

# Leveraging Value-Based Payment Approaches to Promote Health Equity: Key Strategies for Health Care Payers

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For more information on how to design equity-focused improvements in care delivery, see *Best Practices for Designing Equity-Focused Care Delivery Transformation*.

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For more information, visit [solvingdisparities.org](https://www.solvingdisparities.org)

## INTRODUCTION

Given Medicaid's role in delivering care to low-income individuals, including [many from Black and Hispanic communities](#), the program is uniquely situated to [address related health disparities](#). Value-based payment (VBP), which many payers are already utilizing to encourage improved health outcomes and more efficient care, can be a [strong tool](#) to design equity-focused payment and contracting models (payment approaches). These equity-focused payment approaches can support and incentivize care delivery transformation (i.e. tailored [improvements in care delivery](#)) to reduce and eliminate disparities in health and health care.

This resource identifies six broad connected strategies and key considerations to guide payers, including Medicaid agencies and managed care organizations, in developing an equity-focused payment approach to support care delivery transformations in collaboration with provider organizations and members. Given the complexity of developing VBP approaches, this tool is designed to highlight general strategies and key considerations, but does not provide a detailed, step-by-step guide.<sup>1</sup>

### ADVANCING HEALTH EQUITY

This resource was developed as part of the *Advancing Health Equity: Leading Care, Payment, and Systems Transformation* program. The learning collaborative consists of teams made up of state Medicaid agencies, managed care organizations, and frontline health care organizations discovering best practices for integrating payment and health care delivery reforms to reduce health disparities. The learning collaborative is also addressing social determinants of health and generating best practice and policy recommendations for national dissemination. *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.

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<sup>1</sup> For more information on how to design equity-focused improvements in care delivery, see [Best Practices for Designing Equity-Focused Care Delivery Transformation](#).

# Strategy 1. Articulate the equity goal.

**An equity-focused payment approach must be designed to support an identified health disparity, a related equity goal, and care transformations to reach the goal that can be measured over time.<sup>2</sup> Equity goals can address disparities within specific populations, geographic areas, conditions or other issues of interest, and can be measured through access to care, process of care, and clinical or non-clinical outcomes. Engaging all stakeholders, including payers, plans, providers, and members, in identifying the health equity focus area, associated goals, and the necessary care delivery transformations is key to success. Actively engaged enrolled members are critical for identifying disparities and designing care delivery transformations to successfully mitigate disparities.**

**After identifying the health disparity, stakeholders can work together to establish an equity goal that is measurable and can be feasibly accomplished (see sidebar for *examples of maternal health equity goals*).**

## Consider how data will be used to identify health disparities.

The process of identifying and measuring the targeted health disparity should employ valid and reliable data that are available to payers and provider organizations, and can be stratified by key factors (e.g., race, ethnicity, language, gender, geographic location). To use data to identify a health disparity, questions to consider include:

- // Who owns and can provide access to the necessary data?
- // How do stakeholders define the existence of a health disparity?
- // Is the population large enough to detect statistically valid changes in disparities over time?
- // Are there existing requirements or contracting incentives to collect health disparity data? If not, can requirements or incentives be added to new managed care contracts?

### EXAMPLES OF MATERNAL HEALTH-RELATED EQUITY GOALS

- // **Access:** Increase the percentage of Black pregnant individuals seen for first trimester prenatal care.
- // **Process:** Increase screening for Latina pregnant individuals for pregnancy-related health conditions and risk levels.
- // **Outcome:** Increase controlled HbA1c among Indigenous pregnant individuals with diabetes.

In the event high-quality data are not immediately available, stakeholders can undertake a variety of activities to bolster data collection and inform the identification of health disparities. This includes using contracts between health plans and providers to require and/or financially incentivize the measurement and tracking of disparities, while moving forward in addressing disparities with available data sources.

<sup>2</sup>This resource discusses individual care delivery transformations and payment approaches that support a single equity goal, but there may be instances where multiple equity goals are needed to address health equity focus areas, or the converse where a single equity goal could address multiple health equity-focused areas. Similarly, multiple care delivery transformations and/or payment approaches may be needed to support one equity goal.

### Consider what the equity goal will address.

An equity goal can take two general forms: (1) decreasing measurable health disparities between two or more defined groups (e.g. working to close the disparity in pregnancy outcomes for Black individuals compared to white individuals); or (2) improving the quality measures for priority population(s) experiencing the disparity without a requirement to reduce or close the gap.

### Consider the timeframe of the equity goal.

Equity goals can be a mix of short-term (e.g., engage justice-involved individuals in health care upon departure from institutionalization) and long-term objectives (e.g., improve health outcomes for justice-involved populations), both of which may be supported by an appropriate payment approach. A longer-term goal may require cross-stakeholder collaboration to address upstream social determinants of health that impact health inequities (e.g., lack of affordable housing).

### Consider how to measure progress toward the equity goal.

Health disparities can be measured in different ways and stakeholders will need to consider the following questions:

- // How will the disparity be measured?
- // How will progress be measured (e.g., improvement in the priority population relative to what benchmark)?

### BEST PRACTICES FOR DESIGNING EQUITY-FOCUSED CARE DELIVERY TRANSFORMATION

To support the equity goal, the care delivery transformation should consist of three building blocks—levels, strategies, and modes—to tailor the design so it aligns with the equity goal as well as local circumstances and needs. Combining one level (who the activity will target), one strategy (what the activity will do), and one mode (how the activity will be delivered) for each component of the care delivery transformation encourages approaches to disparity reduction that are the most appropriate to the priority population and health condition.

## Strategy 2. Assess the current payment and care delivery environment.

Understanding how an equity-focused payment approach fits into the current payment context and care delivery environment is critical for [buy-in](#) and success from leadership and providers. Assessing payer priorities, existing or planned VBP arrangements, and existing or planned state VBP contractual requirements of health plans enables payers and provider organizations to identify a potential starting point (e.g., existing measures within a VBP contract, team-based bonus payments, care management fees, or performance-based bonuses), so new payment arrangements align with existing or planned activities. Further, clearly understanding the current care delivery environment and priorities of provider organizations and communities can also facilitate success. While examining current payment approaches or requirements can be a good starting point, stakeholders may need to work together to develop new policies and payment approaches that more intentionally advance health equity.

### Consider if any VBP approaches are preferred or “off the table.”

Stakeholders may have prior experience with VBP that might influence their interest in certain approaches. Similarly, local context and need might make one payment approach a better fit than another. Preliminary conversations among all involved stakeholders can help narrow down options.

### Consider if the care delivery transformation will require upfront, one-time costs.

Upfront costs might include reorganizing the care team, updating health information technology, or training providers. Upfront costs are distinct from the financial resources needed to support the day-to-day care delivery transformation (e.g. an upfront payment to support development of an effective referral system is distinct from payments to support ongoing care coordination). When considering financing upfront costs, questions to consider include:

- What level of investments will be required?
- Can upfront investments decrease future expenses?
- Is there an existing funding source to cover these costs (e.g., capitation payments, one-time grant opportunity)?

### **Consider if existing VBP arrangements can be used to support the proposed equity goal and care delivery transformation.**

Existing VBP contracts may be modified to reward reducing disparities, alongside overall population health improvement. For example, performance metrics within existing arrangements may be changed to specifically address health disparities through stratification of data by characteristic of interest (e.g. race, ethnicity, gender). When employing existing arrangements, modifications must explicitly support the equity goal. Stakeholders should ask:

- // What VBP requirements or opportunities are already in place (between state and payer, payer and provider)?
- // What individual provider, team member, or team-level incentives are already in place?
- // Can existing payments be used to explicitly pay for equity-focused care delivery or performance?
- // Can existing metrics be stratified to measure health disparities?
- // Can new metrics be added to existing contracts?

### **Consider other priorities that can increase buy-in for VBP and the care delivery transformation.**

If existing VBP arrangements cannot be modified to support the equity goal, perhaps other stakeholder priorities can provide an impetus to adopt a new VBP arrangement with a health equity focus. For example, the disproportionate impact of COVID-19 on communities of color has led to a [recommitment to addressing health equity](#) among many health care organizations.

## Strategy 3. Select the performance measures that reflect the equity goal and support the care delivery transformation

**In order for a payment approach to be considered value-based, the payment must be linked to performance measures that reflect quality of care, outcomes, and/or patient satisfaction. Payers and provider organizations should assess how progress toward the equity goal will be measured through the selection of performance measures. Ideally, these measures will align with current quality efforts and minimize provider burden.**

### **Consider how measures can be structured to reflect the equity goal.**

Proposed measures should both: (1) reflect the targeted health condition; and (2) be stratified by the key identified characteristics for the disparity (e.g., race, ethnicity, sexual orientation). Examples of equity-focused metrics vary. For instance, payers may require commonly used quality measures that are already linked to payment (e.g., HEDIS measures) to be stratified by characteristics such as race/ethnicity, language, and disability status to track health disparities. Oregon, for example, uses a stratified emergency department utilization metric to reduce health disparities for people experiencing mental illness. While developing equity-focused measures, stakeholders should also consider if selected measures can be impacted by the care delivery transformation.

### **Consider process and outcome measures.**

Process measures monitor care delivery transformation activities while outcome measures relate to achievement of the equity goal. It is best to use a combination of both process and outcomes measures. For example, a diabetes-related outcome measure could be the number of members with controlled blood glucose (e.g. hemoglobin A1c value), while a diabetes process measure could be the number of members who have seen an eye doctor for a diabetes-related eye exam.



### **Consider the feasibility of collecting complete, accurate, and timely data.**

Having high-quality data is a necessary ingredient for designing equity-focused payment approaches. Without the ability to measure health disparities and track changes, it is impossible to pay for improved performance and achievement of the equity goal. Questions to consider include:

- // What are the sources of the data?
- // Who “owns” the data?
- // Can the data be shared?
- // What is required to share the data and under what conditions?
- // How much time is needed to collect the data?
- // What is the lag time from collecting and sharing the data?
- // What is the measurement period (e.g., rolling time period, quarterly, annual)?
- // Does the data have to be complete before payment can be made?
- // How are providers being engaged to determine feasibility of collecting data?

## Strategy 4. Set performance targets that explicitly support the necessary care transformations.

**In VBP, provider organizations must meet certain targets to receive quality payments. Under traditional VBP arrangements, quality targets focus on average outcomes at the attributed patient population level. Under an equity-focused VBP arrangement, quality targets focus on reducing health disparities and achieving equity across and within defined populations.**

### Consider how the disparities will be measured.

Equity-focused VBP should emphasize paying for improvements in health equity, alongside improvements in overall population health. To do so, stakeholders must develop a health disparities measurement approach to accurately gauge changes over time. Disparities can be measured at multiple levels (provider organization level, regional level, state level) and through different comparative methods. For instance, Michigan has developed an [Index of Disparity](#), which estimates the population disparity with one indicator by combining the disparity experienced by all subgroups into one metric. The index is expressed as a percentage, with zero percent indicating no disparity and higher values indicating increasing levels of disparity. Other payers may assess targets by improvement for one specific priority population based on stratified data (e.g. measuring pregnancy and birth outcomes in Black women). Questions to help design measurement approaches that reward reductions in disparities include:

- // What comparative groups will be used to measure the disparity (e.g., disparities across all groups [like the Index of Disparity] vs. disparities experienced by one priority population)?
- // How will improvement be measured (e.g., improvement in the priority population relative to what benchmark)?
- // At what level will disparities be measured (e.g., provider organization, region, state)?

### Consider what types of performance targets will be used for performance-based payment.

In general, performance targets can be: (1) absolute; (2) improvement-based; or (3) relative. Increasingly, Medicare and Medicaid payers measure both absolute achievement and improvement, and link financial rewards to whichever metric is highest. Equity-focused payment approaches may deploy multiple performance targets to ensure that both disparities are reduced and that overall population-level rates improve. Table 1 below defines these target types, provides equity-focused examples, and explores the benefits and drawbacks of using each type to promote health equity.

**TABLE 1. Advantages and Disadvantages by Performance Target Type**

Target Type and Definition	Equity-Related Example	Pros	Cons
<p><b>Absolute</b> Requires health plan/provider to meet a specific score</p>	<p>The disparity in HbA1c control among Black individuals compared to white individuals should be no larger than two percentage points.</p>	<ul style="list-style-type: none"> <li>Targets are clear and consistent</li> <li>Targets may be evidence-based</li> <li>Rewards top performers</li> </ul>	<ul style="list-style-type: none"> <li>Providers/organizations with lower baseline performance may be unable to meet high benchmarks and qualify for rewards, decreasing incentive to engage in care delivery transformation</li> <li>May not recognize differences in individual populations among providers/organizations (e.g., safety net providers may need to address high social needs and impacts of structural racism more than other providers)</li> </ul>
<p><b>Improvement-Based</b> Requires health plan/provider to show improvement compared to a prior score or specific threshold</p>	<p>The disparity in HbA1c control among Black individuals compared to white individuals should decrease by five percentage points compared to the prior performance year.</p>	<ul style="list-style-type: none"> <li>Targets are clear and consistent</li> <li>Avoids penalizing providers who treat individuals with greater social needs or experiencing wider disparities</li> </ul>	<ul style="list-style-type: none"> <li>Providers/organizations with higher baseline performance may have less opportunity for improvement</li> </ul>
<p><b>Relative</b> Requires health plan/provider to achieve a score relative to a benchmark based on other organizations/providers in the region or country</p>	<p>Relative to provider organizations nationally, the disparity in HbA1c control among Black individuals compared to white individuals should be in the 75<sup>th</sup> percentile</p>	<ul style="list-style-type: none"> <li>Rewards top performers</li> </ul>	<ul style="list-style-type: none"> <li>Specific targets are not clear upfront</li> <li>Differences between percentile targets may not be meaningful</li> </ul>

**Consider improvement relative to a provider organization’s own benchmark.**

Measuring improvement relative to a provider organization’s own benchmark facilitates [fairer comparisons](#) across providers and accounts for contextual factors (e.g., COVID) that may influence outcomes. For instance, in Colorado’s Primary Care [Alternative Payment Model](#), provider payment is triggered based on improvement relative to their own historical baseline.

**Consider setting targets that change over time.**

Payers and provider organizations can set targets that change over time and reflect an increasingly higher set of expectations around achieving the equity goal. For example, payers might set targets that reward improvement in the near term, but in the longer term reward organizations that sustain achievement of their equity goal.

### **Consider risk adjustment approaches that support equity.**

Risk adjustment is typically used to modify per member per month (PMPM) payments to accommodate for the different levels of care needed in different patient populations. Traditional risk adjustment only considers clinical complexity, but new models are also including additional factors such as social needs. Payers and provider organizations should consider if and how they will adjust for different characteristics, but also ensure that [risk adjustment](#) does not [adversely affect](#) or mask health disparities. Risk adjustment can also be subjective, because it is based on submission of applicable codes. The payer should consider how many risk modifiers they will accept and how they can ensure that provider organizations are trained to submit relevant information. Resources that may assist in considering how to incorporate risk adjustment include:

- // National Quality Forum's report [Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors](#)
- // National Quality Forum's report [A Roadmap for Promoting Health Equity and Eliminating Disparities: The 4 I's for Health Equity](#)
- // National Academy of Medicine's series on [Social Risk Factors and Medicare Payment](#)
- // ASPE's series on [Social Risk Factors and Medicare's Value-Based Purchasing Programs](#)

### **Consider how individuals will be attributed (i.e., which providers are responsible for which individuals).**

Different providers or care teams will be better suited to address the targeted equity goal than others. Questions to consider include:

- // Does the payment approach incentivize provider collaboration/care coordination (when appropriate)?
- // Is criteria used for attribution clear to provider organizations, providers, and the care team?

### **Consider leveraging non-financial incentives to increase engagement and improve performance.**

Providers can be motivated to advance health equity through non-financial incentives, in addition to equity-focused payment arrangements. Payers and provider organizations can work together to implement methods including: (1) public report cards sharing performance on selected metrics; (2) recognition programs for high-performers; (3) preferred provider status; (4) training/continuing education opportunities; or (5) auto assignment (a larger share of Medicaid enrollees who do not choose a health plan are assigned to managed care organizations/primary care providers with higher scores).

# Strategy 5. Design the payment approach.

The HCP-LAN Alternative Payment Models framework is a useful guide to understand how payment approaches can be structured. To be considered value-based, payment must be tied to quality of care (e.g., use of evidence-based processes) and/or health outcomes. Many models also include an element of financial risk. Alternative Payment Models that prioritize value-based care enable providers to be paid for non-traditional medical services and encourage higher-value care, rather than higher volume of care. However, these models can also cause unintended consequence of avoiding individuals with more complex health and social care needs, including people of color.

Payment models may be organized into two broad categories: retrospective and prospective. Retrospective payments are made after care is delivered; prospective payments are made before care is delivered. Many payment approaches combine prospective and retrospective elements: the prospective payment supports upfront investments in care delivery and the retrospective payment rewards achievement of quality targets. Table 2 provides information on different prospective and retrospective payment types and equity considerations for each.

**TABLE 2. Prospective vs. Retrospective Payment and Equity Considerations**

Payment Types	Description	Equity Considerations
<b>Prospective Payment</b> Paid before care is delivered, often not related to the delivery of care.		
<b>Foundational Payments for Operations</b>	<ul style="list-style-type: none"> <li>Payments to support efforts to deliver higher quality care.</li> <li>May be based on volume of patients served, rather than volume of services.</li> <li>May be paid PMPM.</li> </ul>	<ul style="list-style-type: none"> <li>Covers services that lack billing codes (e.g., supporting care coordination, community health workers, screening and referrals for social care needs).</li> <li>Provides flexibility to cover a range of services tailored to meet individual patient’s needs that reflect equity considerations.</li> <li>Could directly reward achievement of equity goals through higher payment levels or in combination with pay for performance (see below).</li> </ul>
<b>Bundled Payment</b>	<ul style="list-style-type: none"> <li>Payment of a fixed lump-sum for a certain procedure/condition and all procedure/condition-related care over a specified period of time.</li> <li>Tied to quality performance in a VBP model.</li> <li>Payer and provider should agree on definitions for care included in the bundled payment.</li> </ul>	<ul style="list-style-type: none"> <li>Provides incentives and flexibility to deliver care tailored to meet individual patient’s needs that lower costs and may reflect equity considerations.</li> <li>Could directly reward achievement of equity goals through higher payment levels or in combination with pay for performance (see below).</li> <li>Potential to result in discrimination against individuals perceived as high-cost or high-risk, including people of color.</li> </ul>

Payment Types	Description	Equity Considerations
<b>Global Budget</b>	<ul style="list-style-type: none"> <li>Set payment for care provided to all members in a fixed period of time.</li> <li>Payment may be based on individual volume and past expenses.</li> <li>Tied to quality performance in a VBP model.</li> <li>Typically paid PMPM.</li> </ul>	<ul style="list-style-type: none"> <li>Provides the greatest incentives and flexibility to deliver care that can lower costs over a one-year time frame, which could be in ways that are tailored to individual's needs and address health disparities.</li> <li>Could directly reward achievement of equity goals through higher payment levels, quality withholds, or pay for performance (see below).</li> <li>Potential to <b>compromise</b> quality of care unless tied effectively to quality metrics.</li> </ul>
<b>Retrospective Payment</b> Paid after care is delivered, may require spending thresholds for payment. In VBP, requires quality metrics to be met.		
<b>Foundational Payments for Infrastructure*</b>  <i>*can be retrospective or prospective</i>	<ul style="list-style-type: none"> <li>Payments to support development of infrastructure that will be required for care delivery transformation</li> <li>Can be paid as a one-time lump sum, paid out periodically, or as certain activities are achieved.</li> </ul>	<ul style="list-style-type: none"> <li>Supports infrastructure investments in new methods of providing care (e.g., modifications to EHR systems, training staff on overcoming bias or new care models).</li> </ul>
<b>Pay-for-Reporting, Pay-for-Performance</b>	<ul style="list-style-type: none"> <li>Retrospective payments to provider organizations who report, meet, or exceed quality metrics, depending on the approach used.</li> </ul>	<ul style="list-style-type: none"> <li>Directly supports equity-related goals (e.g., quality, outcomes, and patient experience) if measures are stratified by relevant characteristics (e.g., race, ethnicity and/or language) and explicit equity goals are set.</li> <li>Could combine with prospective payments to directly reward achievement of equity goals.</li> </ul>
<b>Episode of Care Shared Savings Payment</b>	<ul style="list-style-type: none"> <li>Maintains fee-for-service (FFS), but sets a predetermined benchmark based on historic spending and projected expenditures for a certain procedure/condition and all related care. Provider organizations share a percentage of savings if expenditures fall below spending benchmarks and quality targets are met. Providers may be at risk for a percent of expenditures above spending benchmarks.</li> <li>Provider organizations are required to meet quality metrics to be eligible for savings.</li> </ul>	<ul style="list-style-type: none"> <li>Could directly reward achievement of equity goals through stratified quality targets and/or a higher percentage of savings.</li> <li>Development and adjustment of spending benchmarks has potential to unfairly penalize provider organizations working with high-cost populations.</li> </ul>
<b>Total cost of care shared savings, shared risk</b>	<ul style="list-style-type: none"> <li>Maintains FFS, but sets a predetermined benchmark based on historic spending and projected expenditures. Provider organizations share a percentage of savings if expenditures fall below spending benchmarks and quality targets are met. Providers may be at risk for a percent of expenditures above spending benchmarks.</li> <li>Provider organizations are required to meet quality metrics to be eligible for savings.</li> </ul>	<ul style="list-style-type: none"> <li>Could directly reward achievement of equity goals through stratified quality targets and/or a higher percentage of savings.</li> <li>Development and adjustment of spending benchmarks has potential to unfairly penalize provider organizations working with high-cost populations.</li> </ul>

### **Consider how different payment types can work with one another.**

Many payment approaches incorporate multiple payment types to support different aspects of care delivery transformation, such as improving data collection, investing in care team changes, and rewarding improved performance. For example, an equity goal to improve maternal health outcomes for Black individuals might be supported by a payment approach that includes upfront investment to train staff in culturally sensitive care delivery, a prospective monthly payment to support care management, and a retrospective pay-for-performance designed to reward provider organizations that increase the proportion of Black individuals supported in first trimester prenatal care. When deciding how best to layer payment approaches, questions to consider include:

- // Does the payment approach support all care delivery transformations required to meet the equity goal?
- // Does the payment approach explicitly pay for reductions in disparities (i.e. addressing outcomes measures) and/or providing more equitable health care for priority populations (i.e. addressing process measures)?
- // Is the payment approach linked to the identified process and outcome measures/targets?

### **Consider the appropriate levels to direct incentives.**

Because equity-focused care interventions often touch multiple levels of the health care system and community, stakeholders should determine where to direct the incentives (e.g., community, health system, provider organization, individual team members). In parallel to developing an equity-focused payment approach between a plan and provider organization, provider organizations may consider implementing complementary changes in team/individual provider compensation. For example, a complementary change to compensation that supports improved maternal health outcomes for Black individuals could use the monthly care management payment to reward doulas when they earn high scores on patient experience surveys. Member/patient input can help determine which team members may be most influential in promoting equity. As such, questions to consider as part of this process include:

- // What level is responsible for leading the care transformation activities: communities, health systems, provider organizations?
- // Is the provider organization implementing a complementary compensation model? Can the payment approach support development of the compensation model?
- // Who is being targeted by the compensation model?



### **Consider the magnitude of the incentive.**

Payers and providers should collaborate to determine the magnitude of the incentive needed to change behavior and cover needed service changes. Key questions include:

- // Is the incentive large enough to sustain changes in care delivery transformation?
- // Is the size of the incentive appropriate to ensure that investment in the care delivery transformation improvement is warranted, i.e., that doing nothing is not a more financially sound decision?
- // Is the magnitude of the incentive appropriate for the level being targeted?

### **Consider how payment approaches may change over time.**

VBP seeks to improve quality while decreasing or maintaining costs of care. If there is strong evidence to suggest a return on investment for an equity-focused payment approach, payers can consider a short- and long-term payment strategy that accommodates upfront costs, but also enables providers and payers to reap the financial rewards. For example, payment approaches could potentially use a pay-for-performance structure in the first year, but shift to a shared savings approach in subsequent years. Another approach might increase the share of savings available year-over-year or increase the threshold level of improvement as providers become more familiar with the equity-focused payment approach (e.g., Year 1 requires a 10 percent increase in performance over baseline to receive shared savings; Year two requires a 15 percent increase in performance over baseline to receive shared savings). As part of this conversation, it is important to understand financial performance of the provider organization, as some provider organizations have minimal ability to finance upfront care delivery changes while waiting for potential reimbursement in the future. Questions to guide this exploration include:

- // What is the expected timeframe for cost savings?
- // Who benefits from cost savings?
- // Is there an expectation for return on investment for this payment approach?
- // Is there both a short- and long-term payment strategy to address upfront costs and potential savings?
- // How will the payment approach encourage continued performance improvement over time?



## Consider what level of risk is appropriate and does not undermine equity goals.

Many approaches phase in financial risk over time. Payment approaches might begin by insulating provider organizations from any downside financial risk, but move to another payment structure over time as provider organizations become more familiar with the payment model and equity-focused care delivery. Payers and provider organizations should consider if they want to expose provider organizations to financial risk, which is most often associated with prospective payment mechanisms, and if risk should increase over time. Questions for this conversation include:

- // How much flexibility is needed for providers to undertake transformative care delivery approaches that will improve health equity?
- // When will payment approaches introduce downside financial risk for provider organizations?
- // How much risk will provider organizations be exposed to?
- // Is the level of financial risk appropriate?

## Examples of Equity-Focused Payment Approaches and Care Delivery Transformations

**Fairfax County, Virginia** worked with partners in the county's safety net clinics to decrease disparities in cervical cancer screening, diabetes control, and hypertension control between Spanish-speaking patients, who had consistent access to on-site interpreter services, and the multilingual, non-Spanish-speaking patients who did not have access to these services. The payment approach involved the county setting a global budget for the participating clinic operator. The clinic operator then changed compensation to award all members of the care team a bonus for meeting quality of care and productivity measures. The clinic operator also paid higher FFS rates for activities that promoted reductions in disparities.

**Mount Sinai Health System in New York City** worked with partners to decrease disparities in postpartum care between Medicaid-covered women (predominantly Black or Latino) and commercially insured, white women. The payment approach gave an annual bonus to OB/GYNs for every patient insured by the partner payer who received a timely postpartum visit. The payment approach also added a salary payment for social workers and community health workers who worked with postpartum patients.

**Advantage Dental in Oregon** worked with partners to increase dental care utilization among patients enrolled in Medicaid or CHIP and living in rural areas. The payment approach used a global budget based on number of patients served. This allowed care to be delivered in innovative ways—for example, expanded-practice dental hygienists were used to screen and treat patients in schools and WIC offices, case managers coordinated care for patients with immediate needs, and regional manager community liaisons coordinated community outreach and education. The payment approach also added a bonus for care teams who met quality targets including increased screening, treatment of at-risk patients, and follow-up care in targeted counties.

## **Strategy 6: Address operational issues and other considerations faced by health plans and providers.**

**Finally, payers and provider organizations should consider operational issues that may influence the uptake and impact of an equity-focused payment approach and care delivery transformation. During development and implementation of the payment approach and care delivery transformation, payers and provider organizations should work together and with their members to explore barriers and solutions to implementation.**

### **Consider the quality of the data used.**

Collection of high-quality data is a prerequisite for equity-focused VBP. Without this data, it is impossible to measure, track, and reward progress toward reducing health disparities. Systems need to allow recording (e.g., are fields free text or system defined?) and prioritization (e.g., does the system default to a particular characteristic if several are selected?) of relevant characteristics.

### **Consider how data will be shared, collected, and analyzed.**

Relevant data needs to be available to providers at the point of care to ensure disparities and required care delivery transformation activities are highlighted. There is also a risk of over-sharing information—providers have limited capacity, and only the most actionable and relevant information should be highlighted.

### **Consider providing training around payment reform.**

Providers need to understand how payment approaches are designed to encourage and support equity-focused care. Provider- and care team-specific training may be useful to increase buy-in for the new payment approach and care delivery transformation.

### **Consider developing a tailored evaluation plan.**

The fit and impact of the payment approach should be assessed. Payers and provider organizations should be prepared to make changes if payment approaches do not seem to reduce health disparities and/or change care processes, though it will take time for impacts to become apparent.

## CONCLUSION

In pursuing opportunities to reduce health disparities and improve equity across care delivery and outcomes, it is important to acknowledge that health disparities are a symptom of larger societal issues. The societal causes underlying disparate health outcomes, including structural racism, require a broad set of policy actions to be implemented in partnership with community members and sustained over time. As a first step, equity-focused payment approaches linked to targeted care delivery improvements can help mitigate health disparities.

The development of equity-focused value-based payment approaches to support care delivery transformation is an important lever that payers can use to advance health equity with their provider organizations and members. To increase the relevance and effectiveness of these payment and care delivery approaches, it is important to incorporate the needs and engagement of the communities facing these disparities as well as the capacity and resources of the frontline staff who will be implementing models on the ground. This resource provides six connected strategies to guide stakeholders in developing equity-focused payment approaches as part of broader efforts to mitigate health disparities at the state and local level.



**ABOUT AHE**

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