Advancing Health Equity through APMs

Guidance for Equity-Centered Design and Implementation

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Call to Action

The Health Care Payment Learning & Action Network (LAN) calls on private and public payers, purchasers, providers, community-based organizations, individuals, families, and their communities, and other relevant stakeholders to come together to eliminate health inequities. The LAN encourages these groups to begin incorporating design elements that advance health equity into new and existing Alternative Payment Models (APMs) in an aligned manner.

Health inequities[1] related to race, ethnicity, disability, sexual orientation, gender identity, language, and geography have endured for reasons such as socioeconomic factors at the individual and community level, implicit and explicit biases, and structural racism. Compared to White patients, patients of color continue to experience worse health care and outcomes in areas such as infant mortality, heart disease, diabetes, and cancer. Individuals with disabilities experience health disparities in cancer screening and care, among other conditions. Individuals living in rural areas are more likely to die from heart disease, cancer, and stroke than urban residents. The disparate outcomes seen in the COVID-19 pandemic have led many within the health care system to examine our role in the perpetuation of health disparities, including our ability and collective power to improve the health care system.

APMs present a significant opportunity to incentivize improvements in care delivery to help make care more accessible, drive better patient outcomes, and reduce inequities in care and outcomes. Multi-stakeholder collaboration is necessary to seize this opportunity and align the design and implementation of APMs that advance health equity. We all have a role to play—payers, purchasers, providers (e.g., physicians, nurses, physician assistants, community health workers, health systems), community-based organizations (CBOs), and other stakeholders must come together with individuals, families, and their communities to address health inequities.

[1] In this document, the terms *health inequities* and *health disparities* are used. These terms are related, but distinct. We use *health inequities* to mean "unjust and avoidable differences in the distribution or allocation of resources between marginalized and dominant groups that lead to disparities." We use *health disparities* to mean "measurable differences in health outcomes that result from inequities."

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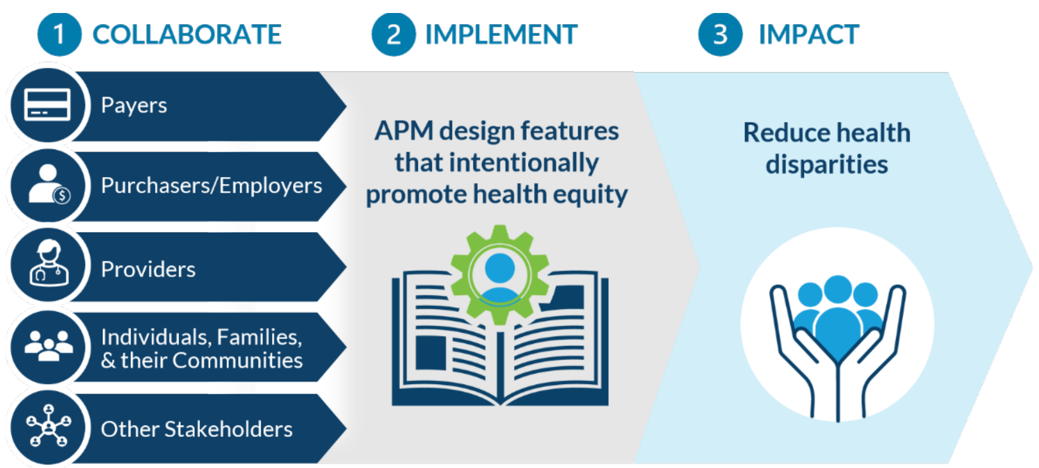

Figure 1: Call to Action to Eliminate Health Inequities

Advancing Health Equity through APMs provides stakeholders with actionable guidance on how they can leverage APMs to advance health equity in ways that are both aligned and tailored to meet their communities' needs. Doing so helps ensure that health equity and person-centeredness are prioritized throughout the design, implementation, and evaluation processes.

Payers and purchasers can adopt promising design elements into APMs in an aligned manner to maximize provider uptake and the positive impact of APMs on health equity.

Providers participating in these APMs can make changes in care delivery that will enable them to advance health equity in a way that is flexible and aligned with their mission.

Individuals, families, their communities, and other relevant stakeholders can work with payers, purchasers, and providers to ensure changes in health care delivery and payment through APMs reflect their needs and preferences for change.

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Background

The LAN was established in 2015 to promote the acceleration of payment reform in the U.S. health care system and has sought to increase adoption of APMs with a population health focus. Private sector support for accelerating adoption of these models is reflected in the shared and individual commitments to the LAN Resiliency Framework. In the context of the disproportionate impact of COVID-19 on communities experiencing inequities, the LAN recognizes the urgent need to advance health equity using approaches that support the ability to provide equitable care and provider resiliency, even in times of unexpected hardships. In July 2021, the LAN turned this momentum into action and launched the Health Equity Advisory Team (HEAT).

To guide this work, the HEAT defined health equity as *the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices—which includes systemic racism—and the elimination of health and health care disparities (adapted from Healthy People 2030).*

Adopt APMs	**Leverage APMs to advance health equity**	**Collaborate to implement APMs designed to advance health equity**
LAN APM Framework: Lays out core principles for designing APMs; establishes a common vocabulary and pathway for measuring successful payment models. **LAN Resiliency Framework:** Lays out key actions payers, providers, and multi-stakeholder groups can take to facilitate transition to the most effective APMs, with an explicit focus on health equity.	**LAN HEAT:** Regional and national implementers and health equity subject matter experts convene to identify and prioritize opportunities to advance health equity through APMs, to influence APM design principles, and to inform LAN priorities and initiatives.	**LAN Executive Forum, State Transformation Collaboratives, and Accountable Care Action Collaborative:** Payers, purchasers, providers, employers, patient advocates, community organizations, and healthcare leaders committed to shaping the strategic direction for value-based care in the U.S. collaborate to align their efforts, share insights, develop regional and national guidance, and implement resilient APMs that address health equity.

Figure 2: Building Bridges--LAN Actions to Advance Health Equity and Promote Person-Centered Care

The HEAT's diverse membership includes representatives from regional and national organizations with health equity subject matter expertise and experience implementing efforts to advance health equity. These leaders bring perspectives essential to identifying and mitigating health inequities across communities and in the nation's health care system (See Appendix for additional information on HEAT members).

Advancing Health Equity through APMs, developed with leadership from the HEAT and in collaboration with the LAN Executive Forum, builds on the LAN's Healthcare Resiliency Framework, which includes promoting health equity as a key action step for payers and providers. Payers, purchasers, providers, individuals, families, communities, and other relevant stakeholders can use this guidance to develop and implement APMs that advance health equity through a person-centered approach. This guidance document also lays the foundation for future LAN initiatives on accountable care and state transformation collaboratives (Figure 2).

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Theory of Change: How APMs Advance Health Equity

APMs are an important lever that the health care system can use to reduce health disparities. However, APMs function within a broader constellation of factors that can support or undermine health equity, including poverty, structural racism, educational or economic opportunity, community resiliency, insurance coverage, and the environment in which people live. In some instances, APMs have resulted in unintentional consequences and penalized providers serving communities of color and people with complex needs, potentially exacerbating health disparities. It is therefore essential to design APMs in a manner that advances health equity and avoids unintended consequences.

CARE DELIVERY REDESIGN
to establish expectations within APM contracts for how care is delivered

PAYMENT INCENTIVES AND STRUCTURES
that reward better care and outcomes

PERFORMANCE MEASUREMENT
to capture performance and drive accountability

Figure 3: APM Features that Can Drive More Equitable Health Outcomes

By incentivizing and supporting care delivery changes that make care more equitable, intentionally designed APMs can help mitigate the negative impact that explicit and implicit biases and structural racism have on historically marginalized communities and the providers that serve them, driving better patient outcomes, reducing disparities, and advancing health equity.

APMs leverage three interrelated features that are especially important for advancing health equity: **Care Delivery Redesign, Payment Incentives and Structures, and Performance Measurement (Figure 3).** These features:

- hold provider organizations accountable for delivering better care and achieving better health outcomes for all people;
- give providers greater flexibility to deliver whole-person care, consistent with each individual's community, culture, and identity; and
- increase accessibility and use of effective, appropriate, and affordable care and services.

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Figure 4 depicts the Theory of Change, illustrating how APMs can be structured to advance health equity. The aim is to achieve more equitable health outcomes. Change starts by incorporating APM design elements that are structured to incentivize and support equitable care delivery and outcomes. If successfully implemented, these changes will result in **people accessing culturally appropriate and integrated care**; **providers delivering more equitable and accessible care**; and **payers, purchasers, and providers identifying opportunities for disparities reduction, setting specific and actionable health equity goals, and monitoring performance.** These intermediate outcomes will support the aim of more equitable health outcomes. **Alignment across payers** for select design elements promotes APM adoption among providers, ultimately bolstering positive impacts on communities experiencing health inequities.

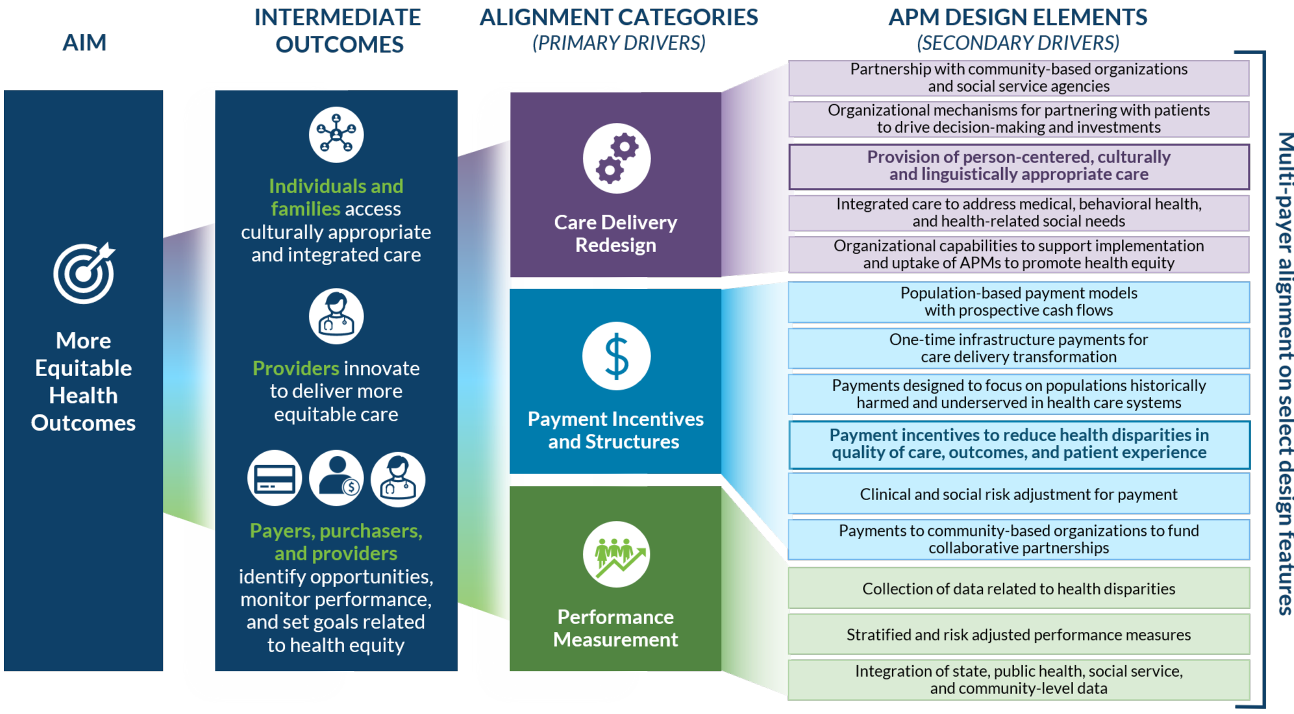

Figure 4: Theory of Change for How APMs Advance Health Equity

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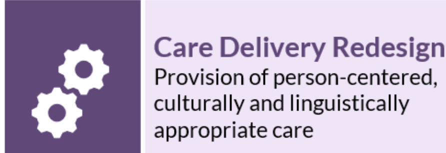
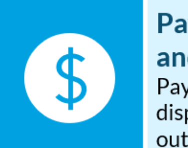
Designing APMs to Advance Health Equity

There are 14 design elements that LAN stakeholders can incorporate into APMs to help advance health equity. The LAN recognizes that adoption will take time due to a variety of important factors, including payer and provider capacity, the availability of complete and accurate demographic data, and access to health and social services. To provide stakeholders with a starting point for action, *Advancing Health Equity through APMs* offers guidance on how to operationalize two design elements within the alignment categories of **care delivery redesign** and **payment incentives and structures** (see the APM design elements in Figure 5). These two design elements were selected based on their potential for impact, necessity, and feasibility. Over time, the LAN plans to develop additional guidance for other design elements and incorporate these into *Advancing Health Equity through APMs.*[2]





Payment Incentives and Structures
Payment incentives to reduce health disparities in quality of care, outcomes, and patient experience

Drawing upon lessons learned from HEAT and LAN Executive Forum members who have worked to advance health equity through payment and care delivery transformation, the LAN developed guidance for how payers, purchasers, providers, and others can structure these two design elements to advance health equity. Multi-payer alignment plays an important role in creating the business case for providers to adopt APMs and change how care is delivered; *Advancing Health Equity through APMs* points to specific areas where alignment within the design elements is key to reducing unnecessary administrative burdens. Stakeholders can immediately begin working together to incorporate these two elements into APMs in an aligned manner. The next section summarizes how each design element should be structured, areas where multi-payer alignment is critical, and actions stakeholders can take to ensure successful implementation. Detailed guidance and illustrative examples that will enable payers, purchasers, providers, CBOs, individuals, families, and communities to come together to develop and implement APMs designed to advance health equity, starts on page 12.

[2] Stratified performance measurement is a necessary building block for APMs to advance health equity. The LAN recognizes the extensive work to date on this issue and has chosen to build upon, rather than duplicate, efforts.

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DESIGNING PROVISION OF PERSON-CENTERED, CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

To provide person-centered, culturally and linguistically appropriate care, APM contracts can be structured to include requirements for care delivery redesign that promote equitable health outcomes through dignity and respect for individuals; sharing timely and complete information with individuals and their families; encouraging, supporting, and collaborating with patients to participate in care planning; and meeting National Culturally and Linguistically Appropriate Services (CLAS) Standards. Equitable care delivery and outcomes can be supported through a diverse and expanded health care workforce, including access to high quality and timely interpretation services.[3] Supporting the provision of person-centered, culturally and linguistically appropriate care requires setting expectations in APM contract language and structuring payments to help provider organizations make necessary changes in staffing and care delivery. A summary of the LAN's recommendations for structuring this design element is provided below. Detailed guidance for implementing these recommendations is provided in the next section.

APM Features to Advance Health Equity

APM contractual terms set expectations for:

- **Encouraging and enabling person-centered, culturally and linguistically appropriate care** that integrates physical, behavioral, oral, and social health; treats people with dignity and cultural sensitivity; and prioritizes promotion of health equity.
- **Incorporating a diverse (e.g., racial diversity, diversity in lived experience) and expanded health care workforce** in collaboration with CBOs to provide services relevant to the needs of populations experiencing disparities.
- **Measuring adoption of person-centered, culturally and linguistically appropriate care practices**, with a focus on patient-reported outcomes and experiences, using a parsimonious set of aligned measures to minimize provider burden.

Payments from payers to providers to support care delivery redesign includes both:

- Time-limited, upfront payments to support capacity-building; and
- Prospective, population-based payments sufficient to support services designed to advance health equity via an expanded health care workforce.

Priorities for Multi-Payer Alignment

- Develop a mutual understanding of the services and staffing approaches that promote person-centered, culturally and linguistically appropriate care.
- Develop an aligned set of monitoring measures to reflect person-centered, culturally and linguistically appropriate care, and meaningful care delivery redesign.

[3] In this document, "expanded health care workforce" refers to health workers who may be considered non-traditional providers (e.g., doulas, community health workers, health care interpreters, and peer recovery services).

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DESIGNING PAYMENT INCENTIVES TO REDUCE HEALTH DISPARITIES IN QUALITY OF CARE, OUTCOMES, AND PATIENT EXPERIENCE

To incentivize reductions in disparities and promote more equitable health outcomes, payments can be structured to meaningfully reward reductions in health disparities and achievement of equitable outcomes. The LAN also recognizes that provider organizations delivering care to underserved communities, including communities with low incomes and/or communities of color, are often underfunded. Therefore, *Advancing Health Equity through APMs* recommends bolstering these providers' resources while rewarding all providers that improve health outcomes for populations experiencing health inequities. A summary of the LAN's recommendations for structuring payment incentives and promoting multi-payer alignment to advance health equity is provided below. Detailed guidance for implementing these recommendations is provided in the next section.

APM Features to Advance Health Equity

APM methodologies are modified to:

- **Create accountability for more equitable health outcomes**, including meaningful rewards for both reducing health disparities and achieving performance benchmarks.
  - Health equity performance represents a significant percentage of a provider's overall quality score; and
  - Prospectively paid primary care/population health APMs, shared savings rates, and other performance-based payments are adjusted upward or downward based on improvement and achievement.
- **Support historically under-resourced providers**:
  - An additional equity pool, available only to providers who have been historically underfunded and serve low-income populations in areas of high social vulnerability, rewards improvements in health equity (independent of adjustments to prospectively paid budgets or shared savings rates they would otherwise receive);
  - A time-limited, upfront payment to support capacity building and practice transformation is part of prospectively paid primary care/population health APMs and shared savings/risk models; and
  - Ensure payments adequately cover patient care costs.

Priorities for Multi-Payer Alignment

- Adopt one aligned health equity performance measure set, stratified by race, ethnicity, language, and other characteristics, to assess health equity performance (i.e., the health equity performance measure set), which reflects the most substantial health disparities in the relevant state or region.
- Adopt a common methodology to measure the size of health disparities and year-over-year changes. This methodology must measure disparities by self-reported race, ethnicity, and language; and preferably disparities by disability status, sexual orientation, gender identity, and geography.

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OVERARCHING GUIDANCE FOR DESIGNING AND IMPLEMENTING APMS TO ADVANCE HEALTH EQUITY

How stakeholders implement these APM changes is key—it is insufficient to incorporate these changes into contracts without making additional efforts to ensure the success of APMs to advance health equity. This section provides recommended actions to help guide successful implementation, including considerations specific to each design element and each type of stakeholder, based on initial lessons from the HEAT and other stakeholders.

- ☐ ***Adopt an aligned definition of health equity.***
  Aligning around a common definition and shared understanding of health equity is an important first step. As a starting point, stakeholders can look to existing definitions from Healthy People 2030, Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, the World Health Organization, and other public health organizations. The HEAT adopted the Healthy People 2030 definition and modified it to specifically name systemic racism as a driver of inequities.

- ☐ ***Partner with communities and analyze root causes.***
  To understand the root causes of health disparities and identify and implement impactful solutions, payers and provider organizations must develop meaningful partnerships with community members to share the results of stratified performance measures, conduct a root cause analysis to better understand proximate drivers of health disparities, and identify feasible solutions. Partnership can be facilitated by existing frameworks and should begin early and continue throughout the process of designing, implementing, and evaluating APMs and making corresponding changes to care delivery.

- ☐ ***Partner with and support individual providers and other staff to help them understand existing health disparities and make the necessary changes to address these disparities and advance health equity.***
  Provider organizations and payers can share the results of the stratified health equity performance measure set (i.e., an aligned set of quality measures, stratified by relevant characteristics including race, ethnicity, and language) and work with individual providers to understand these results in the context of systemic factors that drive health inequities. Provider organizations should involve all staff—not just clinicians—in care delivery redesign and performance-based incentives. Stakeholders can also identify and implement non-financial approaches to motivate and recognize achievements of provider organizations, staff, and payers.

- ☐ ***Modify contracts and include incentives to foster accountability.***
  Payer and provider contracts can reflect new expectations for tracking and incentivizing health equity performance, including delivering culturally and linguistically appropriate care. Payers, purchasers, providers, and CBOs can look for ways to align their population level health equity goals and amend contracts to include incentives related to those goals. For example, if stakeholders align to reduce disparities experienced by individuals with diabetes, performance-based incentives within contracts for payers, provider organizations, health systems' staff, and CBOs can be modified to reflect this shared goal, within acceptable parameters of anti-trust regulations. Organizations can also consider ways to align employee performance-based compensation with achievement of organizational health equity goals. Contracts can also include language on reporting of diversity, equity, and inclusion efforts at established frequencies to foster accountability.

- ☐ ***Develop a plan for monitoring and addressing any unintended negative consequences.***
  APMs frequently do not function as designed; in the past, some APM design elements have unintentionally penalized providers serving communities of color, encouraging providers to avoid caring for individuals who have complex needs, potentially exacerbating health disparities. All stakeholders should be alert to this possibility and develop a transparent approach for quantitatively and qualitatively assessing the impact on both populations experiencing health disparities and historically under-resourced providers. Stakeholders can share the results of this assessment with individuals and community members to create transparency and accountability and disseminate to other LAN stakeholders to facilitate understanding and uptake of efforts at a national level. Stakeholders should revise their APM methodologies if unintended consequences occur.

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Payers Can:

- ☐ Incorporate the *Advancing Health Equity through APMs* guidance into new and existing APM arrangements and contracts with provider organizations and others, including CBOs.
- ☐ Align health equity APM approaches with other payers and purchasers to drive adoption among providers.
- ☐ Develop and strengthen ongoing partnerships with individuals and communities to guide health equity goals and strategies.
- ☐ Adjust performance-based compensation to reward leadership and staff for improvements in health equity.
- ☐ Monitor and address unintended consequences.

Purchasers Can:

- ☐ Modify contractual value-based payment requirements with payers and providers to incorporate the *Advancing Health Equity through APMs* guidance into new and existing APM arrangements with providers.
- ☐ Modify payers' contracts to include measurable goals for reducing health disparities, using an aligned set of health equity performance measures (ideally across purchasers and payers).
- ☐ Adjust performance-based contract incentives to reward payers for achieving health equity goals.
- ☐ Develop and strengthen ongoing partnerships with individuals and communities to guide health equity goals and strategies.
- ☐ Monitor and address unintended consequences.

Provider Organizations Can:

- ☐ Incorporate the *Advancing Health Equity through APMs* guidance into new and existing APM arrangements with payers and others, including CBOs.
- ☐ Collaborate and contract with CBOs to build a person-centered, culturally and linguistically appropriate workforce.
- ☐ Adopt new practices to provide person-centered, culturally and linguistically appropriate care.
- ☐ Develop and strengthen ongoing partnerships with individuals and communities to guide health equity goals and strategies.
- ☐ Adjust performance-based compensation to reward leadership and staff for improvements in health equity.
- ☐ Monitor and address unintended consequences.

Individuals, Families, and Their Communities Can:

- ☐ Collaborate with payers, purchasers, and providers to identify health equity goals, measures, and implement strategies to address health inequities.
- ☐ Identify practices to enhance person-centered, culturally and linguistically appropriate care.
- ☐ Partner with payers and providers to foster transparency and accountability for improvements in health equity.
- ☐ Engage with payers, purchasers, and providers in evaluating the impacts of APMs on health equity.

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Incorporating Changes into APMs: Detailed Design and Implementation Guidance for Advancing Health Equity

This section provides detailed design and implementation guidance for individuals within payer, purchaser, and provider organizations responsible for designing and implementing APM contracts. This guidance is for use in developing APM methodology and contract language for the two APM design elements prioritized for initial implementation.

This guidance is intended to support flexible approaches to designing APMs that advance health equity, taking into account opportunities for improvement and existing practical implementation challenges. *Design* guidance is categorized as "essential" (the baseline requirements for APMs to advance health equity) and "enhanced" (more innovative and advanced approaches for experienced stakeholders). Both essential and enhanced approaches are designed to balance between being specific enough to offer meaningful direction that promotes multi-payer alignment and communicates expectations and being broad enough to allow customization based on local context and the needs of populations they serve.

Included alongside the *design* guidance are illustrative examples of how stakeholders can incorporate these approaches into new or existing APMs and contracts. Finally, this section includes *implementation* guidance for how payers, purchasers, providers, CBOs, individuals, families, and communities can work together to implement these two design elements.

Due to interdependencies between the 14 design elements and the way APMs are structured, some areas of guidance overlap with other design elements. For example, the care delivery redesign element *provision of person-centered, culturally and linguistically appropriate care* includes guidance on the roles that CBOs should play to support such care—a concept that will overlap with the *partnerships with community-based organizations and social service agencies* design element. As additional design elements are specified, linkages between these design elements and their overlapping guidance will be addressed.

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DESIGN GUIDANCE FOR PROVISION OF PERSON-CENTERED, CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

The following sections provide guidance for designing and implementing the care delivery redesign element: *provision of person-centered, culturally and linguistically appropriate care.*

Encouraging and enabling person-centered, culturally and linguistically appropriate care

Essential and Enhanced APM Design Guidance

- Develop a common definition of person-centered, culturally and linguistically appropriate care that is embedded in the APM contract. Incorporate cultural sensitivity and treating people with dignity; address physical, behavioral, oral, and social health.
- Promote the use of a team-based care delivery model to address the holistic health needs of people experiencing disparities. Emphasize the importance of individuals co-creating their care plan, shared decision-making, and self-management.

Examples

- APM stakeholders agree to use the four core concepts of person-centered care defined by the Institute for Patient- and Family-Centered Care as their shared definition. The provider organization develops training programs for new and existing care teams (e.g., training on CLAS standards, trauma-informed care, and collaborative care planning) to meet the agreed upon definition.
- The New York-based Pathway Home program demonstrates how payers and providers can work together to integrate physical, behavioral, and social health. This community-based program offers care coordination and care management for patients with serious mental illness and other complex health histories, with a focus on holistic, integrated care.
- The provider organization develops a collaborative care planning model. Implementation of this model is supported, when possible, by frontline staff who are culturally and linguistically concordant with their patients.

Incorporating an expanded health care workforce

Essential APM Design Guidance

- Develop a common understanding of the services and staffing approaches that promote person-centered, culturally and linguistically appropriate care.
- Provide care using an expanded health care workforce, based on the identified needs of the patient population.

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  - Collaborate with CBOs to hire, train, and manage the expanded health care workforce.
  - Integrate the expanded health care workforce into workflows/care teams to provide services relevant to the needs and priorities of individuals, families, and communities experiencing health disparities.
- Improve access to health care for populations with limited English proficiency or who are Deaf/hard-of-hearing, through easy-to-access medical interpretation services. Whenever possible, provide these services in-person rather than telephonically or through video.

Enhanced APM Design Guidance

Essential guidance, plus:

- Partner with individuals and communities who experience inequities to understand community-defined best practices for care, which are reflected in the services and staffing approach.

Examples

- Oregon Health Authority (Medicaid) covers services provided by an expanded health care workforce (known as "traditional health workers") consisting of birth doulas, personal health navigators, peer support specialists, peer wellness specialists, and community health workers.
- Oregon Health Authority requires provision of high-quality medical interpretation services, paid for as part of a global budget. These requirements include interpretation for languages other than English and for Deaf/hard-of-hearing patients. Oregon measures adoption of this requirement through their Meaningful Language Access metric.
- Medicaid health plans in Washington D.C. contract with Mamatoto Village, a community-based program which supports perinatal health workers in providing culturally appropriate prenatal and postpartum services to women of color, who are more likely to experience inequities in maternal health outcomes.
- APM stakeholders (e.g., payers, providers, and CBOs) work with community members to understand community-defined best practices to address disparities in mental health outcomes. Based on this partnership, stakeholders agree that the APM will include coverage for select new services (e.g., Tribal Traditional Health practices for Native American members).

Measuring adoption of person-centered, culturally and linguistically appropriate care practices

Essential APM Design Guidance

- Develop a concise set of aligned measures, in partnership with APM stakeholders including individuals and CBOs, for monitoring care delivery redesign, particularly the hiring and utilization of an expanded health care workforce and with attention towards minimizing additional provider burden.

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- Monitor engagement with the expanded workforce by individuals experiencing health inequities using measures stratified by race, ethnicity, language, and other characteristics.

Enhanced APM Design Guidance

Essential guidance, plus:

- Develop and test the use of a concise set of aligned metrics for person-centered, culturally and linguistically appropriate care, prioritizing patient-reported experience and outcomes measures. Stratify metrics by race, ethnicity, language, and other characteristics to identify disparities.

Examples

- Existing APM reporting requirements are modified to include questions about hiring and retention of the expanded health care workforce, utilization of the expanded health care workforce (including provision of interpretation services), and implementation of other agreed upon aspects of person-centered, culturally and linguistically appropriate care.
- APM participants test quality metrics related to patient-reported experiences (e.g., Health Confidence Score, collaboRATE tool, CAHPS ECHO Survey). The payer creates a pay-for-reporting incentive to support data collection for these measures.

Structuring payment to support provision of culturally and linguistically appropriate care

Essential and Enhanced APM Design Guidance

- Incorporate time-limited, upfront payment to support capacity-building activities—including development of data collection and analysis capacity—required to provide person-centered, culturally and linguistically appropriate care to populations experiencing health inequities.
- Adjust prospective, population-based payments to sufficiently account for services provided by the expanded health care workforce that are designed to promote health equity but otherwise not accounted for in medical costs.

Examples

- Washington State's Multi-payer Primary Care Transformation Model includes an upfront care transformation payment which will be provided to practices for up to three years in order to build capacity and support care delivery transformation.
- Prospectively paid primary care/population health APMs are adjusted to support services delivered by an expanded health care workforce.

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Implementation Approaches for Care Delivery Redesign

Payers and purchasers can create an APM contract that broadly defines the expanded health care workforce. This allows provider organizations and **CBOs** the flexibility to work with a meaningful subset from this broad definition, ensuring the expanded workforce is well-suited to address the health disparities experienced by the patient population.

Payers and purchasers can develop guardrails that outline acceptable use of upfront payments to ensure capacity-building and infrastructure development activities focus on advancing health equity.

Provider organizations can implement care delivery redesign by supporting the development of their workforce. For example, organizations might consider mandating annual training for all staff (initially supported by the upfront capacity-building payment) that focuses on culturally and linguistically appropriate care and employing community health workers who are specifically trained in collaborative care planning.

Individuals, families, communities can work with payers, purchasers, and providers to develop a parsimonious set of metrics to measure progress on care delivery redesign and assess patient experience. **Providers** can work with **individuals, families, communities,** and **CBOs** to understand what measures reflect patient values and can employ multiple modalities of data collection to ensure that a diverse set of patients are able to report on their experiences and outcomes. **Payers and purchasers** can consider how to support additional data collection by minimizing administrative burden (e.g., replacing some existing measures with new patient-reported measures, creating time-limited pay-for-reporting programs). A**ll stakeholders** can develop methods to share this data and use it to inform interventions that promote more equitable experiences and outcomes.

APM stakeholders, especially **provider organizations**, can consider strategies to support the hiring, retention, and diversity of their workforce. This includes creating a workforce that is more representative of the populations they serve (e.g., people of color, people with disabilities, members of the LGBTQIA+ community, immigrants or people with similar cultural backgrounds in communities with large immigrant populations). Workforce diversity can be a goal at all levels of the organization and may be supported through organizational changes such as changing recruitment or interviewing practices, providing sufficient supervision and mentorship, promoting organizational equity (e.g., equal pay across race and gender identity), and creating pathways for career progression. Organizations can also support broader efforts to increase diversity, such as investing in career pipeline programs for people who belong to traditionally marginalized groups. Different strategies may need to be applied for different types of employees.

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DESIGN GUIDANCE FOR PAYMENT INCENTIVES TO REDUCE HEALTH DISPARITIES IN QUALITY OF CARE, OUTCOMES, AND PATIENT EXPERIENCE

The following sections provide guidance for designing and implementing the payment incentives and structures element: *payment incentives to reduce health disparities in quality of care, outcomes, and patient experiences.*

Adopting an aligned health equity performance measure set

Essential APM Design Guidance

- Within core measure sets, prioritize an aligned subset of measures with the most substantial health disparities in the state or relevant region. Stratify measures by self-reported race, ethnicity, language, and other characteristics to identify disparities.

Enhanced APM Design Guidance

Essential guidance, plus:

- Prioritize outcomes metrics when selecting measure set.
- Stratify measures by self-reported disability status, sexual orientation, gender identity, language, geography, and other demographic and social needs data.

Examples

- Covered California's health equity performance measure set consists of two population health/primary care outcomes measures related to hypertension and diabetes, with a goal of reducing the racial and ethnic health disparities of members served by its health plans.

Adopting a common methodology for measuring health disparities

Essential APM Design Guidance

- Select and implement a common methodology across payers to measure the prevalence, magnitude, and year-over-year changes of health disparities. Include a reference point that serves as the basis for comparisons and aligned methodologies to measure and summarize disparities across and between racial, ethnic, and linguistic groups using self-reported data.

Enhanced APM Design Guidance

Essential guidance, plus:

- Select and implement a methodology to measure health disparities by self-reported disability status, sexual orientation, gender identity, language, geography, and other demographic and social needs data; and summarize disparities within demographic categories.

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- At minimum, use the state or national HEDIS 50th percentile or higher as the reference point for analyzing health disparities.

Examples

- Blue Cross Blue Shield of Massachusetts publicly reports performance measures for commercially insured individuals, stratified by race and ethnicity.
- The U.S. Department of Health and Human Services Office of Minority Health has developed a Health Equity Summary Score methodology, which can be used to compare performance across racial and ethnically diverse populations and assess improvement over time.
- Minnesota Community Measurement publicly reports statewide disparities in care and outcomes by race, ethnicity, language, and country of origin.
- Michigan Department of Health and Human Services (Medicaid) uses the Index of Disparity methodology to measure and summarize health disparities across racial and ethnic groups.

Creating accountability for more equitable health outcomes

Essential APM Design Guidance

- Reward meaningful reductions in health disparities and/or achieving equitable performance across groups year-over-year. The health disparities under consideration must include racial, ethnic, and language disparities.
- Weight a meaningful percentage of the quality composite score to reflect performance in the health equity performance measure set.
- Meaningfully adjust prospectively paid primary care/population health APMs, earned shared savings rates, and other performance-based payments upward or downward based on equity performance credits or penalties reflected in the quality composite score.

Enhanced APM Design Guidance

Essential guidance, plus:

- Reward meaningful reductions or achieving equitable performance in health disparities by disability status, sexual orientation, gender identity, language, geography, and other inequities.
- Weight performance in health equity measure set **at least 20%** within the quality composite score and evolve weighting over time to create a glide path for increased financial accountability and rewards for health equity.
- Develop additional methods to ensure accountability for advancing health equity. This may include applying financial penalties, including creating a glide path as appropriate for failure to reduce health disparities or for meaningful increases in health disparities year-over-year, with considerations for provider type and capacity.

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Examples

- The Center for Medicaid & Medicare Innovation's End Stage Renal Disease Treatment Choices Model includes a Health Equity Incentive as part of performance assessment; providers showing improvement in home dialysis rate or transplant rate for patients who are enrolled in both Medicare and Medicaid or who qualify for Low Income Subsidies can earn additional performance points.
- Contracts between a payer and provider organizations set expectations for reducing health disparities by at least three percentage points in Year 1; four percentage points in Year 2; and five percentage points in Year 3. Performance benchmarks are set collaboratively, with the intent of overcoming rather than perpetuating inequities and under-investment.
    - Payers initially weight the quality composite score at 20% to reflect health equity performance. Weighting increases to 35% over three years.
    - Achieving improvement or achievement performance benchmarks in the health equity performance measure set results in an additional 0.5% in prospective population health/primary care payments for Year 2; 1% for Year 3; and 2% for Year 4.

Supporting historically under-resourced providers

Essential APM Design Guidance

- For providers who have been historically underfunded and serve low-income populations in areas of high social vulnerability:
    - A separate equity pool rewards providers for achieving improvement benchmarks in health equity performance.
    - Under prospectively paid primary care/population health APMs and shared savings/risk models, provision of a time-limited, upfront payment to support capacity building and practice transformation based on an assessment of provider capacity and need.

Enhanced APM Design Guidance

Essential guidance, plus:

- Payers adjust prospectively paid primary care/population health APMs and other payment models to ensure costs of delivering services are adequately covered, regardless of health equity performance.

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Examples

- For primary care practices operating within an area of high social vulnerability and serving low-income populations, those who perform below the national HEDIS 50th percentile are eligible to participate in an equity pool with additional rewards for meeting appropriately set health disparities improvement targets.
- Baseline prospective primary care/population health APM payments are adjusted upwards by 2% for primary care and behavioral health practices operating within an area of high social vulnerability and serving low-income populations.

Implementation Approaches for Payment Incentives

Payers, purchasers, and providers can collaborate with **individuals, families, and their communities** to select two to four measures that reflect high burden or disparities sensitive conditions with historical disparities in the state or region (e.g., diabetes HbA1C control, blood pressure control) that are relevant across payers and are person-centered. It is recommended to:

- measure disparities in both absolute and relative terms to understand their magnitude, especially when making comparisons over time or across populations;
- explicitly identify a reference point when measuring disparities and provide a rationale for selection; and
- use the more favorable group rate as the reference point when making comparisons between two groups.

When determining what improvements and achievements to reward, **payers and providers** can collaborate with **individuals, families, and their communities** to establish clear benchmarks for what constitutes meaningful improvement, equitable performance, and reduced disparities. These benchmarks should take into account factors such as:

- historic under-investment in and under-treatment of communities that have been marginalized;
- increasing performance benchmarks over time as provider capacity to address health inequities grows; and
- measures where performance has "topped-off."

Payers can work with **providers** to structure potential rewards so that they evolve over time, reflect the iterative nature of improving health equity, and do not unintentionally perpetuate existing inequities.

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Conclusion

We are at a unique moment in time, with a window of opportunity before us to make meaningful progress in creating structures and systems that advance rather than undermine health equity. The LAN developed *Advancing Health Equity through APMs* as initial guidance, with the intention of putting forth ambitious but feasible goals for action that all public and commercial payers, purchasers, providers, CBOs, individuals, families, and their communities can begin implementing immediately.

This guidance is grounded in the perspective that APMs must benefit communities that have been historically marginalized and discriminated against and that providers should be rewarded for advancing health equity in ways that strengthen their financial resilience. The LAN recognizes that there is a lack of information on what works when intentionally designing APMs to advance health equity; over time *Advancing Health Equity through APMs* will evolve to reflect implementation lessons, feedback from the field, and evidence of what works as intended and what does not. The LAN looks forward to working with participating stakeholders to support implementation and to generate the lessons and evidence needed to guide future efforts to advance health equity through APM design and implementation.

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Appendix

About the Health Care Payment Learning & Action Network

The Health Care Payment Learning & Action Network (LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care system's adoption of alternative payment models (APMs). The LAN mobilizes payers, purchasers, providers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

Our Vision

An U.S. health care system that pays for value to the benefit of our patients and communities.

Our Mission

To accelerate the shift to value-based care in order to achieve better outcomes at lower cost.

About the LAN Health Equity Advisory Team

The LAN established the HEAT to help identify and prioritize opportunities to advance health equity through APMs, to influence design principles and to inform LAN priorities and initiatives. Its goal is person-centered—leveraging APMs to help make needed care more accessible, drive better outcomes, and reduce disparities. Patient experiences, priorities, and perceptions are crucial elements the HEAT will explore.

Health Equity Advisory Team (HEAT) Members (* indicates also LAN Executive Forum Member)

HEAT Co-Chairs

Dr. Marshall Chin*
Richard Parrillo Family
Professor of Healthcare Ethics
University of Chicago

Karen Dale
Market President
AmeriHealth Caritas
District of Columbia
Chief Diversity, Equity, and Inclusion Officer
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HEAT members

Bukata Hayes
Vice President of Racial and Health Equity
Blue Cross Blue Shield of Minnesota

Cary Sanders
Senior Policy Director
California Pan-Ethnic Health Network

Dr. Craig Jones
Partner
Capitol Health Associates

Dr. David Nerenz
Director Emeritus of Center for the Health Policy and Health Services Research
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Dr. Jennifer Moore
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