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## Recommendations to Advance Equity Through Payment Models

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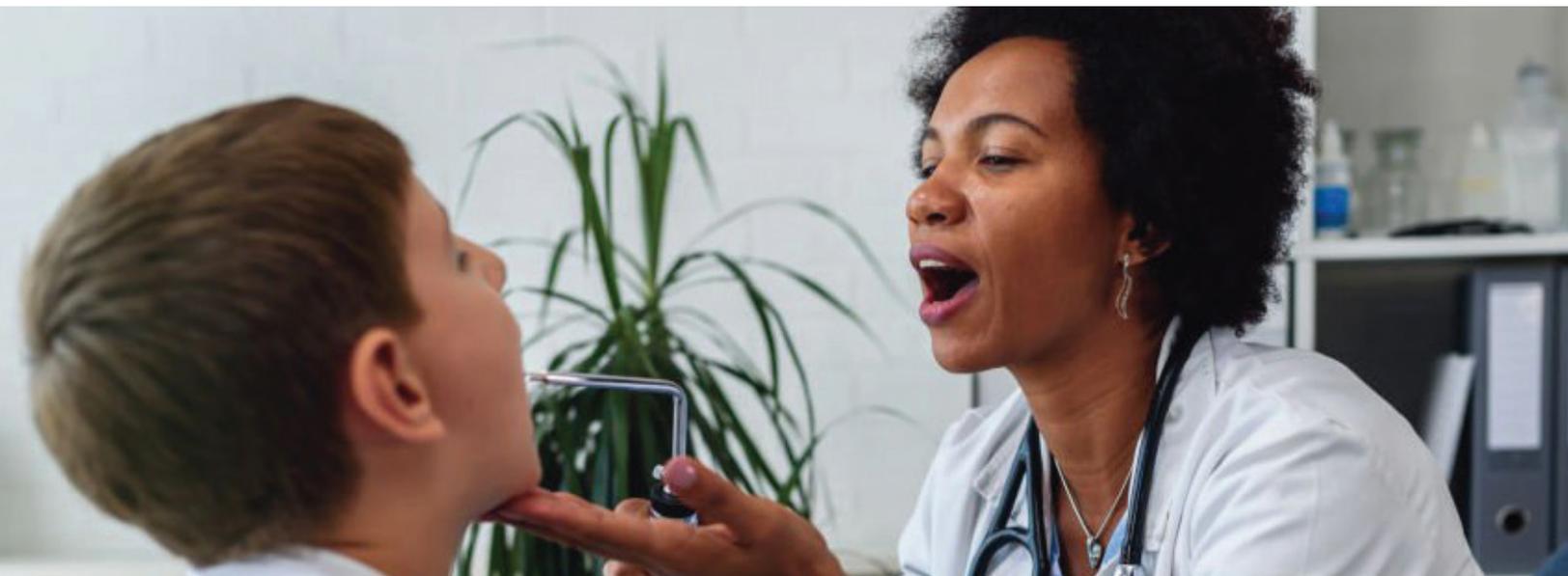
## Introduction

Alternative Payment Models (APM) have the potential to transform the health care delivery system by expanding access to care, improving patient outcomes and mitigating health disparities. However, APMs must be intentionally designed in a way that promotes health equity and prevents unforeseen negative outcomes. Factors such as poverty, institutional racism, educational and economic opportunity, insurance coverage and the living environment significantly impact health equity and are crucial considerations within the space that APMs operate. When capitated payments and performance incentives fail to account for the necessary resources to provide adequate care, practices serving populations with higher medical and social risks may face financial challenges, ultimately impacting health outcomes negatively.

The California Quality Collaborative (CQC) and Integrated Healthcare Association (IHA) have partnered with health plans to design a common hybrid primary care payment model through the [California Advanced Primary Care Initiative](#). CQC conducted interviews with subject matter experts in payment model design and health equity, gathering recommendations to promote equity in the payment model. This involves creating accountability for more equitable health outcomes in purchaser and payer contracts and alleviating unintended negative impacts on clinicians serving marginalized populations. The Health Care Payment Learning & Action Network (LAN)'s [Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation](#)<sup>1</sup> serves as a guiding framework.

The recommendations presented in this brief are intended to strengthen health equity in APM design and implementation, regardless of geography.

<sup>1</sup>[Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation, 2021](#)



## About the California Advanced Primary Care Initiative

Multi-stakeholder collaboration is essential to seize the opportunity to align the design and implementation of a payment model that promotes health equity. Intentionally-designed APMs have the ability to lessen detrimental effects on marginalized communities and the providers who serve them by encouraging and supporting systemwide changes in care delivery.

To this end, CQC and IHA formed the California Advanced Primary Care Initiative, bringing together a coalition of health care payers to take collective action to advance primary care practices. The goal of the initiative is to deliver high-performing, value-based care that lowers costs while enhancing quality and equity.

Payers are collaborating to design and adopt a unified payment model for primary care providers that offers flexibility, supports team-based care delivery and incentivizes the right care at the right time. The initiative's payment model is comprised of three key elements: direct patient care payment, population health payment and performance-based payment.

Payers have considered the recommendations in this brief for integration into the payment model. Some were easily incorporated, while others are being considered in future iterations as the California Advanced Primary Care Initiative builds the capabilities to implement these recommendations.



# Element 1: Direct Patient Care Payment

## Transition from Fee for Service to Capitated Payments

**Recommendation: Use an incremental approach to move to capitated payments, allowing providers a successful path to transition from fee for service (FFS).** Under capitated payment, providers receive upfront funding to support clinical services and key staff roles. This funding can address the social factors that shape health and advance health equity by enabling team-based care and care management. Measures to assess this include the prevention of clinical deterioration and costly emergency department visits, inpatient care and procedures.<sup>2</sup>

Incremental approaches might involve:

- A phased strategy to shift revenue into a capitated per member per month (PMPM) payment gradually and establish broad goals for the transition (e.g., by 2026 practices will receive 50% of revenue as a PMPM, increasing to 75% by 2025).
- Tracking the number of providers selecting the proportion of their reimbursement made as PMPM versus FFS, a model utilized in Colorado's Alternative Payment Model 2.<sup>3</sup> This approach facilitates a glide path into participation for small providers.
- Additionally, APMs could adopt a strategy to reduce FFS claims by a specified percentage and direct the difference into capitated payments for providers to shift over time. If this flexibility is incorporated, APMs could consider requiring a minimum amount of revenue originate from PMPM or offer inducements to take more revenue as PMPM, ensuring a meaningful level of reimbursement to motivate practice transformation.

## Incorporate Risk Adjustments for PMPM

**Recommendation: Adopt risk adjustment into APM contracts.** APMs with risk-adjusted payments offer reimbursements that account for the underlying clinical and social risk of the population, paying more for populations that have higher risk. This approach recognizes that additional resources will be needed to eliminate health inequities.

It is important to set clear goals and determine if this is an actuarial practice or a rebalancing effort, which will be key for building the risk adjustment method and messaging.

- Determine if the goal is to accurately predict costs or to increase investments in care for people with higher social risk.
- Although the LAN recommends adjusting payments up and down for disparity improvement, consider also incorporating distinct payments that are adjusted based on equity performance.

<sup>2</sup> *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity: Paying for Equity in Health and Health Care*

<sup>3</sup> *Colorado Alternative Payment Model 2*

*Alternative Payment Model 2 Guidebook 2023, page 6*

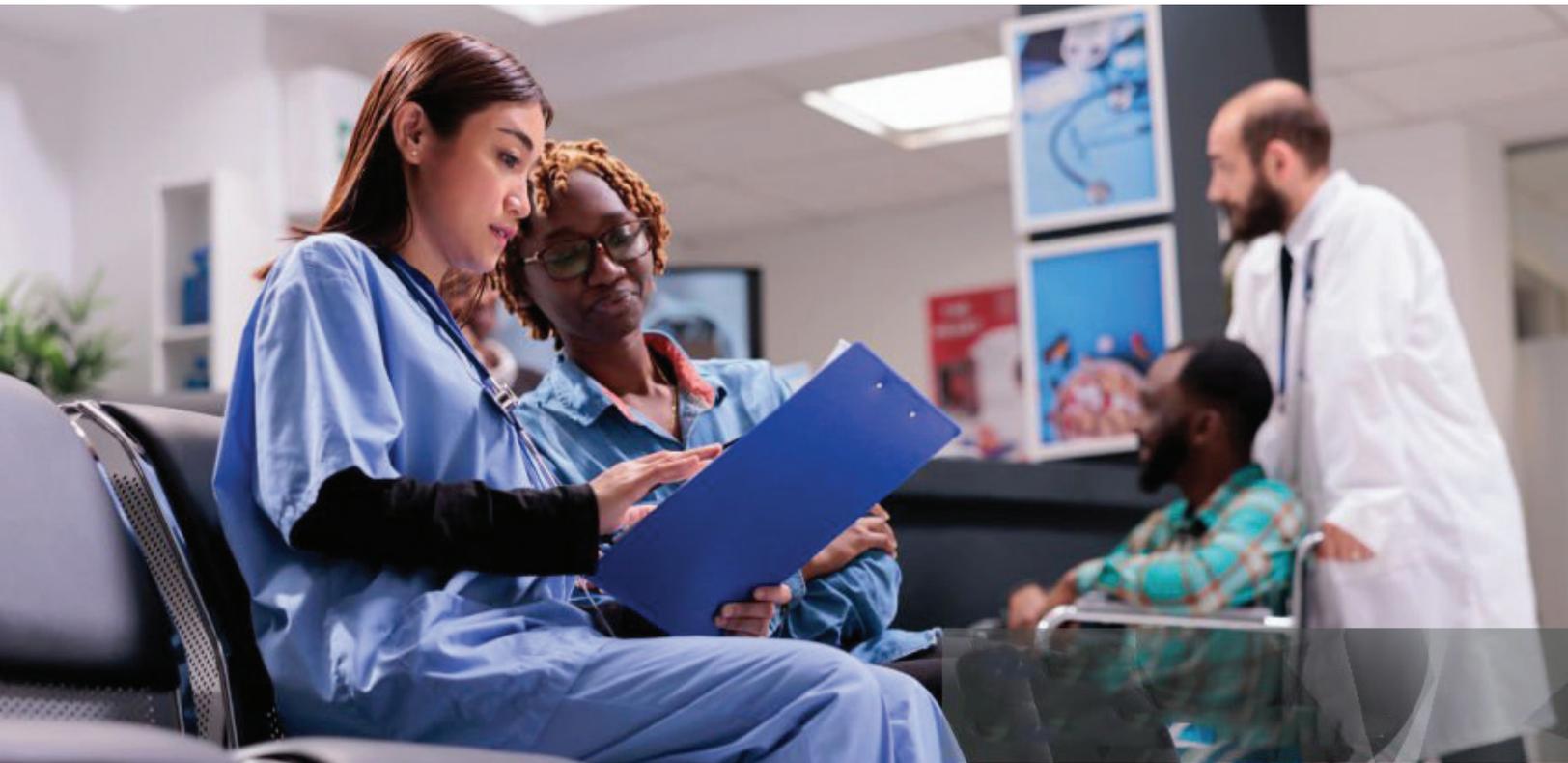
## Case Study: Evaluating Social Risk Indexes

In evaluating different social risk indexes for the California Advanced Primary Care Initiative's payment model, CQC and IHA considered the California Healthy Places Index (HPI), Social Deprivation Index, CDC Social Vulnerability Index and the Area Deprivation Index, taking into consideration the following recommendations:

- Alignment with the Centers for Medicare & Medicaid Services.
- Use of a geographic and community-population level data in combination with data collected from individual screening for social risks and assets for population health improvement.<sup>4</sup>
- Use of a deprivation index in social risk adjustment that includes regional or state-based benchmarks.
- Use of a geographic index, which entails reduced administrative burden (less data collection) and accounts for people who are not currently accessing care.

CQC and IHA ultimately decided on the California HPI, as it was locally relevant and comprehensive, taking in different considerations and data sources from other indices (ie. environmental pollution and results from the American Community Survey). One focal point was around social deprivation and understanding local context (how residents travelled with their community), resource allocation (ie. during times of disasters and if it was used to adjust payment) and size of geographic areas available (census tracts and block groups).

<sup>4</sup>*State of the Science on Social Screening in Healthcare Settings*



## Element 2: Population Health Management Payment

### Incorporate a Distinct Population Health Management Payment

**Recommendation: Include a distinct population health management payment separate from patient care payments.** A transition to population-based capitated payment should include increased flexibility and an expectation of population health management and whole-person care. Population health management payments support practice improvement for smaller providers and providers who historically have served patients experiencing health inequities. Additionally, as some providers will be moving from FFS, a prospective payment will give the financial resources to tackle health equity efforts.

If an APM has incorporated social risk adjustment to predict costs more accurately, population health management payments might be an opportunity to use social risk factors in order to rebalance and directly increase payment. These payments can be tied to specific activities with guardrails that could include:

- Requiring submission of a health equity plan or the design of an equity intervention program to receive population health management payments. If there are requirements, they should be explicitly related to promotion of health equity, and that should be clearly defined. For example, population health management staff, analytic support or infrastructure and providers should be required to report on how they spend funds on an annual basis.
- Time-limited population health management payments to build up infrastructure and capacity to transform care. However, if payments are to support activities like care management, then those payments should not necessarily be time limited.

To account for historically under-resourced providers, payments could also be adjusted based on patient acuity in a tiering system that incorporates some amount of social risk adjustment. Though, some caution should be exercised when adjusting payments for quality performance; practices that perform poorly on quality may have more complex patients who would benefit from more, not less, upfront investment in infrastructure and capacity.

### Provide Technical Assistance

Effective technical assistance should be offered to providers, including guidance and support to undertake quality improvement interventions that are culturally and linguistically appropriate. This may involve translated patient education or self-management materials, group interventions offered in multiple languages or other interventions. Tailored technical assistance should support the integration of more community-based providers into the practice, such as community health workers, patient navigators, doulas, health care interpreters, peer mental health workers and health educators.

Moreover, aforementioned activities aimed at building capacity through population health management payments can be tracked via centralized technical assistance. Practice coaches can provide support gathering information to demonstrate work toward health equity goals.

# Element 3: Performance-Based Payment

## Weight Quality-Based Payments to Equitable Health Outcomes

**Recommendation: Develop financial incentives set up to meaningfully reward the reduction of health disparities and to encourage the promotion of more equitable health outcomes.** Both improvement and attainment goals should be established, along with expectations for stratified data by race and ethnicity that include Healthcare Effectiveness Data and Information Set (HEDIS) measures for which stratification is required. Measures where overall attainment has already been achieved should transition to fully focus on equity performance.

- The APM could start with 20% of the overall quality score tied to equity performance and increase the percentage over time. Start with measuring disparities among race, ethnicity and spoken language and add additional stratification characteristics over time, such as disability, geography and sexual orientation and gender identity.<sup>1</sup>
- Given the state of individual level race, ethnicity and language (REaL) data collection, it may be necessary to start with one to two years of pay for reporting related to REaL data collection before it is possible to link incentive payment to disparities performance.
- Downside risk may cause practices to move out of voluntary APMs. If penalties are considered, begin after a couple of years, as practice transformation often happens on a longer time horizon.

Incentives should also tie to a health equity measure set for achieving equity in a payment model. Aligning with measures that are required to be stratified by race and ethnicity by national and state governing bodies is a preliminary step organizations can take when designing an APM. In addition, performance incentives should start by using state benchmarks and the payment for health equity performance should mitigate the risk of punishing providers serving populations that experience high levels of inequities.

APMs could also consider a designation for practices achieving high quality performance among set benchmarks. Once a practice has received designation: Consider increasing population health payments for practices to recognize and support their additional capabilities and services; and reward practices that achieve designation with a bonus payment, e.g., an annual reward upon verification of designation.

Alternatively, designation could be used as minimum qualification to earn the last portion of an incentive payment, e.g., 80% of the total incentive payment is performance based, and the last 20% is paid out as a bonus for exceptional performance in achieving advanced primary care.

### Case Study: Weighing Equity Sensitive Measures Evaluating

The California Advanced Primary Care Initiative will be weighing a subset of measures (from the Advanced Primary Care Measure Set) that are aligned with state entities, such as Covered California's Quality Transformation Initiative. Measures include:

- Childhood Immunization Status
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Glycemic Status Assessment Hemoglobin A1c Control

CQC, IHA, and payers are committed to rewarding more for these measures, but also balancing incentives to ensure overall improvements.

## Conclusions

APMs can play a unique role in addressing health disparities, given deliberate design considerations to promote health equity and prevent unforeseen outcomes. Payment models need to promote direct investments through methods such as upfront payments to support practices with necessary resources or incentive design focused on measures with known disparities. It is also imperative to provide dedicated support to ensure practices that are serving patients in rural or underserved areas have a path to success within a given payment model.

Gaining multi-stakeholder alignment is key to ensuring accountability. Recommendations throughout this brief have either been incorporated into or will be revisited throughout CQC and IHA's California Advanced Primary Care Initiative, demonstrating cooperative changes with the goal of improving delivery of care. As stakeholders in the health care delivery system launch APMs, it is key to collaborate with and seek guidance from others leading similar initiatives, as well as those who will be affected by the model itself – from payers, providers and community-based organizations, to those receiving care.



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## About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of Purchaser Business Group on Health, is a health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. The program is dedicated to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.

