Five Strategic Components to Support Health Equity in Medicaid

Anne Smithey Center for Health Care Strategies
Shilpa Patel Center for Health Care Strategies
Tricia McGinnis Center for Health Care Strategies

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AHE Advancing Health Equity
Leading care, payment, and systems transformation

Introduction

States and territories increasingly recognize the role that Medicaid should play in advancing health equity for the people it serves and are pursuing health equity strategic plans for their Medicaid programs. Given the fast-paced nature of state work, however, Medicaid agencies do not always have the time or opportunity to take a step back and engage in long-term strategic thinking.

To assist Medicaid agencies in developing or strengthening health equity efforts, this brief proposes five core components of a health equity strategic plan: (1) culture of equity; (2) community engagement; (3) performance measurement and data; (4) value-based payment; and (5) care delivery and benefit design. Though some of these components can be implemented alone, they will be more impactful when integrated and employed in concert with each other. As with any policy/programmatic change, Medicaid agencies should monitor the outcomes of their strategic planning efforts and be prepared to make changes if interventions are not successfully making progress toward goals to mitigate health disparities and advance health equity.

The following sections outline considerations, resources, and innovative state examples to inform Medicaid stakeholders undertaking agency-wide efforts to embed an internal and external focus on health equity.

KEY TAKEAWAYS

- Medicaid agencies across the country increasingly recognize that Medicaid should play an important role in advancing health equity and are pursuing health equity strategic plans for their programs.
- Medicaid agencies can work to create an internal culture of equity, which will bolster support for efforts designed to advance health equity both for their staff and for Medicaid members.
- Partnering with community members is a key step to understanding where health inequities exist and what barriers exist to achieving better health. Medicaid agencies can engage with communities themselves, and/or encourage or require MCOs and Medicaid providers to do so.
- Medicaid agencies should measure their performance to identify health disparities, and design value-based payment models and care delivery interventions to address these disparities. States are increasingly exploring these tools to advance health equity, and many are making innovative changes in order to advance health equity.
- This brief outlines five core components to a health equity strategic plan, including considerations, resources, and innovative state examples for each component.

1. Culture of Equity

Medicaid agencies working to develop a health equity strategic plan will naturally think about refocusing programs and policies that impact people enrolled in Medicaid, but may be less likely to consider the internal culture and practices of the agency. However, agencies that provide staff with training and support to build an internal culture of equity can be more successful at gaining staff buy-in and long-term commitment to advance health equity externally. Agencies will need to identify how their policies and practices may be unintentionally contributing to inequities both inside and outside of the agency, and how to take action to eliminate these harmful activities by understanding the systemic factors that perpetuate inequities, such as structural racism. Medicaid agencies can consider undertaking activities designed to increase a culture of equity, such as:

- Focus the agency's mission, vision, and goals on advancing health equity;
- Identify ways to achieve the agency's mission, vision, and goals by taking action within Medicaid – and, when possible, partnering to work with those outside of the healthcare system (e.g., other state agencies, community-based organizations, people served by Medicaid);
- Educate, train, and align agency staff about why health inequities occur, including a reorientation from the individual/member level to the structural level of health inequities;
- Work with staff to understand that all parts of the healthcare system, including Medicaid agencies, contribute to systemic racism and root causes of inequities experienced by colleagues and people enrolled in Medicaid, and identify how staff can work to mitigate these inequities in their day-to-day work;
- Identify how the agency can hold itself and its partners accountable for more equitable outcomes (e.g., by integrating health equity requirements or considerations and mechanisms for tracking progress into existing Medicaid agency priorities, such as quality improvement); and
- Support efforts to bolster diversity, equity, and inclusion (DEI) at every level of the Medicaid agency.

KEY RESOURCES

- Creating a Culture of Equity and How do you establish a culture of equity? – resources from Advancing Health Equity (AHE) that explain what a "culture of equity" is and the steps healthcare organizations can take to promote a culture of equity.
- Building a Culture of Health Equity from Within: Spotlight on Virginia Medicaid – interview from the Center for Health Care Strategies (CHCS) that spotlights activities taken by Virginia's Medicaid agency to create a culture of equity, including activities focused on Medicaid staff and on programmatic/policy change.

- Establishing a Chief Equity, Inclusion and Opportunity Officer in Indiana – brief from the National Academy for State Health Policy (NASHP) that explores Indiana's creation of a role designed to focus on equity and inclusion as a way to create a culture of equity.
- There Can Be No Progress on Quality Without Equity – set of resources from the Institute for Healthcare Improvement that introduces health equity and shows how health equity can be embedded into organizational priorities, including a focus on equity as a component of quality improvement.

STATE EXAMPLES

Washington State's Health Care Authority created the new role of Equity, Social Justice, and Strategy Manager in spring of 2021 to oversee health equity efforts across the agency. Under their leadership, the agency is developing a state-mandated Pro-Equity, Anti-Racism Plan that explores strategies to advance health equity.

2. Community Engagement

Medicaid agencies should seek community input and partnership when developing and implementing the agency's health equity strategic plan. Community members —particularly people of color and others who experience inequities—can provide insight into the particular barriers that contribute to health inequities, resulting in interventions that are more responsive to community experiences, needs, and priorities. Strong partnerships with the community can also help Medicaid agencies identify existing community assets, which can support and improve interventions. Medicaid agencies have multiple opportunities to support partnerships with community members. States can directly engage with Medicaid enrollees through work groups, advisory committees, and other engagement bodies. States can also create contract requirements that improve how managed care organizations (MCOs) and network providers connect with their members/patients. States, MCOs, and providers should identify how to appropriately compensate community members who provide their expertise during the policy design and implementation process.

KEY RESOURCES

- Convening a Consumer Advisory Board: Key Considerations – blog from CHCS outlining key considerations for successfully and equitably bringing Medicaid members/consumers into the policy development process.
- Increasing Consumer Engagement: Learnings from States [summary] and Engaging Consumers in Medicaid Program Design: Strategies from the States [full report] – research conducted by Oregon Health & Science University on different methods state Medicaid agencies have used to engage Medicaid members.
- Key Findings from the Medicaid MCO Learning Hub Discussion Group – Focus on Member Engagement and Consumer Voice – brief from NORC highlighting their findings on challenges and successes Medicaid MCOs have experienced when engaging with Medicaid members.
- Patient & Family Engagement: Improving Health and Advancing Equity and the Patient & Family Engagement Getting Started Toolkit – guidance from the National Partnership for Women & Families that highlights how healthcare organizations can work to improve engagement with patients and their families, with an explicit focus on ensuring member engagement advances health equity.
- The One-Stop Shop For Healthcare & Community Partnerships – library of resources from HealthBegins that explores how a variety of healthcare organizations can work to successfully partner with community members.

STATE EXAMPLE

The **Oregon** Health Authority (OHA), which oversees the state's Medicaid program, often seeks extensive public input when developing updates to Medicaid policy. For example, while developing updates to the state's managed care program, Coordinated Care Organization (CCO) 2.0, OHA sought public input through public meetings, stakeholder meetings, public forums, and online and phone surveys of Medicaid members, providers, and other community members.

Oregon also requires each CCO (the state's managed care organization equivalent) to have a Community Advisory Council (CAC) and defines the responsibilities of the CAC. CACs must include representatives from each county served by the CCO and member representatives must make up at least 51 percent of the CAC's membership. OHA's Transformation Center and Public Health Division provide funding opportunities and technical assistance to support CCOs in their partnership with members. Many CCOs support the members who participate on the CAC by providing stipends, transportation, meals, or other types of compensation for their time and expertise.

3. Performance Measurement and Data

Gathering demographic data, including race, ethnicity, language, and disability (RELD) data and social needs data is a key first step to identifying existing disparities, but many state Medicaid programs are often challenged by incomplete data. Medicaid agencies are pursuing methods to improve collection and sharing of RELD and social needs data including: (a) requiring collection of member self-reported data (typically by MCOs or primary care providers); (b) using publicly available, neighborhood-level information to identify trends; and (c) sharing data across state agencies. Once collected, demographic data can be used to stratify quality metrics to measure and track health disparities.

Considerations for developing a data and performance measurement strategy include:

- What demographic data will be collected?
- Who will be responsible for collecting self-reported data from members (provider, MCO, state) and how will they be held accountable for doing so? How will they be supported to do so (e.g., training, technical assistance)?
  - What is the required level of data completeness and approach for improving completeness, consistency, and accuracy?
  - What processes will be used to assess data completeness/quality and support improvements?
  - How will data flow between stakeholders (providers, MCOs, Medicaid agency, other partners)?
- What data standards will be used (e.g., OMB data standards, HHS standards, or other)?
- Will all or a subsample of quality metrics be stratified? If a subsample, which quality metrics and will this be increased over time until all metrics are stratified?
- Who will be responsible for reporting stratified metrics to the state and at what level will metrics be stratified for reporting and payment-related purposes?
  - Ideally, both MCOs and provider organizations will stratify metrics whenever possible to guide efforts to reduce health disparities. However, for the purposes of reporting stratified metrics and linking these metrics to payment, states should consider that MCOs have more members than providers, which may make it easier to identify statistically valid disparities. Additionally, MCOs are more able to handle the administrative burden of stratifying metrics; however, providers are better situated to directly impact care delivery and health outcomes, and need disparities data to drive these efforts.
- Who will be held accountable for decreasing health disparities and how will they be held accountable? Refer to the *value-based payment section below to think more about accountability.*
- How can data collected and analyzed by Medicaid or other state agencies be used to identify health disparities and support efforts to advance health equity – both within Medicaid and within the state overall?

KEY RESOURCES

- Using Data to Reduce Disparities and Improve Quality – brief from AHE that explores how quantitative and qualitative data can be harnessed to identify health disparities and measure changes over time.
- Collection of Race, Ethnicity, Language (REL) Data in Medicaid Applications: A 50-state Review of the Current Landscape – brief from State Health & Value Strategies that reviews all 50 states to explore how their Medicaid agencies are collecting race, ethnicity, and language data as a key step to identifying health disparities within Medicaid.
- Unlocking Race and Ethnicity Data to Promote Health Equity in California – report from Manatt exploring opportunities for states to leverage their MCO contracts to collect more robust race and ethnicity data.
- Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity – report from Grantmakers in Health and the National Committee for Quality Assurance exploring challenges and opportunities to improve collection and use of race and ethnicity data.

STATE EXAMPLES

New York State's Medicaid agency collects race and ethnicity data from its members upon enrollment, and the state has improved data collection by requiring a response to the race/ethnicity question upon enrollment. Enrollee privacy is preserved by allowing enrollees to select "choose not to answer" as a response.

Rhode Island links collection of REL data by primary care providers to its performance-based payments as part of the Medicaid program's accountable care organization (ACO) program. This pay-for-reporting measure was worth five percent of the ACO's performance-based payment in 2021.

Many states require MCOs to submit quality metrics stratified by member demographics (usually REL, sometimes RELD) as part of their quality strategy or MCO contract requirements. These states do not necessarily link performance on disparities to financial incentives but reporting requirements could be a pathway to developing the infrastructure and capacity needed to do so.

4. Value-Based Payment and Purchasing

State Medicaid agencies can start developing or bolstering value-based payment and purchasing programs that explicitly promote health equity. One goal of such a model would be to stratify all quality metrics (either for a provider or MCO) by relevant demographic data (e.g., RELD data, sexual orientation, gender identity, geographic data) and directly link performance-based payment to reduction of health disparities. Developing the capacity to do so might require creating a multi-step plan that includes: (1) collection and validation of demographic data; (2) baseline measurement of disparities within quality metrics; and (3) linking performance to payment, with expectations of continual improvement over time.

States can consider how to appropriately weight equity performance, for example by: (a) ensuring that performance on stratified measures counts for a large and increasing percentage of the overall quality score (e.g., start at 25 percent and increase over time); or (b) requiring providers to meet a certain level of performance on disparities (an equity threshold or "gate") in order to qualify for any performance-based payment.

In addition to stratifying quality metrics, there are a number of other opportunities Medicaid programs can explore to embed health equity into value-based payment and purchasing, including:

- Supporting safety net providers, especially FQHCs, to participate in VBP models;
- Providing time-limited upfront payment to providers to support capacity for care delivery transformation;
- Requiring development of interventions to advance more equitable care and outcomes;
- Providing technical assistance or other opportunities for providers and MCOs to learn about health equity;
- Aligning MCO and provider performance metrics with state health equity and population health goals; and
- Considering if or how to implement social risk adjustment.

KEY RESOURCES

- Leveraging Value-Based Payment Approaches to Advance Health Equity – brief from AHE that outlines key steps purchasers and payers can take to develop value-based payment models that are designed to explicitly advance health equity.
- Advancing Health Equity through APMs: Guidance for Equity-Centered Design and Implementation – guidance from the Health Care Payment Learning & Action Network (LAN) to design value-based payment models that explicitly advance health equity, including detailed guidance designed to support development of contract language.
- Harnessing Payment to Advance Health Equity: How Medicaid Agencies Can Incorporate LAN Guidance into Payment Strategies – blog from CHCS exploring how Medicaid agencies can use the LAN guidance to modify their value-based payment strategies to advance health equity.
- CMS Innovation Center Launches New Initiative to Advance Health Equity – Health Affairs Forefront article outlining the CMS Innovation Center's new efforts to create payment models with a focus on health equity.

STATE EXAMPLES

Minnesota is using payment reform, in payments made both to Medicaid MCOs and ACOs (known as Integrated Health Partnerships, or IHPs, in the state), to promote health equity for individuals enrolled in Medicaid in their state.

- As part of the state's MCO withhold program, 2022 MCO contracts award quality points to MCOs whose attributed members experience reduced health disparities (i.e., decreased gaps in outcomes by race/ethnicity) and penalize MCOs whose attributed members experience worsened disparities.
- As part of the 2023 IHP contracts, the state makes upfront population-based payments to IHPs (i.e., capacity-building payments), and health disparities quality performance counts for 40 percent of the quality score influencing the size of these payments. Disparities performance also counts for 20 percent of the IHP quality score influencing the receipt of shared savings.

Minnesota also uses both clinical and social risk adjustment to modify the size of its upfront population-based payments.

5. Benefit and Care Delivery Design

State Medicaid agencies can leverage requirements embedded in specific care delivery models, such as patient-centered medical homes (PCMH), (ACOs), and integrated behavioral health models, to advance health equity. For example, contract requirements at the provider or plan level might include provision of culturally and linguistically appropriate care (either through culturally-specific services or using guidance like the National Standards for Culturally and Linguistically Appropriate Services), training on health equity and bias, leveraging existing accreditation programs (such as the Health Equity Accreditation from the National Committee for Quality Assurance), or tracking performance on health disparities.

Medicaid agencies can also consider opportunities to expand benefits, including covering services provided by an expanded, community-based healthcare workforce (e.g., community health workers, peer recovery specialists, doulas). Leveraging the community-based healthcare workforce has been shown to improve health outcomes and advance health equity for many different patient populations, including people of color, people who primarily speak a language other than English, and people living in rural areas. These providers can build close relationships with patients to support clinical care and provide culturally and linguistically concordant care, and may be well-suited to provide interventions addressing health-related social needs. States across the country are exploring use of State Plan Amendments, 1115 waivers, and managed care contracts to cover these types of providers through Medicaid.

Finally, Medicaid agencies can consider how to support adoption of advanced and integrated care delivery models, including models that address health-related social needs, integrate primary care and behavioral healthcare, or focus on specific populations (e.g., models focused on Black maternal health or behavioral healthcare for Native American people). These models may also support or require collaboration and financial partnership between MCOs, providers, community-based organizations, and faith-based organizations. Providers who predominantly serve Medicaid or uninsured patients may face particular barriers in having the resources to develop these types of care delivery models and could benefit from additional support such as provision of upfront funding to build capacity, technical assistance to develop expertise, or specific funding structures to support new models.

KEY RESOURCES

- Roadmap to Reduce Disparities – tool from AHE that outlines key steps to reduce health disparities, including explorations to identify disparities of interest, identify care delivery transformations to reduce disparities, and develop payment models to support care delivery transformation.
- Promote Health Equity: Advancing Primary Care Innovation in Medicaid Managed Care, part of the Advancing Primary Care Innovation in Medicaid Managed Care toolkit – toolkit from CHCS that explores opportunities for state Medicaid agencies to leverage primary care innovation to advance health equity, including sample MCO procurement and contract language.
- State Medicaid Approaches to Doula Service Benefits and State Community Health Worker Models – trackers from NASHP that show how state Medicaid agencies are incorporating doula and community health worker services into their programs.

STATE EXAMPLES

Oregon, **Ohio**, and **New York** incorporate health equity standards into their PCMH or PCMH-like models. These examples are explored in *Raising the Bar: Using Primary Care Practice Standards to Advance Health Equity in Medicaid.*

California has developed Community Supports, which are designed to cover a number of health-related social needs interventions as *in lieu of* services. Covered supports include: housing services (e.g., housing transition navigation, housing deposits, tenancy sustaining services); assistance with activities of daily living (e.g., personal care and homemaker services, caregiver respite); home modifications for accessibility; medically supportive food; sobering centers; and asthma remediation. More detail can be found in California Department of Health Care Services' policy guide.

Arizona supported behavioral health integration in its Medicaid program through the Targeted Investments Program, started in 2016, which invested $300 million over five years to create incentive payments based on milestones for integrating physical and behavioral healthcare. The state also supports a care delivery model called Justice Clinic Sites, which provides holistic physical/behavioral/social healthcare and probation/parole services to formerly incarcerated Medicaid members at a single site of care.

Rhode Island requires its ACOs to create financial partnerships with organizations including CBOs by allocating at least 10 percent of their annual incentive funds to partners who provide services for behavioral health services, substance abuse treatment, and/or health-related social needs.

Conclusion

In the context of ongoing, unconscionable health disparities, Medicaid agencies and other organizations that disproportionately serve communities of color and people who experience inequities are well-positioned to take action. This brief explores how Medicaid agencies can do so by designing five components of a health equity strategic plan, which can be developed and implemented independently, or, to maximize their impact, in concert with each other.

States should work with community members to identify concrete and measurable health equity goals, which can be used to anchor efforts to develop a Medicaid health equity strategic plan. By working toward a set of statewide goals, Medicaid agencies may be able to more easily understand how each component of the strategic plan complements the others. To achieve success, it is critical for Medicaid agencies to focus on how the agency will hold itself and its partners accountable for the goals and activities outlined in the health equity strategic plan. One powerful method to create accountability is through transparency and public reporting on health equity goals and activities, showing Medicaid members and their community how the state is prioritizing and making progress on these pressing issues.

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ABOUT AHE

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