HEALTH EQUITY TASK FORCE

FOR DELIVERY & PAYMENT TRANSFORMATION

Summary Matrix

Six Domains of Policy Options to Drive Health Equity through System Transformation

Sinsi Hernández-Cancio, Ellen Albritton, Eliot Fishman, Sophia Tripoli, and Andrea Callow

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DOMAIN	OPTION	SUB-OPTION		FEDERAL	STATE	PRIVATE/ LOCAL
1. Payment Systems that Sustain and Reward High-Quality, Equitable Health Care	**1.1 Reform New Medicare, Private Insurance, and Medicaid Payment Models**	**1.1A**	Incorporate robust risk adjustment for social risk factors into all or some risk-based payment programs	Ⓕ	Ⓢ	Ⓟ
		1.1B	Incentivize or require that payment models' quality and cost incentives explicitly include equity measures, both in Medicare and in Medicaid.	Ⓕ	Ⓢ	
		1.1C	Ensure that cost reduction is not overly emphasized; and prioritize access, quality, and, in particular, equity for Medicaid value-based payments and other models that disproportionately serve people of color and other disadvantaged populations.	Ⓕ	Ⓢ	
		1.1D	Make changes to ACO requirements at the federal and state level, including requiring input from communities of color in state planning processes of ACOs, and require ACOs to have a disparities reduction plan with corresponding metrics.	Ⓕ	Ⓢ	
		1.1E	Encourage the spread of All-Payer Hospital Global Budget models, with strong incentives for health equity and an emphasis in governance on communities of color.		Ⓢ	Ⓟ
		1.1F	CMMI should issue a call for proposals linked to technical assistance support for Medicaid models, multi-payer models including Medicaid, and/or models driven/led by Federally Qualified Health Centers (FQHCs) and other essential community providers.	Ⓕ		

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1. Payment Systems that Sustain and Reward High-Quality, Equitable Health Care	**1.2 Build Improvements to Care Delivery into New Payment Models**	**1.2A**	Incentivize or require that payment models include a minimum mandatory set of equity-focused care delivery reforms, when appropriate, such as requiring that federal and state programs: Implement or improve clinical-community linkages; Use community health workers and similar community care team members; and Implement some or all patient-centered medical home criteria.	Ⓕ	Ⓢ	
		1.2B	Require CMMI and state-level Medicaid or multi-payer payment reform initiatives to collect input from a diverse group of consumer advocates, community providers, and other key stakeholders during the Request for Information/early design phase, the Technical Expert Panel/application phase, and the evaluation design phase of new models to ensure that health disparities experienced by communities of color are appropriately accounted for in the efforts to move toward value-based payment models.	Ⓕ	Ⓢ	Ⓟ
		1.2C	Direct CMMI and state-level Medicaid or multi-payer payment reform initiatives to prioritize the scaling of existing models, and continuous development of new models, involving delivery system reforms focused on primary care, medical homes, and the integration of physical health with behavioral health and/or oral health	Ⓕ	Ⓢ	Ⓟ
		1.2D	Direct CMMI and state-level Medicaid or multi-payer payment reform initiatives to prioritize the implementation and scaling of models specifically designed to minimize the health impacts of adverse social determinants of health (e.g. housing, food insecurity), such as the Accountable Health Communities model or the Oregon CCO program.	Ⓕ	Ⓢ	Ⓟ
		1.2E	Encourage state Medicaid programs to take advantage of existing opportunities to fund supportive housing services and evidence-based housing-first models.		Ⓢ	

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1. Payment Systems that Sustain and Reward High-Quality, Equitable Health Care	**1.2 Build Improvements to Care Delivery into New Payment Models**	**1.2F**	Incentivize or require ACOs and similar entities to seek out and include representation from communities of color in governance structures and patient or community advisory boards.	Ⓕ	Ⓢ	Ⓟ
		1.2G	Incentivize or require ACOs and similar entities to include safety net and key community providers in their structures so that these providers' unique and important perspectives are not left out of health system transformation efforts	Ⓕ	Ⓢ	Ⓟ
	1.3 Incentivize Needed Care within Fee-For-Service	**1.3A**	Establish equity in reimbursement for these services, including by reducing payment for specialist services and by increasing payment for primary care or expanding the types of these services that can be reimbursed by Medicare, Medicaid, and Qualified Health Plans (QHPs).	Ⓕ	Ⓢ	Ⓟ
		1.3B	Address the barriers to greater uptake (for both providers and patients) of chronic care management, transitional care management, and similar existing reimbursable services.	Ⓕ	Ⓢ	Ⓟ
		1.3C	Expand the geographic areas and services eligible for telehealth reimbursement across all payers and remove other regulatory barriers to using telehealth	Ⓕ	Ⓢ	Ⓟ
		1.3D	Remove regulatory and administrative barriers to integrating physical health care with behavioral health and oral health care, such as billing and EHRs	Ⓕ	Ⓢ	
		1.3E	Move to fee-for-service payment and provider organization systems in which a single organization and provider is identified as a health or medical "home," responsible for coordination of services across primary care and specialty settings including oral and behavioral health, patient education regarding management of chronic or post-acute conditions, and connection to social service agencies as needed for benefits and eligibility support, housing, and food insecurity	Ⓕ	Ⓢ	Ⓟ

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2. Investing to Support Safety Net and Small Community Providers in Delivery System Reform	**2.1 Continue DSRIP with Safety Net and Small Community Provider Requirements**	**2.1A**	Continue large DSRIP s for states and create mechanisms for states without public hospital networks to participate.	Ⓕ		
		2.1B	Require DSRIP programs to incorporate the same requirements as outlined above for other payment models for measurement and inclusion of communities of color and safety net and community providers.	Ⓕ	Ⓢ	
	2.2 Establish a Targeted Medicaid Waiver to Support Safety Net and Small Community Providers			Ⓕ		
	2.3 Establish a New CMMI Program to Support Safety Net and Small Community Providers			Ⓕ		
	2.4 Expand Medicare MACRA Implementation Support for Small, Underserved, and Rural Practices			Ⓕ		

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3. Building Robust and Well Resourced Community Partnerships	**3.1 Focus Payment and Delivery Reform Models/ Waivers on Incentivizing Community Partnerships**	**3.1A**	Direct CMMI to prioritize the implementation and scaling of models specifically designed to minimize the health impacts of negative social determinants of health (e.g. housing, food insecurity) and that prioritize community partnerships as a key feature of the model, such as the Accountable Health Communities model's "Alignment Track."	Ⓕ		
		3.1B	Incentivize or require ACOs and similar entities to seek out and include representation from communities of color in governance structures and patient or community advisory boards.	Ⓕ	Ⓢ	Ⓟ
		3.1C	Require Medicaid managed care plans to contract with CBOs for appropriate social services, and for outreach, engagement, education, assessment, and follow-up services.	Ⓕ	Ⓢ	
		3.1D	Independently from federal or state requirements, work with local Medicaid Managed Care Plans so they collaborate with CBOs in providing a broad range of services to their members			Ⓟ
		3.1E	Direct CMMI to develop a State Innovation Model (SIM)-like model that is explicitly focused on health equity to assist in the creation of regional planning organizations or other infrastructure to help health systems and community-based organizations coordinate their efforts.	Ⓕ		
		3.1F	Require state Medicaid offices to develop, pilot, and scale models that require significant input and engagement with CBOs.	Ⓕ	Ⓢ	

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3 Building Robust and Well Resourced Community Partnerships	**3.2 Strengthen and Expand Community Benefit Requirements**	**3.2A**	Require all non-profit hospitals and health plans, including Medicaid managed care organizations, to meet Community Benefit requirements.	Ⓕ	Ⓢ	
		3.2B	Require adopting Community Benefit programs as a condition for state Medicaid Disproportionate Share Hospital (DSH) participation.	Ⓕ	Ⓢ	
		3. 2C	Establish a minimum percentage of a non-profit hospital's Community Benefit OR for all hospitals a total budget that must be invested in programs specifically targeted at reducing health disparities by addressing root causes.	Ⓕ	Ⓢ	
		3.2D	Strengthen requirements for the inclusion of community members, particularly those from marginalized communities, in the CHNA process and implementation of Community Benefit programs.	Ⓕ	Ⓢ	
	3.3 Incentivize/ resource Infrastructure Required to Enable Seamless Coordination between Health Systems and Providers and Community-based Resources	**3.3A**	Building on the Beacon Communities, Community Interoperability and Health Information Exchange grants, and other now-closed federal grant opportunities, set up regional IT hubs that under-resourced CBOs providing services can plug into. Include grants for the installation and deployment of these systems and training	Ⓕ	Ⓢ	
		3.3B	Incentivize the multi-purposing and leveraging of existing community infrastructure in addition to CBOs, such as faith-based organizations, schools, and recreation centers.	Ⓕ		Ⓟ

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3 Building Robust and Well Resourced Community Partnerships	**3.4 Incentivize/ require Health Care Providers to Recruit Actively from Their Communities and Contract with Businesses in Their Communities to Provide Needed Services and Supplies**	**3. 4A**	Establish local business contracting programs for health systems.		Ⓢ	Ⓟ
		3.4B	Create outreach/recruiting programs to hire from the community.		Ⓢ	Ⓟ
		3.4B	Create work force development partnerships with schools, community colleges, owners/managers of affordable housing, etc.		Ⓢ	Ⓟ
4 Ensuring a Transparent and Representative Evidence Base	**4.1 Mandate Improved Reporting and Analysis of Demographic Characteristics in Clinical and Delivery Systems Research and Evaluation**	**4.1A**	Require public reporting of the racial and ethnic composition of people enrolled in clinical trials and other research.	Ⓕ		
		4.1B	Require additional notice be given if the effectiveness of any given treatment or intervention was determined based on studies involving homogenous groups.	Ⓕ		
		4.1C	Incentivize researchers and evaluators to analyze their data by race and ethnicity in addition to any other key demographic characteristics that are available, unless statistically inappropriate.	Ⓕ	Ⓢ	
	4.2 Support the Generation of More Community-Specific Health System and Delivery Research	**4.2A**	Reauthorize PCORI and strengthen its mandate to address health inequities, including prioritizing the evaluation of non-clinical, complementary, and community-driven interventions.	Ⓕ		

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4 Ensuring a Transparent and Representative Evidence Base	**4.3 Improve the Translation and Dissemination of Evidence to Decisionmakers, Practitioners, and Communities**	**4.3A**	Require all federally-funded research into health outcomes, new treatments for conditions that disproportionately affect and are high priorities for communities of color and other disparity groups, health care quality, and delivery reform to create dissemination plans and plain-language summaries of all results that are housed in a user-friendly website.	Ⓕ		
		4.3B	Establish funding streams to support community and consumer groups as partners in evidence translation and dissemination in their communities.	Ⓕ	Ⓢ	Ⓟ
	4.4 Ensure Appropriate Use of Evidence in Treatment Guidelines and Reimbursement	**4.4A**	Require all federally-funded medical research on human subjects to indicate the breakdown of their key characteristics by, at a minimum. sex, age group, race, ethnicity, and disability.	Ⓕ		
		4.4B	Require all federally-funded medical research on human subjects to clearly indicate where there are significant variations in results by sex, age group, race, ethnicity, and disability and identify additional research questions needed to better understand them.	Ⓕ		
		4.4C	Require clinical guidelines to clearly indicate when there are significant variations in outcomes based on sex, age group, race, ethnicity, and disability to allow for the appropriate and precise application of the guideline, and also to indicate the need for the development of guidelines specific to the group in question.	Ⓕ		Ⓟ
		4.4D	Require all payers to incorporate into medical necessity determinations any exceptions or evidence-based alternatives developed by treating providers or other appropriate health professionals.	Ⓕ	Ⓢ	Ⓟ

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5 Equity Focused Measurement that Accelerates Reductions in Health Inequities	**5.1 Require Health Care Organizations to Report Performance Data Stratified by Race, Ethnicity, Language, Socioeconomic Status, Sex, Gender Identity, Sexual Orientation, Disability, and Other Demographic Factors**	**5.1A**	Require the stratification of this data for health care organizations and providers who participate in and report performance measures in value-based programs in Medicare, Medicaid, and with commercial insurers. This data should be stratified by age, sex, race, ethnicity, and language, at a minimum, and by other demographic factors as data becomes collected and available.	Ⓕ	Ⓢ	Ⓟ
		5.1B	Require stratification of data as a condition for participating in CMMI demonstrations or grant programs.	Ⓕ		
		5.1C	Provide financial incentives for health care organizations, providers, and commercial insurers who collect and report on stratified measures.	Ⓕ	Ⓢ	Ⓟ
		5.1D	Provide upfront financial support and technical assistance to help organizations and providers build necessary capacity to collect and report stratified data.	Ⓕ	Ⓢ	Ⓟ
	5.2 Require and Incentivize Collection and Reporting of Social Risk Factor Data	**5.2A**	Implement the Office of National Coordinator for Health's 2015 IT standards for collection of patient social and behavioral risk data in EHRs, with the addition of collecting patient information regarding disabilities.	Ⓕ		
		5.2B	Incentivize or require collection of patient social and behavioral risk data through Medicare, Medicaid, and commercial insurance value-based payment programs (e.g. pay-for-reporting in MACRA, CMMI demonstrations, state Medicaid requirements, etc.)	Ⓕ	Ⓢ	Ⓟ
		5.2C	Include patient social and behavioral risk data in electronic health information exchanges.	Ⓕ	Ⓢ	Ⓟ

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5 Equity Focused Measurement that Accelerates Reductions in Health Inequities	**5.2 Require and Incentivize Collection and Reporting of Social Risk Factor Data**	**5.2D**	Support electronic health information exchange with other public assistance programs (SNAP, WIC, housing assistance, etc.) to streamline eligibility decisions and share appropriate information to support comprehensive patient-centered services.	Ⓕ	Ⓢ	
	5.3 Prioritize the Development and Use of Disparities-sensitive and Health Equity Measures	**5.3A**	Increase the number of disparities-sensitive and health equity measures that providers and plans can choose to report on in accreditation programs and in value-based programs in Medicare and Medicaid, as well as in the commercial market.	Ⓕ	Ⓢ	Ⓟ
		5.3B	Require and incentivize providers participating in all or a subset of Medicare and Medicaid value-based programs to report on a certain number of these measures.	Ⓕ	Ⓢ	
		5.3C	Require CMMI to use a minimum number of these measures to evaluate the success of demonstration projects.	Ⓕ		
		5.3D	Target existing resources, and allocate additional ones as necessary, to the development of measures in the identified gaps, with a particular focus on improving patient experience measures.	Ⓕ	Ⓢ	Ⓟ
		5.3E	Prioritize the inclusion of disparities-sensitive and health equity measures in the development of core measure sets used by various public and private initiatives.	Ⓕ	Ⓢ	Ⓟ
		5.3F	Prioritize the addition of disparities-sensitive and health equity measures when other measures become “topped-out” because of high performance and little variation, or when they are decommissioned for other reasons.	Ⓕ	Ⓢ	Ⓟ

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5. Equity Focused Measurement that Accelerates Reductions in Health Inequities	**5.4 Directly Incentivize Providers to Reduce Disparities in Performance Measures**	**5.4A**	Incorporate decreases in health disparities into the evaluation or "scoring" for providers participating in pay-for-performance or other value-based programs.	Ⓕ	Ⓢ	Ⓟ
		5.4B	Establish an additional financial bonus (above normal scoring and payment adjustment methodologies) for providers who perform exceptionally well on reducing disparities.	Ⓕ	Ⓢ	Ⓟ
6. Growing a Diverse Health Care Workforce that Drives Equity and Value	**6.1 Increasing the Diversity of Health Care Providers and Health System Leaders**	**6.1A**	Expand K-12 "pipeline" programs to ensure academic readiness and entryways into health care professions for more people from under-represented groups.	Ⓕ	Ⓢ	Ⓟ
		6.1B	Increase the amount of loan repayment, loan forgiveness, and other financial incentives available for health care providers from under-represented groups and/or to providers who practice in health professional shortage areas, such as through the National Health Service Corps and various state initiatives.	Ⓕ	Ⓢ	
		6.1C	Increase availability of Graduate Medical Education or other support for Teaching Health Centers and other training opportunities in underserved communities to train medical residents.	Ⓕ	Ⓢ	
		6.1D	Require state health profession licensing boards (for physicians, nurses, dentists, etc.) to collect demographic data on recipients of licenses.		Ⓢ	Ⓟ
		6.1E	Require health care organizations to publically report on the diversity of their workforce, leadership, and board.	Ⓕ	Ⓢ	

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6. Growing a Diverse Health Care Workforce that Drives Equity and Value	**6.1 Increasing the Diversity of Health Care Providers and Health System Leaders**	**6.1F**	Provide direct financial incentives for health care organizations to hire and retain health care providers and organizational leaders from under-represented groups, with a particular focus on hiring those individuals from the health organization's own community.	Ⓕ	Ⓢ	
		6.1G	Require or incentivize health care systems to have members of under-represented groups serve in senior leadership positions and as board members.	Ⓕ	Ⓢ	
		6.1H	Establish leadership development programs for clinicians of color to be prepared for trustee board and executive positions in the systems that serve their communities.			Ⓟ
	6.2 Promoting the Sustainable Use and Integration of Community Health Workers (CHWs) and Similar Community Care Team Members	**6.2A**	Remove regulatory barriers at the state level that may be an impediment to increasing the growth and reach of this workforce, or integrating them into the health care system		Ⓢ	
		6.2B	Establish claims payment for CHWs and similar community-based care team members for effective services in traditional fee-for-service Medicaid, Medicare and/or other payment models.	Ⓕ	Ⓢ	Ⓟ

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6. Growing a Diverse Health Care Workforce that Drives Equity and Value	**6.2 Promoting the Sustainable Use and Integration of Community Health Workers (CHWs) and Similar Community Care Team Members**	**6.2C**	Require Medicaid managed care plans (in state contracting) and/or QHPs (in federal or state contracting, depending on the state) to make CHWs and similar community-based care team members and their highly effective services available to their members, by, for example: Specifying which services, at a minimum, they must be available to provide;Including provisions that ensure that contracted CHWs or similar community-based care team members are true to the community-based approach, including spending a significant percentage of their time in the community, outside of the clinic or hospital setting (i.e., not telephonic case managers who are unconnected to the community); andEstablishing a minimum ratio of CHWs or similar community-based care team members to people enrolled in their plan, as well as standards for geographic coverage and distribution.	Ⓕ	Ⓢ	
		6.2D	Build CHWs or similar community-based care team members into the design of Medicaid waivers or other Medicaid value-based payment programs.	Ⓕ	Ⓢ	
		6.2E	Build CHWs or similar community-based care team members into the design of broad CMMI value-based models.	Ⓕ		
		6.2F	Design a CMMI model to specifically test the best models for integrating CHWs and other community-based care team members into the health care system.	Ⓕ		

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6. Growing a Diverse Health Care Workforce that Drives Equity and Value	**6.3 Promoting the Use and Integration of Midlevel Providers**	**6.3A**	Change state legislation and regulations regarding scope of practice, licensing, prescribing, and supervision to allow more midlevel providers to practice at their highest level.		S	
		6.3B	Establish payment or increasing payment rates for these providers in traditional fee-for-service payment models.	F	S	P
		6.3C	Require Medicaid managed care plans (in state contracting) and/or QHPs (in federal or state contracting, depending on the state) to include these providers in their networks.	F	S	
		6.3D	Build midlevel providers into the design of Medicaid waivers or other Medicaid value-based payment programs.	F	S	
		6.3E	Build midlevel providers into the design of broad CMMI value-based models.	F		
		6.3F	Design a CMMI model to specifically test the best models for integrating more midlevel providers into care teams.	F		
		6.3G	Increase the amount of loan repayment, loan forgiveness, and other financial incentives available for midlevel providers from under-represented groups and/or to providers who practice primary care in health professional shortage areas, such as through the National Health Service Corps and various state initiatives.	F	S	

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1225 New York Avenue NW, Suite 800 | Washington, DC 20005 | 202-628-3030 | info@familiesusa.org
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