**COMPILATION OF RFP QUESTIONS – SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY**

This document presents a compilation of questions from recent state Medicaid request for proposals (RFPs), demonstrating state Medicaid agencies’ movement towards including questions around social determinants of health (SDOH), health equity, and racial disparities. We identified and pulled Medicaid RFP questions from recent state procurements including the District of Columbia, Hawaii, Kentucky, Minnesota, Nevada, Ohio, and Oklahoma.

Given the evolving state and national level priorities around social and environmental drivers of health, Medicaid MCO RFPs are currently encouraging and expecting applicant health plans to innovate and compete accordingly. We do not envision this to be a short term “fad” – rather, we fully expect these types of questions to appear in RFPs throughout the foreseeable future. The further a health plan can extend itself to identify and address housing and nutrition needs, health disparities, gaps in care, and health education challenges, the greater the likelihood the entity will emerge successfully from the survival challenge a contract procurement poses.

From a competitive positioning lens, ACAP plans need to consider what they can put in place to further “move the needle” in the SDOH and health equity arenas prior to their next contract procurement/reprocurement situation. Plans are always better served by demonstrating what they *have done* and what they *have achieved* in a state priority area, than relying entirely on new commitments. That said, it is also important for ACAP plans to consider what new commitments they are willing and able to make in the SDOH and health equity areas in any RFP response. Regardless as to how well an MCO is performing, it is always better to bid above the “same store” to demonstrate to the state that what they will be getting will improve upon what they are now getting.

1. **Examples of Recent RFP Questions with Social Determinants of Health Components**

**Oklahoma RFP, Question 28:** Provide a detailed description of how your operational structure and practices will support the integrated delivery of physical health, behavioral health, pharmacy benefits and services addressing Social Determinants of Health. Describe your strategies to ensure coordination of care for Health Plan Enrollees receiving, or in need of, dental services through the separate Dental PAHP and services eligible for 100% federal match delivered by IHCPs.

**Oklahoma RFP, Question 33:** Describe your approach for addressing Social Determinants of Health in accordance with the requirements of Model Contract Section 1.6.9: “Social Determinants of Health.”

In addition, provide an example of an innovative approach you took to address Social Determinants of Health, the results achieved, and how you will apply this experience to SoonerSelect. Limit your examples to 2015 or later.

**Nevada RFP, Question 3.3.12.4:** Describe how the Vendor will identify and address the social determinants of health (SDOH) needs affecting its membership in the context of the Vendor’s population health management strategy. Include an example of the Vendor’s experience and success addressing SDOH to improve population health outcomes.

**Nevada RFP, Question 3.3.12.9:** Adele is a twenty-three (23) year-old woman who has recently been identified as pregnant. She does not work and has two (2) children who live with her, ages two (2) and fifteen (15) months, and a live-in boyfriend who works at a minimum wage job. There is some evidence of potential domestic violence in the home and significant financial stressors. Through pharmacy claims, the Vendor notes she is currently prescribed Xanax for anxiety. The Vendor receives an authorization request for maternal substance use treatment from an OBGYN in the Network. The request indicates that Adele has been using crack cocaine about once per week and has a history of methamphetamine use, but denies using methamphetamine the last four (4) months. Describe the Vendor’s Utilization Management, Care Management, treatment planning, and services for Adele.

The response should address:
a. Early identification and outreach to the individual;
b. Adequate Provider resources to address the SUD during pregnancy;
c. For women whose Medicaid coverage is Medicaid for Pregnant Women (MPW), how to quickly engage the Member in treatment as well as effectively plan to address discharge from services and/or loss of Medicaid;
d. How social determinants of health issues will be managed, including housing; and
e. How the Vendor will use value added services to incent improved outcomes for the family.

**Nevada Question 3.3.15.9:** Describe the Vendor's experience implementing and advancing Value-Based Purchasing (VBP) arrangements, as described in the Health Care Payment Learning and Action Network (LAN) alternative payment methodology framework, with Providers that incentivize Providers to address the social determinant needs of Members, improve health equity in access to and delivery of health care services, and improvements in maternal and child health outcomes. Address the following items in the response:

a. Provide examples of the types of VBP arrangements, types of Providers that participated in VBP arrangements, actual or anticipated number of Members served under VBP arrangements, and indicate whether the examples are planned or implemented.
b. How the Vendor assesses a Provider’s capacity and ability to contract under a VBP arrangement and evaluates whether the Provider is able to progress along the LAN framework;
c. How the Vendor shares quality, utilization, cost, and outcomes data with Providers participating in these arrangements, supports Providers to be successful under these reimbursement arrangements, and implements strategies to reduce Provider administrative burden; and
d. How the Vendor evaluates the success of the VBP arrangement, including the types of performance metrics and the evaluation process.

**Minnesota Section 2 Question 4:** Describe your organization’s approach to addressing social drivers of health to improve population health and prevention. Describe your organization’s work regarding community collaboration efforts, provider and other stakeholder partnerships, and data collection including social drivers of health and analysis. If applicable, provide examples for populations in the various regions of your current or proposed service area covered by this RFP.

**Minnesota Section 2 Question 9:** How has your organization approached disparities in well child visits? What have you learned from these efforts and how will you apply these learnings to future efforts? How are you connecting families to broader social supports?

**Minnesota Section 3 Question 2:** How does your organization use value-based purchasing or other incentive arrangements to address social drivers of health to improve quality of care and health outcomes?

**Minnesota Section 5 Question 4:** Describe how you define, evaluate, and ensure the adequacy of your provider networks, beyond what is required under Minnesota Statutes, section 62D.124 and the MHCP contracts. Describe how you ensure the availability of providers of services often unique to the Medicaid program and who are positioned to address social risk factors.

**Ohio Question 5:** Describe how the Applicant will identify and address the social determinants of health (SDOH) affecting its membership in the context of the Applicant’s population health management strategy. Include an example of Applicant’s experience and success addressing SDOH to improve population health outcomes.

**District of Columbia Question L.2.8.2.2.** Provide a detailed explanation of the Offeror's method to administer services and supports (including value-added services) to address social factors that impact the health and overall wellbeing of Enrollees. The Offeror's method shall include at a minimum the following:

1. Description of how the Offeror will use data analytics to determine the need for services and supports and the targeted populations;
2. Proposed services that best serve the District's Medicaid population;
3. Justification of the Offeror's selection of any value-added services through research and analyses, demonstrating the intended long-term impact, including behavioral modification that influence informed decision making;
4. Include analysis that demonstrates the impact in terms of cost savings, and perceived qualitative value of each service for the targeted population;
5. Identify the category or group of Enrollees to receive proposed value-added Services, with explanation as to why the service is targeted for these Enrollees.
6. Limitations or restrictions that apply to the Value-added Services.
7. Identify the Provider/Provider type or entities responsible for rendering the services and supports, including any limitations on Provider capacity, if applicable.
8. Methods and timing for notifying Providers and Enrollees about the availability of the service and supports; as well as the Offeror's proposed method(s) of outreach.
9. Description of the process by which an Enrollee may obtain or access Value­added Services, including any action required by the Enrollee, as appropriate.
10. Description of how the Offeror will identify the Value-added Services in administrative data ( e.g., Enrollee Encounter Data), if applicable.

**Kentucky Question 60.7.B1a:** Describe the Vendor’s experience in the provision of managed care services to the populations specified in this Contract. Include the following information in the response:

1. Experience in implementation of population health management programs and initiatives. Include information about how the Vendor has addressed social determinants of health.
2. Three (3) examples of initiatives the Vendor has implemented for Medicaid managed care programs that have supported improved outcomes. Describe whether such initiatives were cost effective and resulted in sustained change.
3. A summary of lessons learned from the Vendor’s experience providing similar services to similar populations.
4. How the Vendor will apply such lessons learned to the Kentucky Medicaid managed care program.

**Kentucky Question 60.7.C20:** Provide a detailed description of how the Vendor’s operational structure and practices will support integrated delivery of services (i.e., staff, contractors, systems, calls centers, etc.). In addition, the Vendor’s response should address:

1. Innovative approaches to ensure Enrollees experience whole-person care that integrates their medical and behavioral health benefits and addresses social determinants of health.
2. Approach for coordination with carved-out services (e.g., transportation and transitions to long term supports and services).
3. A description of any value-added services the Vendor proposes to provide to Enrollees.

**Kentucky Question 60.7.C24a:** Provide a comprehensive description of the Contractor’s proposed Population Health Management (PHM) Program, including the following at a minimum:

iv. The Contractor’s approach to each of the three PHM Program defined risk levels: health promotion and wellness, management of chronic conditions, and complex care management. Include information about the following for each risk level:

1. Tools the Contractor will use to identify Enrollees and their risk levels and to support services provided.
2. Risk stratification methodology and descriptions of the types of data that will be used.
3. Methods to identify Enrollees for each of Kentucky’s priority conditions or populations.
4. Services and information available within each risk level.
5. Description of the care planning process, including methods to ensure individualized and person-centered care plans, and summary of how the Contractor will include Enrollees, their caregivers, and multi-disciplinary teams.
6. Stakeholder engagement strategies, including involvement of community resources to meet social needs. Technology and other methods for information exchange, as applicable.
7. Frequency of provision of services.
8. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.).
9. Description of staffing for each risk level, including staff to Enrollee ratios, modes of interface with Enrollees, and use of care managers.
10. If applicable, value-based payment (VBP) or incentive models the Contractor will include in Provider agreements to support involvement in the PHM Program.
11. Methods for evaluating success of services provided.
12. Methods for communicating and coordinating with an Enrollee’s primary care provider or other authorized providers about care plans and service needs.
13. Role, if any, the Kentucky Health Information Exchange (KHIE) will play in the Contractor’s PHM Program as a resource.

**Kentucky Question 60.7.C30.1:** Rhonda is a 30-year-old Enrollee who recently learned that she was pregnant after visiting the Emergency Room, by ambulance, with severe nausea and dehydration. She has a history of high- risk pregnancies. Of 5 pregnancies she has experienced one (1) live birth, three (3) miscarriages occurring early in the second trimester, and one (1) abortion in her teens. In addition to her history of complicated pregnancies she smokes a half pack of cigarettes per day and drinks approximately 2 -3 beers /week. During her pregnancies, Rhonda sporadically kept prenatal visits and had a history of noncompliance with routine care instructions. Rhonda was shocked to learn that she was pregnant since she delivered a baby girl ten (10) months earlier. Her daughter, Amanda, was born at 32 weeks and was in the NICU for three (3) weeks. Amanda is feeding well and is steadily gaining weight. With that pregnancy, Rhonda experienced post-partum depression and was concerned whether she could care for Amanda. Rhonda’s closet family is in Texas but visits are infrequent. She recently separated from an abusive partner who provides minimal financial and emotional support. Rhonda and Amanda sought safety in a family shelter on three (3) different occasions after her partner threatened to harm Amanda. Rhonda became upset upon learning she was pregnant again and kept telling the ER nurse that it could not be true. She explained that she just moved out her apartment after splitting with her partner and was staying temporarily with friends. Rhonda does not have reliable transportation and often relies on friends to provide rides to the pediatrician and grocery shopping. The ER nurse recommended that Rhonda talk with her OB/GYN and her MCO about her options. Rhonda’s electronic medical record was updated and a referral was made to her OB/GYN. Describe how the Vendor would address Rhonda’s situation including a detailed description of prenatal programs and Quality Improvement Initiatives. At a minimum, address the following programs and services:

1. Applicable evidence-based Care Management practices
2. High risk pregnancy initiatives
3. Health Risk Assessment and Care Planning
4. Environmental assessment
5. Behavioral Health Services
6. Family planning
7. Enrollee and family engagement
8. Linkage to community resources and support
9. Social Determinants of Health
10. Provider engagement
11. Transportation.

**Kentucky Question 60.7.C30.2:** Katy is a 20 year old female who is taking classes at a local community college while living at home with her mother to help take care of her younger brother. Katy’s mother works two (2) jobs and has difficulty finding time to shop for and prepare healthy meals. Katy does not assist with grocery shopping or meal preparation. Katy is significantly overweight and rarely exercises. Most of her meals are from fast food restaurants and she only occasionally eats vegetables or fruit. Recently, Katy became light headed after eating lunch and was taken to an urgent care center by a friend. The provider asked Katy about her symptoms and whether this has happened before. Katy stated that the dizziness happens frequently after meals and she is always thirsty. The provider asked Katy if she has diabetes and Katy stated she did not think so. She told the provider that she has not seen a doctor since she was in middle school. The nurse took Katy’s vital signs and a blood glucose reading. Katy’s blood glucose reading was elevated and her blood pressure was 162/90. Her BMI was computed to be 32.6. The provider recommended that Katy contact her MCO to find a PCP as soon as possible before her condition worsened and she ended up in the Emergency Room. Katy contacted her MCO’s Enrollee Call Center and explained her situation. Describe the Vendor’s Enrollee engagement process and Care Management. At a minimum, address the following:

1. Evidenced based practices for Care Management
2. Health Risk Assessment and Care Planning and monitoring
3. Provider engagement
4. Cultural competency
5. Patient engagement and education
6. Community resources
7. Social determinants of health

**Kentucky Question 60.7.C30.3:** The Vendor is implementing a two-year initiative to improve outcomes by addressing a variety of health behaviors (e.g., tobacco use and diet) and social determinants of health in the southeast region of Kentucky. The Vendor has enrolled several primary care and multi-specialty provider groups in the area to participate in the initiative and has developed relationships with various community agencies to support the effort. The Vendor has identified five (five) quality measures for which providers will receive incentives for meeting targeted improvements. The quality measures emphasize physical and behavioral health integration, social determinants of health, and critical community resources. The Vendor intends to make initial incentive payments 14 months after the start of the initiative. Six (6) months into the project, a multi-specialty provider group’s Administrator met with the Vendor to discuss challenges the group is encountering with the initiative and to raise concerns about reporting. This provider group has 50 participating practitioners, including Advanced Practice Nurses, in four different locations. Specifically, challenges are as follows: - Some practitioners in the group are very engaged while others are not interested in supporting the effort, indicating it is too complicated and administratively burdensome as the group is also participating with similar initiatives being implemented by the other contracted Medicaid MCOs, but that have different required measures. - The provider group has a new electronic health record (EHR) system and experienced numerous onboarding issues that haven’t yet been resolved. In addition, the provider group does not plan to contribute or retrieve information from KHIE until the EHR issues are resolved. The provider group does receive ADT data from Southeastern Kentucky Medical Center and the Baptist Health hospitals. - The Administrator has made multiple attempts to outreach to a community housing agency that the MCO indicated is supporting the effort to discuss opportunities to collaborate; however, the agency has not returned calls. - Enrollee compliance is lower than anticipated. Follow up and other outreach has been difficult due to Enrollees not returning calls and also incorrect Enrollee contact information. - The Administrator is frustrated that the MCO had not provided feedback on the first set of required reports that were submitted three months after project initiation. Communication has been minimal and the Administrator is concerned about lack of support. The Administrator and practice leadership are concerned with the extended timeframe for incentive payments and the ability to impact providers’ behaviors. Describe the Vendor’s approach in addressing the Provider’s concerns. At a minimum, address the following:

1. Provider engagement at local, regional, and statewide levels;
2. Provider education, communications, and support;
3. Simplification of provider administrative burden;
4. Enrollee engagement;
5. Vendor assessment of internal operation challenges and mitigation strategies.

**Kentucky SKY Question 60.7G10.g:** Describe how the Vendor will capture data related to Social Determinants of Health and incorporate this information into its Care Management approach.

**Kentucky SKY Question 60.7G13.3:** Shakira, 16 years, entered foster care two months ago after her primary caregiver, her grandmother, Mrs. Miller, passed away. Shakira was nine years old when she went to live with her grandmother in Lexington after her mother was incarcerated twice for shoplifting and drug possession with intent to sell. Before the death of her grandmother, Shakira was an excellent student, a member of the swim team, played the clarinet in the school band, and hoped to go to the University of Kentucky (UK) to fulfill her dream of becoming a veterinarian. She had a boyfriend, Mike, who was the star player on the school’s baseball team. Mrs. Miller had a full-time job with a modest income and was supportive of her granddaughter’s studies and extracurricular activities. Shakira and her grandmother had discussed UK scholarship opportunities with the high school counselor. Three months ago, Shakira’s PCP confirmed that she was pregnant in her first trimester. Shakira and her grandmother discussed options: keep the baby, adoption, and abortion. Eventually, they decided to keep the baby to raise in their home. Mike and his parents strongly recommended adoption and refused to be involved in the baby’s support or upbringing. Within a week of the final discussion with Mike, Mrs. Miller died from a myocardial infarction. She was found in her home by Shakira when she came home from band practice. Shakira stayed with school friends for two weeks but the school counselor contacted DCBS and Shakira was placed in foster care. After two weeks in a Lexington group home, Shakira was placed in a private foster home in Bowling Green. Shakira began seeing an OB/GYN and made plans to keep her baby. She was also diagnosed with depression resulting from the death of her grandmother and transition to a foster home in Bowling Green. Shakira stopped talking about her dream to become a veterinarian. Shakira’s foster parents wanted both Shakira and her baby to stay with them as a teen mother and baby in foster care. The foster parents expressed concerns to the DCBS Social Service Worker, however, about Shakira’s depression, poor school performance, and development of her skills to care for a baby. Describe how the Vendor would address Shakira’s situation and coordination with the DCBS Social Service Worker, the foster family, physical and behavioral health providers, transition from the family to the community, and community resources. At a minimum, address the following programs and services:

1. Care management
2. Access to and coordination between physical health providers (e.g., OB/GYN, pediatrician) and behavioral health providers;
3. Access to network providers
4. Discharge planning for all levels of care
5. Coordination of school based services and an Individualized Education Plan
6. Community services for parenting skills
7. Applicable evidence based practices
8. Coordination of transportation, if needed
9. Options for aging out of foster care and risk management
10. Social determinants of health
11. Provider education and support
12. Access to and sharing of medical records
13. Maintenance of the Care Plan.

**Kentucky SKY Question 60.7G13.4:** Kirk is a 3 year old with cerebral palsy (CP), hydrocephalus with a ventriculoperitoneal (VP) shunt, and seizures. He was placed in foster care when he was two months old after his parents terminated parental rights. Kirk has been in six different foster homes in four different Service Regions. He is on multiple medications for his CP symptoms, including anticonvulsant medication. His infant VP shunt was replaced when Kirk turned two years old but two foster homes have reported problems with the shunt and repeated follow- up visits with the pediatrician and pediatric neurosurgeon. Access to a pediatric neurosurgeon and the availability of Kirk’s medical records as his placements change have been a significant problem. In addition, medication management and pharmacy records are problematic for the DCBS Social Service Worker and foster parents. Kirk’s current foster family lives in a rural community in Webster County. They have discussed adoption with the Social Service Worker but expressed concerns with access to the care that he needs in the long-term. The family has attempted to access care at the nearest children’s hospital but availability of appointments was problematic. The family now must travel to Cincinnati Children’s Hospital, which is more than a nine hour roundtrip commute. The travel and time off from work are hardships for the foster family but their primary concern is for Kirk’s health. The foster family is concerned about availability of primary care and dental providers, clinical specialists (e.g., pediatric neurosurgeons), specialists to support his cognition, behavior, communication and developmental needs, medications to treat his CP symptoms and associated conditions, physical therapy, durable medical equipment, planned family respite care, etc. Describe how the Vendor would address Kirk’s situation and coordination with the Social Service Worker, the foster family, in-state and out-of-state providers, and community resources. At a minimum, address the following programs and services:

1. Care management, including coordination to address fragmented care and timeliness of care
2. Availability of services and network access, including out-of-state providers
3. Availability of services, such as skilled nursing services
4. Access to school based services
5. Applicable evidence based practices
6. Coordination of transportation, as needed
7. Community resources
8. Social determinants of health
9. Planned respite care
10. Provider education and support
11. Access to and sharing of medical records
12. Maintenance of the care plan.
13. **Recent RFP Questions with Health Equity and Racial Disparity Components**

**Minnesota Section 1 Question 1:** Describe the accessibility and availability of your organization’s customer service operations. Please describe how your customer service operations address the various types of diversity that exist within the MHCP populations. Examples of the types of diversity included in a response are racial and ethnic diversity, languages spoken, employment status and availability to contact a health plan, disability and neurodiversity, and proficiency of health literacy.

**Minnesota Section 2 Question 1:** How does your organization address structural racism? What steps have you taken to become an antiracist organization? How do you plan to improve your systems and processes to be more antiracist?

**Minnesota Section 2 Question 2:** Describe a specific initiative your organization has implemented to address racial disparities you see within populations you serve. Describe the selection of the initiative, the planning process, implementation, evaluation, and learnings from that initiative.

**Minnesota Section 2 Question 3:** Describe the various populations that receive coverage through MHCP who experience barriers to health care and describe those barriers. Describe the initiatives you have provided to help improve the experiences for communities that experience barriers and disparities in health care outcomes.

**Minnesota Section 2 Question 6:** How does your organization establish and maintain processes that are culturally responsive and that support the integration and coordination of an enrollee’s primary care, behavioral health, and dental care? How do you identify the enrollees that will benefit from further coordination?

**Minnesota Section 2 Question 8:** Describe steps your organization has taken and/or will commit to taking to reduce implicit, explicit, and institutional bias experienced by Black and Indigenous people during pregnancy, delivery, and postpartum care. How are these actions monitored? How will these actions be sustained and/or adjusted in the future? How will these actions improve health outcomes and address disparities in health outcomes for Black and Indigenous people during and after pregnancy?

**Minnesota Section 3 Question 1:** How does your organization use value-based purchasing or other incentive arrangements to improve racial equity in quality of care and health outcomes?

**Hawaii Question 2:** a.Describe the Health Plan’s experience, innovative approaches providing covered benefits and services, as described in Section 4. The response shall specifically include: Addressing the needs of the unique populations of Hawaii, including Native Hawaiians and Hawaii residents from Micronesian Nations under the Compact. Approaches to providing EPSDT services

b. Describe the Health Plan’s experience, innovative strategies, and comprehensive approach to providing

prevention and health promotion services such as lifestyle classes, self-management and education classes, and smoking cessation services, with emphasis on populations for whom standard outreach and engagement strategies are less effective.

**Hawaii Question 7**: a. Describe innovative methods for communicating, including education and outreach, with the Members as follows:

1. Approach to identifying, developing, and distributing materials that will be of most use to the Member populations, and efforts the Health Plan proposes to target distribution to specific populations as appropriate. The Health Plan shall describe its methods of using culturally appropriate communications to meet the diverse needs and communication preferences of the Members, including but not limited to individuals with diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.
2. Describe innovative technologies the Health Plan will use to ensure high levels of QI Member engagement, as methods to educate the Members and advance their own involvement in their healthcare, and to communicate information specific to individual health conditions. The response should address the Health Plan’s experience in deploying technologies and identifying the populations to which the technologies would best apply.

**Ohio Question 23:** Describe the Applicant’s proposed approach to offering, promoting, and supporting the appropriate and effective use of telehealth services to increase access and health equity for Ohio Medicaid members. In your response assume a post-pandemic environment where access would be balanced with appropriate utilization management.

**Oklahoma Question 94:** Describe your relevant experience and proposed approach for undertaking an outreach strategy for AI/AN HealthPlan Enrollees and how you will use the Tribal Government Liaison position to support AI/AN Health Plan Enrollees and IHCPs in accordance with the requirements outlined in Model Contract Section 1.15.1: “Tribal Government Liaison.”

**Oklahoma Question 95:** Describe how you will make AI/AN Care Managers available to AI/AN Health Plan Enrollees, in accordance with the requirements outlined in Model Contract Section 1.15.3.5: “Care Management.” Discuss how you will contract with qualified IHCPs to perform care management activities.

**Oklahoma Question 96:** Describe how you will meet the network requirements outlined in Model Contract Section 1.15.4: “Indian Healthcare Providers (IHCPs).”

**Kentucky SKY Question 60.7G13.1:** Based on feedback from experienced DCBS Social Service Workers, certain providers in the Eastern Mountain Service Region have limited knowledge of trauma- informed evidence based practices. The DCBS caseworkers have documented numerous examples where Emergency Department (ED) staff and physicians/office staff neglected to conduct and document trauma assessments on children and youth, exacerbated trauma when physical assessments were performed on pre-teen girls, and failed to seek medical records before ordering duplicate testing/services. Describe how the Vendor would address and ensure the delivery of trauma informed care by the contracted provider network for the Kentucky SKY membership. In particular, address how it assesses providers’ knowledge of trauma informed care, the approach for targeted provider education at regional and state levels, as needed, and plans for collaborating with DCBS staff. At minimum, address the following in its response:

1. Evidenced based practices and trauma-informed care for the Kentucky SKY membership
2. Unique needs of children and youth in Foster Care
3. Access to and sharing of medical records
4. Provider contracting
5. Provider education and ongoing support
6. Performance monitoring
7. Cultural competency
8. Community engagement.