Incentivizing Health Equity through Quality Measures

Working Paper Review of State Medicaid Strategies

Version Date: 11 April 2024

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User Guide

This working paper compiles information about how other state Medicaid programs are approaching incentives to achieve health equity as part of quality measurement. It is meant to be an evolving notebook of examples and field notes, not a roadmap. It will evolve over time, and it has limitations that should be acknowledged upfront.

First, this paper does not reflect direct input from affected communities. To improve equity, it is vital to create a continual feedback loop to understand communities' prioritized outcomes, whether measures are appropriately being used, and if improvements are being made. The Coalition of Communities of Color's framework for decolonizing data, for example, can be instructive when thinking about addressing health inequities using quality measures.[1] Using metrics to incentivize improving health equity requires directly engaging impacted communities.

Second, this paper collects examples that are being tried in other states, but all approaches have both pros and cons. Many states use the highest-performing group as a reference point to set benchmarks for reducing disparities. For instance, some of the states reviewed in this paper use the White Non-Hispanic population as the reference group. Critics note, however, that this benchmarking approach does not recognize that White Non-Hispanic Medicaid members may not themselves be getting high-quality care, resulting in an inappropriately low bar for defining high-quality care. Furthermore, the White Non-Hispanic population is not a monolith, and as such, use of this group as a reference can potentially mask disparities within this population, including in relation to intersecting identities and factors such as gender and geography. In addition, "the practice of defining and comparing to a reference group may imply a standard for nonreference groups, suggest that those groups are nonnormative, and promote a need for assimilation and acculturation."[2]

Finally, this version of the working paper contains only publicly available information. Varying levels of detail are available across states. This paper will continue to be updated as more information becomes available.

Despite those limitations, we hope that learning how Medicaid programs across the country have implemented strategies to reduce disparities and eliminate health inequities may spark ideas and conversations. For the purpose of this working paper and the context of quality measurement, incentivizing health equity is defined as providing financial payments for either:

(1) Demonstrating a quantitative improvement in achieving health equity for one or more populations, or

(2) Successfully completing a health equity quality improvement milestone(s). These are activities specifically designated by the state as process or structural measures that contribute to the overall improvement of health equity. Examples of this include staff and provider training on health equity, meaningful community engagement, increasing access to culturally appropriate services, reducing avoidable outcomes which disproportionately affect priority populations, and reporting on quality measures stratified by specified groups.

Summary Learnings to Date (4.11.2024)

Of the states currently included in this working paper:

- Pennsylvania provides incentives for quantitative improvement,
- Louisiana and Washington provide incentives for structural milestone completion, and
- California, Michigan, Minnesota, and North Carolina utilize (or previously utilized) both approaches.

These states have focused their current health equity incentive initiatives on reducing disparities first among racial and ethnic groups. All seven states report quality measures stratified by race and ethnicity. Of the states that provide incentives for quantitative improvement in reducing disparities, the scope of their incentive programs are limited to only a few measures/population groups.

It is also important to note that Oregon's community-led work on Race, Ethnicity, Language, and Disability (REALD) data differs from other states' definitions of race and ethnicity, and there are challenges in comparing programs across states. A comparison of stratification groups can be found in Appendix C.

Context

Health Equity Definition

All of OHA's work is guided by the goal of health equity. The Health Equity Committee, a subcommittee of the Oregon Health Policy Board (OHPB), worked closely with OHA's Equity and Inclusion Division to develop the health equity definition in the box to the right. The development process included feedback from various groups including the Nine Federally Recognized Tribes of Oregon, community-based organizations, OHPB committees, coordinated care organizations (CCOs), and community advisory councils.

In October 2019, the definition was formally adopted by both the OHPB and OHA as a shared definition for use agency-wide and is the driving force behind OHA's strategic goal to eliminate health inequities by 2030.

HEALTH EQUITY DEFINITION

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.

CCO Quality Incentive Program

The CCO Quality Incentive Program (also known as the quality pool) is a pay-for-performance program in which CCOs can earn incentive funds for improving quality of care for Oregon Health Plan members.

The program is one of OHA's strongest levers in terms of measuring performance and paying for improved care and outcomes for members of the Oregon Health Plan.

CCOs receive financial bonuses for year-over-year improvement on the healthcare quality measures included in the program. These measures and targets are currently selected by the Metrics & Scoring Committee.

In May 2021, the Metrics & Scoring Committee reviewed an Equity Impact Assessment[3] of the Committee's work. This included case studies of four incentive measures with the objective of identifying opportunities to use the incentive program to address inequities in access to and outcomes of health care in the state's delivery system.

Key findings from the Equity Impact Assessment were that:

- The program operates within the boundaries of what can be quantified and consistently measured. This can have negative consequences on health equity and therefore caution must be used to ensure the Quality Incentive Program is the best lever for improvement.
- Populations most impacted by measures should have a say in what is incentivized and how measures are operationalized. This includes identification of what is considered a problem needing to be solved, and how it should be solved.
- Monitoring incentive measures by REALD categories is needed to ensure inequities for priority populations are not masked.
- Only two of the case study measures reduced inequities for most priority population groups, suggesting that quality improvement activities may not be implemented using equity principles.
- Meaningful access to health care with appropriate language services remains a key area to be addressed.

As a result of these findings, the authors of the Equity Impact Assessment recommended:

- Including formal consideration of equity in measure selection and retirement criteria.
- Exploring program structure changes to focus on priority populations.
- Increasing input of diverse knowledge and expertise from Medicaid members and priority populations.
- Providing education about inequities and using consistent language to address the identified problem.
- Emphasizing opportunities for both OHA and CCOs to include implementation efforts rooted in health equity principles once a measure is incentivized.
- Identifying additional solutions and process changes to address historical and contemporary injustices.

The findings and recommendations above were instrumental in many of the program changes outlined in Senate Bill (SB) 966 from the 2023 state legislative session. SB 966 states that the design of the program “is primarily focused on addressing health inequities, including the structural drivers of health inequities”. Currently, a study of the program is underway to determine with community, OHP members, CCOs, and providers how to center equity. Because the reorganization requires additional statutory changes, the timeline for structural changes to the program is not yet determined.

Working Paper

This working paper builds on the Equity Impact Assessment recommendations and is part of efforts to lay the groundwork for the new measurement structure. It is meant to spur conversation and additional questions. Both the working paper and the questions, conversations, and additional analyses it leads to will be invaluable in supporting changes to the program. As this is a working paper, staff will add and revise analyses as we learn more about what is being done in other states, and in response to questions from committee members and internal discussions. This is the third version of the working paper, which builds on the initial paper by adding information on the work done in the featured states in 2023.

This working paper currently includes analyses of how seven other states incentivize health equity improvements within their Medicaid programs. These states are: California, Louisiana, Michigan, Minnesota, North Carolina, Pennsylvania, and Washington. These seven states were chosen as the first group of states to be reviewed in this working paper for two reasons:

(1) California, Louisiana, Michigan, North Carolina, and Pennsylvania were featured in NCQA's December 2021 white paper "Evaluating Medicaid's Use of Quality Measurement to Achieve Equity Goals".

(2) Minnesota and Washington were included due to OHA's previous knowledge of their health equity incentive work.

Definitions Used in Working Paper

In alignment with the Equity Impact Assessment and the Deeper Dive Dashboard, the following definitions are used in this working paper to ensure shared understanding:

Health Disparities/Inequalities

Health disparities mean the same thing as health inequalities. They reflect differences in the presence of disease, health outcomes, or access to health care between population groups. For example, male babies are generally born at a heavier birth weight than female babies. This is a health disparity, as we expect to see this difference in birth weight because it is rooted in genetics and an unavoidable difference.

Health Inequities

Health inequities are differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups. For example, babies born to Black women are more likely to die in their first year of life than babies born to White women. A higher percentage of Black mothers are poor and face hardships associated with poverty that can affect their health. Research has shown links between the stress from racism experienced by Black women and negative health outcomes. This is a health inequity because the difference between the populations is unfair, avoidable, and rooted in social injustice.

Cautions and Caveats

As noted previously, this working paper is not a road map. Instead, it represents our field notes of potential lessons learned from other states. Collecting these examples is part of laying the groundwork for changes to the Quality Incentive Program so that it is centered on health equity. Additional information will be added as we learn more, and our understanding of the information contained here may also shift over time.

Given that information and data can be misinterpreted and have harmful, unintended consequences, it is important that the limitations of the information included in the working paper are considered. These include:

- **This paper does not reflect direct input from affected communities.** To improve equity, it is vital to create a continual feedback loop to understand communities' prioritized outcomes, whether measures are appropriately being used, and if improvements are being made. Using metrics to incentivize improving health equity requires directly engaging impacted communities.

- **State Medicaid programs are organized in different ways that may impact the effectiveness of a program model when implemented in another state.** For example, Oregon's CCOs are not directly analogous to Managed Care Organizations (MCOs) in other states. Program models that work in other states may be ineffective here, and vice versa.

- **Needs differ from community to community, and what works in one state may not work in Oregon.** Related to the first point above, priorities in other states may not match the desires of communities in Oregon.

- **Oregon has landmark REALD legislation while most states continue to rely on the federal Office of Management and Budget (OMB) categories**, meaning that race, ethnicity, language, and disability categories, and how they are captured and operationalized to identify and address disparities and inequities, may differ from other states. Moreover, how this information is utilized to inform incentive metrics would likely differ amongst the states explored in this working paper. Further, Oregon recognizes the injustices experienced by LGBTQIA2S+ communities and is also actively collecting information on sexual orientation and gender identity (SOGI).

- **This paper collects examples that are being tried in other states, but all approaches have both pros and cons.** There are many different ways to measure whether disparities exist. These different approaches may be more or less appropriate, show different patterns, different disparity sizes, etc.

- **We are currently limited to publicly available information.** Varying levels of detail are available across states. This paper will continue to be updated as more information becomes available.

Summary Findings Across States

A high-level overview of efforts to incentivize equity improvements can be found in Table 1. The table summarizes findings across all seven states and provides a comparison to Oregon. We used these definitions for each domain in the table:

1. **Use of reference points** occurs when a quantitative rate is used as comparison to the rate for at least one or more racial and ethnic groups within the state. References points are used to highlight population disparities and are not associated with any incentive payments.
2. **Use of benchmarks** occurs when a quantitative goal for a quality metric is set for at least one or more racial and ethnic groups within the state. Meeting a benchmark results in the receipt of an incentive payment.
3. **Equity related incentives** shows which states have previously, currently, or plan to provide financial incentives for achieving health equity-related milestones or demonstrating quantitative health equity improvement.

Starting in 2024, CMS will require all states to report measures by race and ethnicity. This requirement will use federal data standards for measures in the Adult Behavioral and Child Core Set measures. Some states had previously or will be implementing additional requirements to monitor performance by race and ethnicity.

As seen in Table 1:

- Pennsylvania provides incentives for quantitative improvement,
- Louisiana and Washington provide incentives for structural milestone completion, and
- California, Michigan, Minnesota, and North Carolina utilize (or previously utilized) both approaches.

Additional information on each domain can be found below the Table 1.

Table 1. Equity work overview by state

State	Use of **reference points** to highlight population disparities (not incentivized)	Use of **benchmarks** to set a quantitative goal for at least one racial and/or ethnic group (incentivized)	Equity-related incentives	
			Program component incentivizing structural equity milestones	Program component incentivizing quantitative health equity improvement
Oregon	X	X* (2021 only)	X	X* (2021 only)
California	X	X	X	X
Louisiana			X	
Michigan	X	X	X	X
Minnesota	X	X	X	X
North Carolina		X	X	X

Pennsylvania		X		X
Washington			X	

*The Oregon incentive program component referenced here is the Emergency Outcome Tracking (EOT) COVID-19 vaccine incentive program, in which CCOs could earn incentives for demonstrating reductions in vaccination rate gaps across racial and ethnic groups. This program was in place for the 2021 measurement year only. Additionally, benchmarks specifically for racial and ethnic groups were only used in Oregon as part of the EOT COVID-19 vaccine incentive program.

Reference points – summary findings across states

California, Minnesota, and Michigan currently use reference points to highlight population disparities when reporting quality metrics.

California uses the national Medicaid 50th percentile to evaluate measures stratified by race and ethnicity, while Minnesota uses the White Non-Hispanic population as a reference group when evaluating these race and ethnicity stratifications. Michigan utilizes both of these methods, comparing race and ethnicity stratifications to both the national Medicaid 50th percentile and the White Non-Hispanic population.

These reference points are used for reporting purposes only – there are no financial incentives tied to reduction of disparities between the reference point and the race and ethnicity stratified rates.

Benchmarking – summary findings across states

California, Michigan, Minnesota, North Carolina, and Pennsylvania use (or previously used) benchmarks to set a quantitative goal for at least one race and/or ethnicity group in the context of at least one quality metric. These states offer/ed a financial incentive for meeting benchmarks.

California previously provided incentives to MCPs that met benchmarks related to reductions in vaccination rate gaps across racial and ethnic groups in 2021.

Michigan uses the same rates for both reference points and benchmarks: the national Medicaid 50th percentile and the White Non-Hispanic performance rate. However, incentives are only offered for reducing disparities in the African American and Hispanic populations only.

Minnesota also uses the same rate for both reference points and benchmarks: the White Non-Hispanic population group. Incentives are offered for reductions in disparity gaps for all race and ethnicity groups, but only for a subset of reported measures.

North Carolina sets the benchmark for its one incentivized health equity measure to be a 10% relative improvement in the Black population compared to their previous year rate.

Pennsylvania uses the national Medicaid 75th percentile as a benchmark for reducing disparities in the Black population for the seven measures included in their maternal care program. Additionally, Pennsylvania uses the overall statewide rate as a benchmark for the two measures included in their equity incentive program.

Incentivized components – summary findings across states

California, Michigan, Minnesota, North Carolina and Pennsylvania all have at least one current, previous, or future incentive component that rewards quantitative improvement in health equity for one or more populations.

California had a COVID-19 Vaccine Incentive program in 2021, similar to Oregon's 2021 COVID Emergency Outcome Tracking Program (EOT) measure. California Medicaid plans could earn incentive funds by demonstrating improvement in the two race/ethnicity groups with the lowest baseline vaccination rates. In an evaluation report, California felt that the program structure was effective in motivating MCPs to work towards reducing disparities. At the conclusion of the program, DHCS paid MCPs 64% of the allotted funding. The top five performing MCPs for this measure implemented structural solutions and collaborated with community organizations.

California also plans to introduce incentives for health equity improvement across all race and ethnicity groups in the measures included in their Health Equity Measure Set in 2023. As of the publishing of this paper, no further information has been released on California's plan for health equity improvement incentives. By 2027, California will also codify measures and regulations for the Health Equity and Quality Measure Set (HEQMS). With the HEQMS, California may assess administrative penalties for failing to meet a benchmark.

Michigan provides incentives using withheld funds for improvement in the African American and Hispanic population groups on a subset of reported quality measures. All other race and ethnicity groups defined by Michigan (see Appendix C) are reported on, but incentives are not provided for improvements demonstrated in these groups. Michigan previously awarded funds to MHPs that made improvements in reducing racial and ethnic disparities in low birth weight, but it is unclear if this method was effective due to disruptions to the healthcare system from the COVID-19 pandemic.

Minnesota provides incentives through two means. First, MCOs are eligible for a capitation rate adjustment through demonstration of a reduction in disparity gap(s) across all race and ethnicity groups reported within a subset of quality measures. Details on Minnesota's disparity gap calculations can be found in Appendix B. Additionally, MCOs are able to earn withheld funds through fulfillment of performance targets on a designated set of 11 measures. As of 2023, this set includes the Health Equity Stakeholder/Community Engagement measure, which requires MCOs to provide a Health Equity Addendum to their Population Management Report.

North Carolina provides incentives for improvement among Black members for one measure. This measure is weighted higher than all other measures in their withhold-based measure set. Plans must meet the benchmark to earn all of the funds associated with a measure but can earn partial funds relative to their amount of improvement. A portion of unearned funds (if any) are moved to a Bonus Pool, similar to our incentive program's Challenge Pool, but only the highest performing plan is eligible to receive the funds for each measure.

Pennsylvania currently provides incentives for improvement among Black members on two specified HEDIS measures. Like Michigan, all race and ethnicity group performance rates are reported for these measures, but incentives are not provided for improvements in any other race or ethnicity group. Pennsylvania also has a maternal care bundled payment incentive for performance improvement among Black members across seven maternal care measures.

Takeaways & Limitations – summary findings across states

The most common benchmarks and reference points utilized across states are the Medicaid 50th percentile, the population group's previous year rate, and the performance rate of the Medicaid White Non-Hispanic population. In terms of using the White Non-Hispanic population as the reference group, critics note that this benchmarking approach does not recognize that White Non-Hispanic Medicaid members may not themselves be getting high-quality care, resulting in an inappropriately low bar for defining high-quality care. Furthermore, the White Non-Hispanic population is not a monolith, and as such, use of this group as a reference can potentially mask disparities within this population, including in relation to intersecting identities and factors such as gender and geography. In addition, "the practice of defining and comparing to a reference group may imply a standard for nonreference groups, suggest that those groups are nonnormative, and promote a need for assimilation and acculturation."[2]

Some states use confidence intervals when assessing statistically significant changes in performance between the reference population and the population of interest. A limitation of this strategy is that it is only applicable for moment in time measurement and may not be a good indicator of disparities for smaller population groups.

Minnesota utilizes a very detailed methodology for calculating disparity gaps, but this method is very sensitive and could potentially reward or penalize non-statistically significant changes that do not reflect an actual change in performance. Some of the state plans for incentivizing quantitative improvements in health equity have either yet to be implemented or it is too early in the implementation process to assess outcomes.

Ongoing Questions – last updated 11 April 2024

- What is the best way to harness the information here for conversations with community?
- Which of these approaches (if any) does community prefer?
- Which ways of measuring are not only most meaningful, but are understandable and meaningful to those represented in the data?
- Are there other states whose health equity efforts are missing from the analysis?

- Are there any promising areas from the states herein which would merit conversations with other state staff?
- Are there promising international practices that should be explored?
- Do states that incentivize reductions in health disparities for a small set of measures or within only certain population groups have plans in the future to expand to more measures/populations?
- Which measures are used across states to incentivize equity, and how did states choose these measures?
- Does the work from other states align with any of the findings from the Senate Bill 966 study?
- How does the work in Oregon link with national conversations around equity measurement and incentives? E.g., while the methods for measuring and incentivizing may be similar, what is incentivized to achieve health equity may be different across states and require working with communities to identify their needs and how best to meet those needs. How is that thinking being integrated at the national level, and how/does it impact our thinking in Oregon?

APPENDIX A CONTINUES ON NEXT PAGE

Appendix A – State Specific Summaries

A description of each state's current, previous and future work towards incentivizing equity improvements can be found in the state-specific sections below. This version of the working paper builds upon previous versions by including updates from the 2023 calendar year.

California

California has previously incentivized quantitative improvements in health equity through its COVID-19 Incentive Program and plans to begin incentives for health equity improvements in the measures included in the state's Health Equity Measure Set in 2023, though there is currently no further information available on these plans. California additionally provides incentives for completion of health equity quality improvement milestones.

The California Department of Healthcare Services (DHCS) contracts with Managed Care Plans (MCPs) across the state to administer Medicaid services. California requires reporting by MCPs on numerous HEDIS, CMS Core Set, and state-specific measures, stratified by race and ethnicity.[4] California's Health Equity Measure Set launched in 2022, and includes the following measures:

1. Colorectal cancer screening
2. Controlling high blood pressure
3. Comprehensive diabetes care
4. Prenatal and postpartum care
5. Child and adolescent well-care visits
6. Follow-up after emergency department visit for mental illness
7. Follow-up after emergency department visit for substance use disorder
8. Postpartum depression screening and referral

MCPs are required to report all measures in the Health Equity Measure Set, stratified by race and ethnicity. The measures will serve to inform incentive-based disparity reduction efforts in the future. Additional measures may be added to the set in later years.[4]

Additionally, the Department of Managed Health Care (DMHC), which shares regulatory authority over Medicaid MCPs with DHCS, convened a Health Equity and Quality Committee in March 2022. The goal of the committee was to make recommendations to the DMHC Director for standard health equity and quality measures, including stratification methodology benchmarks.[5] The DMHC Director accepted all measure recommendations from the Committee, creating the Health Equity and Quality Measure Set (HEQMS), which consists of the following measures:

1. Colorectal cancer screening
2. Breast cancer screening
3. Comprehensive diabetes care
4. Controlling high blood pressure
5. Asthma medication ratio
6. Depression screening and follow-up for adolescents and adults
7. Prenatal and postpartum care
8. Childhood immunization status
9. Well-child visits in the first 30 months of life
10. Child and adolescent well-care visits
11. Plan all-cause readmissions
12. Immunizations for adolescents
13. CAHPS: Getting needed care, adults and children

The Committee began measure selection by establishing guiding principles, which included alignment with current programs and initiatives, opportunity to identify and reduce disparities, and the ability to collect and stratify data.[5] A facilitator led the Committee through discussion of measures. Committee members then decided on a set of criteria for measure selection:

- Prevalence of health concern
- Addresses drivers of morbidity and mortality
- Opportunity for improvement
- Adequate expected health plan member population for valid measurement
- Setting of care and feasibility of data collection

DMHC informed MCPs in a December 2022 All-Plan Letter (APL) that the HEQMS would go into effect in measurement year 2023, requiring plans to report all measures in the measure set stratified by race and ethnicity using NCQA standards for stratification. Health plans will be required to report their MY 2023 data in Q3 of 2024.The HEQMS is effective through measurement year 2027.

It is unclear if the DMHC Health Equity and Quality Measure Set is meant to replace or be in addition to the DHCS Health Equity Measure Set. Staff will continue to monitor for new information and developments regarding these two measure sets.

Reference Points and Benchmarks

Using the DHCS Health Equity Measure Set data reported for the 2022 measurement year, California plans to establish benchmarks that will be implemented in 2023. These benchmarks will then be used to evaluate performance improvement. Further details on how these benchmarks will be calculated have yet to be determined.[4]

The DMHC Health Equity and Quality Committee recommended using national Medicaid performance as the benchmark for all measures in the Health Equity and Quality Measure Set (HEQMS), but ultimately could not come to a consensus on recommending either the 25th or 50th percentile. The Committee reconvened in October 2023 and ultimately decided to use the national Medicaid 50th percentile as the benchmark for each measure, both overall and by race and ethnicity.[6] This benchmark will be used as a minimum requirement, not a goal to reach.

The Committee also noted that collecting race, ethnicity, language, sex, sexual orientation, gender identity, age, income, disability status, tribal affiliation, and geographic location data are imperative to address health disparities, but reporting limitations at this current time in California greatly hindered their ability to make measure stratification recommendations. The Committee did recommend that DMHC require disaggregated reporting from health plans once it becomes possible.[6]

Additionally, the Health Services Advisory Group (HSAG) collaborated with California to publish the 2020 Health Disparities Report, highlighting 35 measures stratified by race, ethnicity, primary language, age and gender. Benchmarking and confidence intervals were used to identify health disparities by race and ethnicity only. The following benchmarks were utilized:

1. 2020 national Medicaid 50th percentile (for HEDIS measures)

2. The median (50th percentile) statewide performance rate (for CMS Core Set measures)

95% confidence intervals were calculated for each population group's rate using NCQA methodology (detailed in Appendix B). The report recognizes a disparity in a particular measure when the upper interval of the confidence interval falls below the benchmark.[7]

Incentivized Components

California has many incentive options for MCPs, including pay-for-performance quantitative improvement initiatives and incentives for completion of equity-related activities and milestones. These incentive components are detailed below.

Health Equity Measure Set

California requires MCPs to report on the measures included in the DHCS Health Equity Measure Set, stratified by race and ethnicity. Performance on these measures was used to determine and readjust capitated payment rates and member assignment beginning in 2023. California is currently in the process of engaging with stakeholders and gathering feedback on the exact methodology to be used to determine weighting of performance.[4] Staff were unable to find updates on the results of this program component.

Health Equity and Quality Measure Set

Beginning with measurement year 2023, MCPs are required to report the 13 measures that make up the Health Equity and Quality Measure Set. For MY 2023, MCPs must report stratified race and ethnicity rates for nine measures and overall rates for all 13 measures. For MY 2024, MCPs must report stratified race and ethnicity rates for ten measures and overall rates for all 13 measures. California will codify the measures and benchmarks in the HEQMS by 2027. At that point, California may begin implementing administrative penalties for failing to meet benchmarks.[6]

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear plan with the goal of transforming Medicaid in California through bridging gaps across the health care delivery system, building sustainable capacity, investing in delivery system infrastructure, and reducing health disparities. MCPs may earn incentive payments through the successful completion of activities related to this goal. These activities aim to support populations that are at an increased risk of experiencing health disparities.[8]

COVID-19 Vaccine Incentive Program

MCPs were incentivized to improve overall COVID-19 vaccination rates among members and to reduce disparities in rates from September 2021 through February 2022. 20% of the incentive could be earned through completion of process measures, while the remaining 80% was designated for the achievement of outcome measures in overall vaccine uptake and improvement in vaccination rates by age and group and race/ethnicity. Baselines were set using vaccination rates as of August 29, 2021. MCPs were able to earn incentive funds by demonstrating improvement in the two race/ethnicity groups with the lowest baseline vaccination rates. Successful improvement was defined as meeting, at minimum, the lesser of two targets: (1) the baseline rate for the overall population, or (2) 85%.[9]

DHCS published an evaluation report of the program in February 2024.[10] All 25 MCPs participated in the program. At the conclusion of the program, DHCS paid plans 64% of the allotted funding. The program was intentionally designed to be ambitious, with the goal of only paying out all available funding to MCPs if they fulfilled all requirements of the program. MCP leaders noted that the structure of the program, which gave partial credit with thresholds followed by progressive amounts of award, was effective in motivating MCPs, as targets were ambitious but the baseline threshold was achievable.

The evaluation report also highlighted the work done by the top five performing MCPs. These MCPs were more likely to report activities that aimed to remove barriers to vaccination, and less likely to report education-only activities, when compared to the lower performing MCPs. These top MCPs reported that their most successful activities included collaborating with community organizations to provide vaccine appointments, conducting vaccine events/clinics onsite in low vaccinated communities, and giving gift cards or other incentives to members. MCPs also reported that population-specific activities organized and implemented in conjunction with members of that population were more likely to be successful.[10]

Funding

The Governor's budget allocated the following funds for CalAIM incentives: $300 million from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Payments are issued to plans at the beginning of each designated timeframe and are subject to recoupment if the MCP fails to demonstrate a minimum level of effort in fulfilling requirements. The COVID-19 Vaccine Incentive Program was funded through an allotment of $350 million from DHCS.[9]

Takeaways and Limitations

- The identification of a health disparity using confidence intervals is only applicable for moment in time measurement. California's measurement strategy cannot be used for measurement of change over time.
- Confidence internals may not be good indicators of disparities for smaller population groups.
- The lack of reliable and complete data hinders efforts to report and reduce disparities among stratified groups.
- The COVID-19 Vaccine Incentive Program was a fixed-term program that was not continued in future years. However, the program structure was considered successful and effective by both DHCS and the MCPs.

Louisiana

While Louisiana requires reporting of quantitative quality measures stratified by priority populations, incentive payments are not associated with quantitative reductions in inequities. Instead, Louisiana incentivizes the achievement of structural measures tied to health equity quality improvement milestones.

The Louisiana Department of Health (LDH) contracts with Managed Care Organizations (MCOs) across the state to administer Medicaid services. Each MCO is required to develop a multi-year Health Equity Plan that includes reporting the following quality measures, stratified by race, ethnicity, and geographic location (rural/urban):[11]

1. Percentage of low birthweight births
2. Contraceptive care: Postpartum women ages 21-44
3. Well child visits in the first 30 months of life
4. Childhood immunizations (Combo 3)
5. Immunizations for adolescents (Combo 2)
6. Colorectal cancer screening
7. HIV viral load suppression
8. Cervical cancer screening
9. Follow-up after emergency department visit for mental illness (30 days)
10. Follow-up after emergency department visit for alcohol or other drug abuse or dependence (30 days)
11. Follow-up after hospitalization for mental illness

Reference Points and Benchmarks

Performance at the statewide and plan level for each quality measure is compared to the national Medicaid 50th percentile to assess progress.[12] There is no reference point or benchmark set for the stratified race, ethnicity, and geographic location categories within each measure.

Incentivized Components

The incentivized components are structural. Louisiana's contracts with MCOs do not list any specific requirements around measurable reductions of health disparities for MCOs to earn bonus funds. Instead, MCOs may earn health equity bonus funds by completing and reporting on a number of equity-related activities, such as the development of a Health Equity Action Team (HEAT), meaningful community engagement, stratified reporting of quality measures, and staff/provider training requirements.[13]

Funding

Louisiana withholds 2% of the capitation rate to fund incentive-based endeavors. Of this 2%, 0.5% is designated specifically for health equity reporting and activities. The remaining 1.5% is split between a quality withhold used to incentivize quality and health outcomes (1.0%) and value-based payments (0.5%).[13]

Takeaways and Limitations

- Louisiana has a number of opportunities for MCOs to earn funds by completing equity-related activities and structural changes. There are no incentives in place related to reducing disparities on process or outcome measures.
- Though MCOs are required to report 11 quality measures stratified by race, ethnicity, and geographic location, there are no specified reference points or benchmarks for these groups.

Michigan

Michigan requires all reported quality measures to be stratified by race and ethnicity, but incentive payments are tied only to a subset of population groups within a few specific measures.

The Michigan Department of Health and Human Services (MDHHS) began the Michigan Medicaid Health Equity Project in 2011. Michigan requires Medicaid Health Plans (MHPs) to collect and submit data on 14 HEDIS quality measures.[13] In measurement year 2020, MDHHS removed two of these measures from the Equity Project (Children and adolescents' access to PCPs and comprehensive diabetes care-medical attention for nephropathy), citing low-level disparity. These data are consolidated and reported at the statewide level in the Medicaid Health Equity Project Annual Report. Each measure is stratified by race and ethnicity.

Reference Points and Benchmarks

Michigan utilizes **pairwise disparities**, which compare the population of interest to (1) the reference population and (2) the HEDIS national 50th percentiles. The White Non-Hispanic population serves as the reference population for all comparisons. MDHHS notes that this decision was made because the White Non-Hispanic population is not exposed to racial/ethnic discrimination; therefore, disparities compared to this reference population can be an indicator of the health effects of discrimination and racism.[14]

Additionally, Michigan reports on **population disparity**, defined as the amount of disparity that exists in the entire population for one measure. This is calculated by combining the disparity experienced by all subpopulations into the measure.[14]

The Percentage Distance to the Mean (PDTM) included in OHA's Deeper Dive Dashboard is similar to the method used in Michigan, though the reference group differs.

Incentivized Components

Michigan currently uses two incentive methods for reducing disparities, one focused on low birth weight and the other using a subset of 11 HEDIS measures.

Low Birth Weight

Michigan identified low birth weight as an area of severe racial and ethnic disparities and implemented an incentive program with structural milestones. The state began a three-year pay-for-performance initiative in 2018 with the goal of reducing those disparities.[14] MHPs could earn a portion of their withheld funds by successfully completing and reporting on the four components: (1) Baseline Analysis, (2) Intervention Proposal, (3) Intervention Implementation and (4) Intervention Reporting.

To measure success, this project utilized the CMS Core Set measure Live Births Weighing Less than 2,500 Grams. Prior to the start of the project, Michigan reported the 2017 statewide rate of this measure as 8.8%. The 2017 rate stratified by race and ethnicity is not published, but Michigan stated that this metric has notable racial and ethnic disparities.[15] The project ended in 2021, and though Michigan has not published an evaluation report of the project, the statewide rate for this measure worsened from 8.8% in 2017 to 11.6% in 2021.[16] Without race and ethnicity stratifications, we cannot know if this project successfully reduced racial and ethnic disparities. Additionally, the COVID-19 pandemic likely impacted the results for this measure.

Significant Reductions in Disparities

MHPs may also earn withheld funds by displaying significant improvement (as defined in Appendix A) in reducing disparities for members who identify as African American or Hispanic. The program uses the following HEDIS measures:[14]

1. Adult's access to preventive/ambulatory health services – ages 20-44 years
2. Breast cancer screening
3. Cervical cancer screening
4. Chlamydia screening in women
5. Postpartum care
6. Childhood immunizations – Combo 3
7. Immunizations for adolescents – Combo 1
8. Lead screening in children
9. Well-child visits 3-6 years
10. Comprehensive diabetes care – HbA1c testing
11. Comprehensive diabetes care – eye exams

Funding

Michigan utilizes a portion of its capitation withhold to fund health equity initiatives. As of 2021, the total withhold amount is 1% of the capitation rate.[13]

Takeaways and Limitations

- Terminology note: Michigan refers to the structural measures comprising its low birth weight program as a pay-for-performance initiative. The payment for statistically significant reductions in disparities is directly tied to performance on quantitative measures.
- Focus areas: Michigan's statistically significant reduction in disparities program is limited to closing gaps between those who identify as African American or Hispanic and the White reference group. The program does not address disparities affecting other racial and ethnic groups.

- In terms of using the White population as the reference group, critics note that this benchmarking approach does not recognize that White Non-Hispanic Medicaid members may themselves not be getting high-quality care, resulting in an inappropriately low bar for defining high-quality care. Furthermore, the White population is not a monolith, and as such, use of this group as a reference can potentially mask disparities within this population, including in relation to intersecting identities and factors such as gender and geography. However, MDHHS states that they concluded, in the context of Michigan's culture and history, that the White Non-Hispanic population in Michigan is not exposed to racial and ethnic discrimination, meaning that disparities noted when compared to this reference population can be an indicator of the health effects of discrimination and racism.

Minnesota

Minnesota incentivizes health equity quality improvement within a specific group of HEDIS measures and with one state-specific homegrown measure.

The Minnesota Department of Human Services (MDHS) contracts with Managed Care Organizations (MCOs) to administer Medicaid services.[13] MCOs are required to report on the following HEDIS measures:

1. Annual dental visits
2. Childhood immunization status
3. Immunizations for adolescents
4. Well-child visits in the first 30 months of life
5. Child and adolescent well-care visits
6. Breast cancer screening
7. Cervical cancer screening
8. Prenatal and postpartum care
9. Colorectal cancer screening
10. Controlling high blood pressure
11. Comprehensive diabetes care
12. Initiation and engagement of alcohol and other drug dependence treatment
13. Follow-up after hospitalization for mental illness
14. Ambulatory care: Emergency department
15. Plan all-cause readmissions

Reference Points and Benchmarks

Minnesota stratifies each measure reported by the MCO by race and ethnicity, with the Non-Hispanic White population serving as both the reference population. Each MCO's rate is assessed against their own baseline rate calculated from the previous calendar year.[17]

Incentivized Components

Reductions in Disparities

Baselines were set for each MCO on the above quality measures by calculating a disparity gap for each racial and ethnic group stratification in comparison to the Non-Hispanic White group, based on performance in the previous calendar year. MDHS uses the following five race and ethnicity groups: Asian/Pacific Islander, Black, Hispanic, Native American, and Non-Hispanic White.[17] This means that there is a possibility of up to four disparity gaps per measure. A points system is then used to calculate performance based on net change in disparity gaps over time. Details of the points system methodology can be found in Appendix A. MCOs are eligible for an adjustment to their capitation payment risk corridor calculation on each measure only if the baseline rate is met or exceeded.[17]

Health Equity Stakeholder/Community Engagement Measure

MCOs are able to earn withheld funds through fulfillment of performance targets on a designated set of 11 measures. As of 2024, this set includes the Health Equity Stakeholder/Community Engagement measure, which requires MCOs to provide a Health Equity Addendum to their Population Management Report, reporting at least four health equity community engagement activities focused on addressing health disparities.[18]

Funding

The financial incentive for reductions in disparity gaps is included in the calculation of capitation payments and does not require additional funding.

The Health Equity Stakeholder/Community Engagement measure is part of an incentive program using withhold funds. Eight percent of MCO payments are withheld. Of this total, MCOs are eligible to earn back 62.5% of withheld funds through achievement of performance targets on a set of 11 measures. Each measure is assigned a point value, for a total of 100 points possible. The percentage of withheld funds to be returned is calculated by summing all earned points, dividing the total by 100 and converting to a percentage. The Health Equity Stakeholder/Community Engagement measure is worth 12 points.[18]

Takeaways and Limitations

- The methodology Minnesota uses to calculate disparity gaps is very sensitive and could potentially award or penalize non-statistically significant changes that do not reflection an actual change in performance.
- Use of the White or White Non-Hispanic Medicaid population as a reference group overlooks the possibility of a lack of high-quality healthcare for this population.

North Carolina

North Carolina launched its incentive program in 2024, with one measure focused on health equity.

The North Carolina Department of Health and Human Services (NCDHHS) recently transitioned from a fee-for-service model to a capitated managed care structure for Medicaid. Most beneficiaries were transitioned to fully capitated and integrated Standard Plans.[19] Eligible beneficiaries with intellectual and developmental disabilities, traumatic brain injuries, and serious behavioral health disorders were transferred to Behavioral Health and Intellectual and Developmental Disability (BH I/DD) Tailored Plans. These plans offer the same services as Standard Plans, along with specialized behavioral health and I/DD services.[19]

Each Standard Plan and BH I/DD Plan is required to report on the following quality measures, stratified by race, ethnicity, sex, primary language, geography (county) and disability status, where feasible:

1. Child and adolescent well-care visits
2. Childhood immunization status (Combo 10)
3. Immunizations for adolescents (Combo 2)
4. Total eligibles receiving at least one initial or periodic screen
5. Use of first line psychosocial care for children and adolescents on antipsychotics
6. Well-child visits in the first 30 months of life
7. Cervical cancer screening
8. Chlamydia screening in women
9. Comprehensive diabetes care: HbA1c poor control
10. Controlling high blood pressure
11. Flu vaccinations for adults
12. Medical assistance with smoking and tobacco use cessation
13. Follow-up after hospitalization for mental illness
14. Screening for depression and follow-up plan
15. Use of opioids at high dosage in persons without cancer
16. Use of opioids from multiple providers in persons without cancer
17. Concurrent use of prescription opioids and benzodiazepines
18. Plan all-cause readmissions

19. Total cost of care

20. Rate of screening for unmet resource needs

21. Low birth weight

22. Prenatal and postpartum care

23. Rate of screening for pregnancy risk

BH I/DD Plans also report on the following additional measures, with the same stratifications as above:

1. Follow-up for children prescribed ADHD medication

2. Metabolic monitoring for children and adolescents on antipsychotics

3. Antidepressant medication management

4. Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

Reference Points and Benchmarks

In measurement year 2024, the first year of North Carolina's Withhold Program, only one measure, Childhood immunization status (Combo 10), will be evaluated for improvement in reducing racial and ethnic disparities.[20] The other measures in the program set will be evaluated for overall improvement in comparison to the previous year's performance. The benchmark for Childhood immunization status (Combo 10) will be a 10% relative improvement in the priority population in comparison to the priority population's previous year rate. For example, if the previous year rate is 20%, a plan would need to achieve at least a 22% rate to receive the full allotted amount of funds for this outcome. For measurement year 2024, NCDHHS chose Black members as the priority population, and all other members as the reference population.[20]

Incentivized Components

Withhold Program

Four measures are included in the 2024 withhold measure set:

1. Prenatal and postpartum care: timeliness of prenatal care
2. Prenatal and postpartum care: postpartum care
3. Childhood immunization status (Combo 10)
4. Rate of screening for health-related resource needs

All measures will be evaluated for overall improvement. However, Childhood immunization status will also be assessed for improvement among Black members. Childhood immunization status will have two outcomes – one for overall population and one for health equity improvement for Black members.[20] This health equity improvement will be referenced as CIS Combo 10 – Priority population improvement. The remaining three measures each have one outcome.

The five outcomes are weighted to reflect the total withhold payment amount associated with each measure. Overall population outcomes for the prenatal and postpartum care measures are weighted at 15% each. Overall population outcomes for the CIS Combo 10 and HRRN screening measures are weighted at 17.5% each. CIS Combo 10 – Priority population improvement is weighted at 35%, the highest of all five measures in the set.[20]

To earn all of the withhold amount associated with CIS Combo 10 – Priority population improvement, plans must meet the benchmark of 10% relative improvement from their baseline. However, plans are able to earn partial funds in incremental amounts based on the amount of improvement.[20] A table detailing these amounts can be seen below.

Priority Population Improvement Rate	Withhold Payment Amount Earned
At or above 10% (the benchmark)	100%
Between 8% and 9.99%	80%
Between 6% and 7.99%	60%
Between 4% and 5.99%	40%
Between 2% and 3.99%	20%
Below 1.99%	0%

NCDHHS also utilizes a Bonus Pool, similar to OHA's incentive program Challenge Pool. In the case that not all withhold funds are earned by the Plans, 75% of the unearned funds are moved to the Bonus Pool, with the remaining 25% of unearned funds retained by NCDHHS.[20] The highest performing Plan for each measure will earn all of that measure's portion of the Bonus Pool. Plans must meet the benchmark to be considered for the Bonus Pool. This means that if no Plan meets a measure's benchmark, none of the Plans qualify for that measure's portion of the Bonus Pool, and those funds are retained by NCDHHS.[20] It is unclear how NCDHHS plans to reinvest those funds.

Funding

NCDHHS will withhold 1.5% of each plan's total risk-adjusted capitation to fund the Withhold Program.

Takeaways and Limitations

- North Carolina will reward plans for reducing health disparities, but only for one measure and one population.
- 2024 is the first year of North Carolina's Withhold Program, so we do not yet know if the program is effective.

Pennsylvania

Pennsylvania requires reporting on a set of quality measures stratified by race and ethnicity. However, incentives are only tied to improvements among Black members for a specified subset of measures.

The Pennsylvania Department of Human Services (PDHS) contracts with Managed Care Organizations (MCOs) across the state to administer Medicaid services.[21] Annually reported quality measures include (see Appendix F, page 51, for individual measures: https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/Medical%20Assistance%20Quality%20Strategy%20for%20Pennsylvania.pdf).

1. 31 CMS Adult Core Set measures
2. 21 CMS Child Core Set measures
3. 18 CMS Behavioral Health Core Set measures
4. 46 HEDIS measures
5. 26 Pennsylvania-specific measures

Reference Points and Benchmarks

Pennsylvania uses the overall statewide rate as a benchmark for the two measures included in their Equity Incentive Program. Additionally, Pennsylvania uses the National Medicaid 75th percentile as benchmark for the seven HEDIS measures that are included in the Maternal Care Bundled Payment (described below).[13]

Incentivized Components

Equity Incentive Program

Beginning in 2020, MCOs are incentivized to improve performance among Black members on a set of HEDIS measures. In 2024, the incentivized measure is Follow-up after hospitalization for mental illness, 7-day rate and 30-day rate.[22] MCOs that demonstrate greater than or equal to 2% improvement among Black members, relative to the overall population, for both rates, will receive an incentive payment. MCOs with less than 2% improvement in either or both rates will not receive a payout.[22]

Maternal Care Bundled Payment

Pennsylvania created a value-based maternal care bundled payment in 2021. MCOs can earn the payment by reducing disparities and improving performance among Black members across seven HEDIS measures related to maternal care.[23] Pennsylvania has not publicly specified if the bundled payment is earned only by achieving the National Medicaid 75th percentile benchmark, or a reduction in the gap between the performance rate of the Black member population and the benchmark rate also qualifies for the incentive.

Funding

Ten percent of the funds in Pennsylvania's MCO Pay for Performance Program are allotted to the Equity Incentive Program.[23] The Maternal Care Bundle is partially funded by a grant from the Robert Wood Johnson Foundation.[24]

Takeaways and Limitations

- Though Pennsylvania does provide incentives for reductions in disparities through the Equity Incentive Program, these incentives are limited to two measures and one racial/ethnic group.
- More time is needed to see if the program results in more equitable outcomes for the target population.

Washington

The Washington State Health Care Authority (HCA) contracts with both Managed Care Organizations (MCOs) and Accountable Communities of Health (ACHs) to operate its Medicaid Program. MCOs consist of the standard network of providers that receive capitated payments from the state, while ACHs are large regional organizations that bridge health care, social services, governments, and community organizations with the goal of improving health outcomes and health equity.[25] Washington reports on many quality measures, but designates a specific statewide accountability quality metrics set for benchmarking and tracking performance improvement in the state's delivery system transformation goals:[26]

1. All-cause emergency department visits per 1,000 months
2. Antidepressant medication management
3. Medication management for people with asthma
4. Asthma medication ratio
5. Comprehensive diabetes care: Blood pressure control
6. Comprehensive diabetes care: HbA1c poor control
7. Mental health treatment penetration (broad)
8. SUD treatment prevention
9. Child and adolescent well-care visits

Benchmarking

Washington uses a quality improvement model to calculate a quality score at the statewide level for the measures listed above. The quality score is calculated by comparing the performance year result to a range defined by a baseline and a target. For NCQA measures, the baseline is the national Medicaid average, and the target is the national Medicaid 90th percentile.[27] These measures are only evaluated at the statewide level. Though Washington does stratify some measures by race, ethnicity, language, and gender, there are no benchmarks set for these stratification groups.

Incentivized Components

ACHs can receive Delivery System Reform Incentive Payments (DSRIPs) to support projects aimed at accomplishing delivery system reform. These incentive payments can be earned through the achievement of structural milestones and pay-for performance outcomes.[26] While there are no direct health equity milestones or measures that an ACH must achieve to earn an incentive, the broader goals of Washington's delivery system transformation strategy include eliminating disparities and achieving health equity. The DSRIP projects often focus on addressing social needs, community engagement, and health care integration, all of which are connected to improvements in equity.[26]

Funding

The DSRIP incentive payments are part of Washington's 1115 Transformation Waiver and funded through CMS.[26]

Takeaways and Limitations

- Benchmarks are only set at the statewide level. Stratifications are reported by race, ethnicity, language, and gender, but performance improvements across these population groups are not tied to incentives.

Appendix B: Measure Calculation Methodologies

California

California follows NCQA methodology to calculate 95% confidence intervals:

$$Lower\ interval = rate - 1.96\frac{\sqrt{rate(1-rate)}}{denominator} - \frac{1}{2\ x\ denominator}$$

$$Upper\ interval = rate + 1.96\frac{\sqrt{rate(1-rate)}}{denominator} + \frac{1}{2\ x\ denominator}$$

Michigan

Two methods are used to calculate pairwise disparities:

Absolute Disparity (Difference) = Population of Interest – Reference Population / HEDIS national 50th pct.

Relative Disparity (Ratio) = Population of Interest/Reference Population / HEDIS national 50th pct.

Populations are considered to be significantly different if their 95% confidence intervals do not overlap, and significantly similar if their 95% confidence intervals do overlap. A population's rate is considered to be significantly different from the HEDIS national 50th percentile if the 50th percentile is not contained within the 95% confidence interval of the rate, and significantly similar if the 50th percentile is contained with the 95% confidence interval of the rate.

Population disparity is estimated with an Index of Disparity (ID), which describes average subpopulation variation around the total population rate. ID is expressed as a percentage, with 0% indicating no disparity and higher values indicating increasing levels of disparity. An ID less than 5% is considered a low level of disparity.

ID = (Σ|r(n) – R| / n) / R*100

r = subpopulation rate, R = total population rate, n = number of subpopulations

Minnesota

Minnesota uses a points system to calculate performance based on net change in disparity gaps over time per measure. Points are assigned based on the following scale:

Net Change in Disparity Gap	Points Awarded
< -50%	-2.0
-40% to -49.9%	-1.75
-30% to -39.9%	-1.5
-20% to -29.9%	-1.25
-10% to -19.9%	-1.0
-9.9% to 9.9%	0
10% to 20%	1.0
20.1% to 30%	1.25
30.1% to 40%	1.5
40.1% to 50%	1.75
>50%	2.0

Example calculation of one MCO's points awarded for one measure:

Measure A 2019 rates (baseline) and 2020 rates (performance period)

Race/Ethnicity Group	2019	2020
Non-Hispanic White (reference)	40%	42%
Asian/Pacific Islander	30%	35%
Black	35%	40%
Hispanic	25%	30%
Native American	28%	35%

Based on the 2019 rates, baseline disparity gaps for each race/ethnicity group would be as follows:

Asian/Pacific Islander: 40% - 30% = **10% disparity gap**

Black: 40% - 35% = **5% disparity gap**

Hispanic: 40% - 25% = **15% disparity gap**

Native American: 40% - 28% = **12% disparity gap**

Based on the 2020 rates, performance period disparity gaps for each race/ethnicity group would be as follows:

Asian/Pacific Islander: 42% - 35% = **7% disparity gap**

Black: 42% - 40% = **2% disparity gap**

Hispanic: 42% - 30% = **12% disparity gap**

Native American: 42% - 35% = **7% disparity gap**

Change in disparity gaps for each race/ethnicity group:

Asian/Pacific Islander: 10% to 7% = 30% net change in disparity gap. **Points earned: 1.25**

Black: 5% to 2% = 60% net change in disparity gap. **Points earned: 2.0**

Hispanic: 15% to 12% = 20% net change in disparity gap. **Points earned: 1.0**

Native American: 12% to 7% = 41.7% net change in disparity gap. **Points earned: 1.75**

The MCO therefore earns **6 points** for Measure A.

Appendix C: Racial and Ethnic Stratification Groups by State

California

Racial categories reported: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, and Other.

Ethnic categories reported: Hispanic or Latino.

Louisiana

Racial categories reported: American Indian/Alaskan Native, Asian, Native Hawaiian/Pacific Islander, Black/African American, White and Unknown.

Ethnic categories reported: Hispanic or Latino and Non-Hispanic or Latino.

Michigan

Racial categories reported: American Indian/Alaska Native, Asian American/Native Hawaiian & Other Pacific Islander, African American, White, and Unknown/Other/Declined.

Ethnic categories reported: Hispanic.

Minnesota

Racial categories reported: Asian/Pacific Islander, Black, Native American, and Non-Hispanic White.

Ethnic categories reported: Hispanic.

North Carolina

Racial categories reported: African American, American Indian, White, and Other.

Ethnic categories reported: Hispanic/Latino.

Pennsylvania

Racial categories reported: Not specified.

Ethnic categories reported: Not specified.

Washington

Racial categories reported: Not specified.

Ethnic categories reported: Not specified

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