Leveraging Value-Based Payment to Advance Health Equity

A Case Study on the Making Care Primary Model

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national partnership
for women & families

Revitalizing primary care

Primary care is the foundation of any efficient, high-quality, person-centered health care system. It is responsible for a range of health care services, from prevention and wellness to diagnosis and treatment, including chronic care management and care coordination.[1] Primary care physicians once played a fundamental role in the care of the general population. Indeed, evidence shows that people who have a regular primary care provider are more likely to have better outcomes, receive preventive care, and have a better care experience.[2,3]

Moreover, people want and need care that is affordable and person-centered.[4] They want a long-term relationship with a provider whom they can trust and who sees them as an individual, listens to them, and treats them with respect.[5] For many people from structurally marginalized communities, this may also mean having a provider that shares their primary language, or racial or ethnic background, or gender, or a provider who specializes in LGBTQ+ primary care.[6] These attributes of person-centered care are the necessary foundation for providing high-quality care, which primary care plays a vital role in.

Unfortunately, many factors — including the predominant fee-for-service (FFS) payment system — have completely undermined this kind of high-value, equity-supporting care. The U.S. health care payment system elevates the values of procedural medicine in favor of relational medicine (e.g., relationship-building and taking time to listen to and answer questions), as made evident by the rise of specialty care spending compared to primary care.[7] From 2002 to 2016, specialty care accounted for 17.9 percent of increased health spending, while primary care only accounted for 4.2 percent.[8] This underinvestment is in direct conflict with what we know actually works for preserving wellness, improving health, preventing the need for costly care over a person's lifetime, and what patients say they need and value.[9] Instead, the way that primary care is paid and the current imbalance of payments across specialty vs. primary care results in an inefficient and inequitable health care system.[10]

Policymakers and advocates have promoted strategies aimed at addressing the under-resourcing of primary care, such as enhanced care coordination, specialty care and behavioral health integration, and promoting community partnerships, all of which have the potential to mitigate some of the longstanding challenges that primary care providers and patients and families face today.[11] But while these are positive steps, they do not address the heart of the issue. We need to change how (and for what) providers are paid, in order to support and incentivize equitable, high-quality primary care.

CMMI's vision for quality and equity

In 2021, the Centers for Medicare & Medicaid Innovation (CMMI) set its 2030 vision to achieve "equitable outcomes through high quality, affordable, and person-centered care."[12] Along with this vision, they are working towards ensuring that by 2030 all traditional Medicare beneficiaries and the majority of Medicaid beneficiaries are cared for by health care providers who are paid for the quality of care they deliver.[13] One of the objectives is to focus on advancing health equity by, for example, supporting providers who work in systemically underserved communities and encouraging them to participate in CMMI models that test innovations to improve the quality of care for all patients, and by including diverse patient perspectives in every phase of a model — from development, to implementation, to evaluation – to ensure models best serve all patients' needs.

The Making Primary Care Model

The new Making Care Primary (MCP) model recently released by the CMS Innovation Center (CMMI) is a significant step forward. MCP is intended to support advanced primary care, which at its core is about continuous, whole-person care that reflects and honors people's dignity, autonomy, goals, and preferences.[14] Advanced primary care can lead to more equitable health outcomes, lower costs, and better-quality care.[15]

The model will provide a pathway for primary care practices to gradually move toward prospective, population-based payments (PBPs), or upfront, flexible payments tied to quality, based on the number of patients a provider cares for and the expected costs of their care. This is in direct contrast to FFS, where providers receive payment based on the quantity of services provided, rather than the quality or outcomes achieved. The intention in MCP is to allow more flexibility and upfront resources to provide holistic care that prioritizes prevention and wellness, care coordination, and supporting patients' social needs.

Whether the model's design will actually achieve these outcomes, or improve health inequities remains to be seen. Nevertheless, given how urgent addressing primary care shortages and advancing health equity are, we analyzed the model's design, implementation, and evaluation strategy to assess its likelihood for advancing equity and centering consumer priorities, and identify opportunities for improvement.

Summary of the Making Care Primary Model

Goal	Strengthen care coordination to reduce patients' challenges navigating the health care system and better meet their holistic health and social needs.
Participants	Primary care providers, geared towards small, independent, rural, and safety net organizations (including Federally Qualified Health Centers and Indian Health Service and tribal clinics) who voluntarily participate
Metrics of success	• Chronic disease prevention • Fewer emergency department visits • Better health outcomes
Care delivery transformation focus areas	• Care management – comprehensive services and timely follow-ups to ensure that patients with chronic, complex conditions receive the care and attention that they need • Care integration – behavioral health as part of primary care and better care coordination with behavioral health and specialty care clinicians • Community connection – the ability to identify and address health-related social needs (HRSNs), and partner with social service providers
Duration	July 2024–December 2034 (10.5 years)
Reach	Will be tested in eight states (Colorado, Massachusetts, Minnesota, New Mexico, New Jersey, North Carolina, Upstate New York, and Washington). CMMI will also partner with selected payers, including Medicare Advantage, commercial, and purchaser-based plans.
Innovative payment approach	Offers three-tracks, or pathways, for providers to enter the model based on value-based care experience, so that practices can gradually move from FFS payment to prospective PBPs. Each track offers a different level of risk and mix of payment types designed to provide more flexibility and upfront resources as providers become more experienced in value-based care, including for services like expanded, interdisciplinary care teams and community partnership efforts.

Model Design Analysis

To assess the Making Care Primary model's ability to advance equity, we adapted the National Partnership for Women & Families "Choosing Health Equity" tool, which is designed to surface the numerous opportunities or decision points for advancing equity throughout the cycle of generating policies, programs, and practices.[16] Our analysis is organized according to this framework's questions.

1. Does the model prioritize issues that individuals and communities care about?

Background

While the issues that people care about when it comes to improving their health care are pretty clear, for the average person, the relationship between solving for them and alternative payment models are not.[17] Ultimately, people want access to a primary care provider that they can afford, ideally one who has the time and flexibility to offer personalized, whole-person care.[18] Unfortunately, the predominant FFS payment system and persistent undervaluing of primary care services is shrinking the vital workforce. Provider shortages have led to over 100 million people in the United States not having access to a usual source of primary care.[19] Communities of color and people with disabilities experience greater systemic challenges accessing primary care, particularly care that centers their needs and experiences.[20]

Promising Model Features

Support for Person-Centered Primary Care

- Financial support to build capacity to deliver equitable, team-based care that will promote care coordination and reduce patient challenges navigating their health care[21]

- Concrete support for providers to deliver person-centered care such as:

    - requirements to provide individualized care management

    - additional resources and data on regional specialists to help primary care providers coordinate with them

    - financial resources to support the integration of physical, behavioral, and HRSNs services into primary care settings. This includes supporting the hiring of community health workers (CHWs), certified peer recovery specialists, and other health care professionals with training in delivering culturally and linguistically tailored services

- Requirements to report on the Person-Centered Primary Care Measure, or PCPCM, which includes domains such as a patient's access to care, integration of care, relationship with the physician, family, and community context, and ability to reach health goals[22]

Improving Affordability

- Allows patients experiencing financial hardship or high disease burden to receive some cost-sharing support for high-value services, or example:
  - care management for behavioral health conditions
  - interprofessional consultation (i.e., care coordination)
  - remote physiologic monitoring

Suggested Improvements

- **Greater emphasis on patient experience data collection and <u>stratification</u> is needed.** Since the PCPM measure is new, CMMI intends to assess its feasibility, validity, and reliability before incorporating it into measuring overall performance. Furthermore, without stratification by race and ethnicity, disability, etc., it will be impossible for participants to identify for which patient groups care coordination and patient experience has improved or worsened.

- **Achieving the promise of value-based care requires lowering patients' financial barriers further.** Reducing cost-sharing for select patients will not sufficiently address affordability within the Medicare program overall and will likely fail to guarantee access to value-based care for all. CMMI may be creating new avenues to advance health equity through which all patients cannot afford to enter. While reducing cost-sharing will increase access for some, others will need their cost-sharing to be completely eliminated to be able to benefit from the improved care models CMMI creates.

- **Eligibility criteria for reduced cost-sharing must be expansive and streamlined.** In order to make cost-sharing support a real possibility for patients that need it, CMS's definitions of "financial hardship" and "high disease burden" must be as generous as possible, and the process for receiving it must not be burdensome for patients to qualify.

2. Does the model address racial, ethnic, and gender health inequities?

Background
Disaggregated data are essential for identifying inequities, targeting resources to address them, and measuring progress, as well as to support transparency and accountability. Devising strategies and action steps, like addressing and integrating HRSNs, are also critical to achieving a set of defined equity goals. Further, ensuring that communities most impacted by structural and systemic inequities benefit from value-based models is critical.

Promising Model Features
The model provides population-based payments, upfront financial resources, and learning supports (see p. 9 for more details) to help build the capacity for:

Data collection and reporting
- Collecting and reporting patient data on race, ethnicity, geography, and disability
- Screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety, with patients able to opt out
- Screening for behavioral health conditions, including depression and substance use disorder
- Sharing data with CMMI to monitor the model's impacts on health inequities and to stratify patient outcomes on socio-demographic measures

Health equity strategic planning
- Creating and implementing a Health Equity Strategic Plan based on the CMS Disparities Impact Statement[23]
- Identifying inequities and implementing initiatives to measure and reduce inequities over the course of the model
- Reporting progress to CMS annually

Health-related social needs integration
- Collaborating closely with CBOs and social service providers to assist patients in navigating the various community supports and services that are available to them

- Offers providers three tracks to enter the model, based on level of experience and capabilities. Each track will progressively build upon requirements and practices' capabilities to fully implement HRSN integration

  - Track 1: implement universal screening, establish referral workflows, identify resources in the community and forging partnerships, and identify staff, such as CHWs or professionals with shared lived experiences, that can enhance the delivery of HRSNs services

  - Track 2: strengthen referrals and partnerships with CBOs and integrate CHWs into care delivery

  - Track 3: streamline referral processes, establish robust community partnerships and continuously improve the utilization of HRSNs services, and workflows to embed HRSN into all patient care

Reaching Medicaid beneficiaries

- State Medicaid agencies have committed to designing Medicaid programs to align with MCP.[1]

- Responds to FQHCS' feedback that they were being left behind in advanced primary care models, by directly including their participation and freestanding Indian Health Service (IHS) and tribal clinics for the first time.[24]

- The expansion of MCP's primary care transformation goals to reach Medicaid beneficiaries and IHS patients is critical to advancing health equity for communities most impacted by systemic inequities.

Suggested Improvements

- **Hold providers financially accountable for improving equity.** For the strategic plan to be effective, it is key that CMS ensure participants are detailed in their identification and remedies to reduce inequities. It is also imperative that over time, the model move beyond reporting and implement financial rewards or penalties for their performance in meeting health equity goals.

- **Value and invest in self-reported race and ethnicity data.** Self-reported race and ethnicity data are considered the golden standard. When self-reported data is missing, imputed data are often substituted, which increases the potential for racial bias and inaccuracy.[25] Improving the collection and use of self-reported data must be an institutional and organizational priority.

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[1] Nearly half of all U.S. children are covered by Medicaid (Medicaid. "Who Enrolls in Medicaid and CHIP?" accessed October 29, 2023, https://www.medicaid.gov/state-overviews/scorecard/who-enrolls-medicaid-chip/index.html). Given that Making Care Primary is a Medicare-based model, it will not be applicable to pediatric practices. However primary care clinicians with pediatrics as their specialty may be eligible to participate.

- **Prioritize SOGI data reporting.** Without a sustained push to collect data on sexual orientation and gender identity (SOGI), inequities among LGBTQIA+ populations will remain unseen and unaddressed. To date, collecting SOGI data has not been prioritized, leading to data gaps where over 60 percent of adult electronic health records are missing SOGI data.[26]

- **Data collection practices must begin with trust-building.** As CMMI continues to require HRSN and demographic data collection throughout their models, it is important that they address patients' distrust and discomfort in disclosing such sensitive information and consider ways to require model participants to use best practices for emphatic inquiry that honors patients' dignity and builds trust.[27]

3. Are underlying resource inequities taken into account?

Background

Safety-net providers have long been underfunded for the vital services they provide in communities that have been systematically under-resourced. They serve large proportions of uninsured patients, and those covered by Medicaid and CHIP, which provide very low reimbursement.[28] These structural underinvestments are an ongoing driver of health inequities.[29] Without sufficient investment to ameliorate these ongoing resource inequities in medically underserved communities, there is a well-founded concern that value-based care will leave small, rural, and safety-net providers behind.[30]

Promising Model Features

- Targets **small, rural, independent, and safety-net providers** that have never participated in a value-based model, and offers increased learning, support, and financial resources

- Provides **upfront infrastructure payments (UIP)** that can support the provision of whole person care and wraparound services, such as:
  - Hiring or contracting with non-clinical staff, such as CHWs and certified peer recovery specialists
  - Hiring staff with training in delivering culturally and linguistically tailored services
  - Providing services to address social drivers of health, such as housing-related services for patients dealing with housing insecurity or homelessness
  - Investing in practice infrastructure, such as IT system upgrades and physical accessibility improvements

Suggested Improvements

- **A higher level of investment in UIPs.** Currently, the UIP is capped at $145,000. For some providers in chronically under-resourced communities, that may not be sufficient. A larger or more targeted UIP investment may be needed to fully integrate small and safety-net providers into value-based models.

- **Explicitly link UIPs to advancing health equity.** To better align this model with CMS's equity goals and increase accountability, participants should be required to use the UIP for meeting health equity goals as defined in their Health Equity Strategic plans.

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4. Is risk adjustment included in the model and does it effectively account for clinical and social risk?

Background

Social risk-adjusted payment is indispensable to improving health equity. It increases what providers are paid to account for the additional time and resources needed to care for people with complex medical and social needs. Not having these adjustments as part of value-based payment models creates a perverse incentive to avoid patients most in need of comprehensive care, and compromises quality for those providers who persist despite financial challenges. The absence of social risk-adjustment has hindered previous value-based payment models by implicitly prioritizing and unjustly favoring well-resourced providers in higher-income communities.[31]

Promising Model Features

- Provides prospective, or **upfront, monthly Enhanced Service Payments (ESPs)** to pay for care management, patient navigation, behavioral health, and other enhanced care coordination services, adjusted for social risk to ensure providers that serve people with higher needs receive proportionally more resources.

  - The monthly amount will vary for each beneficiary based on three factors: (1) whether the beneficiary is enrolled in the Medicare Part D low-income subsidy (LIS), (2) the Area Deprivation Index (ADI) score based on the beneficiary's residence compared to a regional reference population, and (3) the beneficiary's most recent CMS-Hierarchical Condition Categories (HCC) risk score.

- Takes into account that social risk adjustment alone will not reduce health inequities and disparities, and uses a more **comprehensive, complementary approach to advance health equity** including data collection, payment incentives, and care delivery transformation.[32]

Suggested Improvements

- **Monitor and adjust use of ADI, as appropriate.** ADI is a measure used to rank neighborhoods' socioeconomic disadvantage at the state or national level. National-level ADI can mask health and social inequities in communities with high property values and costs of living, which results in some practices in underserved communities not able to receive the additional resources needed to support high-quality care.[33] MCP uses the national ADI to generate custom regional ADI scores for MCP beneficiaries, relative to other MCP beneficiaries within their region. This customized approach is intended to avoid the aforementioned problem; however, CMS should closely monitor the impact of this customized approach and consider making changes as necessary.

- **Examine the impact of different social-risk adjustment methods.** CMMI should assess the use of ADI and other social risk factor indices and their effectiveness and impact on health equity in value-based care models. Ultimately, using individualized, self-reported demographic and social needs data is the most accurate strategy. Further research is needed to identify the most effective risk-adjustment methodologies and best practices.

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5. Does the model incorporate, support, and build on existing community-level expertise and assets?

Background

Building and maintaining strong, well-resourced partnerships with CBOs that understand the community's history, and cultural context, and hold trusting relationships with the communities they serve is instrumental in ensuring that the people most in need of improved care will access it. This is especially important for reducing health inequities. Furthermore, integrating CHWs or and other professionals with shared lived experiences into care teams can facilitate trust and the ability to identify, navigate, and address unmet health-related social needs.

Promising Model Features

- Requires ***close collaboration with CBOs and social service providers*** to address patients' HRSNs and assist them in navigating the various community supports and services that are available to them[34]

- Provides practices with less experience with **_support and tools to gradually integrate community partnership_** into their care delivery

- Provides additional resources to implement systems to make and **_track patient referrals_**

- Requires **_working with a CHW_** or someone who shares lived experience with their patients

Suggested Improvements

- **Provide resources for CBOs that serve patients referred by the primary care practice.** The MCP model does not address the fact that CBO partners will have an increased influx of referrals made by primary care practices that they may not have the resources and capacity to serve. To effectively address HRSNs, increased resources may be needed to support CBOs organizational capacity to meet greater demand.

- **Ensure bidirectional information-sharing.** Even when primary care practices screen for HRSNs and refer patients to community partners, they may never know whether their patients' needs were met. Requirements and resources to support consistent, bidirectional feedback loops between clinical providers and social support providers must be built into these models.

- **Incentivize contracting with community health workers from CBOs.** CMMI suggests that community-based care team members do not need to be employed by the primary care practice. CMMI should strongly encourage participants to contract with CBOs, where available, and include provisions that ensure that contracted CHWs are true to the community-based approach (i.e., not telephonic case managers who are unconnected to the community).[35]

- **Provide guidance on respecting and incorporating the expertise of CBOs.** Primary care practices must ensure CBOs' perspectives and expertise are heard and respected, and meaningfully inform decision-making around patient and community needs.

6. Does the evaluation of the model include measures to assess its impact on advancing equity or exacerbating inequities, including any unintended consequences?

Background

For a payment model to be considered value-based, payment should be tied to performance measures that reflect outcomes and patient experience. An equity-centered value-based model should directly hold providers accountable for reducing inequities via performance measures based on disaggregated demographic data. Further, addressing long-standing inequities takes time, and the short lifespan of many CMMI models has made it impossible to assess their medium-term impacts on the way providers deliver care or on quality outcomes.

Promising Model Features

- The **performance measure set** offers providers an opportunity to receive incentive payments for demonstrating strong and improved performance on specific measures, such as:

  - Controlling hypertension and diabetes – common chronic conditions with the starkest racial disparities

  - Screening for Social Drivers of Health measure, which focuses on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety[36]

  - Screening for Depression and Follow-up Plan

  - Patient-Reported Outcome Performance Measures (described on page 6)[37]

- The model is **planned to last for a full 10.5 years**, making it one of the lengthiest CMMI models. The longer time horizon can potentially help resolve some of the challenges prior models have experienced in achieving measurable, transformational change, and also allows for refinement over time.

Suggested Improvements

- **Include outcomes-focused equity measures.** CMMI describes the Screening for Social Drivers of Health measure as a health equity measure, and it is the only equity-related measure tied to financial incentives. While reporting the percentage of patients who are screened for HRSNs is necessary and important to identify inequities, greater efforts to measure and incentivize equitable outcomes should be employed.

- **Require stratification of quality measures.** Just as providers will be incentivized and rewarded for improving their performance on quality measures for their patient populations overall, participants should similarly be rewarded for closing gaps in health outcomes by race, ethnicity, disability, and other demographic factors. CMS should require and incentivize the routine stratification of quality measures.

- **Tie payment to the reduction of inequities.** Over time, with better data collection and standardization, routine stratification of quality measures, and more experience in equity-centered value-based models, CMMI must progressively increase the weight of inequity reduction in payment calculations.

- **Consider additional health equity accountability mechanisms.** Providers can also be encouraged to reduce health inequities through non-financial incentives including transparency efforts such as public recognition programs for high or low performers.[38]

- **Strengthen performance measurement.** Given the length of the model, CMMI indicates that as new and innovative ways to measure quality and performance become available, they may update measures over time. It is essential that CMMI consider implementing stronger performance measurement directly tied to advancing health equity.

7. Are the individuals and communities most affected included in the design, implementation, and evaluation of the model?

Background
CMMI is actively working to collaborate more closely with beneficiaries and patient and consumer advocacy groups, to ensure their needs and priorities inform model development and evaluation, and to ensure improved outcomes that are meaningful to beneficiaries, such as better experiences, better quality, and greater affordability.[39]

Promising Model Features
- Provides resources to **build connections with community-based organizations**, which is integral to the success of the design and implementation of the model

- Requires **reporting on the Person-Centered Primary Care Measure**, which recognizes the patient as an expert on many important aspects of primary care and supports personalized care

Suggested Improvements

- **Include requirements and guidance for patient and community engagement.** The model lacks any requirement for providers to seek meaningful input from patients and communities on organizational and care delivery changes that matter to them, such as HRSNs strategies or the health equity plan. CMMI should provide guidance, especially to smaller practices, and technical assistance to select states on meaningful and inclusive engagement.

- **Include resources for inclusive and robust patient and community engagement.** There are no additional resources or guidance to use the UIP to support the necessary infrastructure to facilitate meaningful partnership with patients and communities in practice redesign, implementation, and evaluation. Investment and accountability are needed to create structures and opportunities to listen to patients and communities with the goal of trusting and incorporating their lived experience and expertise.

Looking Ahead

Primary care is the backbone of our health care system and a key lever to advance health equity. We applaud CMMI for launching this unprecedented investment in primary care through the Making Care Primary model. The 10.5-year window offers an opportunity to continue to adjust and refine the model, and we are eager for ongoing collaboration with patient and consumer advocates on how to maximize the impact on health equity and respond to beneficiary experience and feedback.

The promise of MCP and the potential for population-based primary care payment models to advance health equity will not be fully realized unless adequate investment to support better data collection and equitable care delivery is provided, explicit incentives to reduce inequities are implemented, and meaningful partnership with patients and communities is well-resourced and prioritized.

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national partnership for women & families

About the National Partnership

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to achieving equity for all women. We work to create the conditions that will improve the lives of women and their families by focusing on achieving workplace and economic equity, and advancing health justice by ensuring access to high-quality, affordable, and equitable care, especially for reproductive and maternal health. We are committed to combatting white supremacy and promoting racial equity. We understand that this requires us to abandon race-neutral approaches and center the intersectional experiences of women of color to achieve our mission.

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