

Promote Health Equity:

Advancing Primary Care Innovation in Medicaid Managed Care

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Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of *Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit*, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit www.chcs.org/primary-care-innovation.

Health equity — the absence of unfair, avoidable, or remediable differences in health among social groups — can be understood as both a process and an outcome.¹ It is the process of sharing power among people to invest and distribute resources to those with greatest need, with the goal of creating just opportunities that result in the elimination of health disparities.² To achieve health equity, focus must be placed on communities historically excluded, exploited, and deprived of needed resources because of their race, ethnicity, language, gender identity, disability, sexual orientation, or location.³

In particular, communities of color in the U.S. can have less access to primary care and worse health outcomes — inequities that often stem from structural and interpersonal racism.^{4,5} For example, Black people can have more difficulty scheduling timely primary care appointments, have fewer primary care practices in their neighborhoods, can spend more time seeking care, and are more likely to report unfair treatment and discrimination in medical settings.^{6, 7, 8, 9, 10} As a result of these inequities, life expectancy for Black people is substantially lower than that of white individuals — a gap that has widened during the COVID-19 pandemic.^{11,12}

Medicaid covers roughly one-third of Black individuals, Latinos, and American Indians and Alaskan Natives in the U.S., and 10 million people with disabilities.^{13,14} Therefore, Medicaid can serve as an important tool to advance health equity broadly, and improve primary care for marginalized communities, specifically. In the context of larger health reforms, it can help ensure that high-quality primary care is available to every person and family in all communities.¹⁵

This module outlines how states can use their Medicaid managed care programs to strengthen primary care, reduce health disparities, and advance health equity. It primarily focuses on advancing equity for communities of color, and acknowledges the importance of achieving health equity for other marginalized communities, as well as the intersectionality of systems of oppression, such as ableism and sexism, that affect health and well-being.¹⁶

States are in early stages of defining and working toward explicit health equity goals related to primary care and managed care, and few states have published outcomes for this work. The examples included in this toolkit are intended to serve as a starting point for states seeking to establish targeted health equity goals, with the aim of designing more advanced goals in the future.

PROMOTE HEALTH EQUITY: Design Considerations Summary

States interested in advancing health equity in primary care will want to consider opportunities to:

- ✓ Partner with communities to design a more equitable primary care system.
- ✓ Define the state's goals relating to health equity and primary care, within Medicaid and across state government.
- ✓ Monitor and enhance access to primary care.
- ✓ Promote the collection of race, ethnicity, and language data.
- ✓ Integrate health equity goals into existing and emerging primary care transformation efforts.
- ✓ Target social needs associated with health inequities.
- ✓ Address disparities in behavioral health treatment.
- ✓ Design value-based payment models to promote more comprehensive and equitable care.
- ✓ Hold managed care organizations accountable for progress toward the state's health equity and primary care goals.



Design Considerations

✓ Partner with communities to design a more equitable primary care system.

In their role as policymakers and conveners, states can best serve communities experiencing inequities by committing to the principle: “nothing about us without us.”¹⁷ By engaging communities and meaningfully connecting engagement work to decision-making, states can develop more effective policies, including those that advance more comprehensive and equitable primary care.¹⁸

In approaching this work, states should seek to elevate people with lived expertise and earn trust. Because of logistic challenges and limited resources, it may be difficult for states to establish comprehensive community engagement strategies and compensate people for their contributions. States can consider alternative funding and partnership models to support this work. For example, **California**’s state Medicaid agency partners with foundations to secure additional funding for community engagement, which covers travel expenses and a per diem payment for community members.¹⁹ Many states also call upon advocacy organizations, trusted local institutions like health centers, and accountable communities of health to inform primary care priorities.

State community engagement efforts should ideally include a variety of forums, strategies, and partners to capture community and consumer input on primary care and health equity initiatives. State Medicaid agencies can work with Medicaid members through their Medical Care Advisory Committees, and supplement this baseline requirement with other strategies, such as public forums, listening sessions, targeted workgroups, surveys, focus groups, online feedback tools, or a separate member advisory council (as in **Virginia** and **Colorado**).^{20,21,22}

For example, **Oregon** gathers community input and member perspectives at several levels. At the primary care policy level, a health care advocate participates on Oregon’s Primary Care Payment Reform Collaborative to offer a consumer perspective, and the Primary Care Office hosts a listening series to engage communities on health equity priorities relating to the behavioral health workforce and the Patient-Centered Primary Care Home (PCPCH) program.²³ At a broader state policy level, the Oregon Health Authority hosts public listening sessions to gather feedback on proposed equity-focused quality metrics and largescale Medicaid reform initiatives.²⁴ Through its managed care program, Oregon’s coordinated care organizations work with tribal liaisons and a tribal advisory council, and use a Community Advisory Council to set priorities for health equity and social needs investments and co-develop tools, including a community health assessment and community health improvement plan.^{25,26} At the regional level, regional health equity coalitions engage with communities to identify sustainable and long-term policy, system, and environmental solutions to increase health equity in Oregon.²⁷

The Oregon Health Authority's community engagement strategies checklist helps to guide these activities, including questions such as:

1. Are community partners leading the direction of the work, or are we plugging them into our agenda?
2. Is there shared decision-making with all parties impacted?
3. Are community partners at the intersections (e.g., people of color with disabilities) who are most impacted by the topic or issue, present and fully participating?
4. Are there more accessible ways for information be conveyed (e.g., visuals, audio presentation, role-play)?²⁹

It is also important for states to consider how to accommodate the needs of communities in developing these engagement and partnership mechanisms. For instance, to engage non-English speaking communities, who are particularly likely to be left out of community engagement activities,³⁰ states can ensure that activities are conducted in multiple languages — as **New York** did when conducting focus groups to better understand community experiences seeking care.³¹ Using multiple modalities and languages for engagement increases opportunities for different community members to give input and partner in decision-making processes to advance equity in primary care.

✓ Define the state's goals relating to health equity and primary care, within Medicaid and across state government.

To advance health equity, states should examine a wide variety of programs and structures, develop shared definitions of key terms (like "health equity" and "disparities"), and identify comprehensive short- and long-term goals and activities to move the work forward. For example, the **Pennsylvania** Department of Human Services developed a Racial Equity Report for 2021, which included not only an overview of Medicaid managed care initiatives, but also initiatives related to economic justice, early childhood education, and child welfare.³²

Within this broader context, states should assess existing primary care and managed care initiatives and how they can be strengthened and supported to improve care for people of color and other marginalized communities. This assessment can guide states in developing clear health equity goals related to primary care, the needs of communities, and ensuring accountability. Goals might be narrowly targeted toward specific activities or outcomes in primary care, such as improving maternal and infant outcomes for Black enrollees, or broader, like decreasing all racial/ethnic health disparities in primary

Request for Proposal Excerpts: Minnesota²⁸

Following is sample Minnesota managed care request for proposal (RFP) language related to health equity:

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



care through improved access to high-quality, comprehensive primary care. These goals can be tracked at the state, Medicaid agency, and plan levels, and could use existing frameworks — such as quality measures embedded in MCO incentive and withhold arrangements or broader system-level measures like “the health of primary care” scorecard in a recent National Academies of Science, Engineering, and Medicine (NASEM) report.³³ As an example, **Oregon** set a goal to eliminate health inequities by 2030 and is exploring ways to support this goal through its PCPCH program, a diversified health care workforce, and telehealth that works better for those with limited English proficiency, among other broader strategies.^{34, 35}

States can also embed primary care health equity goals in the managed care state quality strategy, and set priorities related to targeted health disparities and populations.³⁶ For example, **Minnesota’s** quality strategy notes specific disparities in prematurity, low birth weight, and infant mortality among Black individuals and American Indians, and describes targeted goals relating to these inequities.³⁷ A similar strategy could be applied to primary care goals. For example, a state might focus on access to and experience of care during well-child visits and establish objectives for managed care to reduce or close racial disparities. Recurring reports, like **Michigan’s** annual Health Equity Report, can help states consistently track progress on quality goals relating to health equity in a way that is transparent to all stakeholders.³⁸ Using these reports to highlight metrics tied to provision of primary care — including immunization rates, well-child visit rates, and blood sugar control for diabetic patients — can reinforce a state’s primary care health equity goals.

Formal teams and offices can also empower state staff to work toward addressing these issues. In 2019, the **Louisiana** Department of Health established an Office of Community Partnerships & Health Equity and developed a Health Equity Framework and Action Plan, which authorized a series of Health Equity Action Teams (HEATs) throughout the Louisiana Department of Health.^{39, 40} The Medicaid-specific HEAT includes diverse members from multiple sections in the Medicaid agency, including the Quality Improvement and Innovations Section, which helps oversee Medicaid managed care and primary care initiatives. The state’s “barriers to health” fact sheet notes five state health priorities (maternal health, cancer, HIV, Hepatitis C, and behavioral health) and lists associated structural and social determinants of health.⁴¹ To work toward these priorities, the state’s most recent RFP asks prospective MCOs to reflect on inequities relating to: low birth weight, postpartum care, colorectal and cervical cancer screening, and HIV viral load suppression, among other quality measures.⁴²

✓ Monitor and enhance access to primary care.

Many people, including communities of color, rural residents, and individuals with disabilities, have inequitable access to primary care, which can lead to disparities in health outcomes.⁴³ To respond to this challenge, states can monitor primary care access in Medicaid managed care programs (e.g., compliance with time and distance standards, among other quantitative network adequacy standards), with a specific focus on communities experiencing health disparities.⁴⁴ For example, states can use mystery or secret shopper programs, geospatial analysis, available claims data, and existing Federal Health Resources Services Administration data and tools to examine primary care access in communities of color.^{45,46} The analysis can also occur in a variety of contexts, such as external quality review, contract monitoring and enforcement, or MCO reporting.

States can ensure that plans connect enrollees to a regular source of primary care, either through enrollee election of a primary care provider or auto-assignment, and consider ways to improve auto-assignment methodologies to direct enrollees to primary care providers that offer high-quality, equitable care.⁴⁸ States can also ensure that, per federal rule, American Indian/Alaskan Native enrollees have timely access to primary care through health care programs operated by the Indian Health Service or by an American Indian Tribe, Tribal Organization, or Urban Indian Organization.⁴⁹

Once gaps are identified, states can also think holistically about opportunities to reduce disparities in primary care access. Potential options could include: Medicaid expansion, robust and responsive non-emergency medical transportation programs, and targeting enhanced payments to primary care practices in low-access areas — particularly in the aftermath of the COVID-19 pandemic.

Finally, state Medicaid agencies should communicate program needs to state legislatures. Clear communication about the needs of Medicaid programs — and the likely effect of inaction — can help states craft a cohesive approach to addressing longstanding health inequities, including primary care and behavioral health care provider shortages. For example, state legislatures can help craft cross-agency initiatives relating to workforce diversity and primary care investment, and authorize more funding for the Medicaid program to prevent or alleviate access to care obstacles.^{50, 51}

✓ Promote the collection of race, ethnicity, and language data.

Race, ethnicity, and language (REL) data enable states and health care organizations to identify racial and ethnic health disparities, and track progress in reducing these disparities. MCOs often collect and analyze REL data and can use this data to identify ways to improve care and reduce disparities in the context of quality and performance improvement and population health management. States can explicitly require these activities in their managed care contracts, or, like **Pennsylvania** (in its Medicaid program) and **California** (through its health insurance exchange), require that plans attain NCQA Distinction in Multicultural Health Care.⁵²

Request for Proposal Excerpts: Louisiana⁴⁷

Following is sample Louisiana managed care request for proposal (RFP) language related to health equity:

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



Strong data-sharing practices between MCOs and primary care teams can help reconcile REL data, standardize data collection practices, and verify data accuracy.⁵³ REL data collection may occur during multiple touchpoints, including by: (1) the state or its enrollment broker during Medicaid enrollment; (2) the MCO during health risk assessments or other contacts with members; and (3) primary care teams through patient intake. The routine contact and closer relationships between primary care teams and individuals makes primary care a natural setting in which to fill gaps and confirm accuracy of existing REL data. For example, MCOs may send REL data in member attribution files to primary care teams and provide incentives to these teams to supplement this data. Additionally, MCOs can send quarterly performance reports that include stratified performance data relating to state health equity and quality goals — such as for postpartum care or HbA1c testing quality measures.

Once REL data has been collected, states, MCOs, and primary care teams can use this data to stratify quality metrics to identify plan- or practice-specific health equity priorities. This data can also enhance practice-level quality improvement activities, such as equity-related patient-reported measures.⁵⁴

Finally, data limitations should not stop work relating to health equity. REL data collected at the state, plan, or provider level can be a powerful tool, but are not the only sources of data. Census-level data and qualitative data gleaned from community engagement activities can also help states identify primary care priorities for health equity and inform the design of health equity-focused interventions.⁵⁵

✓ **Integrate health equity goals into existing and emerging primary care transformation efforts.**

States often have patient-centered medical home programs and other primary care transformation efforts underway and can integrate explicit health equity goals into that work. For example, **Ohio** modified its longstanding comprehensive primary care program to include a specific patient experience requirement for 2021 relating to cultural competence and implicit bias training.⁵⁶ States can also modify these programs to incorporate existing standards and certifications, like the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.⁵⁷

States can also direct MCOs to advance health equity goals through targeted primary care innovations. As an example, states could seek to scale and spread primary care models and services associated with reductions in health disparities in maternal and infant health outcomes, such as group prenatal care and community health worker models.

States can make it easier to provide these modes of care through payment and policy reform and set clear expectations for MCOs. States may consider: (1) adding relevant benefits and billing codes; (2) crafting payment models that allow for team-based, patient-centered modes of care, with a preference for multi-payer efforts whenever possible; and (3) directing MCOs to explore these models in the context of a performance improvement project (PIP), MCO incentive arrangement, value-based payment program, or network provider training. For example, **Michigan** requires its MCOs to work with primary care practices to develop evidence-based approaches to reduce disparities and to support the design and implementation of community health work interventions, which are “tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience.” Community health workers can accompany

clients to, and participate in, office visits, advocate for clients with providers, and problem-solve barriers to care, among other activities.

Likewise, states could call on MCOs to adapt and codesign telehealth and digital health tools to improve primary care access for marginalized communities, embed interpreters into telehealth workflows, and connect members to low-cost internet and digital devices.^{58, 59}

For more on team-based care, behavioral health integration, and technology, see the [Conceptualizing and Designing Core Functions](#) section of this toolkit.

✓ Target social needs associated with health inequities.

Structural drivers of health inequity negatively impact social determinants of health for marginalized communities and produce health inequities.⁶⁰ For example, structural racism negatively impacts Black people's access to quality food, housing, and education, and is the root cause of social issues such as mass incarceration.^{61, 62, 63} Achieving health equity will require an examination of the social and structural drivers of health inequities, beyond broader social determinants of health.

Within this context, state Medicaid agencies can build cross-sector partnerships that seek to identify and address individual- and community-level social needs that impact health, as well as define a specific role for primary care teams and MCOs in the overall system. This process includes defining appropriate upstream, midstream, and downstream efforts related to social determinants of health, and assessing systems and structures that produce and perpetuate health inequities.⁶⁴

States can embed social care integration activities into primary care initiatives and programs, and define how MCOs can support these goals to advance health equity and improve care.⁶⁵ For example, **North Carolina** requires Advanced Medical Homes (AMHs) to assess the social needs of patients prioritized for care management, and develop care plans that address these social needs.⁶⁶ To support the primary care teams engaging in this work, MCOs must provide initial care needs screening results to AMHs, in addition to quality metrics and total cost of care data. MCOs then share consolidated care management data back to the state. In the future, the state will consider whether to require AMHs to screen for social needs more systematically and further encourage use of a statewide services referral system. Similarly, in the next phase of its managed care program, **Louisiana** will ask MCOs to describe, as part of its health equity plan, how they will partner with community-based organizations and reimburse network providers for screening for health-related social needs and submitting applicable diagnosis codes ("Z codes") on claims.⁶⁷

Building upon this multi-directional data sharing, states could require MCOs to provide primary care teams with actionable data on health disparities and associated social risk factors, and consider a suite of quality assessment and performance improvement strategies to close these gaps, including training, technical assistance, PIPs, and targeted investments. For example, **Oregon** expects coordinated care organizations to provide additional "health-related services" that include: (1) flexible services, such as fresh food prescriptions for members and legal assistance for housing-related issues; and (2) community-benefit initiatives, which can include health information technology integration with social resource and referral

systems in the primary care setting.⁶⁸ And **Nevada** requires MCOs to choose two PIPs from a list of potential topics, including “social determinants of health and health equity” and “increased access and use to primary care,” in addition to a statewide PIP on Black maternal and infant mortality.⁶⁹

In addition, states can create structures that coordinate statewide and regional health planning efforts across health care and other organizations, in partnership with communities. These activities can be done broadly for the Medicaid population, but can also be tailored for the needs of specific populations experiencing health inequities, such as people involved in the justice system or Black people who are pregnant. For example, **Pennsylvania’s** Regional Accountable Health Councils collaborate on regional social determinants of health needs assessments and identify high-priority geographic areas impacted by disparities.⁷⁰ Council members include MCOs and health centers that provide primary care, in addition to trusted community institutions.

For more on identifying and addressing health-related social needs, see the [Identify and Address Social Needs](#) module of this toolkit.

✓ Address disparities in behavioral health treatment.

Behavioral health care — including mental health and substance use — is an integral component of overall health. Structural factors, such as differential insurance status, stigma surrounding mental illness, and a lack of diverse and culturally competent behavioral health care providers drive health disparities in access to behavioral health care for many communities, including for people of color.⁷¹ The need for high-quality behavioral health treatment has only increased in the wake of the COVID-19 pandemic, which has led to widespread experiences of depression, toxic stress, and trauma.⁷²

Primary care teams and their MCO partners can work to address mental health disparities by tailoring behavioral health integration efforts to specific communities and patients, such as people with disabilities, Black individuals, Latinos, or LGBTQ+ youth experiencing homelessness.^{73,74,75,76} States may consider how to increase capacity and diversity in the behavioral health care workforce by identifying how to cover services from providers such as peer navigators,⁷⁷ who can use community connections and shared lived experience to promote health equity.⁷⁸ Trauma-informed primary care can further serve the behavioral health needs of populations who experience higher rates of trauma and the resulting negative impacts on mental and physical health.⁷⁹

For more on integrating behavioral health and primary care, see the [Integrate Behavioral Health Care](#) module of this toolkit.

✓ Design value-based payment models to promote more comprehensive and equitable care.

As noted in a recent NASEM report, payers should seek to “pay for primary care teams to care for people, not doctors to deliver services.” This change in focus recognizes primary care’s impact on “measures of population health, equitable outcomes, changing mortality and chronic disease prevalence trends, and overall increased health and well-being.”⁸⁰

To work toward this goal, state Medicaid agencies can design prospective and hybrid payment models that support comprehensive primary care and targeted health equity initiatives, as in **Washington State**.⁸¹ These new payment models

can promote financial stability and flexibility, and can enable more advanced primary care delivery, such as screening for and addressing health-related social needs, increasing access to care through use of technology, providing team-based care, and integrating behavioral health care into primary care.⁸²

States can also consider how to create new or modify existing primary care value-based payment models to explicitly incorporate health equity goals and monitor unintended effects of these models.⁸³ Value-based payment models that are not intentionally designed to promote health equity can mask existing or growing health disparities in the patient population by averaging indicators and exacerbate disparities by penalizing providers who serve members with more complex needs. This risk is a particularly salient concern for primary care providers who serve underserved communities or patients with a diverse set of health needs. For example, **Minnesota** requires their integrated health partnerships to develop a health equity measure and considers performance on these measures when calculating the performance-based payments.⁸⁴

States can also use value-based payment to support health centers, which have a long history of delivering culturally competent, comprehensive primary care and supportive services like translation.⁸⁵ For example, Medicaid MCOs, like the Community Health Plan of Washington, have explored alternative payment model pilots that seek to support whole person care at federally qualified health centers and reward health centers for taking on health equity goals.⁸⁶ Several states, including **Colorado**, **Oregon**, and **Washington State**, have also created state-led advanced payment models for health centers, which encourage investment in quality improvement and population health management strategies that could include health equity goals.⁸⁷

Primary care payment models sometimes experience a “chicken-egg conundrum,” where practices require flexible and enhanced financial support to enable care transformation, but cannot access that flexible funding without first demonstrating advanced capabilities.⁸⁸ To address these challenges, states may consider providing enhanced payments to primary care providers to begin care delivery transformation with a health equity focus, and enable multi-payer efforts to provide new, predictable, and sustainable revenue, tied to streamlined reporting requirements. This approach mirrors that of the Advanced Payment Accountable Care Organization model, which provided upfront payments for practice transformation and strengthened capacity to analyze population-level data used to analyze disparities in care.⁸⁹ For example, **North Carolina**’s Health Equity Enhanced Payment Initiative offers an enhanced payment to primary care practices serving individuals from parts of the state with high poverty rates. Participating practices commit to an initiative that advances health equity, such as recruitment of community health workers, health coaches, and doulas.⁹⁰

✓ **Hold MCOs accountable for progress toward the state's health equity and primary care goals.**

Finally, states should hold MCOs accountable for progress toward the state's goals related to primary care and health equity. For example, states can embed disparity-related measures, goals, and activities into MCO incentive and withhold arrangements, and quality-based auto-assignment methodologies. **Michigan's** 2021 bonus program rewards statistically significant improvement in disparities for Black individuals and Latinos relating to several primary-care related measures, including access to preventive/ambulatory health services.⁹¹ This bonus program is in addition to a longstanding bonus program dedicated to strategies to address disparities in low birth weight,⁹² as well as a robust monitoring program that examines stratified quality measures by region and race, ethnicity, and language and reports progress in an annual Health Equity Report.⁹³

For more information on MCO accountability, see the [Promote Accountability Mechanisms for Managed Care Organizations](#) module of this toolkit.

Promoting Health Equity through Primary Care: Examples of Medicaid Managed Care Requirements

Network Management and Training

The **District of Columbia** requires all managed care programs to have equal access to the District's major physician groups.⁹⁴

California MCOs (according to the state's draft RFP) "must provide annual sensitivity, diversity, cultural competency and Health Equity training for its staff, Network Providers, and Subcontractors. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, and Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the [Population Needs Assessment] findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

- (1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and
- (2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs."⁹⁵

Required MCO Staff

In **Ohio**, MCOs must staff a Family Engagement Director and Youth Engagement Director, who are responsible for obtaining input from populations experiencing disparities in access to care and building practices that promote racial equity.⁹⁶

Oklahoma MCOs must "maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Health Plan Enrollees and from Providers of direct services which are intended to reduce adverse health outcomes among Health Plan Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts."⁹⁷

In its most recent RFPs, **California** (a draft version) and **Louisiana** plan to require MCOs to maintain a full-time Health Equity officer/administrator.^{98, 99}

Quality Assessment and Performance Improvement

Nevada requires MCOs to participate in a statewide PIP focusing on reduction in maternal and infant morbidity and mortality among Black individuals. MCO quality improvement teams must include staff with expertise in health equity.¹⁰⁰

Washington State MCOs must "collaborate with peer MCOs and the [Department of Health] to form a Health Care Disparities Workgroup aimed at reducing disparities in one performance measure. The Health Care Disparities Workgroup shall consult with community experts and organizations as appropriate to disaggregate data on at least one performance measure and examine the data for racial/ethnic disparities. The Workgroup shall implement interventions aimed at reducing health care disparities in the selected measure."¹⁰¹

Population Health Management

Hawaii health plans must use “sophisticated IT infrastructure and data analytics to support DHS’ vision and goals for quality improvement, measurement and evaluation, including the capability to identify sub-populations by age, race, ethnicity, primary language, special populations, or other demographics experiencing disparities. The Health Plan shall also use predictive analytics to identify populations at risk for poor health outcomes and high cost, stratify and report metrics at the state and regional or service area level, and by sub-population, and be able to report data at the patient or provider level to DHS as required.”¹⁰²

Utilization Management

Washington State MCOs must “have written policies for applying [Utilization Management Program] decision-making criteria based on individual Enrollee needs, such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as [Adverse Childhood Events] for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care; and the availability of services in the local delivery system.”¹⁰³

Value-Based Payment

Ohio includes a bonus payment for its Comprehensive Primary Care (CPC) for Kids program tied to foster care supports, school linkages, lead testing, and screening for adverse childhood experiences and health-related social needs. Each provider’s score is risk adjusted using data from the Ohio Opportunity Index, which includes domains like transportation, housing, and crime. The state requires MCOs to pay providers using state-defined criteria. In Fiscal Year 2021, Ohio requires CPC practices to conduct a cultural competency and implicit bias training.¹⁰⁴

MCO Accountability

Oregon has developed a specific quality measure in its quality incentive program, entitled “Meaningful Access to Health Care Services for persons with limited English proficiency.”¹⁰⁵

Rhode Island’s accountable entity and MCO incentive pool includes the following pay-for-reporting measure: “Percentage of AE attributed lives with a primary care visit for whom their attributed primary care provider possesses their race, ethnicity and language data.”¹⁰⁶

ENDNOTES

- ¹ American Medical Association. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. 2021-2023. Available at: <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>.
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