BRIEF • MAY 2024

Center for Health Care Strategies

Building a Health Equity Focus into Value-Based Payment Design: Approaches for Medicaid Payers

By Anne Smithey and Shilpa Patel, Center for Health Care Strategies

TAKEAWAYS

- Value-based payment models focus on improving overall care quality and cost by incentivizing higher value care over volume of care delivered.
- Many Medicaid payers, including state agencies and managed care organizations, are exploring new ways to incorporate health equity considerations into value-based payment model design.
- This brief outlines how payers can embed a health equity focus into key decision points in payment model design.

Value-based payment (VBP) models shift health care payment from rewarding volume of care provided (i.e., fee-for-service payment) to rewarding the delivery of higher value care.[1] As the health care system has increased its focus on health equity, many Medicaid payers, including state agencies and managed care organizations, see promise in aligning high-priority health care payment reform efforts with a focus on health equity. However, payers can't succeed alone — reducing health inequities is complex and multifaceted, requiring a collective effort across the entire health care sector. Designing a successful, equity-focused VBP model involves a number of complex decisions, that should be informed by payers, providers, and the communities they serve.

This brief explores approaches to incorporating health equity in VBP design, creating payment models that positively impact health disparities, outcomes, and costs in Medicaid, including:

1. Engage community members in model design

2. Embed health equity in model requirements

3. Create performance-based payments for reducing health disparities

4. Prioritize safety net provider participation

5. Collaborate with plans and providers to create a data strategy

6. Explore adjusting for social risk factors

7. Provide technical assistance

MEDICAID EQUITY LENS

Practical resources from the Center for Health Care Strategies to embed a health equity focus in Medicaid program and policy design.

1. Engage Community Members in Model Design

For VBP models to positively impact health disparities, patient health care access, and care experiences, it is important to engage Medicaid members to understand their experiences, needs, and preferences when building these models. Payers can learn from previous community engagement projects but should begin any member engagement with a clear understanding of what information they are seeking from community members and how this information can impact VBP program design.[2,3,4]

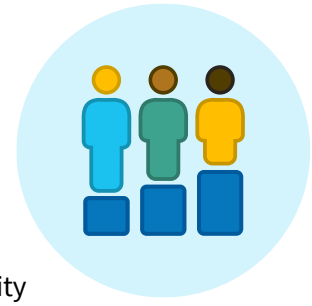
Payers can employ a number of emerging best practices to engage community members in model design and implementation:

- **Seek community member perspectives to inform VBP model goals and health equity focus.** Member insights help shape the overarching VBP model goals and health equity focus, which in turn drive model design.[5] Members' personal experiences receiving health care help inform discussions around what is valuable and what is missing. Members and communities can provide insight into the scope and range of services available, including which care delivery improvements the VBP model design should prioritize to improve health equity. **Connecticut's** Medicaid agency engages with members to understand their goals for VBP.[6,7,8]
- **Form member advisory groups to develop an ongoing, meaningful relationship with community members.** Ongoing, authentic relationships, like the kind facilitated by effective member advisory groups, can make members more comfortable sharing candid feedback and perspectives. Making clear to members how their feedback will be used is key to creating that trust. Advisory committees with a health equity focus — like **Colorado's** Maternity Advisory Committee, composed mainly of people of color who received maternity care while covered by Medicaid — have had success eliciting feedback from members to help guide VBP model design.[9]

Value-Based Payment Basics

Under a VBP model, provider organizations are financially incentivized to achieve better outcomes by meeting established quality of care targets. VBP models may also include incentives to reduce care costs by focusing on preventive care and decreasing the need for acute services.

2. Embed Health Equity in Model Requirements



Medicaid payers can build health equity into VBP models by incentivizing or requiring a health equity focus from provider-led practice transformation efforts. Incentives and care delivery requirements may be more effective when aligned with broader goals. States, plans, and providers may share population-based equity or quality improvement goals (e.g., reducing the high maternal morbidity and mortality rate in Black and Native American communities). Payers can also incentivize the incorporation of community assets in care delivery, such as requirements to partner with community-based organizations or employ community health workers.[10] Additionally, requirements should balance specificity with flexibility to account for a variety of different provider settings.

Payers can consider the following approaches to embed health equity in VBP model requirements, enabling provider organizations to tailor for their patient panel:

- **Require a plan of action.** Medicaid payers can require provider organizations to develop and implement a health equity plan as part of model participation.[11] This type of action plan typically requires provider organizations to identify health disparities in their patient population, design interventions to address disparities, and measure the success of those interventions. For example, both state Medicaid (e.g., **Minnesota's** Integrated Health Partnerships) and federal VBP models (e.g., ACO REACH and AHEAD) require VBP model participants to develop and implement a health equity plan as part of model participation.[12,13,14]
- **Hold provider organizations accountable for health equity work.** Without clear accountability mechanisms, health equity model requirements may be a "check the box" exercise, in which stakeholders do the minimum to meet the requirement rather than making meaningful changes. For example, payers can communicate their values and expectations through assessment of providers' health equity plans. Payers can also gauge how well providers are meeting equity-focused care delivery requirements through multiple pathways, including audits, external evaluations, and public reporting on health equity plans and progress.

3. Create Performance-Based Payments for Reducing Health Disparities

Medicaid programs across the country have begun collecting and sharing demographic data and stratifying quality measures by individual-level factors such as race, ethnicity, disability status, geography, and other characteristics to identify and understand health disparities in different populations.[15]

Given the data they have, payers can then consider how they will link performance-based payments to disparities performance measures:[16]

- **Set realistic, but ambitious performance targets.** Targets for decreasing health disparities might be based on previous experiences (e.g., recent pilot projects focused on disparities) that give a sense of what provider organizations can achieve. Targets can also focus on incentive payments that reward improvement instead of reaching a set goal or can change over time based on achievements to date. Payers can provide a menu of health disparities metrics for provider organizations to choose from, allowing them to focus on disparities identified in their own health equity plans and through patient engagement activities.
- **Develop accountability and incentives for health equity.** Medicaid payers can consider factoring both overall quality performance and performance on decreasing health disparities identified in selected quality metrics into their quality scores and associated performance-based payments, as **Minnesota** Medicaid has done in their Integrated Health Partnerships program.[17] This approach incentivizes provider organizations to focus both on their overall quality results as well as addressing specific health disparities identified in their VBP contract. To ensure sufficient focus on promoting health equity, performance measures to address disparities should meaningfully impact performance-based payment levels. The HCP LAN recommends that disparities performance measures represent a meaningful portion of the overall quality score, starting at 20 percent of the overall score for experienced provider organizations and increasing over time for all provider organizations.[18]
- **Consider whether new quality metrics are needed to promote health equity.** Some payers may be interested in exploring additional ways to promote health equity through quality improvement and performance-based payment. New quality measures, developed in partnership with community members and reflective of their goals, may be helpful. For example, **Oregon's** Medicaid agency developed an incentive metric that assesses meaningful access to language services in response to needs identified through statewide listening sessions.[19] Payers should balance potential new equity-focused metrics with the need for a manageable set of quality measures. If new equity-focused metrics are added to a VBP model, payers may want to consider removing other metrics to support model buy-in and maintain focus on the most critical health outcomes and inequities.

4. Prioritize Safety Net Provider Participation

Provider organizations serving populations that are more likely to experience health inequities — such as federally qualified health centers (FQHCs), Indian Health Care Providers (IHCPs), and rural health centers — are significantly less likely to participate in VBP models than other provider types.[20,21] Their participation is limited due to multiple and often compounding barriers, including fewer resources, smaller patient panels, and VBP model designs that either do not allow their participation due to legal/regulatory constraints or do not support the capacity-building needed for success within the model.

While it may not be possible to design VBP models in which all provider types can participate, Medicaid payers can consider the following options to maximize safety net provider participation:

- **Design models with safety net provider participation in mind.** Medicaid payers can work closely with safety net provider organizations to inform model features that work for them. For example, payers might build a specific "track" within their VBP model for safety net providers, create targeted participation supports, or create an entirely separate model for safety net providers. The model could include a specific track for FQHCs that meets federal requirements (e.g., **Colorado's** APM 2 primary care model), deploy different approaches for measuring quality for small practices, or create a multi-phase model where provider organizations can gain experience and take on more quality accountability and financial risk over time (e.g., the Centers for Medicare & Medicaid Services' Making Care Primary model).[22,23,24,25]
- **Financially support safety net provider success.** National and regional experts from the Health Care Payment Learning & Action Network's Health Equity Advisory Team (LAN HEAT) recommend increasing payment and other resources for safety net providers to address persistent underfunding and encourage participation in VBP models.[26] Even in the absence of additional funding, VBP models that shift some revenue to up-front payment to build capacity and support practice transformation may help safety net providers join and succeed in VBP models.[27]

5. Collaborate with Plans and Providers to Create a Data Strategy

Member-level demographic data — including information about a patient's race, ethnicity, preferred language, disability status, health-related social needs, or other characteristics — is useful for measuring and tracking health disparities at the population level. However, demographic data is often inaccurate or incomplete. This makes it difficult to build health equity into VBP models, as data is necessary to stratify quality measures and assess health disparities and outcomes.

Payers can collaborate with provider organizations to create a multi-pronged data strategy:

- **Pursue activities that do not require complete data.** Many of the VBP design options discussed in this brief do not require robust individual-level data, but still have the potential to promote health equity (e.g., prioritizing safety net provider participation, and providing learning opportunities). Payers can incorporate these design approaches into the VBP model while working on a long-term data collection plan and infrastructure.
- **Identify alternate sources of data, including qualitative data from community members.** While member-level demographic data may be the most helpful, payers and provider organizations can use existing data sets (e.g., U.S. Census data, deprivation indices, or data from other state agencies) to identify what health disparities may be prevalent in the populations they serve.[28,29] Payers and providers can also use qualitative data, collected through community engagement efforts, to understand patient priorities and inform VBP model design and progress.
- **Develop a data plan.** Developing a plan to improve data completeness, data quality, and data sharing can be part of VBP model design. For example, a payment model could include pay-for-reporting of patient demographic data, as in **Rhode Island's** requirements for Accountable Entities (the state's Medicaid accountable care organization program).[30] Because data collection can create burdens at multiple levels (e.g., administrative, provider, community), having a clear understanding of what data are needed and how data will be used and shared to promote health equity is a key component of an effective data plan. Payers can work with providers to tailor data plans according to what data are needed and which opportunities they inform.

6. Explore Adjusting for Social Risk Factors

Recent federal models, along with state Medicaid VBP models in **Massachusetts** and **Minnesota**, have incorporated adjustment for social risk factors into rate-setting methodologies.[31,32,33] Adjusting for social risk factors can help these organizations receive adequate payment to address all patient needs and may encourage provider organizations that serve a more complex patient population to participate in the VBP model.

Medicaid payers can consider the following if they are interested in developing a social risk adjustment methodology:

- ✓ **Clearly communicate the goal of social risk adjustment.** A social risk adjustment methodology designed to accurately predict cost of care might be built differently than a method designed to increase financing for specific patient populations. Focusing solely on predicting cost of care without building in guardrails could result in social risk adjustment models that exacerbate inequitable spending, rather than reducing it.[34] Outlining a clear goal for social risk adjustment will support development of the methodology, and communicating that goal with provider organizations and other stakeholders can help generate stakeholder buy-in.
- ✓ **Determine how risk adjustment will impact rates.** Payers use social risk adjustment in different ways. **Massachusetts'** Medicaid program uses social risk adjustment for all rates paid to managed care organizations and accountable care organizations, while **Minnesota** Medicaid uses social risk adjustment only for an additional up-front payment to accountable care organizations to support care delivery innovation and health equity initiatives.[35,36] Along with deciding how the social risk adjustment method is applied to payment, payers will want to determine how large of an impact social risk adjustment will have, based on budget needs, conversations with actuaries, and the goal of the adjustment.[37]

7. Provide Technical Assistance

Medicaid payers can increase readiness and uptake of VBP models that incorporate health equity by providing learning opportunities and technical assistance to network providers and their partners:

- ✓ **Consider multiple opportunities for learning.** Learning and technical assistance for providers can include presentations and conversations on why and how health equity was built into the VBP model, opportunities for peer-to-peer exchange, and ways to engage, and ultimately partner with, members, patients, and community stakeholders during implementation. Payers can also provide technical assistance to provider organizations and their partners (e.g., community-based organizations who are supporting activities to promote health equity) for the various VBP model requirements (e.g., developing a health equity plan, transforming care delivery, and maintaining financial stability).

Conclusion

Value-based payment can be a powerful tool for improving health equity. Payers can strategically design Medicaid VBP models to incorporate health equity from the outset to increase their positive impact for Medicaid members, especially those from historically marginalized communities.

The design choices outlined in this brief represent key opportunities for payers to increase uptake and success of these models by building health equity into goals and requirements, and by engaging and supporting stakeholders throughout model design and implementation.

ENDNOTES

[1] Center for Health Care Strategies. (n.d.). *Value-based payment*. https://www.chcs.org/topics/payment-reform

[2] Zhu, J. M., Rowland, R., Gunn, R., Gollust, S., & Grande, D. T. (2020, December 15). Engaging consumers in Medicaid program design: Strategies from the states. *The Milbank Quarterly*, *99*(1), 99–125. https://doi.org/10.1111/1468-0009.12492

[3] NORC Medicaid Managed Care Organization (MCO) Learning Hub. (2021, January). Key findings from the Medicaid MCO learning hub discussion group series and roundtable – focus on member engagement and the consumer voice. *NORC*. https://www.norc.org/content/dam/norc-org/pdfs/MMCOLearningHub_MemberEngagement.pdf

[4] Everette, T. D., Sathasivam, D., & Siegel, K. (2023, January 30). *State examples of Medicaid community engagement strategies: Two case studies*. State Health and Value Strategies. https://www.shvs.org/resource/state-examples-of-medicaid-community-engagement-strategies-two-case-studies

[5] Smithey, A., Brykman, K., & Patel, S. (2023, December 13). Getting started with primary care population-based payment: Four decision points for state Medicaid programs. *Center for Health Care Strategies* [Blog]. https://www.chcs.org/getting-started-with-primary-care-population-based-payment-four-decision-points-for-state-medicaid-programs

[6] Smithey, et al., 2023.

[7] Connecticut Department of Social Services. "CT Maternity Bundled Payment Program — Medical Assistance Program Oversight Council Meeting September 9th, 2022" [Meeting slides]. https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20220909/CT%20Maternity%20Bundle%20Payment%20Program%20Update.pdf

[8] Connecticut Department of Social Services. (2023, June 1). "Primary Care Program Advisory Committee Meeting 3, June 1, 2023." [Meeting slides]. https://portal.ct.gov/-/media/departments-and-agencies/dss/health-and-home-care/primary-care-redesign/pcpac-meeting-3_060123vf.pdf

[9] Colorado Department of Health Care Policy and Financing. (n.d.) *Maternity Advisory Committee*. https://hcpf.colorado.gov/maternity-advisory-committee

[10] Health Equity Advisory Team. (2021). *Advancing health equity through APMs: Guidance for equity-centered design and implementation.* Health Care Payment Learning and Action Network. https://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf

[11] Bleser, W. K., Tchuisseu, Y. P., Shen, H., Thoumi, A., Amin, C., Kaye, D. R., McClellan, M. B., & Saunders, R. S. (2022, May 18). ACO REACH and advancing equity through value-based payment, part 2. *Health Affairs Forefront* [blog]. http://dx.doi.org/10.1377/forefront.20220517.755520

[12] Minnesota Department of Human Services. (2023, July). Health equity interventions summary for the integrated health partnerships (IHP) program. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8162-ENG

[13] Centers for Medicare & Medicaid Services. *ACO REACH.* (n.d.). U.S. Department of Health and Human Services. https://www.cms.gov/priorities/innovation/innovation-models/aco-reach

[14] Centers for Medicare & Medicaid Services. *States Advancing All-Payer Health equity approaches and development (AHEAD) model.* (n.d.). U.S. Department of Health and Human Services. https://www.cms.gov/priorities/innovation/innovation-models/ahead

[15] Bailit Health. (2023, April 7). *Compendium of Medicaid managed care contracting strategies to promote health equity*. State Health and Value Strategies. https://www.shvs.org/resource/medicaid-managed-care-contract-language-health-disparities-and-health-equity

[16] Patel, S., Smithey, A., & McGinnis, T. (2021, January 19). *Leveraging value-based payment approaches to promote health equity: Key strategies for health care payers*. Center for Health Care Strategies. https://www.chcs.org/resource/leveraging-value-based-payment-approaches-to-promote-health-equity-key-strategies-for-health-care-payers

[17] Minnesota Department of Human Services. (2023, July). *Integrated health partnerships (IHP) quality measurement overview.* https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8467-ENG

[18] Health Equity Advisory Team, 2021, *Advancing health equity through APMs: Guidance for equity-centered design and implementation.*

[19] Oregon Health Authority. (2021). *Meaningful language access to culturally responsive health care services: technical assistance.* https://www.oregon.gov/oha/hpa/dsi-tc/pages/meaningful-language-access.aspx

[20] Centers for Medicare & Medicaid Services. (2016, October). Medicaid and children's health insurance program (CHIP) managed care final rule overview of the Indian specific provisions [Slides]. https://www.cms.gov/files/document/all-tribes-call-october-2016pdf

[21] Horstman, C., & Lewis, C. (2023, April 13). Engaging primary care in value-based payment: New findings from the 2022 commonwealth fund survey of primary care physicians. *To the Point* [Commonwealth Fund blog]. https://www.commonwealthfund.org/blog/2023/engaging-primary-care-value-based-payment-new-findings-2022-commonwealth-fund-survey

[22] Howe, G., McGinnis, T., & Houston, R. (2020, June 8). How health centers can improve patient care through value-based payment models. Center for Health Care Strategies. https://www.chcs.org/resource/how-health-centers-can-improve-patient-care-through-value-based-payment-models

[23] Colorado Department of Health Care Policy and Financing. (n.d.). Alternative payment model 2 (APM 2). https://hcpf.colorado.gov/alternative-payment-model-2-apm-2

[24] Centers for Medicare & Medicaid Services. (2022). Virtual group participation. Quality Payment Program. https://qpp.cms.gov/mips/virtual-group-participation

[25] Centers for Medicare & Medicaid Services. (2023). Making care primary (MCP) model. https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary

[26] Health Equity Advisory Team, 2021, *Advancing health equity through APMs: Guidance for equity-centered design and implementation.*

[27] Trombley, M. J., McWilliams, J. M., Fout, B., & Morefield, B. (2022). ACO investment model produced savings, but the majority of participants exited when faced with downside risk. *Health Affairs*, *41*(1), 138–146. https://doi.org/10.1377/hlthaff.2020.01819

[28] Trinidad, S., Brokamp, C., Mor Huertas, A., Beck, A.F., Riley, C.L., Rasnick, E., Falcone, R., & Kotagal, M. (2022, December). Use of area-based socioeconomic deprivation indices: A scope review and qualitative analysis. *Health Affairs, 41*(12). https://doi.org/10.1377/hlthaff.2022.00482

[29] Trinidad, S., Brokamp, C., Mor Huertas, A., Beck, A. F., Riley, C. L., Rasnik, E., Falcone, R., & Kotagal, M. (2022). Use of area-based socioeconomic deprivation indices: A scoping review and qualitative analysis. *Health Affairs, 41(12)*, 1804–1811. https://doi.org/10.1377/hlthaff.2022.00482

[30] Executive Office of Health and Human Services, State of Rhode Island. (2022). Attachment K – infrastructure incentive program: Requirements for managed care organizations and certified accountable entities: Program year 7. https://eohhs.ri.gov/media/42321/download?language=en

[31] Rawal, P., Quinton, J., Hughes, D., & Fowler, L. (2023, June 9). The CMS innovation center's strategy to support high-quality primary care. *CMS* [CMS Blog]. https://www.cms.gov/blog/cms-innovation-centers-strategy-support-high-quality-primary-care

[32] Planalp, C. (2020, August 20). *Risk adjustment based on social factors: State approaches to filling data gaps*. State Health and Value Strategies. https://www.shvs.org/resource/risk-adjustment-based-on-social-factors-state-approaches-to-filling-data-gaps

[33] Health Equity Advisory Team. (2021). *Advancing health equity through APMs: Guidance on social risk adjustment.* Health Care Payment Learning and Action Network. https://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs-Social-Risk-Adjustment.pdf

[34] McWilliams, J. M., Weinreb, G., Ding, L., Ndumele, C. D., & Wallace, J. (2023). Risk adjustment and promoting health equity in population-based payment: Concepts and evidence. *Health Affairs*, *42*(1), 105–114. https://doi.org/10.1377/hlthaff.2022.00916

[35] Planalp, 2020.

[36] Minnesota Department of Human Services. (2024, January 2). *Integrated health partnerships*. https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships

[37] Phillips, Jr. R. L., Ostrovsky, A., Gilfillan, R., Price, D., & Bazemore, A. W. (2023, February 1). Accounting for social risks in Medicare and Medicaid payments. *The Commonwealth Fund* [Blog]. https://www.commonwealthfund.org/blog/2023/accounting-social-risks-medicare-and-medicaid-payments