



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.*

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

### ADOPTING AN ALIGNED HEALTH EQUITY PERFORMANCE MEASURE SET

#### Essential Alternative Payment Model (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, 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.
- 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.



### Examples *(Continued)*

- 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, 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.

### 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 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.
  - Meeting 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.

### 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.

