC residents who receive services through the DCHFP and Alliance.
Measurement and Data Analytics
C.5 Requirements **C.5.32 Quality Assessment and Performance Improvement (QAPI)** Analyzes data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees; C.5.32.3 CQI Plan 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; C.5.32.6 Performance Measures Contractor shall: identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language); identify social determinants of health; and identify the causes for health disparities.
Quality Improvement
C.5.32 Quality Assessment and Performance Improvement (QAPI) Develops system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of Emergency Services; C.5.32.6 Performance Measures Contractor shall: identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language); identify social determinants of health; and identify the causes for health disparities. The Contractor shall develop a plan of action and a timeline to remediate the social determinants of health and health disparities identified through targeted interventions and include this plan and timeline in the Contractor's QAPI program and CQI plan submissions to DHCF. This plan of action shall include a performance measurement and evaluation component, in coordination with section C.5.32.6.

Covered California

Covered California 2017 Individual Market QHP Issuer Contract, Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy:
https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-7_2020_Clean_Final-Model.pdf

Covered California's QHP Measurement Specifications Appendix 2 to Attachment 7
https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Jan-16-2018/Appendix-R-Attachment-7_Measurement-Specifications_2017-02-24.pdf

Covered California's QHP Performance Standards (Attachment 14):
https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-14_2020_Clean_Final-Model.pdf

Overview

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

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

As part of its quality measurement specifications and related reporting defined in Appendix 2, QHPs must report approximately half of the required QHP measures separately by race/ethnicity.

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

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

The contractual requirements for Health Equity and Health Disparities are organized in Article 3 in Attachment 7 to Covered California Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy.

ARTICLE 3: Reducing Health Disparities and Ensuring Health Equity
Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

COVERED CALIFORNIA—CONTINUED

Measurement and Data Analytics

3.01 Measuring Care to Address Health Equity

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

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

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

3.03 Expanded Measurement

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

Quality Improvement

NCQA Multicultural Health Care Distinction is encouraged but not required. Contract language:

3.04 NCQA Certification

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

COVERED CALIFORNIA—CONTINUED

Quality Improvement

QHPs are required to participate in one quality collaborative, Smart Care California, which addresses performance in populations/measures that have significant documented Health Disparities: C-section rates, prescription of opioids and appropriate treatment for low back pain/chronic pain. Contract language is below:

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

1) Effective January 1, 2017, Contractor must participate in:
(a) Smart Care California: Sponsored by Covered California, DHCS, and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will provide guidance and steer the delivery system to drive appropriate use of C-sections, prescription of opioids, and low back pain. https://www.iha.org/our-work/insights/smart-care-california

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

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

Interventions

In 2019 Covered California began requiring QHPs to choose 1-2 disparities based on review of plan specific measurement across 14 measures selected by Covered California that are determined to be disparities sensitive by the National Quality Forum. The contract language for these requirements are below.

3.02 Narrowing Disparities
While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level.

Covered California and the Contractor agree that collection of data on clinical measures for the purpose of population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

COVERED CALIFORNIA--CONTINUED

Interventions (continued)

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

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

Other

Performance Guarantees outlined in Attachment 14 of the QHP contracts include the following TWO metrics related to health equity:

3.4a) Reducing Health Disparities – Attachment 7, Article 3, Sections 3.01 and 3.02 – 2% of total performance penalty for Group 3
Contractor will meet intermediate milestones for self-reported racial or ethnic identity by the end of 2018, and will meet the target of 80% self-reported racial or ethnic identity by the end of 2019. Contractor will continue to meet the 80% target during Measurement Year 2020.

Baseline data was used to set an incremental target for 2018 based on information submitted in 2016, 2017, and 2018 via the Applications for Certification for 2017, 2018, and 2019. Contractor and the Exchange have established a mutually agreed upon performance goal which will be documented in the Contractor's Quality Improvement Strategy. Data will be submitted by Contractor in a run chart demonstrating improvement in percentage of self-reported identity compared to baseline reported.

3.4b) Reducing Health Disparities – Attachment 7, Article 3, Sections 3.01 and 3.02 – 3% of total performance penalty for Group 3

Contractor reports required metrics across all lines of business excluding Medicare for diabetes, asthma, Hypertension, and depression by race/ethnicity. The Exchange and Contractor will select at least one, but not more than two disparity measures against which performance in 2020 will be assessed. If the Contractor selects two disparities measures for setting 2020 performance targets, the performance level will be assessed at 1.5% for each measure. Performance will be measured based upon the mutually-agreed upon milestones in the final, Disparity Intervention Proposal which shall be incorporated into this Attachment 14 without an amendment to the Contract.

Performance Requirements: No Assessment for Measurement Year 2017, 2018, 2019

Measurement Year 2020 Performance Levels:
Contractor does not select at least one disparity measure for reduction or does not meet mutually agreed upon milestone(s) selected for the 2020 disparity reduction target: 3% penalty
Contractor meets mutually agreed upon milestone(s) selected for the 2020 disparity target: 3% credit

COVERED CALIFORNIA (Continued)
Definitions
Health Disparities - Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP). Health Equity - Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Appendix:

Michigan: Health Equity HEDIS Measures

HEALTH EQUITY HEDIS MEASURES

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

(*) indicates that this measure is run with Symmetry

Minnesota: MCO Quality Improvement Websites

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

[i] For example, managed care state quality strategies are required to include the state's plan to "identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status."(42 CFR 438.340 (b).