

Leveraging Medicaid Accountable Care Organizations to Address Health Equity: Examples from States

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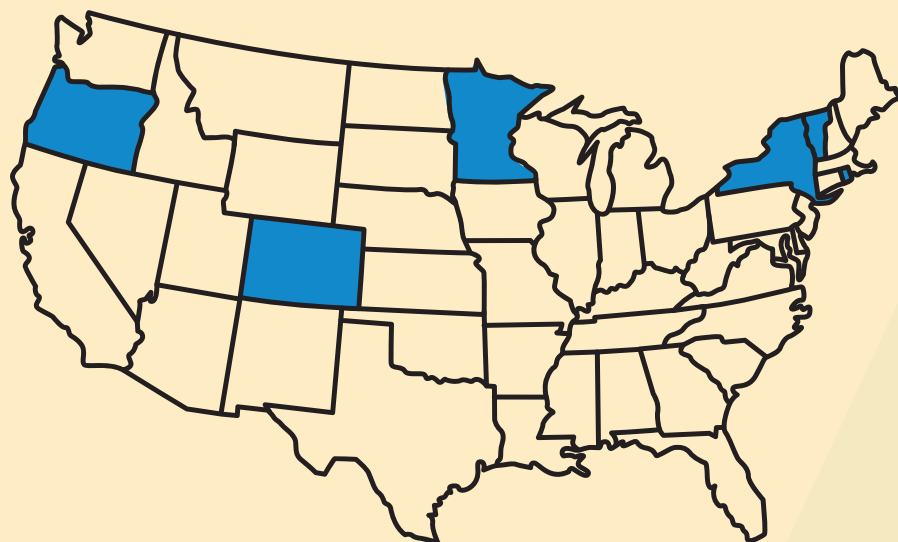
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INTRODUCTION

Medicaid agencies are leveraging contracts and procurement processes to require investment and attention to health equity through a variety of opportunities. This resource outlines promising examples of state incentives or requirements of accountable care organizations (ACOs), which can be used to advance health equity. ACOs can be a powerful resource for addressing health equity given their mission to facilitate better coordination and higher quality care across a spectrum of providers.

While this resource highlights discrete strategies that can be leveraged to intentionally advance health equity, Medicaid agencies will be best served by integrating a number of these strategies into a comprehensive health equity plan, ideally conducted in partnership with health care providers and communities.



STATES HIGHLIGHTED IN THIS RESOURCE

Colorado's ACO program

(the program is known as the Accountable Care Collaborative, or ACC; participants are known as Regional Accountable Entities, or RAEs)

Minnesota's ACO program

(participants known as Integrated Health Partnerships, or IHPs)

New York's ACO program

(in addition to ACOs, New York has requirements designed to increase uptake of value-based payment statewide)

Oregon's Coordinated Care Organization, or CCOs

(have some characteristics of ACOs and Managed Care Organizations)

Rhode Island's ACO program

(participants are known as Accountable Entities, or AEs)

Vermont's All-Payer ACO program

Measuring Equity: Data Collection

The first step to identifying and measuring health disparities is collecting relevant data that can be stratified by variables of interest. For example, race, ethnicity, and language (REL) data can be used to stratify health outcomes information to identify racial health disparities and/or track progress toward closing identified disparities. Data on social needs can help inform efforts to address social determinants of health (SDOH) that can be used to address health equity. Following are examples of state activities to promote data collection:

Rhode Island

Rhode Island's [requirements](#) for 2021/2022 Accountable Entity (AE) performance-based incentive payments allocates five percent of the overall payment based on the percent of AE members for whom the attributed primary care provider possesses their REL data.

Minnesota

Medicaid agencies can [leverage relationships with other state agencies to provide additional data to their ACOs](#). Minnesota's Department of Human Services, for example, includes the state's Medicaid agency, child protective services, housing/homelessness programs, and Supplemental Nutritional Assistance Program. This structure allows the Medicaid agency to collect data from other agencies and programs and share additional social needs information with its Integrated Health Partnerships (IHPs). The Medicaid agency also works with the state's Department of Corrections to collect data on incarceration and with relevant community-based organizations (CBOs) to collect data on food insecurity. Access to these data sources can help IHPs identify social needs for the individuals they serve, which further improves their ability to design equity-focused care delivery.

Other States

Many Medicaid agencies [monitor health disparities in their Medicaid populations](#) and publish this data. ACOs may be interested in using state-level data to identify and target health disparities either as a supplement to ACO-level REL data or as a stand-in metric while ACOs develop data capabilities and improve data quality.

Paying for Equity Using Value-Based Payment

Many states use quality metrics focused on health equity in both their payments to providers through [value-based payment \(VBP\)](#) and through their financial arrangements with health plans. The National Quality Forum's report, [A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity](#) provides guidance on identifying and developing health equity measures that can support equity goals. It also highlights disparities-sensitive metrics, which are clinical measures likely to impact a high proportion of communities experiencing health disparities.

Oregon

Oregon's Coordinated Care Organizations (CCOs) are measured and financially rewarded on two health equity measures: "[Emergency Department Utilization Among Members Experiencing Mental Illness](#)" and "[Meaningful Language Access to Culturally Responsive Health Care Services](#)." The state developed its Meaningful Language Access measure based on feedback from communities during listening sessions across the state, where residents shared a need for more consistent and high-quality interpretation services in health care settings.

Minnesota

Minnesota's [request for proposal](#) for IHP involvement (effective January 1, 2021) asks how IHPs will identify and design an intervention to address a critical health-related social need. IHPs must then create a set of [health equity measures](#) that intend to reduce health disparities and assess the impact of their proposed intervention. Progress on the intervention and performance on health equity measures is reported in the IHP's annual [Population Health Report](#). The health equity measures account for [40 percent](#) of the IHP's quality score, which is used to determine the size of their performance-based payment in the state's VBP program.

Adjusting for Social Risk Factors

Many alternative payment models include per member per month (PMPM) payments, which are adjusted based on the overall health status of the ACO patient population. ACOs serving high-need, high-cost populations can expect higher PMPM payments to address these needs. Traditionally, these models only adjust for health status, but [newer models](#) are experimenting with adjusting payments for other health and social factors. Risk adjustment for social factors may help payers [more effectively target funding for safety net providers](#) who are likely to serve patients experiencing health disparities.

Minnesota

Minnesota's [social risk payment adjustment](#) methodology includes: substance use disorder, serious mental illness, housing instability, prior incarceration, deep poverty, and involvement with child protective services. This information is used alongside clinical data to risk-adjust PMPM payments to IHPs that support activities typically not covered by Medicaid. The state conducted detailed analyses to develop its risk adjustment method, which uses administrative data that is consistently available.

Massachusetts

Massachusetts's [social risk adjustment mechanism](#) accounts for: age, sex, disability status, housing instability, and a neighborhood stress score. The neighborhood stress score is a geographic score assigned based on address, which uses census data to create an indicator based on the neighborhood's income, unemployment rate, households receiving public assistance, households with no car, single parent households, and educational achievement. This risk adjustment mechanism is used to [adjust payments made to managed care organizations \(MCOs\) and ACOs](#), with a goal to decrease the incentive to avoid members with higher needs. Massachusetts uses a mix of administrative data and neighborhood-level data (pulled from the [American Community Survey](#)) to develop its risk adjustment.

Increasing Member Engagement

Meaningful involvement of community members in ACO governance is critical to ensure ACO activities are addressing the needs of their local communities and identifying tailored and relevant solutions to reduce health inequities. Member engagement alone is not sufficient to improve health equity. Rather, engagement processes must intentionally employ an equity lens, as the same structural factors that create and perpetuate health disparities may also keep historically marginalized groups from being meaningfully represented in formal member engagement structures. As part of equity-focused member engagement processes, states, payers, and providers should consider regular opportunities for engagement in policy and program development through multiple modalities. States, payers, and providers should also routinely evaluate their member engagement processes to ensure engagement is authentic, meaningful, and representative of communities experiencing disparities (e.g., BIPOC communities, communities with disabilities, LGBT+ members).

Oregon

Oregon's CCOs provide an example of building a comprehensive model for state requirements that can be leveraged for meaningful member input into CCO governance with an equity lens. Each CCO is required to have a [Community Advisory Council](#) (CAC), which is involved in a number of [activities](#) including: (1) overseeing the development of the community health assessment and corresponding community health improvement plan (CHIP); (2) determining how CCOs [address social needs](#); and (3) being involved in the development of the CCO's [Health Equity Plan](#). CACs must be comprised of at least 51 percent members or member representatives living in the county served by the CCO. To support meaningful member engagement, the state offers [funding opportunities and technical assistance](#) resources to CACs.

CHIPs for each CCO are made [publicly available](#), and many CHIPs include goals to increase health equity. For example, the [Lane County Regional CHIP](#) starts with a statement highlighting their goal to “consider equity [...] especially for those in underserved demographic groups and protected classes” when making decisions and taking action on health disparities. The CHIP highlights economic and social issues tied to income, race/ethnicity, and geography as critical drivers of health and identifies strategies for addressing economic development and affordable housing as methods to advance desired outcomes including health equity.

Colorado

Colorado's Accountable Care Collaborative (ACC) is advised by the statewide [Program Improvement Advisory Committee](#), which focuses on: (1) behavioral and physical health integration; (2) provider and community experience; and (3) member engagement and performance measurement. The committee consists of up to [19 members](#), at least two of whom must be Medicaid members or advocates (one Medicaid member/advocate and one representative of Medicare-Medicaid eligible members). [Current membership](#) includes three members/advocates, one of whom is a co-chair of the committee.

In addition to the Program Improvement Advisory Committee, Colorado's Medicaid agency engages with its members through use of a "[benefits collaborative process](#)" where the agency solicits public comment when making changes to its covered benefits, and through a monthly [Member Experience Advisory Council](#). The Council [increases accessibility of meetings](#) by allowing Medicaid members to join meetings online and give general program feedback via surveys to Medicaid agency staff on a regular basis. Though Colorado's programs do not directly address health equity, the use of multiple feedback mechanisms increases the likelihood that the state and its ACC will hear meaningful responses from a diverse group of members.

Supporting Non-Traditional Providers

Non-traditional providers — a broad category that goes by many names and includes providers such as community health workers, peer navigators, and doulas — can advance equity by increasing access to health care in non-clinical settings from providers with shared lived experience.

Doula Coverage: Minnesota and Oregon

Minnesota covers doula services for its Medicaid beneficiaries. To be eligible for reimbursement under a fee-for-service arrangement, doulas must complete a state-approved training program and register with the state. Upon registration, doulas can practice under the supervision of a Medicaid-enrolled provider. However, a variety of implementation challenges, including low reimbursement rates, difficulties creating structures for doulas to enroll with MCOs and work under other licensed clinicians, and lack of awareness among Medicaid members and health plans about the benefits and coverage of doula services, have negatively impacted access to doula care in the state.

Doula care in Oregon is covered as a preventive service, which allows more flexible coverage for the services than in Minnesota. In Oregon, doulas must also complete certain educational requirements and register with the state, but are then able to practice as a Medicaid-enrolled provider without supervision.

Vermont

Vermont uses community health teams to support its patient-centered medical home program and link patients with community services. Team composition is determined by local need, but provided services may include care coordination, mental health or substance use disorder support, condition-specific education, and connection with women's health services. These teams are reimbursed by all payers (Medicaid, Medicare, and commercial) through PMPM payments that allow them to care for all patients enrolled in the patient-centered medical home. The state also requires ACOs to support these teams through shared savings funds to ensure sustainability.

Increasing ACO Internal Capacity to Advance a Culture of Equity

States are increasingly acknowledging and addressing the role of structural racism in health inequities, especially in the wake of events over the last year and a half. States can increase ACO capacity to understand, identify, and address health disparities experienced by their members by bolstering an internal culture of equity. These activities can include requiring certain types of training that facilitate culturally informed care at the health plan, provider, and care team level, as well as setting expectations on how ACOs and their stakeholders discuss and address equity.

Rhode Island

Rhode Island required its AEs to fill out a Pandemic Safety & Preparedness Plan in fall 2020. Satisfactory completion of this plan was linked to five percent of the performance year's incentive funds as a response to the uncertainty in quality measurement introduced by COVID-19. The plan included a significant section on health equity and broader equity awareness, which asked AEs questions about their approaches supporting patients who have experienced racism, provision of implicit bias training to staff, measurement of health disparities, and incorporation of health equity in organizational strategic planning.

Partnering with Community-Based Organizations

Many states require that ACOs or other provider organizations develop ongoing partnerships with CBOs. CBOs play a crucial role in advancing equity because they may help to: (1) address health-related social needs or behavioral health needs of specific communities experiencing health disparities in these areas; (2) strengthen the ACO's relationship with the community it serves and build community trust in the health care system; and (3) partner on long-term goals and initiatives where ACOs do not have the necessary expertise. However, not all CBOs are equally situated to promote health equity. Future requirements to partner with CBOs may be improved by incentivizing partnerships with CBOs that are located in, trusted by, and have extensive experience serving communities historically affected by systemic inequities.

Rhode Island

AEs can earn incentive payments when they meet certain performance requirements or conduct certain activities. [10 percent](#) of these payments must be used to establish partnerships with CBOs addressing social needs, substance use disorder, or other behavioral health needs. This requirement incentivizes AEs to work with CBOs and supports the financial sustainability of these partnerships.

Minnesota

IHPs are financially incentivized to create meaningful partnerships with CBOs. In IHP 2.0 (effective 2017), IHPs are paid through a total cost of care model with both upside and downside risk. Some IHPs were eligible to enroll in [non-reciprocal risk](#) — greater upside than downside risk — upon entering into a formal, ongoing partnership with a CBO to address a population health goal.

New York

VBP contractors (ACOs and other provider organizations contracting with MCOs) participating in either arrangements including upside and downside risk or capitated arrangements are [required to engage with CBOs](#) to address one or more health-related social need. The state reviews the role of the CBO to ensure they are being adequately included by the health care system and may support further development of these relationships if needed.

Integrating Social Determinants of Health

Many states have implemented a broad range of social determinants of health (SDOH)-related strategies, such as incentivizing the collection of SDOH data, creating referral systems to coordinate care between medical and social services, and targeting social needs at a higher level to aid entire communities rather than individuals. These SDOH strategies can be positioned to more intentionally advance health equity by addressing specific health disparities faced by communities. As with clinical quality performance, SDOH programs can prioritize equity by stratifying outcomes by race, ethnicity, or other characteristics of interest to assess what disparities exist in social needs and if those disparities are being addressed and reduced through SDOH activities.

Rhode Island

Rhode Island's AEs are provider organizations that must meet the state's [certification standards](#) in order to be eligible to operate as an ACO. These standards require that AEs: (1) identify three key social need domains and identify how they plan to provide or refer individuals to pertinent services; (2) include partnerships with social service organization and/or the creation of in-house capacity to address the identified social needs; and (3) develop and implement a screening protocol and a referral protocol for social needs. The state incentivizes AEs to screen for social needs by including percentage of patients screened as a [quality metric](#) in their VBP program.

Oregon

Through state legislative action, Oregon now requires its CCOs to address the social needs of their communities via targeted investment of a portion of CCO profits. The [Supporting Health for All through REinvestment \(SHARE\) Initiative](#) requires CCOs to spend money addressing health inequities and the “social determinants of health and equity” — which includes the domains of economic stability, neighborhood/built environment, education, and social/community health — in accordance with the community needs and priorities identified in the CCO's community health improvement plan. [For example](#), a CCO might meet the SHARE requirements by providing funding for a partner that runs high school completion programs (in the education domain) or by supporting park and bike lane improvements in their region (in the neighborhood and built environment domain).

Additional Resources

A National Priority Agenda to Advance Health Equity Through System Transformation:

These recommendations from Families USA highlight options for equity-focused health system transformation, which include improving payment design, supporting safety net providers, building robust CBO partnerships, ensuring strong evidence, measuring equity, and growing a diverse workforce.

Consumer Engagement in Medicaid Accountable Care Organizations: This tool from Community Catalyst highlights best practices for increasing member engagement within ACOs, with a focus on practical considerations illustrated in a set of case studies.

Marrying Value-Based Payment and the Social Determinants of Health through Medicaid ACOs:

This paper from the Milbank Memorial Fund explores three levers that can be used to integrate SDOH into ACO work: (1) requirements to screen for social risk; (2) requirements to partner with social service organizations; and (3) requirements to include SDOH metrics in quality measurement and payment.

Enhancing Team-Based Primary Care Approaches: This module and supporting equity-focused **webinar** from the Center for Health Care Strategies (CHCS) is geared toward Medicaid managed care and provides insight into how states can create contracts and payment approaches that support team-based care and non-traditional providers.

A Roadmap to Reduce Health and Healthcare Disparities through Measurement: This report from the National Quality Forum introduced the concept of disparities-sensitive measures and discusses how to measure and address health disparities.

Advancing Health Equity in Medicaid: Emerging Value-Based Payment Innovations: This CHCS publication highlights how VBP can be used in Medicaid to advance health equity.

Community-Based Maternal Support Services: The Role of Doulas and Community Health Workers in Medicaid: This publication from the Institute for Medicaid Innovation (IMI) explores how non-traditional providers, specifically community-based maternal services, can be used to address maternal health disparities.

Leveraging Value-Based Payment Approaches to Promote Health Equity: Key Strategies for Health Care Payers: This report, authored by CHCS and IMI, identifies six connected strategies to guide payers, including Medicaid agencies and managed care organizations, in developing equity-focused VBP approaches to mitigate health disparities at the state and local level.



ABOUT AHE

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