HCPLAN
Health Care Payment Learning & Action Network

Advancing Health Equity Through Alternative Payment Models (APMs)

Practical Guidance for Leaders Building Payment Models Incentivizing Health Equity

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How To Use This Guidance Document

This guidance document identifies promising practices from the field that can be adopted across organizations to promote health equity through alternative payment model (APM) contracts. **The objective is to scale promising practices for incentivizing health equity through APM contracts across the health care industry, with the goal of reducing inequities in care and outcomes.**

Drawing from real-world observations and promising multi-sector practices, this document outlines practical steps to operationalize accountable care initiatives that explicitly integrate incentives for health equity.[1]

Included recommendations are offered as voluntary promising practices. Promising practices are generally framed for providers,[2] health plans, and purchasers, as these stakeholder groups play a significant role in the design and negotiation of APM contracts. Many other stakeholder groups, including community-based organizations (CBOs), play a vital role in addressing health equities and should be engaged by organizations when designing and negotiating APM contracts. Implementing organizations will need to make their own decisions about what may be a good fit for their organizations, partners, and communities.

This guidance identifies five building blocks that are essential to enabling contracts or broader adoption of APMs that support health equity. For each building block, a set of short- and long-term voluntary promising practices and examples from across the industry are provided to detail how organizations have made progress in incorporating incentives for health equity into their APM contracts.

In the evolving landscape of health care, progress toward health equity remains an essential and transformational goal. This document is not intended to be comprehensive, as existing efforts to advance health equity through APMs are nascent and may benefit from greater multi-stakeholder alignment. Rather, the recommendations in this document are based on early-stage implementations, with the goal of spreading and scaling early learnings from the field.

Who We Are

The Health Care Payment Learning & Action Network (HCPLAN) 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 and accountable care. The HCPLAN's mission is to advance multi-stakeholder payment reforms to enable coordinated health care that achieves better health, equity, and affordability.

Over 20 industry leaders collaborated to inform and oversee the development of this guidance document and ensure alignment across the industry. These leaders participated in the HCPLAN's Incentives for Health Equity Workgroup, a subset of the HCPLAN's Accountable Care Action Collaborative.

Additionally, this guidance document was informed by 20 semi-structured qualitative interviews with senior leaders from organizations that are advancing health equity through APM contracts. Contributors represented health plans, purchasers, provider groups, and CBOs. For a full list of contributors, see Appendix C.

[1]In this guidance, "incentives for health equity" are defined as financial rewards or penalties and non-financial resources that health plans, purchasers, clinician groups, and health systems can offer to providers/clinicians, CBOs, or patients as part of an accountable care arrangement to promote fair and just opportunities to reduce disparities and attain optimal health for all.

[2]In this guidance, the term "provider" is defined to include both a person who is trained and licensed to give health care (including mid-level clinicians and individuals who provide nutrition services), as well as provider groups.

Building Blocks

Building on Previous HCPLAN Guidance

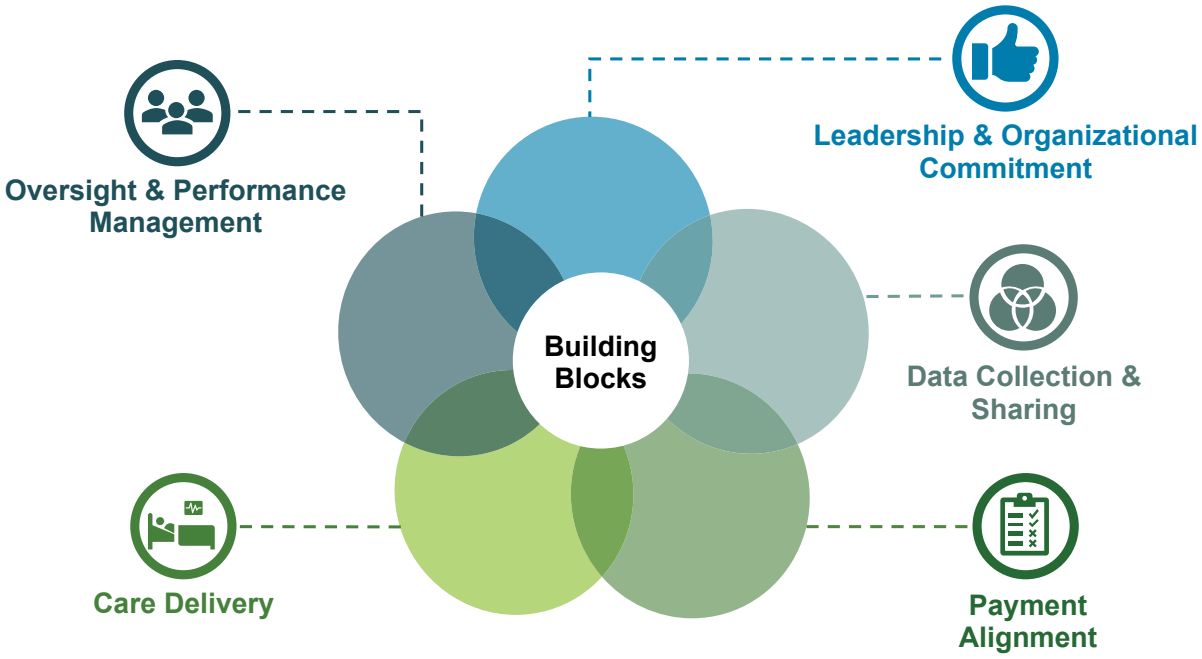
This guidance builds on the previous work of the HCPLAN's Health Equity Advisory Team (HEAT), including the 2021 publication entitled Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation, which lays out how this work can be done from the perspective of payers, purchasers, providers, individuals/families, and communities.

The HCPLAN's Accountable Care Curve encourages enhanced stakeholder capabilities for driving accountable care, including advancements related to health equity. This guidance document seeks to help organizations "move along the curve" through increasing levels of transformation.

Building Blocks

Multiple organizations identified several common enabling actions ("building blocks") that can help address underlying health disparities through design and participation in APMs, including the underlying contracts.

The section below provides explanations and examples of how organizations have used each of these building blocks to advance health equity as part of their accountable care initiative.



The voluntary promising practices are divided into short-term and long-term recommendations to guide readers to potential starting places. Some long-term recommendations are dependent on certain short-term recommendations to be completed first. The time and resources required to accomplish each recommendation is organization dependent. Each organization will have to self-assess to identify the most relevant, high-priority, and realistic recommendations to pursue.

Building Block 1

Leadership & Organizational Commitment

Organizational commitment is crucial in cultivating an organizational culture that prioritizes health equity. Effective leaders can be catalysts for commitment to a culture of change by championing initiatives that address health disparities.

Leadership endorsement of health equity-focused initiatives is essential for legitimizing efforts, inspiring wider organizational buy-in, and securing the necessary resources. Cascading this work from the c-suite throughout the organization will create commitment to the work that will help to realize positive, mission-driven outcomes.

Short-Term Promising Practices:

- ☐ **Vision Setting:** Articulate a clear and compelling vision for health equity that:
  - ☐ Integrates into the organization's overall mission and objectives
  - ☐ Sets goals which impact the community
  - ☐ Is reflected in board-level compacts, such as an enterprise strategic plan and community health needs assessment, which should use a broad lens when determining which communities should be included
  - ☐ Is made clear across the organization, including among front-line employees

- ☐ **Executive-Level Commitment:** Secure commitment from the board of directors and senior leaders. Leadership should be held accountable for this work in ways that are reflected in individual (e.g., reviews and monetary bonus potential) and enterprise (e.g., health equity impact dashboards) performance.

- ☐ **Cross-Organizational Commitment:** Engage employees at all levels of the organization, including front-line employees, early and often, including gathering input on the vision for health equity. Foster buy-in to the vision for health equity, which can lead to greater sustainability.

- ☐ **Resource Allocation:** Ensure allocation of adequate resources — financial, human, and technological — ideally as budgeted efforts, to support health equity initiatives effectively.

- ☐ **Policy Development:** Craft policies (e.g., grant-making policies, public awareness programs, and corporate social responsibility activities) that intentionally promote equity and remove barriers, and show by their personal and professional actions that they are authentic.

Long-Term Promising Practices:

- ☐ **Demonstrate Alignment to Organizational Values:** Demonstrate how health equity initiatives complement and enhance the organization's core values and mission through internal (e.g., workforce diversity and retention) and external (e.g., health outcomes, philanthropic work) impacts.

Building Block 1

Leadership & Organizational Commitment

- ☐ **Continuous Education and Awareness:** Organize workshops and training sessions that educate leaders about the importance of health equity and the role it plays in fostering a sustainable and inclusive business environment.
- ☐ **Impact and Relatability:** Focus leadership attention on concrete, data-driven outcomes and specific measures (e.g., A1c control in diabetes management) and patient and community impacts in the form of patient stories (e.g., how diabetes was identified, diagnosed, and what was done to manage it and maintain it at healthy levels).
- ☐ **Progress Monitoring:** Establish structural measures demonstrating leadership engagement, including but not limited to: number of community partnerships formed, amount of philanthropic dollars raised toward health equity efforts, and leadership accountability in performance outcomes for equitable improvements in care.

Several organizations have demonstrated exemplary leadership and organizational commitment in promoting health equity:

Case Study 1: Blue Cross Blue Shield of Massachusetts invests in pay-for-equity contracts.

Blue Cross Blue Shield of Massachusetts (BCBSMA) became the first insurer to create and sign groundbreaking contracts that pay for health equity. They allocated resources via $25 million in grants that were used, in part, to train staff on best practices for data collection, and created a collaborative community partnership to share data and best practices. So far, more than 550,000 members are covered under these contracts with the state's largest provider groups and health systems.

This initiative was spearheaded by BCBSMA's CEO, and efforts to operationalize this vision were cascaded throughout the organization via leadership from the SVP of Performance Measurement and Improvement. They set up dedicated teams for this effort that sought community input to develop the organization's vision and programs to turn this vision into implemented programs. The organization added parallel health equity components to the responsibilities of existing leadership positions across the organization, rather than creating a separate team for health equity. By doing so, they were able to prevent health equity from becoming siloed within one division or business unit. For example, the chief information officer upgraded data architecture to include FHIR-consistent management of race and ethnicity data, and the VP of Digital Strategy upgraded the membership application to stand up a race/ethnicity survey to collect member-reported race and ethnicity data.

Building Block 1

Leadership & Organizational Commitment

Case Study 2: Arkansas Blue Cross Blue Shield embeds a specific leadership role to oversee equity being threaded into all its work.

Arkansas Blue Cross and Blue Shield (ARBCBS) has embedded a specific leadership role to oversee equity being threaded into all its work. ARBCBS has instituted a Medical Director of Health Equity and Population Health, whose role is to bring a health equity framework to population health management and to the enterprise. This person works closely with the state Medicaid agency and other key constituents across the state (e.g., health system and community health workers) to educate patients, analyze data, and create strategic interventions that deliver impact for their beneficiaries.

Building Block 2

Data Collection & Sharing

Effective data collection and sharing enables health care organizations to tailor their services to the specific needs of diverse populations, ensuring that all individuals receive equitable care. By collecting and analyzing detailed demographic and social data, organizations can identify disparities in care and outcomes, which can then be addressed through focused interventions. Sharing data within and between organizations can lead to greater coordination and enable measurement of equity-focused outcome measures.

A vast majority of interviewees experienced missing and incomplete demographic data and trouble with categorizing patients due to limited collection categories. Challenges also exist around collecting information on health-related social needs (HRSN) and social determinants of health (SDOH). Strategic partnerships, continuous education, and robust data management are essential in overcoming these challenges.

From a tactical data collection perspective, the best time to collect data is at the first point of care — whether during enrollment in an insurance plan or insurance marketplace, or during a wellness visit in a clinic. A multi-stakeholder approach is essential to leverage data for advancing APM adoption and SDOH initiatives effectively.

Short-Term Promising Practices:

Data Collection

- ☐ **Measures and Goals:** Identify measures and goals for health equity initiatives, using existing measure sets that are sensitive to the needs and priorities of the populations served. Measure selection support tools can be found through the Buying Value Measure Selection Tool, which is disparity-sensitive and helps to align measure sets through multi-stakeholder processes. Focus on outcomes that can be aligned to payment incentives.

- ☐ **REL/SOGI Data Collection:** Develop standardized protocols for collecting Race, Ethnicity, and Language (REL) and Sexual Orientation and Gender Identity (SOGI) data and provide comprehensive training for staff on these methods.

- ☐ **Measurement Tools:** Identify and implement reliable survey tools to measure patient-reported outcomes, HRSN, SDOH, and demographic details (e.g., REL and SOGI data), where possible.

Data Stratification

- ☐ **Baseline Inequities:** Define and measure baseline inequities that are identified by data stratification of disease groups and chronic conditions that are causes of comorbidities and overutilization of the health system. Identify specific outcomes with large disparities (e.g., maternal mortality, diabetes) for focused data gathering and collection.

Building Block 2

Data Collection & Sharing

System Integration

- ☐ **Electronic Health Record (EHR) Investment Strategy:** Coordinate EHR implementation and stakeholder collaboration to meet federal regulatory requirements around SDOH data sharing to optimize investment cycle strategies and avoid costly inefficiencies.

- ☐ **Data Governance Frameworks:** Develop and implement internal data governance policies to ensure ethical and legal compliance in data collection, storage, sharing, and usage. Standard enterprise data governance frameworks can be found through the American Health Information Management Association.

- ☐ **Data Capability Advancements:** Identify and engage with partners to leverage their expertise and resources to enhance the richness, completeness, sophistication, validity, and actionability of data. Engage policy organizations to advance alignment across organizations, where needed.

Data Use

- ☐ **Trust Building:** Develop clear communication strategies to inform patients and families about the purposes of data collection and usage. Engage with nurses and clinical support staff to explain the benefits of data collection for care delivery and coordination, ensuring transparency and addressing privacy concerns to build ongoing trust. When possible and appropriate, share aggregated data with clinical staff, patients, and families to build and maintain trust.

- ☐ **Data Standards:** Align internal systems with existing national data standards (e.g., Office of the National Coordinator) that include data protection policies; clear language regarding data definitions; and delivery, usage, and storage parameters for internal use, exchange, and interoperability. Where national standards are absent, work with partners to develop useful, potentially regional, standards for the market.

Long-Term Promising Practices:

- ☐ **Data Integration:** Develop and implement standardized protocols for integrating a strategic set of diverse data sources, including clinical, social, and behavioral health data, to create comprehensive patient profiles.

- ☐ **Interoperability:** Invest in interoperable systems for seamless, multi-directional data exchange among platforms (e.g., Trusted Exchange Framework and Common Agreement, or TEFCA), sharing data appropriately among stakeholders. This ensures continuity of care and requires multi-stakeholder alignment, public and private sector support, and significant investment and collaboration.

Building Block 2

Data Collection & Sharing

Case Study 1: Arkansas Blue Cross Blue Shield leverages a state HIE to promote collaborative data sharing.

Arkansas Blue Cross and Blue Shield (ARBCBS) leverages data sharing with health care providers through the State Health Alliance for Records Exchange (SHARE) health information exchange (HIE) that seeks to make a key source of truth for patient data in the state. The SHARE program aggregates and shares data from payers across the state of Arkansas, allowing ARBCBS to utilize data from the Social Vulnerability Index and the Area Deprivation Index across the state to inform data stratification efforts to better pinpoint areas with high disparities that can be targeted for intervention.

Despite pioneering in data utilization, ARBCBS faces challenges in collecting REL data from patients and families and requires more educational efforts to enhance data-sharing accuracy and acceptance. There is still a need for more conduits of this work across organizations in the state to broker stronger data sharing arrangements moving forward.

Case Study 2: Covered California enhances data collection practices through trust building.

Covered California achieved an 80-percent response rate in demographic data (e.g., race, ethnicity, and language) collection by building trust with patients. Demographic data collection is a necessary component of achieving health equity initiatives. The marketplace garnered this response rate via concerted efforts to educate patients, families, and front-line staff on why data collection was important and how data would be used in planning and managing their individual care needs. Explaining why personal data collection was important and clarifying how it would be protected have been the most critical elements in building trust. Developing educational materials that are embedded into staff training has been a key part of hardwiring these practices.

Covered California works closely with health insurance plans incentivizing investments in demographic data collection through performance standards, convening plan learning sessions, and publicly reporting on stratified measures. Covered California also shares demographic data with health insurance plans using the EDI 834 transaction process for continuous demographic monitoring. The organization has over 20 dedicated staff in the Equity and Quality Transformation division who work to deliver on their mission to reduce health disparities.

Building Block 2

Data Collection & Sharing

Case Study 3: Blue Cross Blue Shield of Massachusetts leverages data imputation to create baseline metrics for performance measurement.

Blue Cross Blue Shield of Massachusetts (BCBSMA) uses a sophisticated data-sharing approach in their pay-for-equity program, leveraging imputed and self-reported race and ethnicity data to operationalize the program in a timely manner (instead of waiting for "perfect" data). Imputing data can be unfamiliar and even controversial for some organizations, but BCBSMA shared that "not letting perfect get in the way of good" is its approach to generating a substantial financial business case for provider organizations to invest in equity improvement. Measuring, reporting, and accounting for the imprecision introduced by using imputed data for population-level health equity measurement has been critical to program design and implementation. The organization has invested heavily in collecting self-reported race and ethnicity data, mainly through member portals online or in digital apps during login processes, with the goal of reducing reliance on imputation over time.

Providers receive equity performance reports, fostering a transparent approach to addressing health disparities. Challenges include uneven data quality, documentation, integration, and interoperability across provider groups and health systems, which are current barriers to using fully self-reported data.

Case Study 4: Highmark Health finds correlation between self-reported social drivers of health and area-level social vulnerability.

Highmark Health, a national health and wellness organization, established a team to develop a social determinants of health (SDOH) assessment tool. The team included clinical case managers, project managers, information technology representatives, and executive and physician leadership from an affiliated health system, Allegheny Health Network. Clinically validated screening questions were used to create a 13-question assessment covering SDOH needs across several domains. The assessment was implemented in phases across multiple health plan and clinical settings, with most assessments initiated by a staff member during face-to-face or telephonic interactions.

Highmark conducted a study on self-reported SDOH needs and the Social Vulnerability Index (SVI) associated with the individuals' residence. Results concluded that the overall level of SDOH needs generally corresponded to area-level vulnerability. Notably, even among individuals from the highest-risk areas, the positive screening rate was roughly 1 in 4. These findings underscore the importance of individual-level SDOH data for service provision planning and highlight that SVI can serve as a good proxy for establishing baseline measure steps as organizations begin to create more comprehensive data collection and sharing strategies.

Building Block 3

Payment Alignment

When determining how payment will be incorporated into a health equity-focused contract or APM, organizations must choose the appropriate payment mechanism that aligns with their business model, strategic priorities, and the preferences and needs of their patient population.

Financial incentives can be powerful tools in promoting health equity within APM contracts. The HCPLAN APM Framework tracks progress toward payment reform and categorizes APMs based on the extent to which payments reward value of services rather than volume of services. APMs in categories 2C and beyond can incorporate incentives which advance health equity to varying degrees. For example, payment models in Category 2C of the APM Framework, the pay-for-performance models, may reward providers for more equitable outcomes on specific quality measures. Meanwhile, payment models in more advanced categories which allow for capitated payments allow for greater flexibility in how care is delivered to promote health equity, including greater flexibility for providers to make upfront investments to assist patients with their HRSNs.

Short-Term Promising Practices:

- ☐ **Strategic Priorities:** Demonstrate alignment of health equity incentives with the organization's strategic priorities to ensure a cohesive approach to accountable care.
- ☐ **Population Served:** Select payment models which bear risk on the specific populations that are most in need of health equity interventions to maximize the impact of accountable care arrangements, which should be customized for each community. Consider implementing safeguards to ensure no populations are entirely excluded or disadvantaged.
- ☐ **Payment Model Alignment:** Seek to establish alignment, or compatibility, of payment models with Medicare and Medicaid to increase provider adoption and prevent further segmentation of services to their patient populations based on payer requirements.
- ☐ **Measure Selection:** Establish aligned, narrow measure sets that are clinically validated, aligned with payment method, and specific to improvements in health equity, such as increased rates of preventive care in underserved populations.
- ☐ **Non-Financial Resources:** Consider non-financial resources in addition to financial, i.e., training and peer learning opportunities and qualitative measures of community benefit.
- ☐ **Business Model:** Prioritize health equity in the mission and ensure that the business model and capabilities of the organization adapt to facilitate its achievement.

Building Block 3

Payment Alignment

- ☐ **Financial Incentives**: Consider and implement financial incentives for health equity, such as:
  - ☐ Linking financial incentives to policies and practices that are focused on health equity (e.g., Hospital Commitment to Health Equity Measures)
  - ☐ Providing incentives for positive performance within stratified quality measures as part of a defined strategic goal to close an equity gap
  - ☐ Making upfront investments and/or prepaid capitated payments to help providers immediately build internal capacity, collect key data, inspire their leadership, train and build excitement among staff and clinicians, and engage with the community from the beginning

Long-Term Promising Practices:

- ☐ **Market Dynamics:** Analyze market dynamics (e.g., trends in age shift or geographic growth in population) to select models that are most conducive to populations with the highest need for intervention (e.g., the significant growth of the Latinx community as a percentage of population in the American Southwest could be well-suited for tailored approaches to culturally competent care).
- ☐ **Internal Operational Integration:** Support integration of health equity incentives into existing contract design and business planning processes such as strategy development, designing and maintaining products and networks, managing contracts, engaging providers/consumers, and analytics reporting.
- ☐ **External Alignment:** Aim for alignment of outcomes (e.g., quality, effectiveness, and patient experience measures) and associated incentives (e.g., performance payments) across partner organizations to the extent feasible.

Building Block 3

Payment Alignment

In some instances, organizations developed their own means to financially incentivize health equity, while others worked within the frameworks of existing CMS Innovation Center models.

Some examples of payment type selection based on interviews include:

Case Study 1: Provider group compensation is adjusted based on quality measure performance.

Blue Cross Blue Shield of Massachusetts (BCBSMA) integrates health equity into its contracts with provider groups that have patient populations of sufficient size and diversity to allow for valid and reliable measurement of changes in equity performance over time. BCBSMA engages an external advisory board and various stakeholders in key elements of contract design, aiming to reward reductions in disparities. Key characteristics of this approach include:

Global Budgets with Condition-Specific Quality Incentives

- The organization uses global budgets with condition-specific quality incentives.
- In the program's current early stages, financial incentives are based on measuring improvement from baseline for specified conditions within populations managed in tandem with partner health systems.
- The approach avoids comparing providers to each other, which could discourage collaboration between providers.
- BCBSMA's Alternative Quality Contracts, where health equity quality performance is embedded, include two-sided risk.
- These structural elements are important, as the program is designed to reward providers and systems for closing performance gaps between racial and ethnic patient groups over time.

Requirements for Participating Provider Groups

- The organization requires participating provider groups to meet certain requirements to ensure statistical reliability of the data and meaningful impact:
  - A minimum of 10,000 patients total
  - Sufficient racial and ethnic diversity among these patients
  - At least one large enough baseline inequity to allow reliable measurement of its closure (All sufficiently large and diverse provider organizations had one or more large internal inequities.)
- Provider groups that do not meet the size and diversity requirements can still receive all components of equity improvement support (e.g., data and coaching) other than the pay-for-equity incentives.

Building Block 3

Payment Alignment

Case Study 2: Agilon Health uses capitated payments to incentivize health equity investments.

Agilon Health, a national value-based care organization, partners with independent primary care physicians to enroll them in the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model. The organization passes along capitated payments to providers in the form of provider incentives that encourage providers to see patients according to the organization's standardized care management structure. This structure outlines best practices for the frequency with which different patients should be seen based on their level of risk.

Patients are risk-stratified based on demographic, clinical, and utilization data from multiple sources. Using proprietary algorithms, patients are identified to be high risk for future avoidable utilization over the next 12 months. These risk scores, when combined with primary care provider (PCP) judgment, can be helpful to ensure the organization is matching the intensity of its care model (e.g., PCP touchpoints, care management, and chronic disease clinical pathways) to the intensity of the needs of each patient. Additionally, through elements of the operating model such as active panel management, which generally includes a regular PCP-led interdisciplinary huddle to develop and monitor a proactive care plan for each high-risk patient, Agilon matches patients to the most appropriate clinical interventions.

To support REACH efforts, Agilon's business model allows it to inject capital into independent practices to ensure they can manage their populations. This practice can be especially necessary for rural populations who historically experience immense disparities in care due to access issues. The organization offers robust technological support and data analytics to assist partner physicians in managing care, improving outcomes, and navigating the complexities of Medicare.

Incentives for health equity may be successfully deployed in payment models where all progress is rewarded. In historical models, moderate progress can be categorized as insufficient progress and elicit financial penalties.

Incentive structures that are tied to high benchmark thresholds set by control groups who may have different confounding factors that influence relatively healthier outcomes can disincentivize participation in alternative payment models. It is important for organizations to select appropriate payment types that provide flexibility for them to augment care delivery and management strategies and remain financially upright.

Building Block 4

Care Delivery

APM contracts can be designed to improve health equity by supporting care innovations that prioritize the organizational strategies and tactics described above, including greater focus on more person-centered, culturally and linguistically appropriate care. APMs can provide the clinical autonomy and organizational resources necessary to redesign care models for the populations organizations seek to impact.

Health plans and provider organizations work across several different models of care delivery that specifically prioritize health equity, such as integrated care and community-based care from independent physicians and qualified health care providers. It is imperative to have the appropriate staff and providers in place to deliver the intended care to desired populations; without the proper care teams, it will be challenging, at best, to achieve meaningful outcomes.

The recommendations outlined in this document were highlighted in promising practices from organizations that were interviewed. Additional recommendations related to care delivery can be found in the HCPLAN's 2021 guidance on Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation.

Short-Term Promising Practices:

- ☐ **Previous Successes:** Leverage insights from health organizations that have successfully revamped care models to enhance efficiency and patient outcomes.
- ☐ **Provider Cultural Competency:** Consider provider and staff cultural competency levels and implement education, training, feedback, technical assistance, and peer learning opportunities to ensure buy-in. Incentives for participation can include credits toward continuing education and/or professional development requirements or creating cultural competency as an area of measurement within individual performance reviews.
- ☐ **Accessibility:** Ensure all materials are available in multiple languages and consider developing digital tools to enhance bidirectional communication and access.
- ☐ **Open Forums:** Schedule regular grand rounds on health equity, encouraging participation from all staff levels. Additionally, organize monthly meetings to discuss health equity, fostering an open environment for sharing experiences and solutions.
- ☐ **Education for Data Collectors**: Provide education to providers and staff on the importance of REL and SOGI data collection and usage. Educating providers and staff on the uses of REL and SOGI data collection can encourage greater commitment to data collection.

Building Block 4

Care Delivery

- ☐ **Data Equity:** Implement equitable data collection, preprocessing, and analysis practices, including bias detection and fairness constraints in models, while involving diverse stakeholders and adhering to ethical guidelines. Regularly audit and update these practices to maintain fairness and equity in health outcomes.

- ☐ **Integrated Care Teams:** Implement integrated care teams (e.g., pharmacists, dietitians, social workers) to provide holistic, coordinated, and culturally competent care, addressing both medical and social needs. Ensure the right provider type is accessible to patients and collaborate with CBOs to enhance care delivery and reduce health disparities.

- ☐ **Patient Population:** Define specific patient populations for focused interventions and consistent measurement.

- ☐ **Measure Patient Perspectives:** Identify and implement reliable survey tools in appropriate languages to measure patient-reported feedback and/or outcome measures.

Long-Term Promising Practices:

- ☐ **Collaborate on Data Collection:** Partner with EHR vendors to develop a commitment to prioritizing the collection and documentation of REL, SOGI, and SDOH data in the clinical workflows in the most efficient ways possible.

- ☐ **Care Redesign:** Design and implement models, in collaboration with targeted patient populations, that specifically address underlying structural barriers to care delivery for underserved populations (e.g., digital health and transportation service offerings for low-income areas with low access to public transportation).

- ☐ **Monitor Community Demographics:** Monitor demographics and trends in the patient population to gain insight into how to adjust care interventions.

Building Block 4

Care Delivery

Case Study 1: Suvida Healthcare designs a regionally focused, culturally competent model focused on targeted interventions for non-medical drivers of health in a specific patient population.

Suvida Healthcare, a regional primary care provider group, focuses on serving Hispanic patient populations using a capitated payment model to tailor care delivery to the specific needs of their patient population, including regional, cultural, and linguistic considerations. Suvida addresses health-related social needs through nutrition-related services such as nutrition counseling and cooking classes, plus other community programming. The organization employs providers and care navigators that speak Spanish to ensure clear communication with the patient population.

Every Suvida patient sees a provider-led care team that includes therapists, dietitians, mental health providers, and a dedicated care coordinator. Additional services can include transportation assistance, clinical pharmacy support, and personalized medication support. Additionally, Suvida has invested in Spanish-speaking support staff to ensure better delivery on cultural competency within care.

Case Study 2: Agilon Health designs a geographically tailored, community-focused care delivery model.

Agilon Health, an ACO focused on specific geographic regions, facilitates positive provider relationships by co-locating ACO staff in local provider offices, which in turn leads to more cohesive management of patient care delivery. Co-located staff assist practices with clinical strategy, understanding the ACO-provided data on the patient population, and understanding patient attribution and contracting with health plans.

The role of co-located staff is dependent on the capabilities and experience of each practice. By embedding staff within the region, Agilon supports providers in adapting to the needs of each region, across diverse populations and both urban and rural settings. This approach fosters an integrated and community-focused care delivery model that equips providers with the data and support they need to provide targeted, tailored care.

Building Block 4

Care Delivery

Case Study 3: Medical Home Network operates a practice-based care management model focused on cultural competence and patient engagement.

Medical Home Network (MHN) partners with Federally Qualified Health Centers and safety-net providers in Chicago to improve care for Medicaid, Medicare, and uninsured patients and their communities. The organization provides funding for health centers to hire practice-based care managers and care coordinators. The practice-based care team receives training on motivational interviewing, health literacy, health equity and implicit biases, and communication skills. The care managers and care coordinators work closely with primary care providers and patients to provide whole-person, culturally competent care to all patients and more intensive care management support for patients with greater complexity of care needs.

The allocation of care management resources is informed by the MHN's risk stratification algorithm which factors in social driver of health data, health risk assessment data, and patient utilization history, among other data points. The organization maintains health equity dashboards to analyze quality, SDOH, and health care access measures by race, ethnicity, and other demographic factors to monitor and address health disparities.

Building Block 5

Oversight & Performance Management

Effective oversight is essential for the successful integration and implementation of health equity initiatives within APM contracts. Oversight ensures that these initiatives comply with established standards, avoid unintended consequences, and remain responsive and adaptable to the evolving needs of health care systems and stakeholders. Oversight mechanisms help maximize the impact of health equity efforts by ensuring that resources are allocated efficiently, objectives are met, and health equity initiatives are aligned with desired outcomes. To establish effective oversight infrastructure, several mechanisms appear promising:

Short-Term Promising Practices:

- ☐ **Steering or Advisory Committees:** Establish committees with diverse members, including health care professionals, patients, and community leaders, to oversee health equity initiatives in APM contracts. Provide funding to participants, especially under-resourced groups, to support their involvement in accountability bodies.
- ☐ **Stakeholder Involvement:** Formally include patient and community representatives within accountability bodies, which is crucial for program design and ongoing management to ensure health equity efforts reflect the needs and lived experiences of underrepresented populations.
- ☐ **Performance Management Systems:** Implement performance management systems to track progress against specific health equity metrics reflecting improvements in access to care, patient health outcomes, and satisfaction across diverse groups.
- ☐ **Reporting Requirements:** Design transparent and consistent reporting systems (e.g., dashboards) to hold all parties accountable for meeting health equity goals and targets.

Long-Term Promising Practices:

- ☐ **Stakeholder Engagement:** Involve a broad spectrum of stakeholders throughout the planning and implementation processes. Include patients and family members, health care providers, community leaders, and policymakers.
- ☐ **Transparency:** Share information about what is being done and why with leaders across partner organizations throughout the planning and oversight processes to build trust and accountability.
- ☐ **Continuous Improvement Processes**: Establish processes for continuous improvement (e.g., review and feedback loops) to allow for the regular review and refinement of health equity initiatives.

Building Block 5

Oversight & Performance Management

Several examples described during interviews illustrate successful oversight and performance management in action. They include:

Case Study 1: Blue Cross Blue Shield of MA organizes a diverse, collaborative group of internal and external stakeholders to support management of its pay-for-equity arrangements.

Blue Cross Blue Shield of Massachusetts (BCBSMA) organized a diverse, collaborative group of internal and external stakeholders to support management of its contracts with provider groups which include incentives for making measurable improvements in health equity. The organization designed and developed a pay-for-equity arrangement in collaboration with leaders in equity, quality, and contracting, and then negotiated other contract features to align closely with organizational goals.

BCBSMA created an internal management group comprised of organizational leaders including those in quality, equity, contracting, and enterprise technology roles. Together, they established broad design principles that directly informed the contract language, streamlined the negotiation process, and ensured that the contracts reflected the organization's commitment to equity. Additionally, the organization works with local health systems and subject matter experts in equity data and improvement topics, who have been crucial in aligning data collection standards and designing equity improvement interventions. This collaboration ensures robust, standardized data collection, enhancing the initiative's effectiveness and alignment with state health objectives.

Building Block 5

Oversight & Performance Management

Case Study 2: The Syracuse Institute for Veterans and Military Families uses a common technology platform to direct, track, and evaluate services for veteran health.

Syracuse University's D'Aniello Institute for Veterans and Military Families (IVMF) was founded in 2011 as higher education's first interdisciplinary academic institute singularly focused on advancing the lives of the nation's military, veterans, and their families. Since 2015, under its America Serves initiative (AS), the IVMF has helped develop 18 networks of health and human service providers that help the military-connected population navigate to resources and care in their communities. AS utilizes a "no wrong door" entry model, where individuals can access services through any participating provider, and a coordination center with trained navigators will conduct intake, screen for needs, and make referrals within the network.

All activity is tracked using a shared technology platform, which enables real-time transparency and accountability, as well as robust ongoing measurement, both monthly and annually. System-level metrics include referral speed and accuracy, provider engagement, and growth/scale. Individual-level metrics include the outcome of referrals and the acuity of needs over time. Based on the available research on resource directory models, AS shows higher closed-loop and resolution rates for requests. By providing technical assistance, convening key partners, and evaluation support, the IVMF ensures that veterans and their families receive the necessary resources effectively, emphasizing holistic care and health equity at every level.

By adopting similar oversight mechanisms and strategies, organizations can ensure that their health equity initiatives within VBC contracts are not only effectively implemented but also capable of achieving sustainable and meaningful outcomes.

Operationalizing Promising Practices

Organizations should consider the following immediate next steps. Deeper strategic consideration will be needed as organizations mature in their health equity goals and initiatives.

1. **Conduct a thorough needs assessment** to identify gaps and opportunities within the five building blocks, taking care not to exclude important sub-populations.

2. **Develop a strategic plan** informed by the needs assessment to activate health equity incentives, including key steps, timelines, and resources. Set organizational goals with clear, measurable objectives aligned with health equity goals. Self-assess the extent to which the organization is prepared to commit to advancing health equity, as this can help determine the staying power of the initiative.

3. **Allocate necessary resources** (e.g., tools, data, personnel, stakeholder engagement mechanisms, etc.) to support the implementation process.

4. **Engage key stakeholders early and often**, including individuals (e.g., patients, caregivers), marginalized communities, and other key partners (e.g., CBOs) to understand their needs and lived experiences. Authentic engagement requires their ongoing inclusion in the codesign of solutions that directly impact them. Advancing health equity requires acknowledging and addressing historical bias and discrimination their families and communities might have experienced and holding stakeholders accountable for equitable engagement moving forward.

Implications: Envisioning the Downstream Impacts

Integrating health equity incentives into APM contracts can lead to significant downstream impacts. Improved health outcomes can include potential reductions in the prevalence of chronic diseases, lower mortality rates among underserved populations, and improved quality of life for marginalized communities. These health improvements can also translate into economic benefits, such as reduced health care costs due to fewer hospital admissions or readmissions and lower incidence of preventable diseases.

The social impacts of integrating health equity incentives are also tangible. Reducing disparities in health outcomes across marginalized communities can foster greater trust in health care systems among marginalized communities. This increased trust can contribute to overall societal well-being, as equitable access to quality care becomes more widespread. For additional information on the social return on investment from investing in health equity, please refer to the HCPLAN's resources from the Health Equity Advisory Team.

There is a strong commitment nationally to health equity, although leaders aiming to address health equity are too often impeded by well-known obstacles, including misalignment of payment incentives, lack of care coordination, and data barriers. This guide brings informed minds together nationally to help leaders overcome those barriers, learn success stories, and find their own path forward. We anticipate this guidance document is only a first step. We welcome feedback, ideas, and more case studies so we can continue to learn and act together.

Appendices

Appendix A: Definitions and Key Stakeholder Groups

In alignment with previous HCPLAN guidance, this document follows the same definition of the terms “health inequities” and “health disparities” previously used in HCPLAN guidance. 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.”

This guidance document also references key stakeholder groups, including health plans, purchasers/employers, providers, CBOs, persons (patients, caregivers, and communities), and policymakers. Each of these stakeholder groups has a distinct role that it can play to advance health equity through participation in an accountable care arrangement. While this guidance document focuses on recommendations for leaders of health plans, care providers, and purchasers, it is important to consider the roles of other stakeholder groups in enabling and influencing incentives for health equity in accountable care arrangements. Prominent among those are patients and families, whose full engagement should be integrated into every action.

Appendix B: Resources

The following technical resources were referenced in the above document:

- The Buying Value Measure Selection Tool is a suite of tools intended to assist state agencies, private purchasers, and other stakeholders in creating health care quality measure sets.
- The American Health Information Management Association’s (AHIMA’s) Patient Identification and Matching Naming Policy provides guidance to help accurately identify patients through patient demographics.
- The Blue Cross Blue Shield of Massachusetts Pay-for-Equity Technical Methods provides the technical approach to designing a pay-for-equity financial incentive for provider organizations participating in BCBSMA’s Alternative Quality Contract.
- The Blue Cross Blue Shield of Massachusetts Health Equity Report provides an example of transparent public health equity reporting and includes information around methodologies.
- The HCPLAN’s APM Framework provides a common vocabulary and pathway for measuring successful payment models.
- The HCPLAN’s Accountable Care Curve provides resources to enhance stakeholder capabilities for driving accountable care, including advancements related to health equity.

- The HCPLAN's Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation 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. This document focuses on the provision of person-centered, culturally and linguistically appropriate care and payment incentives to reduce health disparities in quality of care, outcomes, and patient experience.

- The Office of the National Coordinator for Health Information Technology (ONC) has data standards to support the adoption of health information technology and the promotion of nationwide, standards-based health information exchange to improve health care. Specifically, the Trusted Exchange Framework and Common Agreement (TEFCA) establishes a universal governance, policy, and technical floor for nationwide interoperability to simplify connectivity for organizations to securely exchange information to improve patient care, enhance the welfare of populations, and generate health care value, as well as to enable individuals to gather their health care information.

- In April 2024, the Office of Management and Budget (OMB) issued updated standards for maintaining, collecting, and presenting race/ethnicity data across federal agencies, allowing for more specific demographic collection.

- In May 2024, the Journal of the American Medical Association article "Self-Reported Social Determinants of Health and Area-Level Social Vulnerability" was published by Emily Brignone, Ph.D.; Keith LeJeune, Ph.D.; Amanda E. Mihalko, M.A.; et al.

- In Fall 2024, Deloitte Center for Health Solutions' analysis revealed an opportunity for a $2.8-trillion increase in GDP by 2040 if health inequities are appropriately addressed.

Appendix C: Key Contributors

The workgroup wishes to acknowledge and thank the following organizations for their contributions and for sharing their insights and experiences to help inform the development of this guidance document.

- Agilon Health
- Aledade
- Arkansas Blue Cross and Blue Shield
- Blue Cross Blue Shield of Massachusetts
- California DHCS
- Centene
- Center for Medicare and Medicaid Innovation
- Covered California
- Elevance
- Health Care Transformation Task Force
- Kentuckian Health Collaborative
- The Leapfrog Group
- Medical Home Network
- National Association of ACOs (NAACOS)
- National Alliance of Healthcare Purchaser Coalitions
- National Partnership for Women & Families
- Partnership to Align Social Care
- Partners in Care Foundation
- Suvida Healthcare
- Syracuse University D'Aniello Institute for Veteran and Military Affairs
- Trinity Health

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