STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

Promoting Health Equity in Medicaid Managed Care: *A Guide for States*

Authored by Bailit Health

Promoting Health Equity in Medicaid Managed Care: *A Guide for States*

Table of Contents

I. Introduction and Purpose

State Medicaid programs play a central role in transforming health care systems to improve the health of individuals and communities. Medicaid provides health care coverage to nearly 71 million people or roughly one in five Americans.[1] The Medicaid population is diverse, including adults with low-incomes, children, individuals who are pregnant, individuals with disabilities, and older adults. Population groups covered by Medicaid are often among the most economically and socially marginalized. Imbalances of power and opportunity rooted in the inequitable distribution of resources, racism, discriminatory policies and practices, and lack of decision-making influence contribute to disparate health outcomes in Medicaid. Medicaid's role in providing health care coverage to individuals who experience economic and social disadvantage is leading many states to integrate health equity into their population health management strategies, focusing specific attention on reducing health disparities and addressing conditions that create health inequities.

Health equity means that everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography or any other social barriers/factors. Advancing health equity is often characterized as 1) a process; 2) a way of being/doing; and 3) an end goal.[2] Working toward health equity involves reducing and eliminating disparities in health, with particular attention to disparities that are rooted in inequitable distribution of resources and other systemic factors, such as racism, discrimination, and bias, both historical and contemporary.

This guide describes recommended process steps for states to integrate a focus on health equity in their Medicaid managed care programs. It offers a series of concrete steps to be more intentional about advancing health equity in Medicaid, and specifically through Medicaid managed care programs. It focuses not on the end goal, but on the internal agency commitments and changes that are the necessary antecedent steps to addressing systemic barriers to accessing high-quality health care and improving health outcomes, particularly among populations that experience persistent health inequities. Thus, in the beginning, the work may be more process-focused until health equity is more firmly established in the norms, practices, and operations by which the agency functions and through which priorities are set and policy decisions made.

Table 1 includes key terms developed and used by State Health and Value Strategies (SHVS) and throughout this guide. As described later in this guide, Medicaid agencies should clearly define key terms related to health equity and expect to revisit their equity-related terms over time as the work evolves.

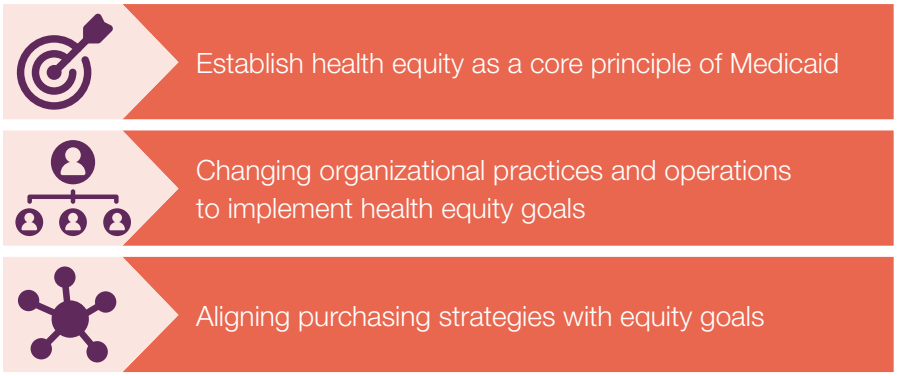
TABLE 1: Key Terms Related to Health Equity Developed by SHVS[3]

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, etc.). Measuring disparities can help benchmark progress towards equity.
Health equity	Health equity means 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. When focusing on racial equity in health, advancing health equity means dismantling the systemic racism that underlies differences in the opportunity to be healthy, including addressing social and economic barriers to positive health outcomes
Health inequities	Differences that are unfair and unjust without comparison to another group. An equity frame connects the dots between disparate outcomes and the disparities in power and privilege in which they are rooted. Focusing on disparities can lead to the assumption that one group's behavior, intelligence, or genetics are the cause of any differences. Focusing on inequities draws attention to the root causes of these differences.
Social Determinants of Health	The daily context in which people live, work, play, pray, and age and that affect health. Social determinants of health encompass multiple levels of experience from **social risk factors** (such as socioeconomic status, education, or employment) to structural and environmental factors (such as structural racism and poverty created by economic, political, and social policies). These latter factors are also known as **upstream factors**, or root causes of inequities. Factors closer to the individual level are known as **downstream factors**.

II. Overview of the Guide

The guide is organized into three primary sections, each containing specific actions for Medicaid agencies. The first section identifies the foundational components needed to initiate health equity work and deliberately establish equity as an agency-wide priority. The second section describes the internal organizational and operational changes needed to implement and sustain the work. Once those internal building blocks are established, Medicaid agencies can look to their managed care programs as one avenue to pursue their health equity goals. The third and final section identifies how states can leverage their managed care programs to advance health equity. (*Figure 1.*)

FIGURE 1: Promoting Health Equity in Medicaid



This guide presents the three overarching sections as steps in sequential order. Ideally, Medicaid agencies would build a solid foundation internally to inform their strategies with their managed care organizations (MCOs). This would help to ensure alignment across the Medicaid agency and managed care strategies to maximize impact. The guide is intended to provide a framework for state health officials wherever their state may be in the process of integrating a focus on health equity into their Medicaid programs. States should feel free to utilize the guide as is most effective for their Medicaid program and not feel constrained to follow the steps sequentially. The goal of the guide is to be a resource for states, which could mean working on a variety of the steps simultaneously or adapting the guide as needed. States that are already taking action with their MCOs will benefit from reviewing the internally focused steps to sustain health equity work and integrate it into the agency's culture and practices. Doing so will position Medicaid programs to align their vision and operations more effectively with that of their managed care program strategies.

FIGURE 2: Promoting Health Equity in Medicaid Managed Care

The steps identified for Medicaid agencies to promote health equity are presented in the guide in sequential order, but they are interconnected. Progress in one area may stimulate action in another so that agencies are working on multiple steps simultaneously. Medicaid agencies should adapt the guide to suit their environment.

Throughout this guide, the following icons are used to indicate community and member engagement practices and state examples, as described below.

Community and member engagement examples are represented with the arrow icon. There are points in the guide where the arrow icon is used to highlight specific community engagement activities that align with the definition of meaningful engagement described in the guide. This is not meant to suggest that actions without an arrow icon do not warrant community engagement.

Meaningful Community and Member Engagement: An Essential Cross-Cutting Practice

Addressing health inequities and eliminating health disparities require that Medicaid programs listen to and understand the priorities and experiences of those they are serving. It is imperative that states develop a formal engagement process with community members, particularly Black, Latino(a), Asian American/Pacific Islander and American Indian/Alaska Native populations, individuals with disabilities, people living in rural areas, and other population subgroups that experience inequities.

The community engagement process should be collaborative, and community members must have a meaningful role in *shaping* policies, which includes honoring and integrating their wisdom. This is distinct from seeking input from community members on a policy or approach that has already been developed and for which feedback from the community is unlikely to have a substantive impact. Meaningful engagement—also characterized as "transformational" engagement[4]—is structured to empower community members to influence decisions and actions through a bidirectional exchange of information, expertise, and resources to ensure outcomes are beneficial to the community.[5,6] Importantly, a clear understanding of how information will be used is established at the outset of the process by the Medicaid agency and community members involved. Community-based organizations can serve as partners to assist Medicaid agencies in recruiting community members to participate in activities and sustain engagement. Communications and meetings are accessible, individuals experiencing inequities are represented, compensation for time and expertise is provided, and reimbursement for transportation or child care coverage is offered to remove barriers to participation.

The community and member engagement processes described in this guide may represent a sizable shift in the way state Medicaid managed care programs approach community and member engagement. Meaningful community and member engagement, as characterized in this guide, may be challenging for states. The examples are limited but highlight how some states are overcoming challenges and beginning to shift to a more transformational approach to engaging communities and members.

State Example(s)[7]

This icon is used throughout the guide to indicate an example of state action, either from a Medicaid program or another state program, for which there could be relevance or applicability to Medicaid.

III. Establishing Health Equity as a Core Principle of Medicaid

Health equity needs to be viewed and embedded as a core, cross-cutting principle of Medicaid, and not a separate, standalone initiative. Thus, initiating meaningful and lasting change to promote equity begins with explicitly identifying health equity as a core principle of Medicaid.[8] This section describes the steps for Medicaid programs to begin work on health equity. The steps are summarized in Table 2 below.

TABLE 2: Steps for Medicaid Programs Beginning Work on Health Equity

- ✓ A. Demonstrating Leadership Commitment
- ✓ B. Defining Health Equity
- ✓ C. Identifying Equity as a Strategic Priority

A. Demonstrating Leadership Commitment

Health equity work begins with a commitment from leadership to signal that the agency is actively and intentionally prioritizing equity—both internally (e.g., recruitment, retention, and other operational and hiring processes) and in the administration of the Medicaid program. The Medicaid Director or most senior agency official should explicitly identify health equity as an agency-wide commitment and priority and describe a plan for implementing the work. That communication and commitment should clearly define why health equity is important and why systemic changes are needed to improve health outcomes.[9] The plan should include both internal operational steps and actions the agency will take in administering Medicaid benefits. A process for setting goals, tracking progress, engaging staff, and hearing and reflecting community and member perspectives should be part of the plan. This process should begin with convening a primary team of leaders and staff to drive change.[10] Reiterating the importance of health equity in routine follow-up communication, especially early on, is equally important to signal that leadership remains focused and committed to equity.

In early 2019, the **Louisiana** Department of Health (LDH) created the Office of Community Partnerships & Health Equity (OCPHE) and tasked it with creating, implementing, and monitoring the first agency-wide health equity framework and plan to ensure LDH's services are "equitably accessible and informed by the people, populations and communities it serves." Within the first year, OCPHE completed a health equity assessment, issued a *Barriers to Health Fact Sheet* and then a call to action as part of its *LDH Phase I Health Equity Plan*. Some key action steps of the LDH health equity plan include a requirement that each office within the department form a Health Equity Action Team (HEAT); identify an ambassador to document and monitor community engagement requirements defined in the plan; utilize community-based participatory research principles; and implement culturally and linguistically appropriate practices. Externally, LDH's OCPHE is building individual and community capacity by identifying and supporting community ambassadors to provide health promotion education and resources in their community. OCPHE is also creating a new statewide advisory board to review, advise, and inform LDH's health equity practices, protocols, and results.

Womazetta Jones, secretary of **Rhode Island's** Executive Office of Health and Human Services leads the state's Equity Council, an advisory council created by then-Governor Gina Raimondo to address the impact of COVID-19 in high-density areas, poor neighborhoods, and communities of color, and to consider equity in all state operations, beyond the response to COVID-19.[11] Secretary Jones's role on the Equity Council signals to the community and the agency that equity is a priority. Her leadership has ensured that community members, particularly members from communities of color are heard. Each meeting includes a standing agenda item asking members the following questions: *"What are you hearing from the community? What should the state know?"* The state then researches and addresses specific issues that members raise and reports back to the Equity Council on a resolution or status in subsequent meetings.

B. Defining Health Equity

The key terms defined in Table 1 are included as reference and context for how health equity and related terms are being used in this resource. States should establish their own definitions of health equity and other key terms to guide their work and expect to re-visit terms to re-evaluate them. The definitions should apply across the Medicaid agency and ideally align with definitions in use by other state agencies. In some cases, Medicaid managed care programs might adopt slightly different terms to ensure it applies in the context of managed care, for example, if a managed care program covers only a certain subpopulation, e.g., individuals with disabilities. A key component of establishing definitions is identifying population groups that experience inequities to inform the distribution of resources and shape intervention strategies. It also requires naming the underlying social and structural conditions that contribute to worse health outcomes, including racism.[12]

Oregon's health equity definition evolved from one that the state's Public Health Advisory Board had adopted.[13] The Oregon Health Policy Board's Health Equity Committee worked to develop a definition the Board and its committees would adopt. Consistent with best practices, the Board will revisit the definition as the equity work evolves. The Health Equity Committee and the Oregon Health Authority Equity and Inclusion Division sought stakeholder input to update the definition. The Oregon Health Policy Board then adopted it for use by its committees and all divisions under the Oregon Health Authority. The definition intentionally reflects the principles of social justice across all populations (e.g., race, ethnicity, disability status.) It states: *"Oregon will have established 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, age, 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 regions and sectors of the state, including tribal governments to address: The equitable distribution or redistribution of resources and power; and Recognizing, reconciling and rectifying historical and contemporary injustices."*[14]

Virginia's definition of health equity states *"health equity is achieving the highest level of health for all people…[and] entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices."*[15] The state adapted the Healthy People 2020 definition of health equity. Virginia's Medicaid managed care program incorporates by reference into managed care contracts the definition adopted by the state's Office of Health Equity.

The **Louisiana** Department of Health used the following definitions in their agency-wide *Phase I Health Equity Plan.*[16]

- ***Health Disparity:*** *Difference in health that is closely linked with social, economic, or environmental disadvantage. Health disparities impact groups that systematically experience greater obstacles including communities of color, American Indians,*[17] *and persons with disabilities.*
- ***Health Equity:*** *Achieved when every person in a community has the opportunity to reach their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.*
- ***Health Inequity:*** *Differences in outcomes that are a result of systematic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.*

C. Identifying Health Equity as a Strategic Priority

Leadership will need to identify and communicate equity as an explicit strategic priority to guide, expedite, and sustain progress toward health equity. States can integrate health equity into the agency's mission, strategic priorities, decision-making processes (including recruitment and contracting), core principles, and goal statements. Those steps initiate action and can sustain progress during leadership changes and help to position health equity to become part of everyday processes and practices within the organization. Identifying health equity as a strategic priority will provide the framework for which the agency can pursue equity initiatives through their managed care programs.

Seeking input early from staff at all levels and from community members representing individuals and population groups that have been socially marginalized can shape the state's health equity mission, operational definition, agenda, and goals in a substantive way. States can accomplish this by convening a health equity team with staff and community members, including Medicaid managed care enrollees, to guide the work; yet the process of engaging stakeholders is not confined to defining equity and strategic goals—it is an ongoing process to realize the goals of health equity. This process will require building or rebuilding trust with community members, and it will take time.

Louisiana has incorporated the phrase "nothing about me without me"[18] to guide the state's implementation of a community and member engagement process. As part of this process, LDH is organizing regional advisory boards comprising organizational and community members to support health equity practices and protocols. Another approach states can take is to implement a consumer-driven design and implementation advisory group. The **Massachusetts** One Care Implementation Council, which supports the demonstration project for individuals dually eligible for Medicare and Medicaid in the state, is an example.[19] The Implementation Council is an independent entity that works actively and collaboratively with the Medicaid agency to identify priorities and shape policies related to One Care. Council members are reimbursed for their travel to meetings (or receive travel stipends) and are compensated for their time to prepare for and attend meetings.

Minnesota and **Pennsylvania** incorporated health equity goals and principles into their states' respective strategic plans. Minnesota's Department of Human Services' strategic plan includes *"creating a culture of equity"* and *"institutionalizing equity practices"* across the department. The Pennsylvania Department of Human Services identifies health equity as a guiding principle in its strategic plan and states that the department "will work to promote equity for everyone, regardless of race, ethnicity, national origin, gender, sexual orientation, gender identity, age, and disability, so that everyone has an equal opportunity to live the healthiest life possible."

Together, these steps signal an authentic state commitment to equity and set a strong foundation for reshaping the agency to effectively implement and maintain a focus on health equity.

IV. Changing Organizational Practices and Operations to Accomplish Equity Goals

Grounding equity in an agency's mission and priorities is a first step; creating a culture of equity and changing operational practices to align with equity goals is an entirely different—and more challenging—process. The latter requires that Medicaid agencies focus specific attention on and act intentionally to promote health equity. This means explicitly naming health inequities as they manifest for Medicaid population groups. It also means making anti-racism part of the work and recognizing that racism is a primary driver of inequities in the United States.[20] Directing organizational changes requires an assessment of existing workplace culture, practice, and operations. It also requires education to ensure agency leadership and staff are fluent and comfortable in the health equity terminology and historical context around systemic and structural barriers that limit opportunities for attaining optimal health.

This section describes specific actions for Medicaid agencies to begin to assess and implement changes necessary to translate health equity priorities into action and day-to-day practices and norms. Table 3 below summarizes those actions.

TABLE 3: Action Steps for Medicaid Agencies

✓	A. Staffing to Advance Equity
✓	B. Health Equity Assessment
✓	C. Measuring and Assigning Accountability for Progress
✓	D. Staff Engagement
✓	E. Enrollee Demographic Data Collection

A. Staffing to Advance Equity

An executive-level position within the Medicaid agency can centralize health equity work, coordinating and aligning efforts with other departments or state agencies, and serving as a leadership point of contact for state staff and community members on health equity-related matters. This position also creates accountability for making progress on the agency's health equity goals.

The **Indiana** Family and Social Services Administration (FSSA), which oversees the state's Medicaid program, created a Chief Equity and ADA Officer position "to provide leadership in the evaluation of policy decisions that affect race equity, to build metrics for agency accountability, ensuring agency adherence to the Americans with Disabilities Act, and to serve at the executive level working to build a culture of equity across the agency." The position reports directly to the Secretary of FSSA and is also responsible for leading FSSA's Office of Healthy Opportunities, which is described in more detail below. Likewise in **Minnesota**, the Chief Equity Officer of the Department of Human Services reports directly to the Department's commissioner and is responsible for making the department an anti-racist institution, among other duties. (A description of the responsibilities of this position is included as Appendix A.)

B. Health Equity Assessment

Under the direction of the executive-level equity position, the Medicaid agency should, either internally or with support from an external entity, perform an equity assessment of its policies (both internal policies and policies impacting the administration of the Medicaid program for enrollees), structure, and operations. This will require dedicated resources for states to evaluate policies, practices, and norms systematically and comprehensively, and apply an equity lens or rubric to assess policies for disparate impact on population groups, either positively or negatively. States should pay specific attention to those groups that historically and presently experience health inequities and worse health outcomes due to systemic barriers. The equity assessment should inform changes to the way an agency operates, inclusive of policy development, internal operations, and organizational practices.[21]

Key areas to be assessed include:

1. Agency commitment to equity and clear definition of health equity goals
2. Composition of agency staff and recruitment and retention practices, including and especially in leadership and decision-making positions
3. Processes for shaping the Medicaid program agenda and embedding equity in decision making practices
4. Criteria for awarding state grants, contracts, or other funding
5. Infrastructure to obtain and analyze qualitative and quantitative data to:
   - Identify disparities by race, ethnicity, language preference, disability status, and sexual orientation, gender identity, and/or other characteristics
   - Understand inequities in enrollment processes, utilization, and outcomes
   - Report disparities and inequities publicly
   - Inform policy and programmatic decisions
6. The extent to which community members and enrollees are meaningfully engaged in developing the policies that apply to them
7. The internal and external policies that govern the agency and administration of the Medicaid program for enrollees to determine impact on inequities, either by improving inequities or exacerbating them. (*This step represents a significant undertaking and will require that Medicaid programs develop a multi-year plan for examining current policies*.)

Louisiana implemented a Community Partnerships Health Equity Assessment to inform the development of the department's Health Equity Plan. It developed assessment tools to administer interviews with departmental leaders. The tools were used to assess *"LDH leaders' knowledge and operationalization of health equity concepts to evaluate fairness and reach of programming, policies, and measures within the Department."* The findings were used to shape the department's health equity strategies and action plan.

There have been calls on Congressional policymakers to add a health impact and racial health impact scoring methodology to federal legislation. A July 2020 house bill, H.R. 7510, the Assimilating Health and Equity Assessments into Decision-making (AHEAD) Act, proposes to study tools that can be leveraged to assess a policy's impact on health and wellness.[22] States could apply a scoring methodology using equity or racial impact assessments to their own policies and future proposals.

C. Measuring and Assigning Accountability for Progress

Medicaid programs need mechanisms and accountability structures to measure their progress and hold themselves accountable for advancing equity. The health equity assessment described above should generate specific indicators and milestones in each assessment area to evaluate progress.*

The planning process is necessary for states to examine measure options with stakeholders and content experts and develop the data and reporting infrastructure to implement a measure(s). This will inform selection of measures with community input based on identified needs and analysis that can more precisely target aspects of care that contribute to disparate outcomes.

States should hold themselves accountable and be transparent about their progress in meeting key internal and external performance measures or milestones. Medicaid agencies should frequently report to staff on internal progress in meeting milestones and establish a schedule for doing so that is also communicated internally.

D. Staff Engagement

Staff buy-in, engagement, empowerment, education, and awareness are critical to changing an agency's culture to be more equity-focused. This will require time and trust. Without staff buy-in, the commitment to equity could be disconnected from the day-to-day staff experience and fail to translate into meaningful action and long-term change. Engaging staff successfully relies on a leadership team *and* mid-level management team that are educated about health equity and committed to integrating equity into the work of the agency.

States must define a process for engaging staff and prioritizing time and space to *listen* to staff and reflect staff feedback in organizational priorities and changes. It also means soliciting feedback from all staff on the current culture and how they experience the culture, with specific attention to diversity, inclusion, and decision-making power or influence. States should look at their Medicaid staff to evaluate the extent to which it reflects the demographics and lived experiences of the communities the agency serves.

States should provide resources and information to staff and create opportunities for staff discussion. It is important that staff have a safe space—separate from formal training and development programs—to talk and learn about the impact of racism, ableism, and discrimination related to sexual orientation and gender identity on health equity and the workplace. The Government Alliance on Race and Equity has found that employees may be more engaged in racial-equity or diversity trainings if the trainings are part of a professional development program rather than one of a

* Indicators may include, for example: implementation of new criteria for state funding with explicit attention to programs and contractors that have demonstrated readiness and capacity to advance health equity, and tracking and reporting on investments; survey and analysis of staff and manager experience with specific attention to implicit or explicit bias, racism, discrimination and developing of a plan based on findings; documentation and implementation of approach to reviewing and assessing new policy proposals using an equity lens; evaluation of programs to demonstrate impact on reducing disparities and promoting equity; number of trainings implemented; number of staff surveys administered.

series of trainings employees are required to attend.[23] Medicaid programs can invite outside facilitators or community-based organizations to moderate discussions. Leaders should acknowledge and respect that some people may prefer not to talk about racism in a group of individuals of different races because of power structures and dynamics that may not create an inclusive environment for open dialogue. States should honor those preferences and create space for separate discussions to occur.

States should engage managers in developing strategies to integrate equity into the agency culture and operations to ensure that the equity goals are represented in day-to-day interactions among staff and between leadership and staff. Mentoring and coaching programs and task forces focused on equity and inclusion are other approaches states can take.[24]

The **Orange County Health Department in North Carolina** formalized a staff-driven and organized Racial Equity Commission (REC) to "apply a diverse, inclusive, and racially-equitable lens to internal organizational processes in order to dismantle structural racism."[25] Nine volunteers serve on the REC with five seats open to individuals from the different departmental divisions and four seats reserved for staff members. All members of the REC are required to participate in a racial equity training. The monthly departmental newsletter includes a standing section for the REC to identify resources and materials about racial equity for staff, and the REC is working closely with department leadership to develop a strategic plan to advance equity.

The **Minnesota** Department of Health maintains a resource library for advancing health equity on its website. A section on helping staff understand equity includes a video of Camara Jones, M.D., M.P.H, Ph.D., applying a "cliff analogy" to demonstrate the impact of social conditions on health, including racism and poverty, and calls for action to address underlying social conditions to reduce disparities. The video is an important tool for connecting state social determinants of health work (with which staff may have more familiarity) with health equity. The **Arizona** Medicaid agency brought in outside speakers to help educate the leadership team on health equity and promoted discussion of equity and anti-racist resources among leaders to enhance their knowledge and build cohesion.

E. Enrollee Demographic Data Collection

Medicaid agencies should examine processes and practices for collecting demographic information on enrollees, including race, ethnicity, language, and disability status (RELD) information. With more granular demographic data, states can begin to identify where disparities exist and develop targeted interventions and evaluation strategies to monitor effectiveness in reducing disparities and improving health. States can also use this information to inform performance improvement expectations and other strategies with their MCOs.

Oregon Health Authority (OHA) developed a series of presentations to support increasing standardization of RELD data across the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA). Reasons for asking about RELD and the core principles that guide conversations between enrollment assisters, providers, or others, are addressed in the series.

V. Leveraging Medicaid Managed Care to Advance Health Equity

Once the principles of health equity are more firmly grounded within the Medicaid agency, states can begin to convey their mission and goals related to health equity and their expectations of their contracted MCOs more deliberately and effectively.

States can use MCO procurement processes, contracts, and performance improvement initiatives, to advance health equity through their managed care programs. Federal Medicaid rules require states to implement a managed care quality strategy with a plan *"to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status."*[26]

Table 4 presents a list of options for states to consider pursuing in their managed care programs. These are not mutually exclusive. This section of the guide highlights specific approaches and strategies states are pursuing through their Medicaid managed care programs to advance health equity. SHVS has also produced *Medicaid Managed Care Contract Language: Health Disparities and Health Equity*, a compendium of Medicaid managed care contract language related to health equity and health disparities as a separate resource for states.

TABLE 4: Options for Medicaid Agencies to Leverage Managed Care to Advance Health Equity

✓	A. Performance Improvement Projects
✓	B. Health Equity Reports
✓	C. Procurement Process
✓	D. Population Health Management
✓	E. Performance Monitoring and Improvement Targets
✓	F. Provider Training
✓	G. Financial and Non-Financial Incentives
✓	H. Enrollee Engagement
✓	I. Engaging with Medicaid Leadership

A. Directing Performance Improvement Projects to Reduce Disparities

Federal Medicaid rules stipulate that managed care entities contracting with states must "establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees…"[27] An important component of the strategy is the development and implementation of clinical and nonclinical performance improvement projects (PIPs). States have flexibility to require managed care entities to implement a state-defined PIP or permit entities to select their own. States can require health plans implement a specific PIP focused on health equity or include an equity-focused PIP as an option from which a health plan can select.

California performs disparities analyses at the health plan level and shares its findings with each plan. (The state also produces Health Disparity Reports to identify disparities among the state's Medicaid managed care enrollees.) Health plans then use the data to inform their action plans as part of the required annual Population Needs Assessment (PNA).[28] They may also use the data to identify a health equity PIP.

The **Ohio** Department of Medicaid required its contracted managed care plans to implement the Hypertension Control Improvement Project.[29,30] Informed by data showing higher rates of uncontrolled hypertension among Black patients as compared to white patients, the state launched the project to reduce the disparity and improve control of hypertension. The initiative required managed care plans to support clinical efforts to implement best practices to control hypertension and reduce disparities.

B. Requiring Submission of Reports Related to Health Equity Activities

Requiring managed care plans to submit reports, sometimes with planned public distribution, signals heightened state interest in a particular area and increases health plan attention to a specific topic. Some states are requiring Medicaid managed care plans to submit reports, outside of other managed care reporting activities, specific to health equity. This forces health plans to focus on the singular topic of health equity and can be a catalyst for health plan and state discussions to identify improvement opportunities.

The **Oklahoma** Health Care Authority issued a request for proposals for the state's Medicaid managed care program in November 2020 that would require health plans to develop a cultural competency and sensitivity plan as part of a readiness review.[31] Health plans must describe how they will evaluate and monitor disparities in service quality and promote the provision of care in a culturally competent manner. **Virginia** requires Medicaid managed care plans to submit annual reports describing policies and procedures related to identifying, addressing, and tracking employment, food security, and housing instability, conditions that contribute to health inequities.

C. Incorporating Equity into the Procurement Process

Through their procurements, states can communicate their expectations of MCOs regarding their role in promoting health equity and use responses to evaluate MCOs for the purpose of awarding contracts. States can use their MCO procurements to articulate their health equity expectations and requirements and obtain plan commitments to advance equity through specific actions. The procurement process enables states to determine the capacity of potential contractors to make substantive progress toward reducing health disparities. It can also establish financial and non-financial performance incentives for holding contractors accountable for performance on health equity. Additionally, states can require respondents to conceptualize their approach to managed care within the context of advancing health equity, something many may not have considered.[32]

States can assign points in their scoring methodology for applicant responses to specific equity-focused questions or sections. States can structure questions to assess MCO programming directed at reducing health disparities and to evaluate an MCO's practices that promote equity. States can weigh those questions more heavily to align with their goals of achieving equity, signaling that MCOs are expected to have the capabilities to meet the equity-focused requirements.

Minnesota's 2021 request for proposals (RFP) for Medicaid managed care contractors includes a section of questions on improving outcomes and eliminating disparities. Respondents must describe how the organization addresses structural racism, steps it has taken to become an anti-racist organization, and specific initiatives undertaken to reduce racial disparities and remove barriers to health care. The RFP contains specific questions about reducing racial disparities in maternal health outcomes and how respondents will *"reduce implicit, explicit, and institutional bias experienced by Black and Indigenous people during pregnancy, delivery, and postpartum care."* Another question requires respondents to describe ways they will address disparities in well-child visits.

In 2021, the **Louisiana** Department of Health (LDH) requested feedback from stakeholders in preparation for the state's forthcoming Medicaid managed care procurement.[33] Health equity was one of the seven specific topics on which LDH requested input. LDH asked for stakeholders to offer suggestions of how LDH could require MCOs to focus on addressing social determinants of health and health disparities in Louisiana. LDH also requested input on how best to hold MCOs accountable for significantly improving health equity among Medicaid managed care enrollees.

D. Addressing Equity Within Population Health Management

States can require that health plans integrate health equity into population health management strategies and interventions. States can identify specific interventions or care models found to reduce disparities, represent the perspective of enrollees of color, and improve access to care for disadvantaged groups. States can also impose staffing and training requirements on MCO staff, particularly those responsible for developing and implementing population health strategies. Importantly, states should require that MCOs monitor the programs for impact on improving population health and reducing disparities. (See *Analyzing Health Disparities in Medicaid Managed Care* and *Leveraging American Community Survey (ACS) Data to Address Social Determinants of Health and Advance Health Equity* for information about data sources to support identification of disparities and inform interventions.)

Ohio issued a Medicaid managed care request for applications (RFA) in November 2020 through which the state seeks to leverage MCO population health management strategies to advance health equity. The state will require contractors to include staff dedicated to health equity on its population health team and identifies a Health Equity Director as key MCO staff, indicating that this position will work in close coordination with the Population Health Director. Senior leadership of the MCO is required to ensure that population health initiatives support health equity and that the information system that supports population health management identify health disparities and support analysis over time to track performance in reducing disparities. More information about Ohio's RFA and specific equity-focused language and expectations can be found in *Medicaid Managed Care Contract Language: Health Disparities and Health Equity*.

E. Setting Provider Expectations

Through their MCOs, states can require network providers to implement health equity-focused initiatives or take action to advance equity. The requirements would parallel those of the MCO in many aspects but also stipulate that providers detect and correct bias in care delivery. This may include a requirement that Medicaid MCOs implement the national standards for culturally and linguistically appropriate services (CLAS), which are intended to advance health equity, improve quality, and help eliminate health care disparities and ensure their contracted providers are meeting those standards. States can also require or incentivize MCOs and providers to implement quality improvement

initiatives focused on health equity, including examining underlying non-medical conditions and causes that contribute to patient outcomes. The state and MCOs should share data with providers to further their understanding of health inequities. In addition, states and MCOs can support provider learning about the impact of racism on patient health outcomes. Ongoing learning programs can help MCOs and providers detect bias in care and identify opportunities for improvement. States may also consider convening a forum where MCOs can more easily work together on provider education strategies related to health equity to reduce the chances of a redundant or inconsistent approach to provider education in this area across MCOs.

One Medicaid provider in **Massachusetts** analyzed rates of referral to substance use treatment programs and found that rates of substance use were higher among populations of color but referrals to treatment were lower. With that understanding, the provider is able to focus attention on understanding the cause(s) of lower referrals and take action to address the root cause.

New York's 2019 Value-Based Payment Roadmap includes guidance for providers (and MCOs) on implementing member incentives to improve health outcomes. The state established a set of equity-focused principles to guide the design of such incentives and programs, including that they are culturally sensitive and assess any barriers that may prevent individuals, particularly groups of individuals, from accessing the incentive. The state indicates that *"designing member incentives is complex and will need to consider underlying disparities and social determinants of health including community needs, and local planning efforts. Above all, member incentives must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support."*

In its new Medicaid managed care contracts, **Oklahoma** requires MCOs to develop a cultural competency and sensitivity plan, which includes a description from the plan for how it will provide annual training to care managers, network providers, and enrollee-facing staff to *"ensure the delivery of culturally and linguistically appropriate care."*[34]

F. Monitoring Performance and Setting Improvement Targets

States can require health plans to stratify performance measures by population groups, including by race, ethnicity, primary language, disability status, rurality, and other demographic characteristics. Stratifying performance measures is important to identify disparities and their magnitude and enables states to monitor rates and trends by population group. Many states go beyond monitoring to use the data to a) establish targets for disparities reduction; and b) develop or direct targeted interventions 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.)

Reducing the disparities gap between two subpopulations may be a primary goal for states, but focusing on that alone—without expectation and measurement that absolute performance improves for the target group—can be misleading for two reasons. First, the gap can be reduced because the group with the highest performing rate (i.e., the comparison group) may have seen a decline in performance while the target population group's rate remained unchanged. Second, the disparities gap can appear to be constant despite performance improvement in all population groups. States should monitor performance with twin goals of both a reduction in disparities and improvement in performance for populations experiencing inequity.

The **District of Columbia** requires Medicaid managed care plans to 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. Plans are required to submit a plan and timeline to address identified disparities through a targeted intervention of the plan's own choosing. Medicaid MCOs in **Louisiana** are required to stratify and report certain quality measures[35] by race/ethnicity and urban/rural status. These measures are a subset of measures the state includes in its quality withhold approach. LDH has established absolute performance and improvement targets for MCOs to earn back the withhold.

Medicaid managed care organizations in **Washington** are required to collaborate with other plans and the state's Department of Health to form a Health Care Disparities Workgroup. (This requirement is incorporated in the 2021 Apple Health - Integrated Managed Care contract.) In consultation with community experts and community-based organizations, the Workgroup identifies a performance measure for which racial or ethnic disparities exist and implements interventions aimed at reducing the disparities in the select measure. For example, the state partnered with DPH to conduct focus groups with members whose primary language is Spanish to understand their experience with well-child visits. In 2019, **Louisiana** conducted a series of regional town hall meetings to solicit input from providers, clinicians, and community members on the selection of Medicaid MCO performance measures the state should consider in its value-based payment strategies. As a result of the feedback obtained during this provider and community engagement process, the state made a number of changes to MCO incentive-based measures, including incorporating new measures focused on behavioral health care.

G. Encouraging Improvement with Financial or Other Incentives

Value-based payment strategies are commonly employed by Medicaid programs to improve the quality of care to enrollees, but payment incentives to promote health equity are not widespread. States may employ financial or non-financial incentives for managed care plans (and may require that their plans do the same with network providers) to improve performance. States can develop or modify financial or non-financial incentives to focus attention and action on health equity. This may include implementing performance-based incentives aimed at reducing disparities, improving absolute performance rates for specific population groups, or directing actions intended to reduce inequities.

As part of the Medicaid health plan performance bonus program, plans in **Michigan** have a financial incentive to reduce disparities in certain Healthcare Effectiveness Data and Information Set (HEDIS) measures related to care for Black, Latino(a) and white Medicaid members and for reporting on low-birthweight intervention results. (See *Medicaid Managed Care Contract Language: Health Disparities and Health Equity* for more information about Michigan's incentive structure.)

Coordinated Care Organizations (CCOs) in **Oregon** are financially accountable for performance on a state-defined health equity measure.[36] Measurement year 2021 is the baseline reporting year, and CCOs must satisfy the requirements to be eligible to receive the full amount of quality pool funds.

H. Enrollee Engagement

States should require that MCOs engage and empower enrollees in an authentic way. This means enrollees have substantive influence on plan policy, implementation, informing opportunities for performance improvement, and evaluation to ensure actions are meeting intended objectives. Contractors must demonstrate that enrollee feedback is sought to set and shape strategic priorities, allowing for meaningful involvement in guiding decisions. These actions extend beyond what is typically required of a member advisory committee and professional advocate engagement. MCOs should designate a health equity advocate or ambassador representative at the plan to serve as the point person and lead enrollee engagement.

Ohio requires MCOs to implement processes to gather input from members from population groups with disparate health outcomes and reflect the perspective of members in strategies to reduce disparities. At a minimum, MCOs must preview consumer-facing materials with members to ensure cultural appropriateness and understanding of the intended message.

I. Engaging with MCO Leadership

States should establish regular meetings with senior-level officials at each MCO, including the individual(s) responsible for health equity activities to discuss progress to address inequities and reduce disparities. The Medicaid program should identify the specific areas it expects plans to report on, including: workforce diversity and inclusion efforts; training of plan staff and providers on health equity, racism, ableism, cultural competency, and LGBTQ issues, and other topics; data identifying health disparities and progress on improving outcomes for targeted groups; and updates on enrollee engagement and specific initiatives targeting disparities.

VI. Conclusion

As states endeavor to address persistent health disparities and advance health equity, many seek to understand how to position their Medicaid programs, and specifically their Medicaid managed care programs, to achieve their equity objectives. This practical guidance will support states' efforts to advance health equity in Medicaid with actionable steps. Medicaid agencies need to assess their internal organizational policies, practices, and norms to ensure their expectations for contractors are reflected in their own operations. Medicaid managed care programs represent one avenue for states to pursue their health equity goals, and there are multiple strategies states can adopt with their Medicaid managed care plans. However, reducing and eliminating disparities will require an array of interventions across the health care system, community, provider, and patient levels.[37,38] In addition to Medicaid managed care strategies, states should simultaneously consider other initiatives that together can make progress toward achieving health equity.

Appendix A

The following are excerpts from the Assistant Commissioner for Equity and Inclusion position in the Minnesota Department of Human Services (DHS). The authors thank DHS for sharing this information.

Position Title: Assistant Commissioner for Equity and Inclusion
Reports to: Commissioner of DHS
Supervises: Equity Coordinators *(indirectly)*

POSITION PURPOSE

The purpose of this position is to support the Commissioner of Human Services in the overall administrative and operational responsibilities of a cabinet level state department. This position will also serve as the chief advisor to the Commissioner in the area of Equity and Inclusion, will assist in managing high profile DHS initiatives, performing special projects and providing liaison with agency personnel, Governor's Office, Human Services partners, media representatives and representatives of public and private sector organizations. Specifically, this position will develop intercultural competencies within DHS in order to offer services with an equity lens to the communities we serve.

PRINCIPAL RESPONSIBILITY 1 *(20%)*

Participate in DHS management as a member of the Commissioner's Executive Management Team to develop policies and strategic initiatives so that action plans to implement quality DHS programs are developed and resource allocations are made in a manner that fulfills the mission of the Department.

A. Develop and maintain comprehensive knowledge of the department's current activities and understanding of the current objectives of all department programs.

B. Communicate effectively with other Assistant Commissioners and DHS managers so that issues are identified and resolved, and programs are improved.

C. Identify and affirmatively propose to the Commissioner suggested policies, priorities, and legislation which facilitate the development or improvement of DHS human services programs.

D. Participate in developing the DHS budget; recommend funding and program adjustments to the Commissioner in order to reflect department goals, resources, and priorities.

E. Actively participate in the acquisition of federal discretionary funds for DHS programs and policies.

F. Direct the analysis and evaluation of existing and proposed federal, state, and department rules, regulations, policy and proposals, and legislation to determine their impact on DHS issues.

G. Direct special and ongoing studies and evaluations that address policy issues relating to the needs of the department in order to assure appropriate policy development.

H. Maintain effective working relationships with federal, state, and local officials, external stakeholders, and tribes; convey their concerns to the Commissioner and other top-level staff.

PRINCIPAL RESPONSIBILITY 2 *(60%)*

Plan, evaluate, and implement intercultural competencies within DHS in order to offer services with an equity lens to the communities we serve. Advance equity, reducing disparities in DHS program outcomes, and improving access to human services for communities experiencing inequities. Address broad social, economic, and political factors that result in systemic disadvantages as well as the needs, assets, and challenges of communities experiencing inequities.

A. Assess intercultural competence using tools such as the Intercultural Development Inventory (IDI).

B. Develop and implement culturally responsive practices by creating an organizational climate that encourages and supports such practices.

C. Develop and facilitate cultural competence committees.

D. Develop policies and procedures to support intercultural competencies.

E. Help strengthen the equity culture in DHS programs.

F. Attend eight hours of equity training annually. Trainings can be sponsored by DHS or an outside entity.

G. Follow policies and practices that improve access to effective and respectful health and human services for members of communities experiencing disparities.

H. Review contracted providers to make sure they promote client equity when helping people with disabilities.

I. Institutionalize an equity focus in decision-making for DHS.

J. Incorporate equity analysis into the development of policies, rules, procedures, budget and legislative proposals, as well as program design and implementation.

PRINCIPAL RESPONSIBILITY 3 *(10%)*

Guide senior leaders, division directors, managers, and staff in community and stakeholder engagement around equity. This includes forming and maintaining relationships with key leaders inside and outside DHS to establish and develop collaborative partnerships. Build the capacity of staff and managers to collaborate with stakeholders and promote equity work.

A. Develop and maintain strong working relationships with key DHS and state agency policy groups that have equity as a key concern: The advisory councils that provide input on equity, the Employee Engagement Teams, the DHS Community Relations Division, DHS Human Resources, the DHS Office of Equal Opportunity, the Cultural and Ethnic Communities Leadership Council, the Olmstead Implementation Office, the Minnesota Department of Human Rights, and the Governor's Inclusion and Civic Engagement Initiatives.

B. Work with staff to identify target communities and key organizations and individuals representing communities that experience inequities.

C. Guide and support staff to initiate or foster collaborative partnerships or projects with various communities and organizations.

D. Oversee the conceptualization and creation of trainings related to equity and inclusion.

E. Guide managers and staff as they work to improve communication, engagement, accessibility, project performance, and outcomes with diverse communities and populations.

F. Help build partners' capacity and/or opportunity to participate in projects or processes. This may include both new and existing outreach and forums for dialogue.

G. Mentor and build the capacity of equity leaders within the agency.

H. Support involvement in the DHS Stakeholder Engagement Community of Practice and lend expertise to that group when requested.

PRINCIPAL RESPONSIBILITY 4 (10%)

Lead the measurement, tracking, and reporting of the administration's progress on equity-related goals.

A. Oversee strategies for assessing and measuring equity-related activities and partner outside DHS on the development of these strategies.

B. Lead staff and stakeholders to develop measures appropriate to the agency's equity activities.

C. Work with performance improvement managers to develop appropriate performance management indicators and dashboards to track progress on equity within the agency.

D. Direct ongoing assessments, continuous improvement plans, and performance management to improve equity and inclusion within the agency.

E. Provide consultation to the agency's performance management, evaluation, and continuous improvement efforts to ensure that equity is considered during the development, implementation, and reporting of measures for activities that are not directly' equity-related.

RELATIONSHIPS

Building and maintaining effective relationships is a priority in this position. The incumbent must initiate and develop relationships with internal and external people to foster open communication, understand the agendas and perspectives of others, and resolve conflicts and disagreements collaboratively.

The incumbent must be sensitive to and respectful of the cultural and other differences that will affect interactions with co-workers, administration partners, and the people served by the administration. Because trust is an essential component of the sometimes-difficult discussions around equity, inclusion, race, and oppressions, the incumbent must be able to build and maintain trusting relationships with a wide variety of people.

The incumbent will work directly with the senior leadership, supervisors, and staff across DHS. The incumbent will represent the agency in new or ongoing meetings with external organizations that represent or serve communities that experience health inequities.

KNOWLEDGE, SKILLS, AND ABILITIES—The incumbent must have:

- Knowledge of the influence of culture on beliefs, values, traditions, and behaviors of self and others; understanding significance of culture and diversity in shaping day-to-day services and the organization.
- Knowledge of intercultural competencies.
- Knowledge of and ability to use the Intercultural Development Inventory.
- The ability to provide policy and operational analysis and recommendations.
- The skills in analysis and interpretation of raw data and statistical output, statutes, policy proposals, and alternatives and the ability to design, organize and prepare documents.
- Experience in working with ethnically and culturally-diverse communities, American Indian communities, people with disabilities, and other communities that experience health inequities.
- Knowledge of the research and professional literature on building equitable and inclusive organizations, including promoting accessibility.
- Experience in building equity and inclusion in medium or large organizations.
- An understanding of the role and operation of state government in building the health and human services infrastructure.

Support for this guide was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit **www.rwjf.org**. Follow the Foundation on Twitter at **www.rwjf.org/twitter** or on Facebook at **www.rwjf.org/facebook**.

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 health care 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 health care 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 guide was prepared by Erin Taylor, Mary Beth Dyer, and Michael Bailit. 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**.

ACKNOWLEDGMENTS

The authors thank Health Equity Solutions, Speire Healthcare Strategies, staff from Advancing Health Equity at the University of Chicago Medicine, and certain state Medicaid officials for reviewing and offering insightful feedback on earlier versions of this guide.

Endnotes

1 *Medicaid and CHIP Enrollment Trend Snapshot*. Medicaid. (n.d.). https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html.

2 Everette, T. D. (2019, June 20). Advancing Health Equity Through Medicaid Managed Care: An Introduction for States. Retrieved January 21, 2021, from https://www.shvs.org/wp-content/uploads/2019/05/Health-Equity-Webinar-1-2019-6-20.pdf.

3 Everette, T. D., Sathasivam, D., & Siegel, K. *Health Equity Language Guide for State Officials*. August, 2021. Accessed August 25, 2021. https://www.shvs.org/resource/health-equity-language-guide-for-state-officials.

4 Curren R., Nelson, J., Marsh, D.S., Noor, S., Liu, N. "Racial Equity Action Plans, A How-to Manual.": Haas Institute for a Fair and Inclusive Society, University of California, Berkeley, 2016.

5 *Understanding Carnegie Community Engagement Classification.* New England Higher Education. (2018). Accessed March 8, 2021. https://nerche.org/carnegie-engagement-classification.

6 Israel, Barbara A., Edith A. Parker, Zachary Rowe, Alicia Salvatore, Meredith Minkler, Jesús López, Arlene Butz, et al. "Community-Based Participatory Research: Lessons Learned from the Centers for Children's Environmental Health and Disease Prevention Research." *Environmental Health Perspectives* 113, no. 10 (October 1, 2005): 1463–71. https://doi.org/10.1289/ehp.7675.

7 Descriptions of racial and ethnic groups vary among states. This guide reproduces the terminology used by states in examples referenced.

8 Chin, M. (2019, August 27). Evidence-Based Strategies for Reducing Health Disparities. Retrieved January 21, 2021, from https://www.shvs.org/wp-content/uploads/2019/08/Consolidated-HE-Webinar-3-Slide-Deck.pdf.

9 For example, Arizona leaders underscored the need for broad changes to the health care system because American Indian residents in Arizona experienced, on average, a life expectancy that was 16 years shorter than other Arizonans (See *Arizona American Indian Health Status Summary Report for Data Year 2015*. Arizona Department of Health Services, June 2017. https://azdhs.gov/documents/director/tribal-liaison/health-status-report-2015.pdf.)

10 Keleher, T. (2018, September). Racial Equity Core Teams: The Engines of Institutional Change. Retrieved January 21, 2021, from https://www.racialequityalliance.org/resources/racial-equity-core-teams-the-engines-of-institutional-change.

11 Hammer, G., & Kennedy, H. (2020, October 19). Engaging Staff to Be Equity-Minded: A Conversation with Public Sector Leaders [Web log interview]. Retrieved January 21, 2021, from https://www.milbank.org/2020/10/engaging-staff-to-be-equity-minded-a-conversation-with-public-sector-leaders/?utm_medium=email&utm_campaign=Milbank%20Monthly%20October%202020&utm_content=Milbank%20Monthly%20October%202020+CID_e8bdfe8d80017aca3d9891168961d01c&utm_source=Email%20Campaign%20Monitor&utm_term=Engaging%20Staff%20to%20Be%20Equity-Minded%20A%20Conversation%20with%20Public%20Sector%20Leaders.

12 American Public Health Association. *Creating the Healthiest Nation: Advancing Health Equity*. Accessed August 25, 2021. https://www.apha.org/-/media/Files/PDF/factsheets/Advancing_Health_Equity.ashx.

13 Oregon's definition continues to evolve, acknowledging that the work is dynamic. Oregon adheres to a best practice by continuously assessing and updating its definition. Personal communication with Oregon Health Authority official.

14 "Health Equity Committee (HEC)." Oregon Health Authority. Office of Equity and Inclusion. Accessed March 8, 2021. https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx.

15 "Virginia Department of Health." Virginia Department of Health. Health Equity Definitions. Accessed March 8, 2021. https://www.vdh.virginia.gov/health-equity/definitions.

16 "LDH Call to Action: Health Equity Plan and Framework." Louisiana Department of Health. Accessed March 8, 2021. https://ldh.la.gov/assets/cphe/Equity_Framework.pdf.

17 Descriptions of racial and ethnic groups vary among states. This guide reproduces the terminology used by states in examples referenced.

18 Barry, M. J., & Edgman-Levitan, S. (2012). Shared Decision Making—The Pinnacle of Patient-Centered Care. *New England Journal of Medicine*, 366(9), 780-781. doi:10.1056/nejmp1109283.

19 Case Study of the One Care Implementation Council. (2018, June 30). Retrieved January 22, 2021, from https://www.healthinnovation.org/resources/publications/case-study-of-the-one-care-implementation-council.

20 See for example "Racism and Health." RWJF, May 11, 2021. https://www.rwjf.org/en/library/collections/racism-and-health.html.

21 Health Equity Solutions. Health Equity Policy Assessment. Forthcoming.

22 Murphy, K., & Pollack Porter, K. M. (2020, September 22). Time For A Second Public Health Revolution: A Congressional Health Office To Score Federal Legislation: Health Affairs Blog. Retrieved January 21, 2021, from https://www.healthaffairs.org/do/10.1377/hblog20200915.68239/full.

23 Nelson, Julie, Lauren Spokane, Lauren Ross, and Nan Deng. Issue brief. Advancing Racial Equity and Transforming Government. A Resource Guide to Put Ideas into Action. Government Alliance on Race & Equity, n.d. https://racialequityalliance.org/wp-content/uploads/2015/02/GARE-Resource_Guide.pdf.

24 Dobbin, F., & Kalev, A. (2016). Why Diversity Programs Fail. *Harvard Business Review*, (July-August),52-60. Retrieved February 9, 2021, from https://hbr.org/2016/07/why-diversity-programs-fail.

25 "Orange County Health Department, North Carolina." Government Alliance on Race and Equity. Accessed April 8, 2021. https://www.racialequityalliance.org/jurisdictions/orange-county-health-department-north-carolina.

26 § 42 CFR 438.340 (b)(6).

27 § 42 CFR 438.330.

28 State of California Department of Health Care Services (2019, September 30). Health Education and Cultural and Linguistic Population Needs Assessment (Supersedes APL 17-002). Retrieved January 22, 2021, from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

29 The Ohio Department of Medicaid Managed Care Quality Strategy. (2018). Retrieved January 22, 2021, from https://medicaid.ohio.gov/wps/portal/gov/medicaid/about-us/qs/medicaid-managed-care/odm-managed-care-quality-strategy.

30 Ohio External Quality Review Organization State Fiscal Year 2019 Annual EQRO Technical Report. (2020, June). Retrieved January 21, 2021, from https://medicaid.ohio.gov/wps/portal/gov/medicaid/about-us/qs/odm-quality-reports/external-quality-review-tech-report.

31 Oklahoma Health Care Authority SoonerSelect RFP. (2020, November 13). Retrieved January 21, 2021, from https://oklahoma.gov/ohca/about/procurement/soonerselect-rfp.html. This managed care program was suspended in June 2020 prior to going into effect. The Oklahoma Supreme Court ruled that the actions of the Oklahoma Health Care Authority (OHCA) to implement a capitated managed care plan for Medicaid expansion members violated state law and was therefore void. The Court said OHCA acted without legislative authorization and without first adopting necessary administrative rules for the bidding process.

32 Chomilo, N. T. (2020, December 01). Building Racial Equity Into The Walls Of Health Policy: Health Affairs Blog. Retrieved January 21, 2021, from https://www.healthaffairs.org/do/10.1377/hblog20201119.508776/full.

33 Lousiana Department of Health, Medicaid Managed Care RFP 2021 Feedback. Retrieved July 29, 2021 from https://ldh.la.gov/index.cfm/page/4155.

34 Oklahoma Health Care Authority SoonerSelect RFP. (2020, November 13). Retrieved January 21, 2021, from https://oklahoma.gov/ohca/about/procurement/soonerselect-rfp.html. This managed care program was suspended in June 2020 prior to going into effect. The Oklahoma Supreme Court ruled that the actions of the Oklahoma Health Care Authority (OHCA) to implement a capitated managed care plan for Medicaid expansion members violated state law and was therefore void. The Court said OHCA acted without legislative authorization and without first adopting necessary administrative rules for the bidding process.

35 The measures MCOs in Louisiana are required to stratify by race and ethnicity and geography are: Percentage of Low Birthweight Births, Contraceptive Care—Postpartum Women Ages 21–44; Well-Child Visits in the First 15 Months, Childhood Immunizations (Combo 3), Percentage of Eligibles Who Received Preventive Dental Services, Immunizations for Adolescents (Combo 2); Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening.

36 Health equity: Meaningful language access to culturally responsive health care services. (2020, December 30). Retrieved January 21, 2021, from https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx.

37 Taylor, J., Novoa, C., Hamm, K., & Phadke, S. (2019, May 2). Eliminating Racial Disparities in Maternal and Infant Mortality. Retrieved January 21, 2021, from https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality.

38 Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3.