Center for Health Care Strategies

Using Medicaid Financing and Payment Strategies to Advance Health Equity: Checklist for State Decision-Makers

Medicaid plays a crucial role in providing health services for nearly 80 million people nationwide. Every day, state Medicaid decision-makers grapple with how to responsibly spend public program dollars to best serve their members. State decision-makers can use this checklist to strategically guide financing and payment decisions to advance health equity. The checklist includes eight key questions to help state Medicaid agencies and other payers build a focus on health equity into their financing and payment strategies.

1. What does Medicaid pay for and support beyond mandatory benefits?

Medicaid agencies must provide certain federally mandated benefits, but also have flexibility to offer additional services to meet the needs of Medicaid members in their state, including populations experiencing health inequities, such as older adults, birthing persons, non-English speaking populations, justice-involved populations, or other historically marginalized populations. Medicaid agencies can also consider what they pay for internally to advance health equity, including investments to promote a workplace culture of equity (e.g., pay equity, diversity initiatives, equity-focused training).

2. Who does Medicaid contract with?

Consider the state's provider network. What are provider-related contract requirements for managed care organizations (MCOs)? Who qualifies as a provider, how a community-based workforce is included and paid, and how rates are determined all contribute to health equity outcomes. Expanding the scope of Medicaid providers — e.g., community health workers, doulas, family caregivers, and peer support specialists — can help improve health outcomes for all individuals with Medicaid, including people of color, rural populations, and non-English speaking members. Contracting and procurement are also an opportunity for state agencies to incorporate equity by focusing on partners — including actuaries, consultants, technology vendors, and others — who reflect the communities Medicaid serves. Finally, supporting a diverse, culturally competent, and locally knowledgeable provider network is essential.

3. Who does Medicaid cover and when?

States can extend Medicaid coverage to specific populations facing disparities in health care access and quality through tools like 1115 waivers, state plan amendments, or executive orders. For example, some states are pursuing pre-release coverage for people leaving jails and prisons, who are at greater risk of death and overdose. Almost all states have extended postpartum care coverage, which is especially important for Black and Native American individuals more likely to experience poor health outcomes in the postpartum period. Twelve states and the District of Columbia now cover all income-eligible children and pregnant people regardless of their immigration status, and six states and D.C. do the same for adults.

4. What financing and payment strategies are used at the health plan and provider levels to promote health equity?

States can design provider payment to encourage care delivery innovation that supports health equity priorities. Upfront payments can be tied to specific goals, for example, expanding the use of doulas and community health workers to improve outcomes for high-risk pregnant members. States can use directed payments with MCOs to reimburse for activities that address health-equity priorities; Texas uses directed payments to provide food insecurity screening and follow-up plans for its Medicaid population. States can also use capacity-building payments to support safety-net providers in communities with high poverty rates.

5. How can Medicaid payment create accountability for advancing health equity?

Medicaid agencies can use payment strategies to create accountability in MCOs, providers, and other partners prioritizing health equity. This can involve methods such as payment withholds or using value-based payments linked to improving health equity by reducing specific disparities. Requirements related to the National Committee for Quality Assurance's health equity or health equity plus accreditation can give plans a framework for pursuing health equity internally and in plan operations. State Medicaid agencies can explore paying providers for demographic data to better track disparities, risk-adjusting payments based on the social needs of patients, requiring MCOs to submit a health equity strategic plan, or incentivizing internal equity leadership roles, like a chief health equity officer. Whatever the case, it is important to have well-defined equity goals and align goals with agency priorities.

6. How can Medicaid implement health equity payment changes?

Changes in payment and spending that prioritize health equity can vary widely in terms of resource needs and feasibility. Small adjustments may be easier to implement, while adding benefits or increasing spending significantly will be more challenging, and may require legislation, federal approval, or other oversight. Linking health equity spending and payment changes to broader agency quality priorities will help create cohesion and make it easier to move the work forward within the agency. State Medicaid agencies can also consider how staffing can support the process, ensuring there is a coordinated team of individuals across multiple departments who have the bandwidth and resources to implement changes in payment and financing strategies related to health equity.

7. What partners can Medicaid involve in developing health equity payment strategies?

State Medicaid agencies can work across sectors to better understand the communities they serve. Engaging Medicaid members directly through formal structures, like member advisory committees, is a key way to generate meaningful input to inform programs and policies. Accessibility is an important consideration when involving members. When scheduling meetings, consider language and disability needs, geography, and other logistics. MCOs, providers, other state agencies, and community-based organizations are also important partners to involve.

8. How can state Medicaid agencies use data to measure health equity and progress?

Collecting and analyzing enrollee-level demographic data, such as race, ethnicity, and language data, is a key starting place. States can measure health equity progress through both outcomes and process measures. Remember, progress and impact could occur in multiple areas outside of the health care arena; Medicaid spending may represent savings in other areas of a state's budget — better educational performance, a healthier workforce, fewer people in jails or prisons. Seek input from multiple perspectives and consider a variety of metrics (e.g., patient and community trust, social return on investment) for the full picture.

Learn More

This fact sheet draws from a brief authored by the Center for Health Care Strategies for ***Advancing Health Equity***, a national initiative led by the University of Chicago and supported by the Robert Wood Johnson Foundation, that is working with states to promote health equity through payment innovations. View the **full brief**.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.