

Developing a Payment and Spending Strategy to Advance Health Equity: Checklist for Medicaid Decision-Makers

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October 2022

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Introduction

Medicaid agencies provide access to critical health services for more than 85 million people across the country. In doing so, state agencies make decisions every day about how to responsibly spend program dollars. Those spending decisions are a key tool Medicaid leaders can use to achieve their programmatic goals, including advancing health equity. Many state agencies are starting to use payment approaches – including [value-based payment](#) and [quality withholds](#) – with providers and managed care organizations (MCOs) to advance more equitable health care and outcomes. However, states have not fully maximized opportunities to create a comprehensive payment and spending strategy to advance health equity.

This brief includes a checklist of eight key questions to help Medicaid agencies and other purchasers and payers develop a robust payment and spending strategy focused on advancing health equity. Each of the key questions is illustrated by state examples to show concrete steps for adopting health equity focused payment strategies.

Checklist for Addressing Health Equity

Following are eight key considerations for state purchasers and other payers in developing payment approaches that support the goals of advancing health equity.

- What do we pay for?**
- Who do we contract with?**
- Who do we cover, and when?**
- How do we support innovation?**
- How can payment support accountability for advancing health equity?**
- Who is involved in developing this strategy?**
- How do we implement these changes?**
- How do we measure success?**

KEY TAKEAWAYS

- Medicaid agencies make daily decisions about how to responsibly spend program dollars and can use this opportunity to guide spending and payment strategies to advance health equity.
- States can use a variety of payment and spending decisions to advance health equity. For example, they might cover culturally specific benefits or expand Medicaid coverage to groups who may not always be covered. States can also consider how to support innovations that advance health equity and create financial accountability to decrease health disparities.
- State agencies can involve a variety of stakeholders, including people served by Medicaid, to develop a comprehensive strategy to guide spending and payment decisions focused on advancing health equity for people enrolled in Medicaid.
- This checklist outlines key questions to help decision-makers design a payment strategy for advancing health equity, with a focus on: (1) what the strategy includes; and (2) how the strategy is developed.

DEFINING HEALTH EQUITY

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

SOURCE: P. Braveman, et al. *What Is Health Equity?* Robert Wood Johnson Foundation, 2017.

1. What do we pay for?

States have flexibility around the selection of benefits covered in their Medicaid programs. They can opt to go above and beyond federally mandated benefits, though many of these changes may require legislative action and/or approval from the Centers for Medicare & Medicaid Services (CMS). To promote equity, some states cover culturally specific health care services, such as **New Mexico's requirement** that MCOs offer traditional healing services to Native American members or **Arizona's American Indian Medical Homes**. States can ensure appropriate services are made available to transgender and gender non-conforming people by **explicitly covering gender-affirming care** in Medicaid, which is already done in 20 Medicaid programs. States are creating benefits to address the health-related social needs that deeply impact health for many Medicaid enrollees, notably **California's** use of the *in lieu of* services authority to provide new **Community Supports**. Finally, states can consider how to equitably rebalance care for older adults and people with disabilities away from institutional settings and toward home- and community-based services (HCBS), such as **California's** work to more **accurately measure expenditures** on HCBS and improve access to these services.

Medicaid agencies can also reflect on what they pay for internally to advance equity. Agencies can work to build an internal **culture of equity**, through activities impacting staff (e.g., pay equity, diversity initiatives, training around health inequities) and programmatic work (e.g., creating a policy review process that includes equity implications, hiring an equity manager or team). For example, **Louisiana** has developed a **Medicaid Health Equity Action Team**, per requirements from the state's department of health, which has worked to increase an understanding of health equity within the agency and has overseen development of tools to support equity-focused policy review. These activities require time and financial resources, but can improve morale and create a deeper understanding of how staff can promote equity for colleagues and Medicaid enrollees through their day-to-day work.

2. Who do we contract with?

Medicaid agencies and their contracted MCOs can consider who they pay to support the Medicaid program and how their provider network (i.e., health care worker and site of care) can promote health equity. Critical decision points such as [how health workers will be paid](#) by Medicaid and [if rates are sufficient](#) will ensure that programs can be implemented successfully. **Oregon's traditional health workers** program covers the community-based health care workforce (e.g., community health workers, doulas, peer recovery), allowing for increased diversity of lived experience among health care workers and provision of culturally concordant care. [Self-directed personal assistance programs](#), such as **New York's Consumer Directed Personal Assistance Program**, allow people with disabilities who require in-home or personal care to select their own caretakers, who will then be paid by Medicaid. Integrated care improves access for underserved populations, such as **Arizona's Integrated Justice Clinics** that provide holistic services for justice-involved populations at a single site, including behavioral and physical health care, probation/parole activities, and connection to social services. Telehealth or telementoring models such as **New Mexico's Project Echo** can support access to high-quality specialty care in rural areas or other areas with health care worker shortages.

Medicaid agencies and MCOs also pay other partners who help administer and support the Medicaid program, including consultants, actuarial firms, technology vendors, community-based organizations, and external quality review organizations. When thinking about the organizations that Medicaid contracts with, state agencies have the opportunity to advance health and racial equity by focusing on diversity, equity, and inclusion in the [procurement and contracting process](#) and building relationships with partners that reflect and support communities served. Medicaid agencies and MCOs can also acknowledge the inherent power imbalance present in their contractual relationships with partners, and identify methods to build [strong, equitable, and supportive relationships](#). For example, **New Jersey** has [developed training materials and employs Doula Guides](#) to help these health care workers better navigate the Medicaid credentialing and contracting process.

PATIENTS AS PARTNERS

In some cases, Medicaid agencies may be interested in making payments directly to Medicaid members, who are critical partners in ensuring improved health outcomes and designing programs that address equity. That might include direct payments related to healthy behaviors, such as **North Carolina's** success using [direct patient incentives](#) to increase their COVID-19 vaccination rates. Medicaid agencies can also strive to pay enrollees to share their lived expertise during the policy design process. For example, **Washington State** [passed legislation](#) that allows compensation for people who bring lived experience to the policymaking process by sitting on boards, commissions, councils, committees, and other similar groups at the state level. When making direct payments to Medicaid members, states and other stakeholders should always assess how they can [compensate members without jeopardizing their eligibility](#) for Medicaid or other public programs.

3. Who do we cover, and when?

States can consider who they cover through Medicaid and how to cover people during life transitions that can lead to loss of stability and worsened health. For instance, many states are working to extend [fully state-funded Medicaid benefits](#) to people who are ineligible for federal reimbursement based on their status as undocumented immigrants. Six Medicaid agencies (**California; Washington, D.C.; Illinois; New York; Oregon; and Washington State**) cover all income-eligible children – regardless of immigration status – under Medicaid, and additional states are pursuing this option. **Four states (California, Colorado, Illinois, and Oregon)** are pursuing legislative options to cover all income-eligible adults. States can extend greater access to care for pregnant or child immigrants by [ending the five-year waiting period](#) for lawfully present immigrants to be eligible for Medicaid. Thirty-five states have ended the waiting period for children and 25 have ended it for pregnant people.

Under incentives in the American Rescue Plan Act, 34 states have implemented or plan to implement [increased postpartum coverage](#) to one year after childbirth, recognizing that many maternal deaths occur in the [year following birth](#). Extending postpartum coverage is critically important to address maternal health inequities, as people of color – particularly Black and Native American women – are [more likely to experience](#) poor maternal health outcomes.

States are also exploring how to provide Medicaid coverage to people transitioning out of institutions, such as jails, prisons, or state hospitals. While in these institutions, Medicaid is often not the payer for health care needs, resulting in a gap in coverage when people re-enter the community and re-enroll in Medicaid. Many states are working to [connect incarcerated individuals to Medicaid prior to release](#), allowing people to work with care coordinators, set up appointments, and access medication as soon as possible upon release.

Finally, 12 states still have the opportunity to dramatically increase access to care, improve health equity, and stimulate the state economy by [expanding Medicaid](#) to all eligible people.

4. How do we support innovation?

Payments to providers can be structured to create opportunities for innovation, leading to more equitable health care delivery and outcomes. Upfront payments can be used to develop interventions directly tied to a state's health equity goals. For instance, a state prioritizing maternal health equity could provide upfront payment earmarked to help obstetrics providers contract with community health workers or doulas to provide additional care and resources for high-risk pregnant patients. Managed care states can also use [directed payments](#) to reimburse for specific activities related to health equity, such as **Texas'** [directed payment](#) for food insecurity screening.

Alternatively, upfront or supplemental payments can be broadly linked to health equity goals with no restrictions on how the money is spent, such as **North Carolina's** [capacity-building payments](#) to support providers who predominately serve communities with high poverty rates. Medicaid agencies can also explore how to tie existing payments (e.g., disproportionate share hospital payments) or capacity-building payments (e.g., **California's** [Public Hospital Redesign & Incentives in Medi-Cal Program](#)) to [quality and equity performance](#).

5. How can payment support accountability for advancing health equity?

To the extent possible, Medicaid agencies should structure payments to promote accountability for health equity. Payments to MCOs, providers, and other partners can be structured to support and encourage equity through [MCO accountability mechanisms](#) such as withholds, or through [equity-focused VBP](#). States have explored MCO accountability by linking quality payments to improvements in measured health disparities (e.g., closing gaps in quality metrics between people of color and white people; closing gaps in quality metrics for people with disabilities), such as **Michigan's** Medicaid managed care [quality withhold](#). They are also exploring how payments to providers can promote health equity, including by starting with [payment](#) for collection of demographic data to track disparities in **Rhode Island**, adjusting provider payment rates based on the [social needs](#) of patients in **Massachusetts**, or linking [provider performance-based](#) payments to disparities performance in **Minnesota**.

A common goal of value-based purchasing and payment programs is to control health care costs. But it is critical to acknowledge that value-based purchasing and payment designed to advance health equity may not always result in cost savings. Evidence shows that groups of people who experience health inequities (e.g., [people of color](#), [people with disabilities](#), [LGBTQ+ people](#), [people living in rural areas](#)) are disproportionately likely to lack access to health care. Advancing health equity for these groups may only be achievable by increasing utilization – particularly of high-value primary and preventive care – among these historically underserved groups.

6. Who is involved in developing this strategy?

Medicaid agencies can consider who to involve in the development of a comprehensive payment and spending strategy to advance health equity, including working with a broad variety of external stakeholders to better understand the priorities and goals of the community they are serving.

Medicaid agencies should create processes to develop partnerships with Medicaid members and create opportunities for them to provide meaningful input on agency activities. Many states use creative strategies to develop and strengthen these partnerships. **Pennsylvania** operates a [subcommittee](#) within its Medical Care Advisory Committee made up only of Medicaid members, leveraging this federal requirement to create a more robust and person-centered engagement process. Membership in advisory committees should be diverse and ensure access for all community members, such as **New York's** efforts to [host sessions for Medicaid members in multiple languages](#). States should also ensure meetings are accessible to all members of the community, including those with disabilities, for example by using meeting locations that are physically accessible, providing transportation to meetings, using sign language or other interpreters, and holding meetings both virtually and in-person. Using a variety of approaches to engage with community members and those served by Medicaid, and particularly focusing on engagement with people who experience health inequities, can provide insight into if and how payment and spending strategies are operating to promote health equity on the ground.

Additional key stakeholders to engage may include MCOs, health care providers, other state agencies working on related health and social needs, and community-based organizations. Considering a wide variety of perspectives helps create a payment and spending strategy that addresses key barriers to health equity.

Internally, this strategy should be adopted by Medicaid leadership to drive the activities of many divisions in an agency, including departments involved in quality improvement, vendor relationships, MCO procurement and contract development, benefit design, value-based payment and purchasing, and member eligibility and enrollment.

7. How do we implement these changes?

Medicaid agencies interested in advancing health equity through changes to payment and spending strategies should consider implementation details and approaches. Changes with minimal spending increases for the Medicaid program may be easier to implement, while changes that add new benefits or increase Medicaid spending significantly will be more challenging – as they may require legislative action, approval from CMS, or other long-term strategies.

To move these ideas forward, agencies need to gain buy-in from Medicaid leadership and state government officials who have a say in Medicaid budgetary decisions. In some states, building a [culture of equity](#) within the Medicaid agency and state government in general can help support equity-focused payment and spending decisions. An [executive order](#) in **Washington State** requires each state agency to create a Pro-Equity Anti-Racism plan. This statewide prioritization can help put equity-focused spending decisions into practice. In other states, activities to advance health equity can be integrated into existing state priorities such as addressing health-related social needs or quality improvement efforts. Organizations focused on health care quality, including the [National Committee for Quality Assurance](#), the [Institute for Healthcare Improvement](#), and the [National Quality Forum](#), are increasingly emphasizing equity as an intrinsic aspect of health care quality.

8. How do we measure success?

As with any new policy or programmatic effort, Medicaid agencies should ask themselves what success looks like. Agencies can start by specifying their equity goals, aligning goals and strategies across the agency, and collecting and analyzing data that can be used to measure the impact of their efforts. Ideally, Medicaid agencies would set up monitoring and evaluation plans that are designed in partnership with community members to track if implementation is going as planned and if payment and spending changes are successfully promoting equity.

Medicaid agencies can determine if interventions will have a short- or long-term financial ROI and set reasonable expectations about the financial benefits of equity interventions. They may also acknowledge the “[wrong pocket problem](#)” in which some spending in Medicaid may result in savings for other parts of the state’s budget, such as payment for uncompensated care or provision of social services. After all, [health inequities are costly](#) to the health care system and to society as a whole. Health disparities cost the health system about \$320 billion per year, and roughly \$42 billion of lost productivity can be attributed to inequitable health annually.

Whether or not a proposal includes a financial ROI, it is equally important to conceptualize ROI in terms of non-financial benefits. Measuring improvements in quality of care, health outcomes, patient/community trust, or [social return on investment](#) can be an effective way to ensure payment and spending decisions have a positive impact, meet the mission of Medicaid agencies, and display value to stakeholders.

Conclusion

Medicaid agencies and other payers and purchasers can develop a comprehensive equity-focused payment and spending strategy that considers how the variety of payments they make might be used to promote equity. Medicaid agencies should assess the current state of payment and spending – identifying where money flows out and how that is impacting equity (or not). They can then use this checklist to work with communities and other Medicaid stakeholders to create a strategy focused on advancing health equity through payment and spending decisions. Finally, agencies should implement changes to payment and spending and monitor the impact of these efforts.

Medicaid agencies should be prepared to address any unintended consequence that might arise. Unintended consequences related to payment and spending may take many forms – for example, value-based purchasing strategies may [disproportionately penalize](#) providers who care for people experiencing inequities, or expanded benefits may not be accessible to people who experience the most severe health disparities. By creating a plan to monitor new programs and policies, agencies can nimbly respond to problems.

At the same time, Medicaid agencies should not be afraid to take action. The status quo of longstanding health inequities is unacceptable, and Medicaid agencies and their partners should be open to using the many levers available to them to learn about ways they can work toward health equity. While there is risk to trying any new strategy, agencies should not only consider what could go wrong, but should be imaginative and ask themselves what could go right.



ABOUT AHE

Advancing Health Equity: Leading Care, Payment, and Systems Transformation is a national program based at the University of Chicago and conducted in partnership with the Institute for Medicaid Innovation and the Center for Health Care Strategies. Support for this program was provided by the Robert Wood Johnson Foundation.

The views expressed here do not necessarily reflect the views of the Foundation.