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Making Progress Toward Health Equity: Opportunities for State Policymakers to Reduce Health Inequities Through Payment and Delivery System Reform

A robust body of evidence documents a legacy of health inequities in our country — inequities that are rooted in structural racism and other forms of oppression and shaped by industry and policy choices.[1] As the coronavirus pandemic wreaks havoc on the lives and health of people across the world, data continues to mount that confirms its disproportionate toll on Black, Indigenous, Latinx, and other people of color (BIPOC). In light of the stark disparities in COVID-19 illnesses and deaths, decision-makers should prioritize policy solutions that measurably improve health equity.

Payment reform has emerged as an important lever that can be used to advance equity in health care delivery. And some states are making progress in linking equity measurement to risk-based payment and pay-for-performance (P4P) initiatives. But without implementing thoughtful guardrails, P4P approaches can be risky for states and could unintentionally disincentivize or penalize providers that care for patients who need complex care or increased health-related social support.

Several states are navigating these challenges by creating financial incentives for health equity in Medicaid. This issue brief explores this important new strategy. It builds upon a previous Families USA report that identified opportunities for state and federal governments to measure and pay for equity.[2]

The purpose of this follow-up brief is to share lessons learned from three model states: Oregon, Minnesota and Washington. We explore the measurement and payment approaches they use that can inform similar efforts across the country. This brief also describes key lessons from these states regarding comprehensive reform of Medicaid-funded payment and service delivery. And it concludes with actionable recommendations that state policymakers ought to adopt to reduce health disparities using equity-focused payment mechanisms.

As detailed below, these states are developing Medicaid health equity incentives as part of broader efforts to reform how health care is financed and organized in ways that are intended to improve population heath in communities of color. The importance of these state programs lies both in their progress toward financial incentives for equity and in their broader approach to delivery system reform and the social determinants of health. New payment structures designed to improve health equity will fail if they are not embedded in broader reforms that address the conditions that perpetuate health inequities, including structural racism.

The three states we have analyzed are all pursuing Medicaid-led health system transformation using common approaches, including distinct payment models, risk adjustment, financial incentives, equity-focused measures, and requirements for stratification of quality measures.

Our multi-state analysis provides an action plan for state policymakers who are interested in advancing equity through payment and delivery system reform.

Multi-State Analysis of Efforts to Implement Equity-Focused Health System Improvements

The three states we have analyzed are all pursuing Medicaid-led health system transformation using common approaches. These approaches include distinct payment models, risk adjustment, financial incentives, equity-focused measures, and requirements for stratification of quality measures (see Table 1 on page 10).

In this section we summarize the value-based payment (VBP) frameworks established in Oregon, Minnesota, and Washington, along with early signs of these states' success and challenges.

Oregon

In 2012, the Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 waiver for Oregon that focuses on Coordinated Care Organizations (CCOs) and capitated provider networks (the networks include providers of behavioral and oral health care). CCOs work collaboratively with their communities to serve people who rely on Medicaid, with the goal of improving health outcomes — including health equity — and reducing health care costs in a specific geographic area.[3] CCOs receive global capitated payments from the state for the total cost of care, as well as incentive payments based on meeting performance benchmarks and improvements on a set of outcome and quality measures.[4] Notably, performance-based payment metrics such as CCO incentive measures are a subset of the overall state quality measures and are reviewed and updated annually.

In the approved renewal of this waiver, Oregon committed to building on the CCO model through:

1. Expanding on a performance-driven approach to integration of physical, behavioral and oral health.
2. Focusing strongly on health equity and social determinants of health.
3. Committing to a sustainable rate of growth and advancing value-based payment approaches.[5]

Among the earlier health equity metrics that were tied to performance-based payments, the CCO State Quality measures included a metric on follow-up after hospitalization for mental illness. The state quality metrics were expanded in 2018 to include follow-ups on emergency department use by members with mental illness. In 2019, reduction in emergency department use for mental illness was included as an incentive measure.

Through the Health Equity Measurement Workgroup, beginning in measurement year 2021, CCOs will be required to report on an additional health equity

measure: Meaningful Language Access to Culturally Responsive Health Care Services. This measure was developed to address disparities in access to care for people with limited English proficiency (LEP) or who communicate in sign language. Incentive payments to CCOs are based on measuring their unadjusted performance in delivering quality interpreter services, which generally includes services provided by a certified or qualified health care interpreter. Data from most incentive measures are disaggregated by race, ethnicity, language, gender and disability status. However, some gaps in data persist, which limit the state's capacity to identify and address disparities.

Beginning in calendar year 2021, the Oregon Health Authority (OHA) has an ambitious goal of eliminating health inequities in 10 years. This explicit goal is intended to signal CCOs and providers in their network that health equity is a top priority that they must address through how they pay for and deliver health care. As part of the Section 1115 waiver renewal, the CCOs' state quality measures reports must include the difference in these measures among racial and ethnicity categories. As a result, Oregon has made considerable progress in three key areas: stratification of quality measures, implementation of managed care (CCO) contracting requirements that support interventions designed to improve equity, and development of equity-specific quality measures.

Stratification of Quality Measures

Oregon is an important national leader when it comes to stratifying Medicaid outcomes data to identify specific populations and communities that experience disparities in health and health care outcomes. The state has had some success in the stratification of quality measures by race, ethnicity, language and disability status (REALD). For instance, their collection of this demographic data has been critical in the context of the pandemic, as it enables the state to better understand which communities are most affected by the virus and how to target resources and interventions.[6] And the state legislature and Medicaid administration are holding CCOs accountable for better coronavirus data collection.

On the other hand, the state has only partly overcome its significant implementation challenges in achieving comprehensive collection of REALD data. For example, CCOs self-report data on the new language access measure, rather than requiring the state to analyze claims data or having a third party collect the data. This limits the state's ability to gauge whether CCOs are meeting their data collection goals. State officials have noted that self-reporting data is a necessary workaround to make up for the current lack of a reporting infrastructure. But the pandemic has only compounded data reporting challenges, because the shift to telehealth may affect data collection and reporting, as well as patient experience and outcomes.

Among the states we studied, Oregon is the furthest along in incentivizing providers based on equity performance. This is due in part to the state investing in a robust workforce that is specifically dedicated to implementing health equity activities. However, Oregon also has faced ongoing challenges in stratifying quality measures. These challenges including the federal "public charge" rule, which may have a chilling effect and increase immigrants' fear of providing demographic information.[7] Stigma may also affect reporting related to disability status, and reporting their race or ethnicity may feel intrusive for some patients.

In part, these challenges have emerged from consumer suspicions of REALD data collection that are based in a problematic history of how the government has used this data, specifically in regard to communities

of color, LGBTQ+ people, immigrants and people with disabilities. But Oregon also has opportunities to improve its data collection process and not misuse the data. In particular, state officials emphasized the need to more clearly delineate whether (or when) providers or CCOs are responsible for collecting and sharing REALD data.

Managed Care Contracting Requirements

The latest contract between OHA and CCOs includes requirements for CCOs related to the following:

- Implementing culturally and linguistically appropriate services (CLAS) standards.
- Addressing social determinants of health in care management.
- Improving health literacy in member communications.
- Increasing workforce diversity.
- Employing traditional health workers, including community health workers.
- Training CCO staff and contracted providers on cultural responsiveness, implicit bias, CLAS standards and trauma-informed care.
- Developing community needs assessments and community health improvement plans.

Beyond these requirements, CCOs have the opportunity to increase their profit margin by covering additional health-related services that address social drivers of health. More details are provided in the contract.[8]

Measuring and Incentivizing Health Equity Performance: The Power of Consumer Voices

Oregon stratifies most of its CCO performance measures as a tool for incentivizing equity, but it also has begun to implement targeted equity-specific measures. As noted above, its first specific health equity measure, which pertains to meaningful language access, will be included in its CCO incentive structure. This is a "hybrid" measure that draws on both claims and reviews of individual medical records, and it is designed to account for limited availability of data.

Community concerns about the low quality of language interpretation services and a lack of health materials available in other languages drove the selection of the language access measure. In 2018, Oregon undertook a statewide engagement process and asked community members to answer this question: "What are the most important ways that CCOs can address health disparities?" The top three responses included increasing resources dedicated to health equity, improving cultural awareness and language access across the provider community, and addressing provider discrimination and bias.

Following the community engagement process, OHA formed a heath equity measurement workgroup that included measurement experts, providers and CCO representatives. A health care interpreter council and a health equity committee provided extensive input on the measurement development process. State advisory groups will continue to provide recommendations on proposed benchmarks for measuring and incentivizing CCO improvements in access to interpreter services. The state is also developing a learning collaborative to help CCOs achieve the goals of the language access measure.

The process Oregon used to select this measure is significant: It shows how much effort is involved in coming to consensus around a new equity measure, and that there is a need for much broader and more comprehensive equity measurement in Oregon that collects data on race, ethnicity, primary language, and disability status, at a minimum.

Minnesota's IHPs have developed interventions to address the social determinants of health and strengthen relationships with community-based organizations.

Minnesota

Minnesota's Medicaid provider-based Accountable Care Organizations (ACOs), which are called Integrated Health Partnerships (IHP), covered over 460,000 beneficiaries as of 2019. This is a substantial increase from the 100,000 beneficiaries covered when IHPs were first launched in 2013.[9] The IHP program emphasizes social determinants of health and IHP accountability for quality outcomes. And while IHPs are not yet receiving equity-based financial incentives as detailed below, the state has made some progress toward equity measurement. The population-based payments to IHPs are risk-adjusted to account for clinical and social risk, such as income, behavioral health, and housing needs.

Minnesota's IHP program includes several key elements that have been promoted by health equity advocates, including Families USA. These elements include a provider-based ACO model that brings together health care providers and community-based organizations (CBOs) to implement community-based interventions that respond to medical and other health-related problems, in addition to risk adjusted payment to ACOs that accounts for social factors. However, Minnesota's use of quantified measures for incentivizing equity is still at an early stage of implementation.

Community-Based Interventions

Minnesota's IHPs have developed interventions to address the social determinants of health and strengthen relationships with CBOs. These interventions include:

- Screening patients for social risk factors.
- Developing resource lists, tailored treatment plans and educational tools for patients.
- Employing care coordinators, patient navigators, and community health workers to connect patients with community and onsite resources to address social risk factors such as food insecurity.

Adjusting for Social Risk

Minnesota's IHPs receive a capitated, population-based payment that is adjusted for social risk factors experienced by their patients, including deep poverty, homelessness, mental illness, substance use disorders, past incarceration, and involvement with child protective services. Adjusting payment to IHPs based on social risk encourages IHPs to serve patients with greater social needs, since the costs associated with addressing these needs are accounted for in their capitated payment.

Minnesota's IHP program offers two tracks for participating providers with varying levels of risk, which allows newer and smaller IHPs to take on less risk. Under Track 1, the IHP receives risk-adjusted, population-based payments that are contingent on health equity, quality, and utilization measures. Under Track 2, in addition to population-based payments, IHPs must enter into a two-sided shared risk model where 50% of the shared savings is tied to quality measures.

Measuring and Incentivizing Performance Based on Measures of Social Risk

IHPs are required to develop consumer-focused measures and milestones that target health-related social needs as part of their equity-focused interventions. For example, IHPs have measured and reported on the percentage of patients who were screened for health-related social needs, the percentage of screened patients who report food insecurity, patient participation in patient satisfaction surveys, changes in patients' social history outcomes following referral to social service providers, and the nature and frequency of patients' use of emergency services. IHPs also report their progress in developing tracking systems, contracting with community-based social service providers, and hiring navigators and community health workers.

These measures are relatively flexible, as IHPs can develop their own performance measures based on their interventions. Furthermore, while IHPs' receipt of population-based payments is tied to developing and reporting on these measures, the measures do not influence the amount of the population-based payment — only the renewal of the IHP contract. This results in a limited incentive, since payment within the contracting period is not tied to performance. However, this incentive structure allows IHP interventions that are in the early phases of implementation enough time to get up and running and to identify and correct issues that might influence performance early on. It also allows IHPs to generate more reliable historical data that can be used to measure performance in subsequent contract periods.

Although IHP interventions are focused on advancing health equity, IHPs are not directly incentivized to reduce health disparities through these interventions. For example, IHPs are contractually required to implement interventions that could eliminate disparities, but these disparities are not always measured. That means payment isn't tied to a measurable reduction in disparities.

Inconsistent collection of demographic data and minimal REALD stratification of quality measures are hurdles Minnesota must clear to achieve a successful, equitable IHP program. Without direct measures of progress in addressing disparities, financial incentives are only tangentially related to improvements in health equity outcomes.

Washington State

Washington state began moving to managed care in 1987 and first implemented Accountable Communities of Health (ACHs) in 2008. Managed care organizations (MCOs) and ACHs both operate in Washington's Medicaid program and are intended to work in tandem. As in other Medicaid managed care programs, MCOs are networks of providers that receive a capitated payment from the state for providing services to beneficiaries. ACHs are broader regional organizations that bring together MCOs, CBOs, and tribal health systems to support payment and delivery reform and health equity projects.

According to state officials, Washington's ACHs have been taking an important leadership role in transforming payment and delivery to achieve health equity across the state. The formal mission of ACHs is to "support local and statewide initiatives such as value-based purchasing" and to "promote health equity throughout the state."[10] Under a Medicaid waiver that runs from 2016 through 2021, ACHs receive federal and state Delivery System Reform Incentive Payments (DSRIPs) to support specific transformation

projects, some of which are designed to eliminate disparities and achieve health equity.[11] As with other Medicaid DSRIP programs set up under the Obama administration, incentive payments for transformation projects are contingent on whether ACHs achieve project milestones and meet performance metrics related to these projects.

State-developed equity measures are part of the performance measures that influence incentive payments to the regional ACHs. These performance measures — some of which are stratified by race or ethnicity, language, and gender — are based on existing outcome and access measures, as well as state-developed measures that focus on beneficiaries' behavioral health, utilization of the health system, and social determinants of health.

Washington's ACH program is an important experiment in building regional Medicaid capacity separate from and alongside of Medicaid managed care. The ACHs are intended to engage community members, support integrated health care, tie health care to social service CBOs, and promote health equity. We describe the state's challenges and accomplishments in ACH community engagement below.

Engaging Communities

Some ACHs have created formal structures and processes to facilitate community participation in their decision-making. For example, the HealthierHere ACH has hired dedicated staff for community and tribal engagement. One-third of HealthierHere's governing board must be comprised of consumers, tribal leaders and CBOs. The governing board also includes a special committee made up of community members and representatives from local community-based and consumer advocacy organizations.[12] The Greater Columbia ACH has used Medicaid DSRIP waiver funding to establish a Community Health Fund that addresses the social needs of the community it serves, such as housing, transportation and food insecurity.[13]

Through such structures, Washington's ACHs are working to authentically engage the communities they serve to better understand and effectively meet community health and social needs, and to ensure that equity is part of the ACH's broader transformation efforts.

Despite ACHs' commitment to include the voices of community-based stakeholders in their transformation efforts, state officials report that effective engagement and collaboration remain a challenge. For example, ACHs that serve large regions of the state have difficulty reaching stakeholders in less accessible locations. ACHs have made progress with tribal engagement and coordination with Indian Health Care Providers, but tribal participation and engagement vary across the state. The state provided guidance and assistance to recognize the sovereignty and independence of the numerous federally recognized tribes and urban Indian health programs in the state, which have varied perspectives, health care infrastructures, community health priorities, and decision-making norms and practices.[14]

Stratification of Quality Measures

The state is making strides in stratifying ACH and MCO performance metrics, some of which are stratified by race or ethnicity, language and gender.[15] By stratifying metrics for equity-focused transformation projects, the state has taken a crucial first step in identifying health disparities. However, not all data from performance metrics is disaggregated. For some performance metrics, minimal patient-level data of any kind is collected or reported, which makes it difficult to accurately disaggregate that data. However, some MCOs now contract with External Quality Review Organizations, which has helped overcome the limited

ability to collect and stratify data. This kind of cooperative agreement serves as a model that other states could follow. Additionally, ACHs and MCOs in the state are working together to develop a database that will include disaggregated data on the patients they serve.

Measuring and Incentivizing Health Equity Performance

ACH and MCO incentive payments based on existing performance metrics are not directly tied to eliminating health disparities. This challenge presents the state with an opportunity to use the disaggregated data from performance metrics to identify specific disparities in health outcomes and treatment, to develop specific performance metrics designed to incentivize the reduction of health disparities, and to make incentive payments contingent on reducing these disparities. .

Summary of the Multi-State Analysis

Oregon, Minnesota and Washington are all leading comprehensive efforts to reform Medicaid delivery and payment approaches that drive health equity. Factors that have helped these states succeed include:

- Approval of Section 1115 waivers that include new payment mechanisms designed to improve population health.
- Commitments from state leaders to invest in health equity interventions.
- Stratification of outcomes data to identify disparities and develop new measures to address them.
- Partnerships with stakeholders and CBOs that have a history of addressing social risk factors.

We have derived the recommendations below from the successes and challenges that Medicaid system transformation efforts have faced in those three states. The recommendations apply to states that are at different stages of payment and delivery reform, and they offer states with existing VBP incentive structures a path forward.

State Policy Recommendations

States should incorporate equity measures into the primary Medicaid pay-for-performance and value-based payment structures they currently use.

The core recommendation of this report, and the most exciting and important development we are describing, is that states should follow the model set by Oregon, Minnesota and Washington and use existing P4P models to incorporate equity measures that address health disparities. States that have implemented P4P in managed care can withhold a portion of the MCO's (or provider network's) global capitated payment in a pool and make payments from that pool contingent on equity-focused performance, as Oregon does. Alternatively, if a provider network has a shared savings and/or shared risk arrangement under an MCO contract or a direct contract with the state, then the amount of savings (or losses) they earn could be made contingent on their equity-focused performance.

States are also proceeding step by step with introducing specific equity measures that influence performance-based payment. As a start, states can identify a specific equity issue or subpopulation that experiences disparities and incorporate a performance measure to address that equity issue. For example, Oregon has a disparity measure that focuses on the disparity in utilization of the ED among the subpopulation of patients with severe mental illness.

Or, states and their networks can stratify existing measures to identify specific disparities in outcomes or treatment and establish a baseline level for reduction in these disparities, or improvement among all stratified populations.

States should consider pay-for-reporting as a first step toward developing the infrastructure needed to identify and address health disparities.

Before states can use P4P models to effectively incentivize equity, provider networks and Medicaid agencies must first incorporate equity measures and data collection processes and establish a baseline for performance. States should also ensure that they have an adequate data infrastructure and stratification approach in place.

Pay-for-reporting can incentivize the stratification of all measures by race, ethnicity, language and disability to identify disparities. It can also help states track and assess their networks' ability to develop and implement new equity-focused measures and community-based interventions. In the short term, public reporting alone can begin to drive change.

State Medicaid agencies and provider networks should collaborate with community members to develop measures and incentives that accurately identify and address their unique, highest-priority health needs.

As states move forward with "pay for equity" initiatives, they should require managed care plans and/or provider networks to develop processes for meaningfully engaging the communities they serve, including tribal organizations and providers, in planning the measures and other program design elements. This is crucial for ensuring that payment and delivery reform efforts remain focused on equity and the needs of the community.

States must clearly delineate the data collection responsibilities of their Medicaid agencies, provider networks, CBOs, and contractors.[16]

States and their stakeholders should face decisions regarding data collection responsibilities head on. Contracting with external partners such as universities or capable External Quality Review Organization that have the infrastructure to collect and report stratified data may avoid issues associated with self-reporting and relying on providers or networks that may not have the appropriate capabilities.

Conclusion

The time is now for states to center equity in their health system transformation efforts. Key lessons from states demonstrate that pursuing this goal is not only feasible, but essential to achieving health equity. To be sure, leveraging health system transformation is just one part of a much larger strategy that is needed to transform our political and economic environment and eliminate the grave inequities in our communities' health. State policymakers need to continue to push for policy solutions that address the underlying systemic injustices that shape health inequities. And reforming health care payment structures is one of our best tools for improving population health and promoting health equity.

Table 1. Equity-Focused Financial Incentives in State Medicaid Programs

	Medicaid Model	Payment Mechanisms	Equity Measures and Stratification	Progress in Paying for Equity

Oregon 	**Medicaid Provider-Affiliated Managed Care Organizations**
	• Known as "Coordinated Care Organizations," responsible for significant provider and community governance.
	• Networks of medical, dental and behavioral health providers organized at the regional level.
	• Receive global capitated payments from the state for the total cost of care for all services for which they are responsible.
	• Required to develop value-based payments for providers in their networks and expand the use of these payments over time.[17]
	  • Beginning in 2020, CCOs are contractually required to have 20% of their payments to providers be in the form of a value-based payment that includes pay-for-performance incentives. That percentage must increase each year.
	  • By 2023, CCOs are also required to make 20% of payments in the form of a global, population-based payment that includes two-sided shared risk. That percentage must also increase in the final year of the contract.
		Quality Pool Incentive Payments
		• A percentage of the annual global payments to CCOs are withheld in a quality pool.
		• CCOs receive an incentive payment from the quality pool based on performance benchmarks and improvements on a set of outcome and quality measures (see next column).
		
		Challenge Pool Payments
		• Remaining funds in the Quality Pool are dispersed to CCOs that meet "challenge criteria."
		• These criteria are historically based on CCO incentive measures for the quality pool.
			CCO Incentive Measures
			• Data from some measures are disaggregated by race or ethnicity, language, gender and disability status.[18]
			• CCOs earn withheld payments from the quality pool based on their performance on a set of incentive measures.[19]
			• The Oregon Health Authority, which administers the CCO program, collects, analyzes and reports data from these sets of measures by race and ethnicity,[20] as well as language and disability.[21]
			
			Health Equity Measure
			Meaningful access to health care services for people with limited English proficiency or who communicate in sign language.
			
			State Quality Measures
			• As part of the state's Section 1115 waiver for health system transformation, CCOs are required to collect and report on a set of quality and access measures.[22]
			• CCOs must report on the difference in these measures between racial and ethnicity categories.
				Oregon has made considerable progress in three key areas
				1. Stratification of quality measures.
				2. Equity-focused contracting requirements.
				3. Equity-specific performance measures.
				
				The state still faces challenges in collecting and reporting stratified READL data.

Table 1. Equity-Focused Financial Incentives in State Medicaid Programs

	Medicaid Model	Payment Mechanisms	Equity Measures and Stratification	Progress in Paying for Equity

Minnesota 	**Medicaid Accountable Care Organizations**
	• Known as "Integrated Health Partnerships."
	• Provider organizations contracted to serve attributed populations in Medicaid managed care and Medicaid fee-for-service systems.[23, 24]
	• Receive value-based payments based on cost and quality of care.
	  • Track 1: IHPs receive quarterly, risk-adjusted, population-based payments tied to health equity, quality and utilization measures.
	  • Track 2: Population-based payments, plus a two-sided shared risk model with 50% of shared savings tied to quality measures.
	
	Medicaid Managed Care Organizations
	• Networks of providers who serve Medicaid beneficiaries.
	• Contract with the state to receive a risk-adjusted capitated payment.[25]
	• MCO enrollees are also enrolled in IHPs, and the state uses MCO enrollee data to calculate population-based payment for IHPs.
		Risk Adjusted Payments
		• The population-based payments to IHPs are risk-adjusted to account for clinical risk and social risk.
		• Social risk factors include poverty, homelessness, mental illness, substance use disorders and involvement with child protective services.
		
		Population-Based Payments for IHPs
		• Based on measures of equity, utilization and clinical quality agreed upon in first year of contract.
		• Annual evaluation of IHP performance is based on these measures.
		• Used to determine IHPs eligibility for the population-based payment; failure to exceed benchmarks results in discontinuation of population-based payments at the end of contract period.
		
		Shared Savings for IHPs
		• IHPs on Track 2 can receive savings based on their performance on a set of quality measures.
		• 50% of the IHPs' share of savings may be reduced based on their quality score, which is calculated using this set of quality measures.
		
		Accountable Care Partnerships
		• IHPs on Track 2 may receive a more favorable risk arrangement if they formally partner with community partners to address population health goals.
		• These risk arrangements depend on the substantiveness of the partnership.[26]
			IHP Measures
			All IHPs are contractually required to propose interventions that addresses the social determinants of health and develop equity measures tied to these interventions.[27]
			
			IHPs on Track 2 are also required to report on a set of quality measures, which affects the amount of shared savings they receive. Categories for these measures include prevention and screening, care for at-risk populations, behavioral health, access to care, and patient-centered care.
			
			IHPs still face challenges in consistently collecting demographic data and stratifying quality measures.
				Minnesota is not yet incorporating equity incentives into IHP payments. The state has required IHPs to identify equity measures and appears headed toward incorporating these measures into VBP.

Table 1. Equity-Focused Financial Incentives in State Medicaid Programs

	Medicaid Model	Payment Mechanisms	Equity Measures and Stratification	Progress in Paying for Equity

Washington 	**Medicaid Managed Care Organizations (MCOs)**
	• Health Plans with networks of providers that contract with the state Medicaid agency.[28]
	• Responsible for coordinating and delivering Medicaid services to beneficiaries.
	• Receive a capitated per-member, per-month payment for the total cost of care.
	
	Accountable Communities of Health (ACHs)
	• Regional organizations comprised of providers, community-based organizations, tribal organizations and MCOs.
	• Not responsible for the delivery of services.
	• Receive incentive payments from DSRIP as part of the "Washington State Medicaid Transformation Project" Section 1115 waiver.[29]
	• Required to develop at least four "transformation projects" related to 1) health systems and community capacity building, 2) care delivery redesign, and 3) prevention and health promotion.
	  • Prevention and health promotion projects are designed to eliminate disparities and achieve health equity."
		Managed Care Withhold
		• The Medicaid agency withholds a percentage of monthly capitated payments to MCOs.
		• MCOs earn back these withheld payments based on VBP adoption and performance measures (see next column).
		
		Delivery System Reform Incentive Payments (DSRIPs)
		• Incentivize transition to value-based payment arrangements, beginning with pay-for-performance and ultimately shared risk and population-based payments.
		• Statewide accountability metrics:
		  • Statewide performance on these metrics influences DSRIP payment to ACHs.
		
		Incentive Payments to ACHs
		• ACHs are initially paid for reporting on milestones related to specific transformation projects (see next column).
		• As transformation projects progress, ACHs are increasingly paid based on performance metrics (see next column).
		
		Performance-Based Payments to MCOs
		• MCOs receive DSRIP payments only after transitioning to value-based payment models.
		• Time-limited, with DSRIP demonstration ending on 12/31/21.
			MCO Performance Measures
			• Healthcare Effectiveness Data and Information Set adult and pediatric measures and state-developed behavioral health measures.
			• MCOs are required to collect demographic data for performance measures and must develop a workgroup that disaggregates data for at least one performance measure, identifies a disparity based on that measure, and develops an initiative to address that disparity.
			
			ACH Project Milestones and Performance Metrics
			• Project milestones are used to measure progress in planning, implementation, and scale and sustainability of transformation projects.
			• Performance metrics are based on existing outcome and access measures, as well as state-developed measures.
			  • State-developed measures focus on beneficiaries' behavioral health, utilization of the health care system, and social determinants of health (that is, arrests, employment and homelessness).
			• For transformation project selection and evaluation, ACHs are expected to conduct subgroup analyses to assess disparities in access and outcomes measures based on a number of factors, including race or ethnicity, age, gender, geography, housing stability and criminal justice involvement.
			
			Statewide Accountability Metrics
			• Reported to CMS as part of a Section 1115 waiver.
			• Related to behavioral health, utilization and management of chronic conditions.
				The state is paying ACHs based on stratified performance on select quality metrics. It is making strides in stratifying all ACH and MCO performance metrics. However, minimal collection and reporting of patient-level data for some performance metrics makes it difficult to accurately disaggregate these measures by REALD.

Endnotes

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