CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

July 1, 2021

Jacey Cooper
State Medicaid Director and Chief Deputy Director Health Care Programs
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA, 95814

Sent via: CSBRFP8@dhcs.ca.gov

RE: Draft Request for Proposal #20-10029, Medi-Cal Managed Care Plans

Dear Ms. Cooper:

On behalf California's public health care system, the California Association of Public Hospitals and Health Systems (CAPH) is pleased to submit comments on the draft Request for Proposal #20-10029, Medi-Cal Managed Care Plans.

As you know, California's public health care systems are the core of the state's health care safety net, delivering high-quality care to more than 3.7 million patients annually, regardless of ability to pay or insurance status. Public health care systems include both county-operated or -affiliated facilities as well as the University of California medical centers. Statewide, public health care systems provide nearly 40 percent of all hospital care to the uninsured, and over 35 percent of all hospital care to Medi-Cal enrollees in the communities they serve. Nearly 60 percent of patients served at public health care systems identify as persons of color, and one in five patients report a primary language other than English. Public health care systems also operate over half of the state's top-level trauma and burn centers, and train half of all physicians in the state.

California has a long history of creating policies and structures within the Medi-Cal managed care program to support of safety net providers, dating back to the creation of the two-plan model. Some of these policies are still in practice today; plans that have a higher participation of safety net providers are awarded an increased percentage of assigned lives through the default algorithm. Amidst the unprecedented combination of a pandemic, a pending economic recession, and upcoming major transformations that will be driven by CalAIM, it is more important now more than ever that all Medi-Cal managed care plans, not just the public plans, support the sustainability of the safety net delivery system, protect and expand on the gains that have been made through efforts such as Whole Person Care, and partner with providers to best meet the needs of the enrollees they serve. Accordingly, we see the Department's reprocurement and recontracting efforts as an important opportunity to renew and strengthen Medi-Cal managed care's commitment to supporting public health care systems that have long served as the backbone of the Medi-Cal delivery system, and this is a key focus of our comments.

This reprocurement process should be a thorough, transparent endeavor to ensure that health plans, safety net providers, county partners, and beneficiaries trust the selection process, and that the needs of key Medi-Cal managed care provider partners are considered and addressed throughout.

CAPH supports the overarching goals of the Medi-Cal managed care plan reprocurement to improve access, quality, and coordinated and integrated care, address the social determinants of health, and meet CalAIM objectives. Unfortunately, due to the timing of this draft RFP release, some significant elements are not available for public review — most notably, many of the CalAIM requirements, state budget decisions and their accompanying trailer bills, the narrative proposal requirements, and DHCS' evaluation and scoring criteria. Therefore, our comments on the draft RFP that follow should be viewed as incomplete. For a more complete process, we respectfully urge DHCS to solicit public feedback on these missing elements before a final RFP is released later this year.

Thank you for the opportunity to provide comments for your consideration. We would be pleased to further discuss our comments with you or answer any questions you may have.

Sincerely,

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CAPH Comments in Response to DHCS' Draft Request for Proposal # 20-10029 Medi-Cal Managed Care Plans

RFP Reference	Section and Page Number	Issue, Question, or Comment	Remedy Sought
RFP Main	P; County Letter of Support; page 33	CAPH believes that reprocurement is an important opportunity to ensure that the commercial plans in Medi-Cal are fully committed and prepared to effectively partner with, and support safety net providers to best serve the Medi-Cal population and achieve the goals of CalAIM. Public health care systems are major providers of care to the Medi-Cal population, providing high-quality hospital care to over 35 percent of all Medi-Cal enrollees in the communities they serve, and serving as the primary care provider for nearly 560,000 Medi-Cal enrollees who have gained coverage since 2014. Public health care systems, with their county partners, have led efforts to improve care for low-income, vulnerable patients through the Whole Person Care (WPC) pilot program. As we now look to CalAIM to sustain and improve the health of this population, reprocurement will have a profound impact on the plans that assume the responsibility for this important county-plan-provider partnership. Because of WPC, over 177,000 individuals, many of whom face extreme challenges such as homelessness, severe mental illness, and involvement in the criminal justice system, have received coordinated health and social services that	CAPH urges that county letters of support be required for MCPs to be considered in the RFP selection process for two-plan model counties. As an initial deadline has already passed, county letters of support should be allowed to be resubmitted.

		are not traditionally covered by Medi-Cal. These services include supportive housing services, peer support, facilitated re-entry transitions, and recuperative care for medically vulnerable homeless individuals. Under CalAIM, these critical services will transition into enhanced care management (ECM) and in lieu of services (ILOS). A smooth and successful transition and continuation of this work requires robust partnership in which Medi-Cal managed care plans (MCPs) coordinate with each other to implement ECM/ILOS and recognize and rely on the expertise of counties and public health care systems in providing these innovative services and caring for these unique populations. Regardless of the Medi-Cal managed care county plan model type, counties should have a strong voice in the selection of the commercial Medi-Cal managed care plan that will operate in their county because of their critical role described above. The proposed RFP process will not allow for a county letter of support for consideration of MCP applications for two-plan county models. As such, the reprocurement of MCPs in those counties will be missing a critical voice in the selection process.	
• **RFP Main; and** • **Attachment 3**	• RFP Main; R; 3. Content Requirements; f. Proposing Firm's	The proposed RFP lacks any required endorsements or references from safety net or county providers, who, as stated above, will be integral to the success of CalAIM and	In cases where an MCP has previously contracted with a public health care system, they should be encouraged to submit a reference from a public health care system

	Capability Section; 5); page 41; and • Client References; page 1	sustaining current investments and improvements under WPC, as well as providing high-quality care overall to Medi-Cal managed care beneficiaries. Public health care systems are major providers of safety net care, delivering over 35 percent of all hospital care to Medi-Cal enrollees in the communities they serve. Nearly 60 percent of patients served at public health care systems identify as persons of color, and one in five patients report a primary language other than English. These systems should be supported by Medi-Cal MCPs and leveraged to achieve the goals DHCS has set out in the reprocurement. Similar to when Medi-Cal MCPs were established in the 1990's, they must be expected to demonstrate a strong commitment to supporting public health care systems, in recognition of their essential role in caring for low-income and vulnerable communities.	and should receive higher points in the application scoring process for doing so.
RFP Main	f. Proposing Firm's Capability Section; 3); pages 39-41	CAPH appreciates the narrative topics that MCPs will be required to address, as described in the draft RFP, as part of the MCPs' proposals. However, we believe that the RFP should also require plans to submit concrete evidence to demonstrate a history in these areas, as well as their plans for partnering with and supporting safety net providers in the future to achieve the overall objectives in the RFP to improve care delivery and health outcomes for patients (e.g., strengthening access, quality and integrated/coordinated services, reducing	In counties with public health care systems, MCPs should specify their approach to maintain a strategic partnership with the public health care system, including monitoring and responding to the evolving needs of the public health care system and its patients. Such descriptions of the future strategic partnership should include ways that the MCP intends to ensure robust communication and collaborative problem-solving. In addition, the MCP must demonstrate its commitment to this patient population through historical expertise with

		health disparities, and addressing social needs, etc.) and to meet the CalAIM objectives, if awarded the contract.	this patient population. For instance, if an applicant is new to the Medi-Cal market, the RFP should also assess whether the plan has the necessary expertise and successful experience with low-income and vulnerable populations, and MCPs should describe specific actions they have taken, including any prior efforts to coordinate care for patients or address social needs, and future actions they intend to take to meet the needs of this population. Beyond a self-reported description of previous experience and current investment in providing In-Lieu-of-Services-like services, MCPs that currently offer these types of services, especially current Medi-Cal MCPs, should be required to submit the number and types of ILOS they currently contract for and offer to enrollees as part of their narrative, as well as plans for intended future ILOS offerings. Because ILOS will be optional for MCPs but will also be a critical component in sustaining WPC work, MCPs that contract or plan to contract for ILOS in a meaningful way should receive higher points in the application scoring process. Additionally, for ECM, MCPs operating in WPC and Health Home Program counties, will already have implemented this new benefit by the time they submit their proposal to be a contractor under this RFP. Accordingly, those MCPs should be required

			to submit their Model of Care for ECM as part of their narrative statement, describing their previous experience and current investment in ECM services. MCPs that have already made significant investments to support and sustain WPC infrastructure should be given a higher weighting in their RFP applications for making such investments. Where quantitative metrics can be used to support self-reported narratives, such as previous efforts to reduce health disparities or improve quality outcomes, MCPs should be required to support their statements with relevant data. For example, for narrative statements addressing MCPs' prior efforts to identify and reduce health disparities and to improve quality outcomes, MCPs should be required to submit data to substantiate their narrative statements.
Exhibit A, Attachment III	2.1.2 Encounter Data Reporting; page 35	A new provision should be added to sample contract in the Encounter Data Reporting section specifically for managed care directed payments.	The sample contract should be amended to add: "Contractor is responsible for submitting complete, accurate, reasonable, and timely Encounter Data to DHCS, which includes the Encounters related to the Managed Care Directed Payments (as approved by CMS and permitted through 42 CFR 438.6(c)). Contractor shall work with Subcontractors and Network Providers to reconcile the applicable Encounter Data within the timelines as specified by DHCS."
Exhibit A, Attachment III	2.1.2 Encounter Data Reporting; F.; page 36	The sample contract should be amended to consider Encounter Data concerns raised by	The sample contract should be amended to state: "If DHCS finds or is notified by a

		subcontractors and network providers as well as any potential recalculations of Managed Care Directed Payments that are dependent upon the Encounter Data.	Subcontractor or Network Provider of deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Encounter Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Encounter Data, Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the data of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Encounter Data, which shall include any potential recalculations of Managed Care Directed Payments that are dependent upon the Encounter Data."
Exhibit A, Attachment III	2.1.4 Network Provider Data Reporting; F.; page 38	The Network Provider Data Reporting Section F., should be amended to consider Network Provider Data concerns raised by subcontractors and network providers as well as any potential recalculations of Managed Care Directed Payments that are dependent upon the Network Provider Data.	The sample contract should be amended to state: "If DHCS finds or is notified by a Subcontractor or Network Provider of deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Network Provider Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Network Provider Data, Contractor must ensure that corrected Network Provider Data is resubmitted within 15 calendar days of the data of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Network Provider Data, which

			shall include any potential recalculations of Managed Care Directed Payments that are dependent upon the Network Provider Data."
Exhibit A, Attachment III	2.1.4 Network Provider Data Reporting; page 38	The Network Provider Date Reporting section should be amended to add a provision specifically for Managed Care Directed Payments.	The sample contract should be amended to add a new provision: "Contractor is responsible for submitting complete, accurate, reasonable, and timely Network Provider Data to DHCS, which includes the Network Provider status related to the Managed Care Directed Payments (as approved by CMS and permitted through 42 CFR 438.6(c)). Contractor shall work with Subcontractors and Network Providers to reconcile the applicable Network Provider Data within the timelines as specified by DHCS."
Exhibit A, Attachment III	3.3.5 Claims Processing; page 81	A new provision should be added to the Claims Processing section that specifies that directed payments calculated by the State meet the definition of clean claims.	The sample contract should be amended to add a new provision: "Contractor shall issue payments to specified Network Providers at the direction of DHCS in accordance with 42 CFR 438.6 and within 30 days of receipt of the direction from DHCS."
Exhibit A, Attachment III	3.3.16 Emergency Services and Post-Stabilization Care Services; B. B. Post-Stabilization Care Services; 5.; page 88-89	The reference to "lower rate" in this section of the sample contract should be replaced with "different rate."	The sample contract should be amended to state: "Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), and 422.214, Contractor is financially responsible for payment of Post-Stabilization Care Services, following an emergency admission, at the hospital's Medi-Cal FFS payment rates for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a different rate is

			agreed to in writing and signed by the hospital."
Exhibit A, Attachment III	3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements; A. and B.; page 90	Today, hospitals generally wait on average from 60 to 90 days before they receive all the directed payments as directed by DHCS. For providers, including public health care systems, that contribute toward the non-federal share associated with directed payments, this places many hospitals in a distressed financial position – while many health plans delay in issuing payments. This section should be amended to conform amendments with clean claims and timely payments.	The sample contract should be amended in both A. and B. of the Compliance with Directed Payment Initiatives and Related Reimbursement Requirements section, following "technical guidance," to add "and 30 days of receipt of funding or the direction of payment from DHCS, whichever is later."
Exhibit A, Attachment III	• 4.3.5 PHM Delivery Services; 3) Transitional Services pages 112-113; • 5.2.3 Network Composition; page 169; • 5.3.1 Covered Services; page 197; and • 5.3.7 Services for All Members; G; 4); page 210	The responsibility of finding and managing discharge placements should not fall on hospitals' shoulders, but it often does today. As a result, safety net hospitals, including public health care systems, experience significant financial hardship. Beds are occupied by patients who no longer meet medical necessity criteria for inpatient reimbursement and are not available for patients in need of inpatient care. MCPs often do not reimburse hospitals for these administrative days, which results in a twice-over impact for public health care systems from incurred costs and lost revenue. Section G. 4) of the contract should be amended to clarify this responsibility for MCPs.	The RFP contract should clarify that MCPs are responsible for maintaining adequate networks and timely access to subacute facilities and other levels of step-down care for beneficiaries ready to leave the hospital setting, as well as for step-down care, as needed. Should a beneficiary need to remain in an inpatient hospital bed because of the lack of availability of beds in lower-level facilities, MCPs should ensure, through the RFP selection process, that their contracts with providers will specify that MCPs are responsible for safely discharging patients and are required to reimburse hospitals for these services until such discharge occurs. The sample contract should be amended to state: "Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level

			of care is not available, including but not limited to Administrative Days as defined in Exhibit A, Attachment I, Section 1.0 (Definitions), unless otherwise provided by contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including by offering to contract with facilities within and outside of the Service Area."
Exhibit A, Attachment III	4.3 Population Health Management and Coordination of Care; page 106	MCPs must be expected to make significant investments in the safety net delivery system. All Medi-Cal MCPs should be expected to invest in expanding ECM and ILOS service capacity, and do so by leveraging the investments made through WPC. Local infrastructure that has already been built up to serve WPC target populations should be strengthened and expanded upon to meet the ECM target population's needs. The draft RFP lacks any discussion of ILOS expectations and scope. Because public health care systems and counties have led efforts under WPC, they have firsthand experience and a foundation of providing ILOS; this expertise should be leveraged by MCPs to ensure high quality care for the most vulnerable in the MCPs' networks.	The draft RFP should clarify MCP objectives and responsibilities around ILOS. MCPs should be required to offer the right of first refusal to contract for ILOS and ECM at competitive and reasonable rates to counties, thereby protecting existing WPC infrastructure and leveraging the expertise of WPC pilot providers.
Exhibit A, Attachment III	4.3 Population Health Management and Coordination of Care; page 106	To promote transparency, accountability, and continuous improvement, contractors should be required to publicly post their Population Health Management analyses and strategies. This includes findings related to the Population Needs Assessment and	The sample contract should be amended to require MCPs to publicly post their Population Health Management analyses and strategies.

		strategy, risk tier assignment, and risk stratification algorithm, which comprise each contractor's population health management strategy. Sharing these findings will allow key partners, including public health care systems and other providers, to have a complete picture of the contractors' population health approach and to align their own health management efforts, preventing duplication and strengthening coordination across the network.	
Exhibit A, Attachment III	4.3.1. Population Health Management (PHM) Program Requirements; page 106	As stated previously, because of public health care systems' critical role and experience, MCPs should be required to engage and consult with these systems to develop their population health management strategy (PHMS), and this should be included specifically in the contract.	The sentence "Contractor must engage local public, behavioral health, and social services departments to develop a PHMS that includes all elements as set forth in this Section 4.3." should be amended to specifically reference public health care systems as entities that must be engaged in the development of the PHMS.
Exhibit A, Attachment III	4.3.5 PHM Delivery; page 118	ECM will be used for care management for the highest risk Medi-Cal patients to coordinate care delivery and social needs factors. Because these patients will receive intensive care management through ECM, they should not need Basic Care Management (BCM) in addition to ECM. The draft sample contract states that ECM would be in addition to BCM, which may lead to redundant services for patients. Similarly, Complex Care Management (CCM) should be reserved for patients with major medical conditions who need care coordination for	The sample contract requirements should be amended so that ECM enrollees are not also required to receive BCM or CCM in addition to the coordination they will receive under ECM, and made consistent with DHCS' proposed CalAIM ECM and ILOS Contract Template Provisions.

		acute health care needs. An enrollee who needs ECM may not have the same needs as enrollee who needs CCM. CCM should also not be required to be in addition to ECM services. Additionally, the recent CalAIM ECM and ILOS Contract Template Provisions released by DHCS indicates that beneficiaries would be excluded from ECM while enrolled in BCM or CCM (discussed in "2. Populations of Focus for ECM; d. v." on page four of the contract template provisions), which conflicts with the draft RFP sample contract.	
Exhibit A, Attachment III	4.3.5 PHM Delivery; page 116	The proposed sample contract states that individual care plans for care management would indicate the primary care provider as the primary lead, however, the primary care provider may not always be the appropriate lead for members who are receiving ECM services.	The sample contract should be amended to state "Be supported by an Interdisciplinary Care Team (ICT) with the Member's PCP or ECM provider as the primary lead."
Exhibit A, Attachment III	• 4.3.1. Population Health Management (PHM) Program Requirements; page 106; • 4.3.3. Population Needs Assessment (PNA); pages 106-107; and • 4.3.4. Member Population	The draft sample contract remains unclear regarding how the MCPs' risk tiers will work in tandem with the Population Needs Assessment strategy and risk algorithm results. For example, what will risk tiers indicate and how would they tie to services? Is it the State's intention to analyze risk tiers across the Medi-Cal program and, if so, how would this be done with each contractor using different eligibility criteria to assign tiers? Similarly, how will providers use the information regarding risk tiers, if tier	The sample contract should clarify the intended purpose and goals of the risk tiers.

	Identification; pages 107-110	definitions are inconsistent across health plans?	
Exhibit A, Attachment III	4.3.4. Member Population Identification; pages 107-110	CAPH supports the requirement for an MCP to "analyze its population risk stratification mechanism or algorithm to identify and correct biases that exacerbate Health Disparities." We appreciate DHCS's responsiveness to stakeholder input in adding this important step, which will help prevent unintended consequences for patients of color.	
Exhibit A, Attachment III	4.3.4. Member Population Identification; pages 107-110	The proposed sample contract does not discuss expectations for how MCPs' risk algorithms would be validated and updated to accurately assess enrollees' needs. Based on years of experience, public health care systems have learned that risk algorithms are constantly evolving as new data sources become available and should be continuously tested for validity and specificity.	The sample contract should be amended to require MCPs to regularly validate their risk stratification algorithms to ensure they accurately assess members' needs and appropriate levels of care.
Exhibit A, Attachment III	1.2.5 Medical Loss Ratio (MLR); page 15	We appreciate that the contract includes an MLR of 85 percent, however, Medi-Cal MCPs should strive for keeping managed care administrative costs as low as possible and that the vast majority of limited Medi-Cal dollars are prioritized for direct patient care.	MCPs should be required to, at a minimum, meet an 85 percent MLR for all Medi-Cal managed care enrollees assigned to the plan, as well as for any operative incentive payments the plan receives. To ensure competitiveness and that funds are used as efficaciously as possible for direct patient care, MCPs should be encouraged to increase their MLR for all enrollees, as well as incentive payments, with extra weight given to applications that include such higher estimates. If that MCP does indeed

			win the contract, the higher MLR should be binding.
Exhibit A, Attachment III	3.3 Provider Compensation Arrangements; page 80	Research has shown that social needs factors, such as income, housing, transportation, education, and social isolation, among other factors, have been linked to greater utilization of emergency services, and adverse health outcomes such as diabetes, heart disease and strokes, and account for roughly 20 percent of premature deaths nationally. Many of the patients served at public health care systems face these adversities and have more acute needs than the general population. Social determinants of health contributes to higher rates of health care utilization, the need for higher acuity services, and cost of providing care. Providers who serve high-risk patient populations should be compensated accordingly to effectively meet the needs of these patients. Successfully factoring in social needs into health care payment policies could help allow for improvements in the health and well-being of individuals who face socioeconomic and environmental challenges and help reduce avoidable health care utilization and spending.	MCPs should be required to risk-adjust payments to providers who serve higher-risk patients with greater social needs and adversities. As MCPs will already be required to stratify patients based on risk and health-related social need factors, this may allow for an accurate determination of enrollees who are at a higher risk due to their social needs' circumstances. Providers who serve a greater number of high-risk enrollees should have adjusted rates to account for this to best serve their patients. MCPs who commit to risk adjusting their rates to providers should be weighted more heavily as part of the RFP selection process.
Exhibit A, Attachment III	3.3.14 Major Organ Transplants; page 86	The proposed sample contract indicates that the MCP "shall reimburse a Network Provider furnishing major organ transplants to a Member the amount the Provider could collect if the Member accessed those services in the Medi-Cal fee-for-service delivery system as defined by DHCS in the	The sample contract should be amended to say: "The provider shall accept the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal fee-for-service delivery system as defined by DHCS in the Medi-Cal State Plan and other

		Medi-Cal State Plan and other applicable guidance, unless Contractor and the Network Provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to DHCS." However, this language should be consistent with the CalAIM trailer bill language and should be revised to ensure that rates received are identical to the Medicaid state plan.	applicable guidance, unless Contractor and the Network Provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to DHCS."
Exhibit A, Attachment III	5.3.7 Services for All Members; F. Major Organ Transplants, page 209	CAPH supports the sample contract's requirement that MCPs will be required authorize and cover costs for organ donors, including living donors and cadavers, regardless of a living donor's Medi-Cal eligibility.	
Exhibit A, Attachment III	• 5.3.1 Covered Services; page 198; • 5.5.3 Outpatient Mental Health Services Providers; page 224; and • 5.2.13 Network Reports; page 191	Telehealth modalities, like phone and video visits, and remote enrollment in state health programs have been critical in providing health care during the COVID-19 pandemic and have been one of the few silver linings over the past year. Telehealth has transformed healthcare during our nation's worst health crisis in a century, allowing patients to maintain timely access to care, in a more person-centered and convenient way. CAPH supports the references made to telehealth as an allowable modality for medically necessary covered services, for meeting timely access to outpatient mental health services, and for use if an MCP cannot meet time or distance standards for adult	

		and pediatric primary care providers, core specialists and outpatient mental health providers.	
Exhibit A, Attachment III	• 5.2.11 Cultural and Linguistic Programs and Committees; page 183; • 1.1.7 Health Equity Officer; page 5; • 2.2 Quality Improvement Systems; page 43; and • 2.2.7 Quality Improvement and Health Equity Annual Report; page 46	Addressing racial inequality continues to be at the core of public health care systems' mission and a main priority for their work. Because of their longstanding role serving a diverse, low-income patient population who are at greater risk for health disparities, public health care systems have undertaken specific efforts to address inequities in care. For example, public health care systems have developed tailored methods to reduce disparities between specific populations and have invested in culturally and linguistically competent care practices. Now through the Quality Incentive Program (QIP), public health care systems are collectively working to improve diabetes for African American and Latinx patients. Public health care systems are also continuing to collect and will report on data stratified by race and ethnicity for several QIP measures, which will help identify disparities and inform future efforts for addressing them. Still, the injustices we witnessed over the past year, and the disparate impact of the COVID-19 pandemic, further exposed the deep-rooted racial and ethnic inequalities in our society and required a moment of internal reflection for public health care systems. We are now collectively examining	

		where more work is still needed to improve health equity for patients. CAPH is pleased to see the commitment and focus of improving health equity and addressing health disparities as a main objective of the upcoming MCP reprocurement and we look forward to partnering with MCPs and the State to continue this extremely important work.	