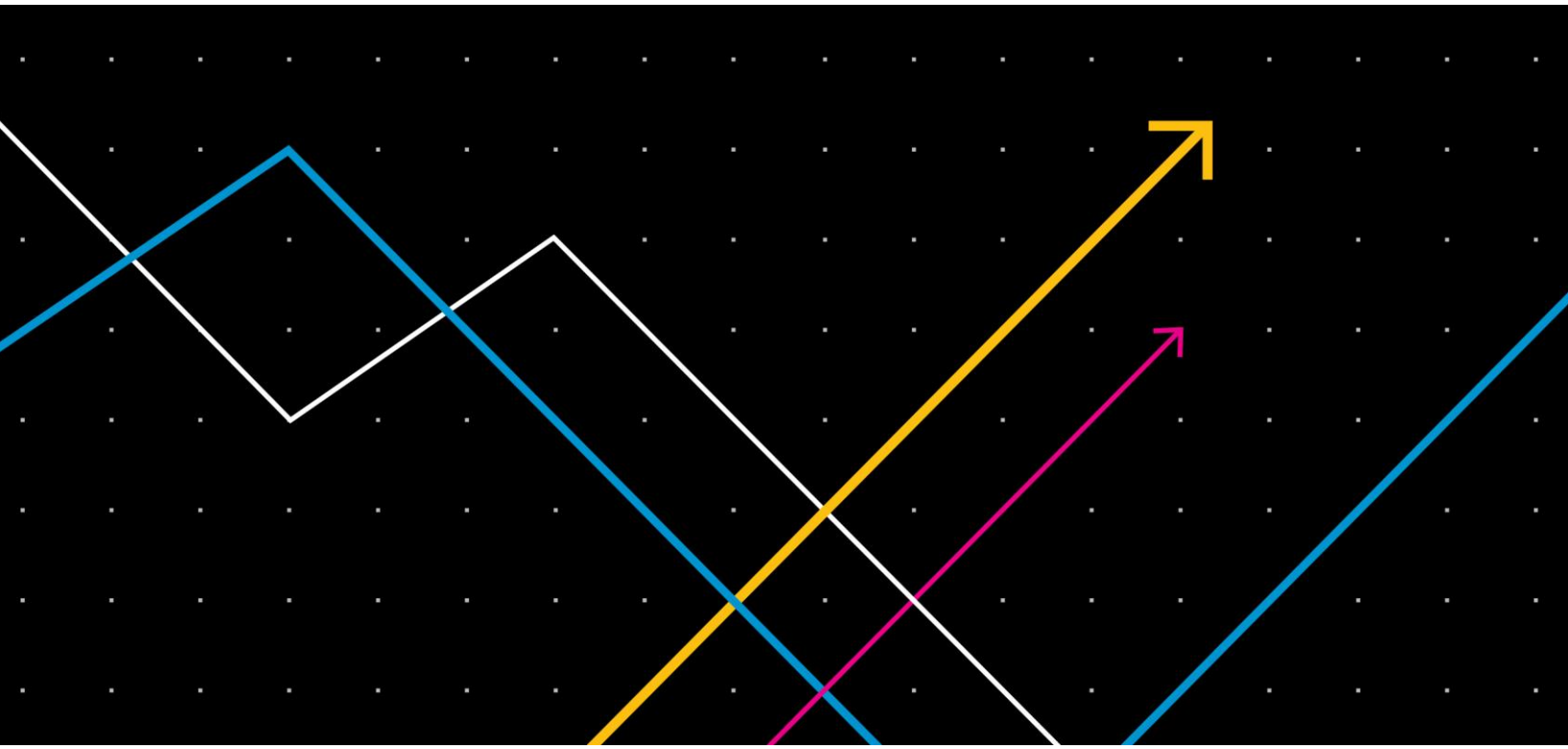

RESEARCH REPORT

Can Medicaid Payment and Purchasing Strategies Advance Health Equity?

Key Considerations, Limitations, Lessons, and Examples from Four States

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Can Medicaid Payment and Purchasing Strategies Advance Health Equity?

The landmark 2003 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* brought national attention to shocking racial and ethnic disparities in access to and quality of health care (IOM 2003). Among other findings, the study concluded that the way health care services are delivered and financed, such as through Medicaid, may contribute to racial and ethnic disparities in access to health care (IOM 2003). Though disparities in access and quality of health care occur across the US health care system, Medicaid is the nation's largest public health insurer, covering one in five US residents, who are disproportionately people from racial and ethnic minority groups (Guth et al. 2023; Radley at al. 2021).[1] We do not have a complete understanding of disparities in the Medicaid program, largely due to the absence of consistent and complete data on members' race and ethnicity, but available evidence suggests that Medicaid members from racial and ethnic minority groups experience more barriers to care and have worse health outcomes than white Medicaid members (GIH and NCQA 2021; MACPAC 2021). Policy analysts have been increasingly calling on Medicaid to use available levers and authorities to reduce persistent racial and ethnic health disparities (Chen and Ghaly 2022; Dihwa, Shadowen, and Barnes 2022; MACPAC 2022b).[2] Because of its large footprint in the US health care system and importance as a source of coverage for people at high risk of experiencing health disparities, Medicaid policies and initiatives have the potential for a big impact on advancing health equity.

This report examines the potential of Medicaid payment and purchasing strategies to advance equity, such as by managed care contracting, benefit and delivery model design, payment reforms, and Section 1115 waiver demonstrations. Inspired by the Robert Wood Johnson Foundation, we broadly define equity as conditions under which every Medicaid member—regardless of their health status, geographic location, sexual orientation and gender identity, or demographic background—is able to access health care services, receive high quality and culturally effective health care, and achieve optimal health and well-being.[3] Equity essentially requires holistic care that recognizes and addresses each person's unique health care and social care needs. We analyzed published literature and conducted interviews with Medicaid policy experts and stakeholders in four states to understand how payment and purchasing strategies could promote equity in Medicaid. Minnesota and Ohio explicitly center

health equity goals in their newly developed payment and purchasing strategies, while North Carolina's and Oregon's efforts predate the recent focus on health equity but have the potential to promote greater health equity by virtue of addressing systemic barriers to health. Across these four states, we identified several common themes and key considerations in developing effective purchasing and payment approaches for reducing health disparities in Medicaid:

- Payment and purchasing strategies may not always have explicit health equity focus, but strategies that support holistic care and direct resources to the most underserved Medicaid members hold promise for reducing disparities.
- Advances in Medicaid health equity interventions may be supported by clearly defining roles and expectations while allowing sufficient flexibility to promote innovation.
- Stakeholder engagement, including meaningful Medicaid member engagement, is increasingly prioritized in facilitating collaboration and developing and continuously improving interventions that effectively identify and address disparities.
- Infrastructure investments—including adequate provider payments and support for capacity building, effective information exchange, and improvements to Medicaid operations and data systems—are fundamental to operationalizing and sustaining health equity interventions.
- Though often not prioritized, evaluation of Medicaid health equity initiatives is essential given the gaps in evidence for which interventions are effective for reducing disparities.

In the remainder of this brief, we describe our methods and provide background on the Medicaid program and available Medicaid authorities that states can use to reduce disparities in the health care and health of Medicaid members. We then describe key features of select Medicaid payment and purchasing initiatives in Minnesota, North Carolina, Ohio, and Oregon and discuss promising mechanisms and caveats for how these state efforts could reduce health disparities. We then present key takeaways from these initiatives and their implications for Medicaid policy and practice.

Unequal Treatment at 20

This work is part of a series of publications that commemorates the 20th anniversary of the 2003 Institute of Medicine report, U*nequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. This report found that people of color received lower-quality health care than white patients, even when access-related factors were held constant. Two decades later, we still observe the same inequities, which has motivated thought leaders to imagine how to redesign the health care system so it works equitably.

Research Methods

In the fall of 2022, we reviewed literature published throughout the previous decade on payment reform, alternative payment programs, purchasing levers in Medicaid, and the implications such initiatives have on health equity. We identified (1) managed care contracting, (2) benefits and care delivery model design, (3) payment reforms, and (4) Section 1115 waiver demonstrations as the main financing mechanisms to explore further. We then conducted six interviews with Medicaid policy experts to learn more about the strengths and weaknesses of using Medicaid purchasing in advancing health equity and to identify promising state initiatives to study in more detail. The community advisory board for a project of the Urban Institute Health Policy Center funded by the Robert Wood Johnson Foundation informed the key research questions and direction of the project. Based on the literature review and input from national experts and advisory board members, we selected Minnesota, North Carolina, Ohio, and Oregon as case study states because of their unique purchasing and payment strategies in the four key areas that were explicitly focused on health equity or could promote health equity by virtue of addressing systemic barriers to health.

Between December 2022 and April 2023, we conducted 11 interviews with 21 stakeholders across the four states, including Medicaid officials, health plan representatives, providers and provider representatives, and consumer advocates. We identified informants through a review of relevant publicly available information on each initiative and through our professional networks, and we used a snowball technique whereby interviewees provided recommendations for other stakeholders to include in the study. Interview topics included key features of Medicaid purchasing and payment strategies; how equity goals are defined and measured; and successes, challenges, and lessons learned from state efforts to advance equity in Medicaid. We recorded and transcribed the interviews and conducted a thematic analysis of the notes to identify key insights. We supplemented our interview findings with a review of relevant and publicly available Medicaid policy documents. The study protocols were approved by Urban Institute's Institutional Review Board, and study participants were assured of confidentiality; therefore, statements are not attributed to individuals by name.

Because we interviewed a relatively small number of informants, we may have missed some perspectives in our analysis. Further, we focused on policy and program design, and while we gathered some higher-level perspectives on the implementation of various interventions, this study did not examine implementation process and progress in detail. Our findings cannot be generalized across all state Medicaid programs. The existing evidence to assess whether various Medicaid purchasing and payment strategies reduce disparities is limited and inconclusive. Our findings and conclusions should therefore be interpreted with these limitations in mind.

Why Medicaid and What Are Medicaid Payment and Purchasing Powers?

The COVID-19 pandemic and racial justice movement have increased national attention to systemic barriers to optimal health and racial and ethnic disparities in access to and quality of health care services and health outcomes (Bailey, Feldman, and Bassett 2021).[4] Regardless of a person's socioeconomic status or type of insurance coverage, people from racial and ethnic minority groups are more likely to have less access to health care, experience poor-quality care, and have worse health outcomes than white Americans (AHRQ 2022; Baciu et al. 2017; Radley at al. 2021). Medicaid in particular has been increasingly highlighted as an important player in advancing health equity because the program disproportionately serves populations from racial and ethnic minority groups (Chen and Ghaly 2022; Dihwa, Shadowen, and Barnes 2022; MACPAC 2022b; Michener 2022). For example, about 19 percent of all Medicaid members were Black / African American in 2021, higher than the 13 percent of the US population identifying as Black or African American.[5] In particular, more than half of children who are American Indian / Alaska Native, Black / African American, Hispanic/Latinx, and Native Hawaiian or Other Pacific Islander are covered by Medicaid (Guth et al. 2023). People from racial and ethnic minority groups are more likely to experience poverty and rely on Medicaid than white people because of racist policies that continue to exclude nonwhite Americans from educational and employment opportunities and wealth (Bailey, Feldman, and Bassett 2021; Braveman et al. 2022).[6] Similar to inequities observed in the broader health care system, the available evidence demonstrates persistent racial and ethnic disparities in access to and quality of care and health outcomes of people covered by Medicaid (MACPAC 2021; Radley at al. 2021).

An important level-setting is to acknowledge that inequity has been a part of the Medicaid program from its inception and continues to shape the program today (Goyan et al. 2023; Somers and Perkins 2022). Though both Medicare and Medicaid were established in 1965 under the Social Security Act,[7] Medicare is administered by the federal government while Medicaid was created as an optional jointly funded program that gives states control over their programs, including the eligibility rules (Goyan et al. 2023; Somers and Perkins 2022). As a result of racial politics, many conservative states with a large share of racial and ethnic minority populations were slow to adopt Medicaid, have implemented very restrictive eligibility policies, and have chosen not to expand Medicaid under the Affordable Care Act, leaving an estimated 1.9 million people, of which 61 percent are nonwhite Americans, without an affordable health insurance option (Goran et al. 2023; Rudowitz et al. 2023; Somers and Perkins 2022).[8] Nearly a decade of research shows that the Affordable Care Act's Medicaid expansion contributed to reductions in racial and ethnic disparities in coverage, access to care, and health outcomes (Guth,

Artiga, and Pham 2020). Furthermore, at the time Medicaid was created, eligibility was linked to welfare programs for the elderly, blind, disabled, and mothers with dependent children, creating the stigma of "deserving poor" and fueling discrimination that is felt by Medicaid members to this day (Moore and Smith 2005; Somers and Perkins 2022).[9]

As noted above, states have considerable leeway in how they administer their Medicaid programs within the broad federal requirements, subject to approval from the Centers for Medicare and Medicaid Services (CMS). As such, state Medicaid policy decisions on matters such as who is eligible to enroll and under what conditions, what services are covered, and how they are reimbursed have tremendous potential to affect health disparities, both positively and negatively. For example, by making Medicaid coverage more attainable to individuals living below or near the poverty line, such as by increasing income limits for eligibility and simplifying enrollment processes, states can make strides in reducing disparities in health coverage and access to care.[10]

However, the federal government has often failed to enforce the Medicaid law, likely due to its complexity and concerns of federal overreach, leaving state Medicaid policies unchecked and open to lawsuits (Rosenbaum 2017, 2018; Somers and Perkins 2022). The lack of federal enforcement is particularly evident in Medicaid provider payments. By law, Medicaid programs must ensure that enrollees have the same access to covered health care services as the general population by ensuring sufficient provider payments.[11] Yet Medicaid provider payments are notoriously lower than those from other payers, which, coupled with administrative hurdles, deters providers from participation in Medicaid and in turn limits enrollees' access to health services (Alexander and Schnell 2019; Decker 2012; Dunn et al. 2023; Timbie et al. 2019; Zhu et al. 2023; Zuckerman, Skopec, and Aarons 2021).[12] States often choose not to pay providers at the same rates as Medicare or private health insurance and in fact often cut provider rates and restrict benefits to control Medicaid spending during economic downturns (Snyder and Rudowitz 2016). CMS has not adequately ensured compliance with the payment adequacy mandate and only recently began setting payment levels as part of Section 1115 waivers (Forbes 2022). But those new requirements still fall short of payment parity because states are asked to increase Medicaid provider payment rates only for primary care, behavioral health, and obstetrics care and only to at least 80 percent of Medicare rates.[13] Chronic Medicaid underfunding and low provider reimbursement rates thus remain fundamental roadblocks to achieving equity in access to and quality of care and health outcomes in Medicaid and the US in general.[14]

Medicaid Payment and Purchasing Levers

States have many available authorities to ensure that procurement and payment programs and policies make the best use of limited Medicaid resources; by considering equity in the payment and purchasing decisions, they have the opportunity to reduce health disparities in their Medicaid programs (Bailit Health 2023; Kenney et al. 2019; Manatt Health 2022; Smithey, Patel, and McGinnis 2022).[15] In this report, we examined four payment and purchasing strategies that states have at their disposal to drive improvements in health equity: (1) managed care contracting, (2) benefits and care delivery model design, (3) payment reforms, and (4) Section 1115 waiver demonstrations (table 1).

TABLE 1

Medicaid Payment and Purchasing Levers at a Glance

Examples of ways in which Medicaid purchasing and payment strategies can incorporate health equity

Strategy	Description	Authority
Managed care contracting	▪ Including contracting requirements and/or financial incentives for managed care plans to address health disparities	▪ Medicaid managed care authorities, including State Plan Amendment, Section 1915 (a) and (b) waivers, Section 1115 waiver
Benefits and care delivery model design	▪ Defining and covering expanded, nontraditional benefits that could reduce disparities, such as community health workers, doulas, and home visiting ▪ Supporting implementation of advanced and integrated delivery models focused on special populations that also experience disparities, such as enhanced chronic disease management, pregnancy care management, and services for justice-involved populations	▪ State Plan Amendment ▪ Medicaid health homes ▪ Medicaid waivers ▪ State-initiated pilots
Payment reforms	▪ Developing and testing alternative payment models or value-based purchasing models that tie payments to demonstrated reduction in health disparities ▪ Developing and implementing innovative risk-adjustment methodologies to more equitably allocate payments to providers who care for underserved populations at high risk of experiencing disparities ▪ Supporting safety-net providers through adequate and flexible payments	▪ State Plan Amendment ▪ Medicaid managed care authorities ▪ Medicaid waivers ▪ State-initiated pilots
Section 1115 waiver demonstrations	▪ Developing and testing innovative delivery programs that integrate health-related social services with health care	▪ Section 1115a of the Social Security Act

Source: Authors' analysis of Medicaid policy and guidance.

Note: Safety-net providers include community health centers and hospitals that disproportionately serve Medicaid and uninsured populations.

Managed care contracting. Rather than directly paying providers who deliver health care services, most Medicaid agencies contract with health insurance plans known as managed care organizations

(MCOs) to administer Medicaid services and develop provider networks (Hinton and Raphael 2023). Nearly three-quarters of Medicaid members were enrolled in managed care programs as of 2020.[16] State Medicaid programs therefore have the opportunity to shape the care members receive by incorporating a focus on health equity in contracts with MCOs. For example, states include requirements in managed care contracts for plans to report performance on quality metrics (such as control of diabetes or attendance at prenatal care visits) by members' race/ethnicity and other characteristics (such as language, rural/urban residence) and to develop interventions to reduce identified disparities among their members (Bailit Health 2023; Kenney et al. 2019; NCQA 2022; Taylor, Dyer, and Bailit 2021).

Other common health equity–focused managed care contracting approaches include requirements that health plans achieve National Committee for Quality Assurance (NCQA) Health Equity Accreditation; train their staff and providers on health equity, disparities, and implicit bias; facilitate the provision of culturally effective care such as on-site interpretation services; and meaningfully engage Medicaid members in developing and implementing programs and interventions (Bailit Health 2023).[17] Managed care contracting is well within the states' purview, even without the need for regulatory changes, and as such is an example of a tool that is readily available to state Medicaid agencies to advance equity (Taylor, Dyer, and Bailit 2021). At least 21 states include health equity–related provisions in their managed care contracts as of April 2023 (Bailit Health 2023).

Benefits and care delivery model design. State Medicaid agencies can also incorporate equity in their benefits and delivery system design decisions by considering how certain services or care models may improve care for members who have complex health care needs (such as multiple chronic health conditions, disabilities, or high-risk pregnancy) or face adverse circumstances (such as homelessness or incarceration) that may increase their risk of experiencing health disparities (Smithey, Patel, and McGinnis 2022). For example, states have been expanding benefits to address disparities in maternal and infant health, such as by increasing access to an evidence-based midwifery model of care and doulas or by expanding Medicaid postpartum coverage (Artiga et al. 2020). Growing evidence suggests that community health workers (CHWs) are effective in providing community-based and culturally effective health promotion and navigation services and improving health outcomes, including among Medicaid members and underserved populations (CDC 2014; Landers and Levinson 2016; Vasan et al. 2020). But only 29 states cover CHW services in their Medicaid programs (Haldar and Hinton 2023). Furthermore, Medicaid agencies can support high-quality and equitable primary care, for example by more explicitly centering health equity in existing advanced primary care models such as the patient-centered medical home (Wong et al. 2012).[18] This could include requiring improved collection of patient self-reported

race/ethnicity and other critical demographic data, using these data to identify and close disparities, ensuring language access through translation and interpretation services, and partnering more effectively with patients in quality improvement and equity-focused initiatives.[19]

Payment reforms. The US health care system has been increasingly moving away from the traditional reimbursement model, also known as fee-for-service, that pays providers depending on how many services they deliver, which may incentivize delivering a high volume of care (i.e., more services to more patients) while not focusing on medical necessity or quality of care. In contrast, value-based purchasing or alternative payment models rest on the premise that the amount of payment providers or health plans receive depends on their performance in meeting predefined goals such as improved process (e.g., collection of patients' race and ethnicity data), quality (e.g., timeliness of follow-up treatment), or cost of care (e.g., reductions in avoidable hospitalizations).[20] Medicaid programs too have been implementing value-based payment strategies, for instance by requiring MCOs to implement alternative payment models in their networks and by developing state-designed provider payment models (Bailit Health and NAMD 2016). These payment reforms may take various forms, such as additional payments to providers (e.g., a per member per month [PMPM] fee) to support infrastructure improvements, or provision of services that are typically not reimbursable, such as case management (Bailit Health and NAMD 2016).

Another common value-based strategy in Medicaid includes population-based payments where providers are responsible for care they deliver to a specific population within a specific spending target or capped budget, which provides both incentives and flexibility to allocate resources where they are most needed to improve the overall quality of care (Bailit Health and NAMD 2016). States often use population-based payments for accountable care organizations (ACOs), which are groups of health care providers that work together to deliver coordinated care to patients.[21] Payment reforms thus present another opportunity for states to more explicitly center equity in the design of value-based payment models, such as by tying incentive bonuses to reductions in disparities on specific quality measures.[22] Equity-centered payment models should recognize the high needs of certain populations to avoid penalizing providers who care for patients facing complex chronic health issues or adverse circumstances that may negatively affect their outcomes. This can include assessing providers' improvements against their own historical data instead of comparing them with other providers, or adjusting performance targets for providers who care for populations that disproportionately experience high health and social risks (SHADAC 2020).[23]

Section 1115 waiver demonstrations. Finally, Section 1115 waiver demonstrations allow states to receive federal matching funds to develop, test, and evaluate innovative delivery and payment

approaches that may otherwise not be possible in a standard Medicaid program, such as for services and populations not included in the Medicaid state plan.[24] Nearly all states use 1115 demonstration projects to implement changes in eligibility, benefits, provider payments, and other aspects of their programs or to implement more narrowly defined and targeted interventions for certain populations, such as justice-involved populations or people with mental health and substance use conditions.[25] In recent years, CMS waiver policy and guidance have made it increasingly easier for states to pursue demonstrations that propose to identify and address Medicaid members' health-related social needs and address health disparities.[26] For example, CMS is allowing states to use Medicaid funding for evidence-based services that address health-related social needs such as housing, nutrition assistance, and transportation, as well as for developing capacity to effectively deliver these services to Medicaid members (Hinton 2023). By prioritizing health-related social needs services for high-need Medicaid members, such as people experiencing homelessness and those in incarceration, these demonstrations have the potential to improve equity among systematically underserved populations. For example, Oregon's Section 1115 waiver offers up to six months of food and housing assistance (including rent) for people experiencing destabilizing life transitions, such as people discharged from mental health institutions, youth involved with the child welfare system, and people affected by extreme weather events (OHA 2022). However, 1115 waivers represent an opportunity to advance health equity in Medicaid, which may be the hardest for states to implement because they require approvals from state legislatures and CMS.

While the payment and purchasing strategies are distinct, they often overlap or are used in combination to achieve specific goals. For example, managed care contracts may include requirements for health plans to make a specific share of provider payments through value-based arrangements. Delivery-system reforms are often accompanied by supplemental payments to allow providers to build capacity for practice transformation, such as upgrading their information systems or hiring new staff. Similarly, Section 1115 waiver demonstrations may include new requirements for MCOs, delivery model changes, and payment reforms, all aligned to support health care transformation goals.

Before diving more deeply into examples of how these strategies are used in practice, note that evidence on the effectiveness of these policies in reducing disparities is limited at best and that if not carefully designed and monitored, some strategies could worsen disparities instead of reducing them (Kenney et al. 2019). For example, some research suggests that value-based payment models, where providers are held accountable for certain outcomes, may exclude most underserved populations from the interventions and unfairly penalize safety-net providers, who are more likely to care for patients with complex medical and social risks and poor health outcomes (Chen et al. 2017; Gondi, Maddox, and

Wadhera 2022; Navathe and Liao 2022; Yasaitis et al. 2016). Furthermore, as discussed earlier, Medicaid payment and purchasing programs may not be as impactful in promoting equitable access and quality of care if provider payment levels remain much lower than Medicare or private insurance payment rates. Some critics argue that directing scarce Medicaid dollars to address social determinants of health adds complexity to an already underfunded and strained system and that the resources would be better used by paying providers at Medicare or private insurance reimbursement levels to ensure broad access to health care services.[27] CMS attempts to ensure that funding for health-related social services does not encroach on Medicaid's obligation to provide basic health care by imposing a cap on health-related social needs waiver funding and by requiring, as a condition of approval, that primary care, behavioral health, and obstetrics provider rates are at least 80 percent of Medicare rates.[28] But only time—and evaluation—will tell how effective these protections will be in ensuring access to comprehensive health care services for Medicaid enrollees.

Payment and Purchasing Strategies in Four State Medicaid Programs That Could Advance Equity

In this section, we examine the experiences of four diverse state Medicaid programs that implemented different approaches with the potential to reduce health disparities. Ohio has developed an innovative approach to driving health equity through collective managed care strategies. Minnesota is explicitly prioritizing equity in its longstanding Integrated Health Partnership (IHP) initiative, an accountable care organization–like delivery system in which participating providers are accountable for the cost and quality of care delivered to Medicaid members. Oregon has had more than a decade of experience attempting to shore up its safety net through an alternative payment approach for community health centers to promote high-quality, holistic care. And North Carolina is using Medicaid funds to pay for social services as part of the first-of-its-kind Section 1115 waiver demonstration aiming to better address health-related social needs of eligible Medicaid members.

Two states—Ohio and Minnesota—explicitly center health equity goals in their recently developed payment and purchasing strategies focused on identifying and addressing health disparities. On the other hand, Oregon's and North Carolina's featured strategies do not explicitly integrate health equity in their approaches or goals. However, because of the importance of social determinants of health and the critical role of safety-net providers in promoting health equity, both Oregon's and North Carolina's approaches have the potential to advance health equity by addressing systemic barriers to health

(Hinton 2023; HMA 2021; Rosenbaum et al. 2022). Common themes across the Medicaid payment and purchasing strategies in these four states are summarized in table 2 and further discussed below.

TABLE 2

Summary of Key Themes from Medicaid Payment and Purchasing Strategies in Four States

Common themes and key considerations for advancing health equity in Medicaid

	Ohio	Minnesota	Oregon	North Carolina
Payment/ Purchasing Lever	**Managed care contracting**	**Delivery and payment system reform**	**Alternative payment model**	**Section 1115 waiver**
Explicit focus on health equity	●	●	○	○
Clearly defined roles, expectations	●	●	●	●
Stakeholder engagement	●	◖	◖	◖
Infrastructure investments	●	●	●	●
Evaluation	◖	◖	○	◖

Source: Authors' analysis of publicly available information and data from key informant interviews.

Notes: ● = factor is present; ◖ = factor is partially present; ○ = factor is not present in the featured payment or purchasing strategy.

Ohio Next Generation Managed Care: Advancing Equity through Collective Impact

In February 2023, Ohio launched its redesigned Medicaid managed care program, called Next Generation Managed Care (table 3).[29] According to key informants, the "Next Gen" program was developed out of a desire to better meet health care needs and reduce disparities in care and outcomes of its more than 3.6 million members. To achieve this vision, the managed care procurement process began in 2019 with stakeholder engagement that included 17 listening sessions in communities across the state and two public comment periods through which the state collected over 1,000 comments from Medicaid members, consumer advocates, and providers.[30] Over 100 Medicaid members attended listening sessions in person.[31] As state officials described, this engagement was instrumental for the Ohio Department of Medicaid (ODM) to better understand the frustration members and providers experienced with the pre-existing managed care program and how it could be improved. ODM designated a team of staff who were solely responsible for processing feedback and designing key aspects of the Next Gen program, which key informants characterized as helpful in staying focused and making progress despite the pandemic and other priorities that otherwise might have delayed the process.

TABLE 3

Key Features of Ohio's Next Generation (Next Gen) Managed Care Program at a Glance

Key considerations for advancing health equity in Medicaid

Explicit focus on health equity	Health equity goals are articulated in the managed care contracts and focus on reducing disparities is promoted through financial incentives.
Clearly defined roles, expectations	Managed care contracts detail requirements and expectations for MCOs to incorporate health equity in plan operations, as well as quality improvement and population health strategies.
Stakeholder engagement	In designing the Next Gen program, the Medicaid agency collected and acted upon feedback from a broad range of stakeholders including providers and Medicaid members. The agency collaborates with MCOs in developing and implementing health equity interventions and community reinvestment strategies.
Infrastructure investments	The state implemented a centralized provider credentialing system and a single pharmacy benefit manager to provide pharmacy services across all MCOs, modernizing Medicaid information systems to streamline claims and prior authorization processes.
Evaluation	While independent impact evaluation is not included in the Next Gen program, MCOs are responsible for documenting implementation and impacts of interventions developed to reduce identified disparities (i.e., Plan-Do-Study-Act cycle).

Source: Authors' analysis of publicly available information and data from key informant interviews.

One example of how feedback informed the design of the Next Gen program is the development of a new workforce category—care guides—who will provide short-term, personalized assistance to members who do not qualify for full-scale, long-term chronic disease care management but could benefit from guidance and support for addressing acute care needs. Care guides are intended to provide light-touch support to any and all Medicaid members who otherwise would not be able to access care management because they do not have qualifying conditions such as disability, chronic diseases, or other serious health issues. For example, a care guide could help a Medicaid member find an in-network provider, make an appointment, and figure out transportation options to get to the appointment on a one-time basis. While the care guide mode looks like a CHW program, state officials said they stopped short of prescribing how the care guide function should be operationalized because, for example, educational and certification requirements for CHWs could be a barrier to implementing care guides.

Ohio's Next Gen program centers on addressing social determinants of health and advancing equity for Medicaid members, as outlined in the broad managed care contract expectations, requirements, and incentives (box 1). Population health and quality improvement strategies are the primary vehicles through which the state expects MCOs to address health disparities. The expectations for advancing equity are detailed in the contracts, including staffing requirements like creating a health equity director position to oversee MCO health equity efforts and outlining expectations of senior leaders around monitoring health disparities and promoting health equity within the organization and its provider networks. Additional strategies include the creation of population health management

systems to address health equity, stratified reporting of quality measures by member demographic characteristics, engagement of members within a newly created MCO Member and Family Advisory Council, quality withhold payouts based on an evaluation of the MCO's population health programs, and community reinvestment requirements (ODM 2023).

BOX 1

Select Health Equity Features of Ohio Medicaid Next Generation Managed Care Contracts

Ohio Medicaid managed care contracts, effective as of February 1, 2023, include several provisions and expectations for health plans to advance health equity, including, in broad terms:

- addressing health care disparities and ensuring equitable access to health care services (as defined by the National Standards for Culturally and Linguistically Appropriate Services in Health Care) for all members, including those with limited English proficiency, people from different racial and ethnic backgrounds, people with disabilities, and regardless of a person's sexual orientation or gender identity;
- establishing a Member and Family Advisory Council, ensuring diverse representation and meaningful engagement of council members in population health and quality improvement efforts, and obtaining ongoing input from members experiencing disparities in developing and implementing interventions and defining measures of success on closing disparities;
- creating a health equity director position, responsible for overseeing the design, implementation, and evaluation of health equity efforts;
- training staff on health equity and implicit bias and promoting cultural humility among MCO leadership and staff and within network providers to ensure delivery of health care services in a culturally effective manner to all members;
- identifying and reporting disparities in access, utilization, satisfaction, health outcomes, intervention effectiveness, social risk factors, and survey results by members' demographic characteristics;
- ensuring all population health and quality improvement efforts support health equity and participating in health equity initiatives requested by ODM;
- identifying available community resources, partnering with community-based organizations to address social determinants of health, and ensuring active referral to and follow-up on members' identified needs around social determinants of health;
- demonstrating significant impact on priority populations identified as experiencing disparities as part of MCO quality improvement efforts, including collectively advancing ODM's population health strategy and earning quality withhold payments, which are tied to evaluation of MCO performance on the collective efforts; and
- contributing up to 5 percent of MCO's estimated annual after-tax profits to community reinvestment activities to support population health; MCOs must collaborate effectively with each other to maximize the impacts of community reinvestment funding.

Source: ODM 2023.

An innovative feature of the Next Gen program is the expectation that MCOs work collaboratively to maximize their collective impact on addressing ODM's health equity priorities and meeting the needs of the communities they are serving. This approach is supported by the quality withhold program, in which ODM identifies areas and targets for MCOs to collectively achieve as a group in each contract year, determined to be 3 percent of the MCOs' payments in fiscal year 2022 (ODM 2023). The first MCO performance period has been defined as July 1, 2022, to December 31, 2023, with two goals: (1) improving outcomes for members with diabetes (such as by connecting members to diabetes education and continuous glucose monitoring) and (2) improving birth and infant outcomes by increasing rates of early entry to prenatal care. MCO performance will be evaluated on several different aspects, such as establishing effective organizational capacity to support interventions (e.g., sufficient staffing and data analytics capacity); continually assessing member and provider experiences to inform the selected interventions; monitoring and documenting the implementation and lessons learned; effectively coordinating with providers, community partners, other stakeholders, and health plans; and demonstrating reductions in identified disparities (ODM 2023). As one key informant explained, this process ensures not only that the collective goals are reached but that evidence is generated on which strategies are effective and sustainable in reaching them.

Unlike in the past, when the Medicaid agency would generally not get involved in routine MCO operations, the Next Gen program includes daily strategy meetings that are attended by ODM staff as well as medical directors, health equity officers, and other relevant MCO staff to facilitate collaborative information sharing and problem solving. If the collective targets are not met, no plan receives a payout. The collective approach was first tested during the pandemic when MCOs shared the responsibility for ensuring that Medicaid members received COVID-19 immunizations. Besides setting an overall vaccination goal, ODM also established sub-goals for improving member vaccination rates in certain low-opportunity areas identified by the Ohio Opportunity Index. The index assesses opportunities for Ohioans to achieve optimal health and well-being based on several measures of economic and neighborhood conditions such as housing, employment, and transportation.[32]

Another area where plans are asked to work together is the community reinvestment contract requirement, which stipulates that each plan must gradually provide up to 5 percent of its annual after-tax profits to support community and population health. The reinvestment activities must be developed with community input and be responsive to community health needs. Then, plans must work together to determine where to invest their pooled resources and how to measure short- and long-term impacts of those investments. As one key informant explained, the collective impact model forces the agency and plans to work together like never before and provides space for innovation, shared learning, and

continuous feedback within the bounds of federal and state regulations. ODM sets benchmarks, provides guidance, and reviews MCOs' proposals through an equity lens, while the plans are responsible for developing and testing evidence-informed strategies, documenting implementation and outcomes, and sharing lessons from interventions—the Plan-Do-Study-Act cycle.

As we plan interventions, we are making sure that we lead with health equity, that we're looking at data we have available not only by race or ethnicity or language. We just started collecting sexual orientation and gender identity data, looking at geography, looking at those data to help identify disparities, and then let that drive the intervention. I'd say that's one big piece [of the Next Gen program]: the marriage of quality improvement and population health.
—Ohio health plan representative

The collective component of the program is not without its challenges. One key informant noted that while greater collaboration among health plans is a promising strategy for accelerating progress on reducing disparities, at the end of the day, health plans are competitors. This may lead to some tension around what information to share in collaborative efforts. Another potential concern relates to a group project dynamic: one or a few plans could be disproportionately leading the effort or doing more work than other plans to reach the common goal—though key informants have not observed this to be a problem thus far. Finally, while key informants appreciated the flexibility and latitude MCOs have to develop and test innovative solutions, one of them said that in some cases, a little more clarity and direction from the state would be helpful. For example, MCOs are required to reimburse providers for using Z codes, which are diagnostic codes that document patients' unmet social determinants of health needs in the medical records,[33] but Ohio Medicaid reportedly does not have a fee schedule for those codes. Furthermore, the contract does not specify whether reimbursement should be tied to simply recording a Z code or whether providers should also be required to make and follow up on referrals to address identified needs in order to be reimbursed. These are examples of some of the operational challenges that MCOs face in executing on the state vision.

Also, in response to stakeholder feedback, an important focus of the Next Gen program is to reduce providers' administrative burdens to allow them, as a state official put it, to focus more on their patients

and less on administrative tasks. These initiatives include implementing a centralized provider credentialing system and a single pharmacy benefit manager to provide pharmacy services across all MCOs, and modernizing Medicaid information systems to allow for more streamlined processing of claims and prior authorizations.[34] The state also launched a new electronic data interchange to increase transparency into member care and services. There have been some early challenges, particularly with the technology pieces and making sure all the systems talk to each other as intended, which contributed to delays in the launch of the Next Gen program.[35] As key informants noted, the state is still in the discovery phase—learning what works well and where there are hiccups in the processes. But overall, key informants stressed there have been no major disruptions for providers or members following the implementation of the Next Gen program.

Why This Matters for Equity

States are increasingly leveraging managed care contracting to incentivize and require MCOs to prioritize health equity and social determinants of health (Bailit Health 2023; HMA 2021). Community reinvestment is also emerging as a Medicaid managed care strategy to improve broader population health and promote health equity (Cantor, Powers, and Sharma 2023). The Next Gen program in Ohio is pushing the envelope on using contracting to test whether MCO collaboration on achieving collective quality improvement goals and making joint community investments can spur innovation and maximize positive impacts on health equity and social determinants (table 3). Though the Medicaid agency is allowing considerable leeway for MCOs to develop and test interventions, the lack of specificity could potentially pose barriers and slow down implementation in some cases, such as with the use of Z codes described earlier.

At the same time, the Medicaid program is launching improvements to the underlying infrastructure and health information systems to reduce provider burden, which has been associated with reluctance of providers to treat Medicaid patients (Dunn et al. 2023). These developments present an opportunity to restructure the Medicaid program in a way that prioritizes member needs and better supports providers, with a potential to create a more accessible and equitable health care system. Although it remains to be seen whether the collective impact strategy improves health outcomes and reduces disparities, the requirement that MCOs document implementation of and impacts from these interventions could strengthen the evidence for health equity interventions in Medicaid. If distributed widely, lessons that emerge from the Next Gen program can inform future efforts not only in Ohio but in other states as well.

Minnesota Integrated Health Partnerships: Incorporating Equity in an Accountable Care Delivery Model

The Minnesota Department of Human Services began the IHP demonstration in 2013 using the ACO model, which is still a relatively rare model of care in Medicaid and present in just 14 states as of April 2023.[36] As one key informant described it, the Minnesota Department of Human Services contracts with "participating health care providers to work together across specialties and service settings to deliver more efficient and effective health care" to Medicaid members. The initiative was developed following a 2010 legislative mandate to test innovative delivery and payment models in Medicaid (also known as MinnesotaCare).[37] In the first five years, the IHP program grew from 6 participating provider groups serving about 99,000 MinnesotaCare members to 21 providers serving over 462,000 members enrolled both in managed care and fee-for-service Medicaid (Spaan 2017).

The IHP program uses a shared payment arrangement for a subset of its partners, whereby participating providers share in the savings or losses based on the total cost of care for MinnesotaCare patients who are assigned to them. Target to total cost of care comparisons are conducted for a specific performance period. The total cost of care includes a set of primary care, inpatient, and ambulatory care services as well as other related services.[38] All expenditures for the members who have been assigned to a provider participating in the IHP program are counted toward the total cost of care, regardless of whether the participating providers (hereafter referred to as integrated health partners) provided the service. Integrated health partners are eligible to receive shared savings based on their performance on various quality and patient experience measures (Dybdal et al. 2014). Between 2013 and 2017, the IHP program generated about $277 million in Medicaid savings, of which about $92 million was paid to the partners as shared savings (Chun 2018).

According to key informants, although the original IHP program was successful in containing costs while maintaining or improving quality of care for MinnesotaCare members, state officials realized that the initial program fell short of addressing broader social determinants that affect health and well-being of Medicaid members and did not sufficiently incentivize participating partners to tackle existing disparities across geography, race/ethnicity, and other characteristics. In soliciting comments from the public on how to improve the IHP program, state officials learned that the program needed to provide upfront payments to participating providers to facilitate the development of a delivery system that is capable of providing holistic care, including addressing unmet social needs of Medicaid members and reducing disparities in the population. One key informant commended the state leadership for effectively engaging providers and incorporating their input in the program redesign. Other key

informants highlighted the efforts to align the goals, processes, and procedures of the IHP program with those of other initiatives and programs in Minnesota Medicaid, such as the managed care contracting. The alignment helps to ensure that health equity is consistently prioritized across all programs and operations within the Minnesota Medicaid program, thereby making it difficult to remove the programs if funding priorities shift over time.

This learning and feedback led to the IHP 2.0 model, which was implemented in 2018 (table 4). The 2.0 program is designed around a set of core principles including creating value-based payment arrangements that focus on equity, cost, and quality. Further, the IHP 2.0 model prioritizes sustainability through the introduction of population-based payments to address the need for upfront payments to support practice transformation and innovation (box 2).

TABLE 4

Key Features of Minnesota IHPs at a Glance

Key considerations for advancing health equity in Medicaid

Explicit focus on health equity	Health equity is an explicit component of the IHP 2.0 program through the health equity performance measurement and health equity interventions.
Clearly defined roles, expectations	The IHP contracts between Medicaid and providers outline acceptance and retention criteria for the program. The contract outlines reporting and monitoring activities and expectations for all parties involved around health equity.
Stakeholder engagement	The Medicaid agency solicited and incorporated input from providers and other stakeholders in the 2.0 version of the program. Health equity interventions must be designed and implemented to address documented population needs in collaboration with community partners, including community-based organizations, social service organizations, and public health agencies.
Infrastructure investments	Providers participating in the IHPs receive population-health payments to assist with infrastructure or other necessary upfront investments.
Evaluation	The IHP program is evaluated annually across five performance domains. Partners are also required to submit Population Health Reports annually to assess current progress on health equity interventions, document challenges, and disseminate learnings as the intervention progresses.

Source: Authors' analysis of publicly available information and data from key informant interviews.
Notes: IHP = Integrated Health Partnership.

BOX 2

Core Principles and Goals of the IHP 2.0 Model

- Developing value-based payment arrangements that incorporate both cost reduction and quality improvement goals, and supporting expanded provider participation in value-based payment contracts
- Designing payment arrangements, including population-based payments, to promote sustainability and innovation in care, including by developing appropriate targets and payment methodologies[a]
- Incentivizing partnerships between medical and nonmedical providers to effectively address the health and social needs of patients and populations
- Promoting access to high-quality primary care, including flexibility to include nontraditional providers, such as doulas and CHWs, on care teams
- Strengthening health care data and technology capacities to improve ability to share and act upon timely and accurate data
- Ensuring alignment with other federal, national, and state-based value-based payment initiatives to minimize provider burden

Source: Matthew Spaan, "Integrated Health Partnerships2017 Request for Proposal Overview," Minnesota Department of Human Services, 2017.

[a] For more information, see "Integrated Health Partnerships (IHP): Quality Measurement Overview," Minnesota Department of Human Services, July 2023, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8467-ENG.

Providers are required to meet a series of eligibility requirements to participate in the IHP program. These include the ability to provide or coordinate a full array of health care services, such as having an innovative care delivery model that incorporates partnerships with community-based organizations, social services agencies, counties, and public health resources. Integrated health partners are also required to demonstrate meaningful engagement with patients and families as partners both in the delivery of care and in quality improvement efforts. Finally, participating providers must be able to take on financial risk and to receive and engage with health data provided by the Minnesota Department of Human Services (Spaan 2017).

The redesigned IHP 2.0 program also introduced a population-based payment, authorized by the 2017 legislature,[39] which is a per member per month mini-capitated payment. According to key informants, population-health payments are meant to be flexible and can be used for care coordination and delivery as well as infrastructure improvements. Population-based payments are modified based on the clinical risk of the Medicaid members (e.g., substance use disorder or serious mental illness diagnoses) and are further adjusted based on social risks for factors known to negatively affect a person's health and lead to poor outcomes. These could include housing insecurity, low income, and

involvement in the child welfare or criminal justice systems. As one informant noted, the population-based payments reportedly led to greater provider participation and engagement in the redesigned IHP initiative.

Integrated health partners are also required to develop and launch health equity interventions. To enable innovation in the intervention design, the Minnesota Department of Human Services requires that participating providers establish a formal agreement or contract with additional providers, community-based organizations, social service organizations, public health organizations, and others. For health equity interventions to be approved by the state Medicaid agency, all parties must agree on the population's priority needs, the health equity intervention, and accountability structures to support the work. Reportedly, the state Medicaid agency uses the review and approval function to engage with integrated health partners to ensure that health equity initiatives adhere to the needs of community and have the potential to advance health equity. According to key informants, health equity interventions that have been launched thus far focus on addressing clinical and social risk factors. Clinically focused interventions include improving access to medical services such as mental health care, substance use services, prenatal care, and medication management, and addressing overutilization of emergency department services. Other integrated health partners focus on addressing social needs, including food and housing insecurity, lack of transportation, education, and income (MN DHS 2023a).

Every time we contract and negotiate with integrated health partners, they have to identify a health equity intervention which has a number of [process] metrics, clinical health metrics, utilization metrics, as well as more qualitative types of metrics… within the health equity frame.
—Minnesota state official

Many IHP contracts utilize a shared savings model whereby at least 50 percent of payment to the integrated health partner is contingent on their overall performance across five domains: quality, care for children and adolescents, quality improvement, closing disparity gaps, and equitable care (table 5).[40]

TABLE 5

IHP 2.0 Quality Measure Set

Domain	Description	Example of a potential measure
Quality core set	▪ Focuses on monitoring performance for various conditions and multiple aspects of care	▪ Colorectal cancer screening
Care for children and adolescents	▪ Includes preventive health measures for members age 21 and younger	▪ Well-child visits in the first 30 months of life
Quality improvement	▪ Focuses specifically on improving quality for selected measures ▪ Requires integrated health partners to choose three measures with the option to add one additional measure	▪ Follow-up after hospitalization for mental health illness (30-day)
Closing gaps	▪ Focuses on reducing and eliminating disparities in care for different populations ▪ Monitors disparities in care for Medicaid population compared to the commercial population for select measures	▪ Optimal asthma control adult
Equitable care	▪ Includes measures from the Healthcare Effectiveness Data and Information Set developed by NCQA that align with the state's goals to eliminate health disparities and ensure equitable care across racial and ethnic groups ▪ Requires integrated health partners to focus on two measures with the option to add one additional measure	▪ Prenatal and postpartum care

Source: Excerpted from "Integrated Health Partnerships (IHP): Quality Measurement Overview," Minnesota Department of Human Services, July 2023, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8467-ENG.

Integrated health partners are provided a one-year ramp-up period before their data are reviewed for progress toward closing identified disparities. The Minnesota Department of Human Services provides the integrated health partner with baseline data on their assigned population to help the partner determine where to focus their efforts. Integrated health partners are encouraged to assess disparities both within their MinnesotaCare population and compared to the commercial population in an effort to make health care system-level changes that close both sets of gaps. In addition, the IHP program uses a set of quality and patient experience measures to assess provider eligibility to partake in shared savings (MN DHS 2023b).

The Integrated Health Partnership program is evaluated annually across the aforementioned domains. Performance is tied to payment, and lack of improvement can result in being removed from the program. Equity interventions are also assessed annually through the Population Health Report and other state mechanisms. The Population Health Report is specific to the integrated health partner and

allows the state to assess the current progress for the intervention, document challenges, and disseminate learnings as the intervention progresses.[41]

Why This Matters for Equity

The IHP program highlights the impact of intentionally focusing on advancing health equity in a Medicaid ACO model. In Minnesota's case, this led to a model of health care delivery and payment methodology that promotes person-centered, holistic, and equitable care. While ACO initiatives have been widely used in Medicare, adoption in Medicaid has been somewhat slower, with only 14 states currently reporting having a Medicaid ACO (Rosenthal et al. 2023). Furthermore, available evidence suggests that, though Medicaid ACOs have achieved some improvements in health care quality and reductions in costs, few have also contributed to reductions in disparities among Medicaid members (McConnell et al. 2018; Muoto et al. 2016). Insights from the design and implementation of the IHP program could encourage more states to consider ways in which the ACO model could be adopted to promote health equity.

In addition, key informants noted Minnesota's intentional alignment of priorities, processes, and measures across the IHP program, managed care contracting, and quality improvement initiatives as a necessary step for "building equity work into the walls" of the Medicaid program. Translating equity goals into actionable policy and programming allows the approaches to become a norm that cannot be easily uprooted by changes in administration or funding priorities.

Oregon Alternative Payment and Advanced Care Model: Supporting Health Centers in Delivering Holistic Care

Oregon's Alternative Payment and Advanced Care Model (APCM) program began in 2013, as a result of effective collaboration between the Oregon Health Authority (OHA) and the Oregon Primary Care Association (OPCA), which represents community health centers. The APCM program was built in response to Oregon's Patient-Centered Primary Care Home model, which is an Oregon-specific version of a patient-centered medical home model.[42] Several community health centers and OPCA partnered with OHA to build a payment model that could allow community health centers to deliver "high-quality, efficient provision of patient-centered health care" that incentivizes high-value services as opposed to a high volume of visits.[43] According to key informants, the central tenet of the model is that investment in nonbillable person-centered care coordination and enhanced support services will result in a reduction

in billable visit-based services, thereby resulting in improved health for the person and cost reduction for Medicaid.

An important part of our story is we first started with a care model … then we found we were limited in what we were able to do because of the payment model. We then started to look at how do we adapt.
—Oregon provider

Key informants noted that, while the Oregon APCM was not explicitly designed to advance equity, it is focused on adequately supporting safety-net providers who care for Medicaid members and underserved communities in delivering holistic patient-centered care (table 6).

TABLE 6

Key Features of the Oregon Alternative Payment and Advanced Care Model at a Glance

Key considerations for advancing health equity in Medicaid

Explicit focus on health equity	While the term "health equity" is not an explicit goal of the Oregon APCM, it promotes health equity by supporting community health centers in delivering holistic, person-centered care to underserved patients in underresourced communities.
Clearly defined roles, expectations	The care delivery standards and expectations are defined and described in 18 services that make up the Care and Service That Engage Patients or Care STEP model.
Stakeholder engagement	The model was collaboratively designed and continues to be refined by the OHA and community health centers. The degree to which stakeholder engagement includes patients and Medicaid members themselves or their representatives is unclear.
Infrastructure investments	The APCM program provides participating health centers with per member per month payments, which allow the health center greater flexibility to fund and sustain activities that contribute to the health and care of the patients but may not be traditionally reimbursed for medical services, such as care coordination and health education.
Evaluation	The Oregon APCM is authorized using a state plan amendment that does not require formal evaluation. The model has not been formally and independently evaluated for impacts on access, quality, and outcomes of care.

Source: Authors' analysis of publicly available information and data from key informant interviews.
Notes: APCM = Alternative Payment and Advanced Care Model; OHA = Oregon Health Authority.

Community health centers are traditionally paid using the Medicaid prospective payment system methodology, which is a per-visit amount that is tied to the volume of in-office visits.[44] In contrast, the

APCM program provides participating health centers with PMPM payments, which allow the health center greater flexibility to fund and sustain activities that contribute to the care of the member but may not necessarily be clinical services, such as case management or health education (box 3).[45] When the program was designed, the PMPM rate was based on prior prospective payment system payments for Medicaid members who had a claim with the health center in the past year. The PMPM payments only applied to physical health services associated with primary care and excluded dental services, mental health and addiction services, prenatal and obstetrics services, laboratory, radiology, specialty, urgent care, and emergency department care (OPCA 2015). While the PMPM rate is adjusted once per year, the number of PMPM payments changes throughout the year based on the number of people who are assigned to the health center and choose to continue receiving services from the health center. This feature incentivizes the health center to provide high-quality person-centered care as a way to retain and grow the Medicaid patient population seeking care at the community health center. While the APCM has no explicit downside risk at this time, health centers are effectively penalized when Medicaid patients choose to receive primary care services elsewhere, as the health center's total PMPM amount is adjusted downward to reflect the loss. Key informants stated that moving to the APCM was initially made possible because it was easy to convert prospective payment system rates into PMPM payments.

BOX 3

Oregon APCM Model Care STEPs (Care and Service That Engage Patients)

New Visit Types

- Online portal engagement
- Health and wellness call
- Home visit (billable encounter)
- Home visit (nonbillable encounter)
- Advanced technology interaction

Coordination and Integration

- Coordinating care: clinical follow-up and transitions in care settings
- Coordinating care: dental
- Behavioral health and functional ability screenings
- Warm hand-off

Education, Wellness, and Health Promotion

- Care gap outreach
- Education provided in group setting
- Exercise class participation
- Support group participation
- Health education supportive counseling

Reducing Barriers to Health

- Social determinants of health screening
- Case management
- Accessing community resource/service
- Transportation assistance

Source: Excerpted from OPCA n.d.

Key informants emphasized that an important and valuable feature of the APCM is the predictability of Medicaid revenues. PMPM payment allows participating health centers to rely on revenues that are not tied to a billable office visit, which provides a relatively stable source of income that health centers can use to enhance services and expand patient outreach and engagement efforts. According to one informant, "the APCM allowed us to do the panel management, and the care that we wanted to do, but felt like we couldn't do with the fee-for-service structure." The APCM also allows participating health centers to negotiate pay for performance incentives or shared savings with managed care organizations in addition to the PMPM payments (OPCA 2015). The APCM program evaluates a health center's readiness for the new care model, including assessing whether they have enough Medicaid members to actualize the benefits of PMPM payments. While no health center that wants to participate is turned away, the changes necessary may not benefit all equally or make financial sense for some specialized health centers that do not serve a large share of Medicaid members.

Informants also shared that APCM is linked with a specific care delivery model. The APCM structure requires participating health centers to document Care and Service That Engage Patients (Care STEPs). "A Care STEP is a specific direct interaction between the health center staff and the patient, the patient's family, or authorized representative(s) through in-person, digital, group visits, or telephonic categories."[46] There are 18 services included in Care STEPs that span the following four categories: (1) initial engagement of new patients ("new visit types"); (2) education, wellness, and health promotion services such as exercise classes; (3) coordination and integration services, such as screening patients for behavioral health conditions and connecting patients to specialty care; and (4) reducing barriers to health, such as by assisting patients in accessing available community resources (box 4). Community health centers are required to submit quarterly reports on select quality metrics and Care STEPs. Participating health centers must also submit data on patient experience using questions from the Consumer Assessment of Healthcare Providers and Systems survey.[47] While Care STEPs have not yet been formally evaluated for their impact on patient satisfaction, utilization, or costs, one informant noted that enhanced care coordination and support services made possible through Care STEPs, such as nutritional counseling and cooking classes, are very popular among patients.

Lessons-learned documents cited significant stakeholder investment in the design and implementation of the Oregon APCM.[48] Key informants also commented that a key facilitator of the APCM program was stakeholder partnerships, noting that the APCM steering committee includes health center representatives and the OPCA. Committee meetings are designed so that health centers can raise concerns and potential solutions. OPCA meets regularly with the OHA to relay health centers'

feedback. Key informants stated that this allows for a collaborative relationship between the providers and the OHA, while allowing health centers to co-drive the program.

Furthermore, the Oregon APCM is preparing health centers for implementing collective goals around value-based purchasing (VBP). One informant noted that "we want to make sure that we are seeing overall health outcomes that are positive … We definitely want to make sure that we're moving toward health equity and healthy outcomes." Participating APCM providers are introduced to the building blocks and critical infrastructure necessary for eventually moving to VBP. As Oregon accelerates its transition to VBP, key informants reported that the state is also building new systems and shared technology platforms that will allow community health centers to participate in shared savings and pooled downside risk payment arrangements. This will allow smaller health centers to participate in VBP, as the model would spread downside risk across a consortium of health centers so that no one center would have to absorb potential losses alone. Furthermore, VBP payments will be tied to specific measures of quality, cost, and equity improvements that will allow Oregon to assess provider performance on these measures and evaluate the effectiveness of the advanced VBPs.

Why This Matters for Equity

The core tenets of the primary care medical home delivery model center on effectively engaging patients in their care and reducing barriers to good health, including addressing patients' unmet social needs. While this type of holistic, patient-centered care is integral to how community health centers operate in general, Oregon's APCM program gives health centers flexible and reliable resources that allow them to focus on patients' needs instead of worrying about billable encounters. As a result, the community health centers participating in the APCM program report that they have more time and resources to effectively improve access and quality of care to Medicaid members and that those patients value the additional services and supports that are available. However, the program has not been formally evaluated to document its impacts on the access to and quality of care, or cost savings. Community health centers are essential safety-net health care providers for Medicaid members and uninsured patients, particularly those most at risk of experiencing barriers to health care and health disparities, who thus are critical partners in promoting health equity (Rosenbaum et al. 2022). The APCM incorporates the building blocks that are necessary to achieve health equity as it supports a health care delivery and payment model that is designed to provide high-quality person-centered care using a safety-net infrastructure of trusted community health centers.

North Carolina Healthy Opportunities Pilots: Laying the Groundwork for Delivering and Evaluating Medicaid-Funded Health-Related Social Services

While the North Carolina Medicaid program (NC Medicaid) has several initiatives that incorporate health equity, we focus here on the Healthy Opportunities Pilots program of North Carolina's Section 1115 waiver demonstration (table 7).[49] In 2018, North Carolina received approval from CMS for a first-of-its-kind demonstration to use up to $650 million over five years to address certain health-related social needs of Medicaid members (Hinton et al. 2019). As part of the Medicaid transformation initiative, which includes the transition from fee-for-service to Medicaid managed care and other reforms, the state leadership saw an opportunity to test interventions that would integrate medical care with social services, including housing, food, and transportation assistance, and with interventions to address interpersonal violence and toxic stress.[50] In support of this vision for a more integrated and comprehensive health care system, North Carolina developed a screening tool for social determinants of health and launched an online referral platform supported by a public-private partnership, NCCARE360, to connect people with health-related social needs to available resources and track their outcomes (Hinton et al. 2019; Thomas and Ferguson 2019).[51]

TABLE 7

Key Features of North Carolina's Healthy Opportunities Pilot at a Glance

Key considerations for advancing health equity in Medicaid

Explicit focus on health equity	Health equity goals are not explicitly articulated in the design of the interventions or the evaluation. However, the state is incorporating focus on equitable access to interventions and equitable representation of participating organizations as part of the implementation.
Clearly defined roles, expectations	The state developed a new system for delivering social services in Medicaid by delineating roles of various partners and clearly defining a new set of services.
Stakeholder engagement	The state has developed strong relationships and feedback loops with MCOs and providers to facilitate implementation of Healthy Opportunities Pilots. However, broader stakeholders or Medicaid members have not been meaningfully engaged in design or implementation.
Infrastructure investments	The state developed underlying infrastructure to support implementation of Healthy Opportunities Pilots, including engaging in public-private partnership to launch the NCCARE360 electronic referral platform that is used to coordinate delivery of social services and reimburse human service organizations.
Evaluation	Healthy Opportunities Pilots are being independently evaluated for effectiveness. However, the evaluation design lacks focus on assessing impacts on health disparities.

Source: Authors' analysis of publicly available information and data from key informant interviews.

Healthy Opportunities Pilots gradually launched in three regions of the state (comprising 33 counties), starting in March 2022.[52] To operationalize the concepts of Medicaid-funded nonclinical services, the North Carolina Medicaid program (NC Medicaid) developed standardized service definitions and reimbursement rates and methodologies for a total of 29 specific services related to housing, transportation, and food assistance and interpersonal violence and toxic stress interventions.[53] According to key informants, the services consist of a wide array of supports such as housing services that include assisting Medicaid members with obtaining or retaining housing, home remediation and safety modifications, and one-time stipends for moving expenses, utilities, and security deposits. The service list also includes so-called cross-domain services to provide enhanced case management to people who experience multiple unmet social service needs, referrals to legal consultation, and medical respite for people experiencing homelessness post-hospitalization. The state implemented various reimbursement methods depending on type of service. For example, counseling and navigation services are reimbursed on a per member per month basis, while services such as home-delivered meals are paid as a fee-for-service, and others such as transportation are reimbursed on a cost basis up to a cap.[54]

A portion of the funding for Healthy Opportunities Pilots, up to $100 million, was set aside for developing the infrastructure to deliver the services and facilitate tracking and reporting of outcomes (box 4). According to key informants, the bulk of this work consisted of recruiting and strengthening the capacity of local community-based organizations and social service agencies (referred to as human service organizations) to deliver Pilot services and receive Medicaid reimbursement. To facilitate and streamline interactions between human service organizations and managed care plans, NC Medicaid recruited so called "network leads"—organizations responsible for contracting with, overseeing, and supporting the capacity of human service organizations in their respective regions. Network leads contract with managed care plans on behalf of all human service organizations in their networks. NC Medicaid developed model contracts that network leads use for contracting both with managed care plans and separately with human service organizations. According to key informants, the network lead model minimizes the administrative burden on human service organizations that are typically not well versed in nor staffed for functioning as medical billers.

BOX 4

Healthy Opportunities Pilots Infrastructure

The following entities make up the Healthy Opportunities Pilots infrastructure and support delivery of health-related social services:

- ***Managed care plans*** (also known as Prepaid Health Plans) are responsible for identifying Medicaid enrollees who qualify for Pilot services, reviewing referrals and authorizing services, and ensuring services providers are reimbursed.
- ***Network leads*** are organizations that serve as liaisons between managed care plans and local service providers. They oversee and support service providers, including by providing technical assistance and resources. Each Pilot region is managed by one network lead. Network leads contract with managed care plans on behalf of service providers.
- ***Human services organizations*** are social service agencies and community-based organizations that deliver Pilot services. Human service organizations contract with their respective network leads.
- ***Care managers*** assist Medicaid members with complex care needs in accessing medical care and needed social services. Care managers facilitate referrals and monitor member access to and utilization of Pilot services.
- ***NCCARE360*** is an electronic tool and statewide resource directory that enables health care providers, care managers, community-based organizations, and health plans to connect people to available social services in their community. The tool also supports monitoring and tracking of referral outcomes.

Sources: "Healthy Opportunities Pilots," North Carolina Department of Health and Human Services, last modified November 16, 2023; "Building Connections for a Better North Carolina," NCCARE360, 2023.

The NCCARE360 platform, which includes information on over 13,000 services in all North Carolina counties,[55] plays a vital role in supporting the delivery and reimbursement of services by enabling all the different key entities in the Pilots to coordinate and interact with each other. When a referral is made in NCCARE360 for a social service, the member's managed care plan determines eligibility based on qualifying health and social needs defined by NC Medicaid and authorizes the service. Once the services are delivered, a human service organization issues an invoice in NCCARE360, which is then reviewed by their network lead and sent to the managed care plan. The plan pays the service provider directly. Finally, the managed care plan converts the invoice into an encounter and submits it to NC Medicaid, so the state can effectively monitor and track utilization of Pilot services. The state is working on eventually moving the invoice system into a claims-based process to streamline the workflows even further. According to key informants, figuring out how to integrate human service organizations into the Medicaid reimbursement system was one of the most challenging aspects of operationalizing the delivery and reimbursement of health-related social services in Medicaid. Although

the interim step of invoicing and converting invoices to encounters is somewhat cumbersome, it allowed the state to move forward with the implementation while continuing to work with human service organizations on enhancing their capacity and technology. According to one key informant, effective engagement and collaboration with all partners to stand up the Pilot infrastructure and successfully collect nonmedical encounters are some of the most significant early accomplishments of the initiative.

We could have tried to perfect the [Healthy Opportunities Pilots] program and would have never launched. We decided to launch with minimum viable product, and we are continuing to refine and improve it along the way.
—North Carolina Medicaid official

As with any new program, there have been some challenges; the main one is identifying eligible members for the Pilot services, who must live in one of the Pilot counties and have at least one qualifying physical or behavioral health condition (such as having two or more chronic health conditions or having high-risk pregnancy for adults, receiving care in neonatal intensive care units for children ages 0–3, or having three or more adverse childhood experiences for all children and youth under age 21) and at least one social risk factor (housing instability, food insecurity, lack of transportation, and being at risk of or experiencing interpersonal violence) (CMS 2022). As of December 2023, more than 16,500 members were served by the program.[56] As one key informant explained, multiple factors contribute to the somewhat low uptake of Pilot services, including the fact that most Medicaid members in North Carolina are children and pregnant women and may not be eligible for the interventions. Another explanation may be low awareness about available resources and assistance, as patients may not consider turning to their doctor's office for help with social needs or may not be comfortable disclosing those needs if they are asked. The scarcity of resources in some communities, particularly housing and transportation, may prevent some providers from screening patients because they do not want to identify a need for which there is a shortage of services. However, key informants emphasized that understanding the scale of unmet needs is important to effectively directing investments where resource gaps exist. NC Medicaid is working with health plans to identify eligible members through data mining and devoting some of the Pilot funding to recruitment and training of community health workers to conduct outreach and refer eligible Medicaid members to Pilot services.

Another key challenge is related to the interpersonal violence services that have not launched yet as of December 2023 because of unresolved questions around appropriate data privacy and security protocols. The existing laws and regulations that protect confidentiality of domestic violence survivors pose challenges for how to effectively identify and offer services to Medicaid members who may need them. The state has been collaborating with the North Carolina Coalition Against Domestic Violence on how to offer these services while protecting a participant's confidentiality. Ultimately, this will require changes in the existing data infrastructure and contract requirements around data privacy and security. The state is continuously monitoring implementation and troubleshooting challenges, including collecting and sharing member stories of how Pilot services have positively affected their lives.[57]

NC Medicaid officials acknowledged that, while health equity goals were not included in the original design of Healthy Opportunities Pilots, the COVID-19 pandemic both delayed the implementation and allowed the state to consider how these interventions could be used to advance health equity. For example, managed care plans are now held accountable for ensuring equitable access to and utilization of Pilot services among eligible members. In the first year, milestones are tied to infrastructure building, followed in the second year by process-based metrics such as enrolling a minimum number of Pilot participants and timely payment to health service organizations. The state hopes to move to VBPs tied to ensuring equitable access to Pilot services among Medicaid members and human service organization network adequacy in including local and minority-run community-based organizations.

NC Medicaid contracted with the UNC Sheps Center for Health Services Research to conduct an independent evaluation of the Pilots using the Sequential, Multiple Assignment, Randomized Trial design (CMS 2019). In the early implementation phase, the evaluators produce interim rapid cycle assessments to inform continuous improvements of the interventions (such as how services are defined, delivered, and reimbursed). For example, the assessment conducted over the initial six months of the implementation suggest relatively smooth implementation, noting that almost two-thirds of enrolled participants (63 percent) received at least one Pilot service, most services were delivered within two weeks of enrolling in the program, and that slightly more than half of invoices were paid within 30 days (Sheps Center for Health Services Research 2023). The findings on effectiveness of the Pilot services in reducing social needs were mixed and preliminary, including because of the small number of Pilot participants and the short period of time (Sheps Center for Health Services Research 2023). According to key informants, the goal of the evaluation is to show whether using Medicaid dollars to pay for social services improves health outcomes of Medicaid members and reduces health care costs, and to build evidence for scaling and sustaining these interventions in the long term. While the state tracks enrollment in Pilot services by race and ethnicity to monitor equitable access, the evaluation plan lacks

a clear focus on health equity and assessing whether Pilot services reduce disparities in social needs and health outcomes (CMS 2019).

Why This Matters for Equity

Although it is well documented and understood that factors such as unstable housing, food insecurity, and toxic stress have a profound negative impact on health, there is a need for more evidence that shows impacts of addressing these needs on Medicaid members and family health and well-being, including which types of social needs interventions may be most effective. North Carolina's Healthy Opportunities Pilots have developed infrastructure to deliver social services through Medicaid, and the claims-based system allows the state to systematically collect data and assess the impact of Medicaid-funded social services on health care utilization, spending, and health outcomes. Furthermore, North Carolina has also led the way for other states in setting up the infrastructure and processes for defining benefits and reimbursement for social services and enabling community-based organizations to bill Medicaid programs. As more states consider implementation of similar health-related social needs demonstrations, lessons from NC Medicaid efforts—particularly around the infrastructure for delivering Medicaid-reimbursed social services—will be informative. Because the state has high-quality race and ethnicity data for its Medicaid population,[58] the evaluation of the Pilots could also assess whether Medicaid members have equitable access to available resources and experience reductions in health disparities. However, an important flaw of the approved evaluation design is the lack of focus on assessing outcome results by participants' race and ethnicity (or other characteristics such as language or rural residency) which is a missed opportunity to assess whether the Pilot services promote health equity.

Policy and Practice Implications

Medicaid has an important role to play in reducing persistent racial and ethnic health disparities in the United States (Chen and Ghaly 2022; Dihwa, Shadowen, and Barnes 2022; MACPAC 2022b).[59] Our key informants, as well as the published literature, support the notion that payment and purchasing strategies can be effective in advancing progress toward health equity, building on state experience in using financial mechanisms to improve their Medicaid programs. While payment and purchasing strategies have been used to motivate health plans and providers to improve access, quality, and reduce costs, the evidence is inconclusive on whether these strategies have had the desired impacts. (Doran, Maurer, and Ryan 2017; Gondi, Maddox, and Wadhera 2022; Kenney et al. 2019). Furthermore, focus

on equity has often been missing in delivery and payment reform initiatives, leading to unintended consequences such as excluding underserved populations from interventions or penalizing providers who disproportionately care for people with complex health and social needs (Gondi, Maddox, and Wadhera 2022; Yasaitis et al. 2016). It is also important to recognize that any innovations and new programs lead to more complexity and strain on deeply underfunded Medicaid programs and providers who serve Medicaid members as, for example, has been the case for adoption of electronic health records that, despite years of effort and billions of taxpayer dollars spent, have yet to deliver on the promise of more efficient and safer health care (Schulte and Fry 2019).

As Medicaid programs are increasingly articulating health equity and disparity reductions among their goals, careful consideration of how health equity is incorporated in purchasing and payment decisions is warranted (Kenney et al. 2019; Liao, Lavizzo-Mourey, and Navathe 2021; Navathe and Liao 2022). Common themes and key takeaways from the four state initiatives we examined can be informative:

- Payment and purchasing strategies may not always have explicit health equity focus, but strategies that support holistic care and direct resources to the most underserved Medicaid members hold promise for reducing disparities.
- Advances in Medicaid health equity interventions may be supported by clearly defining roles and expectations while allowing sufficient flexibility to promote innovation.
- Stakeholder engagement, including meaningful Medicaid member engagement, is increasingly prioritized in facilitating collaboration and developing and continuously improving interventions that effectively identify and address disparities.
- Infrastructure investments—including adequate provider payments and support for capacity building, effective information exchange, and improvements to Medicaid operations and data systems—are fundamental to operationalizing and sustaining health equity interventions.
- Though often not prioritized, evaluation of Medicaid health equity initiatives is essential given the gaps in the evidence for which interventions are effective in reducing disparities.

Directing resources to underserved populations is viewed as a strategy with potential to reduce disparities. Though health equity may not always be an explicit goal, states have increasingly been pursuing payment and delivery system reforms to better serve the most underserved Medicaid members and support the providers who care for them (Bailit Health 2023; Cantor, Powers, and Sharma 2023; Manatt Health 2022; Smithey, Patel, and McGinnis 2022).[60] Key informants agreed that, although the evidence of impacts of these policies on disparities is not nearly as strong as is needed, the urgency of addressing persistent health disparities is motivating state Medicaid programs to test various approaches that have the potential to reduce disparities, including by directing resources to

populations and providers that have been historically marginalized. Oregon's Alternative Payment and Advanced Care Model (APCM), for example, was designed to better support the enhanced and comprehensive care integration and coordination that is central to the mission of community health centers. Stable and predictable APCM payments allow community health centers to focus on addressing patients' health and health-related social needs without having to worry about billing codes. North Carolina's Healthy Opportunities Pilots directly provide social services and supports to qualified Medicaid members who face both challenging personal situations and complex health care needs, thus allowing participants to prioritize their health. Neither initiative explicitly focused on addressing health equity when originally designed, but stakeholders in Oregon and North Carolina believed both these interventions lend themselves well to promoting equity by addressing some of the systemic barriers that contribute to health disparities. It is essential that we carefully examine and learn from these efforts to fully understand their effects.

Clearly defining roles and expectations while providing flexibility to promote innovation can support advances in Medicaid health equity interventions. Key informants emphasize the importance of having all stakeholders aligned in pursuit of common goals, such as equity, while promoting innovation. Examples from our case studies indicate that this alignment requires Medicaid agencies to develop clear definitions of roles and expectations about health equity and how progress toward it can be achieved and measured. Through years of trial and error, the Minnesota Department of Human Services learned that Integrated Health Partnership (IHP) contracts had to be more explicit about expectations for interventions that reduce health disparities, while allowing sufficient flexibility to tailor these pursuits to meet the unique needs of each community. Providers participating in IHP programs must engage community members and community-based organizations in assessing community needs and must agree on the purpose of the initiative, metrics for success, and how the initiative will operate. The state Medicaid agency is responsible for evaluating and approving the health equity plans to ensure that health equity initiatives meet community needs and have the potential to advance health equity. Similarly, Ohio's Medicaid agency took a very deliberate approach to setting an expectation that health equity is prioritized in all aspects of the Next Generation managed care program. While allowing managed care plans broad discretion in developing interventions to reach health equity goals, the agency closely monitors design and implementation of select interventions to ensure progress on health equity goals without impeding innovation. Setting clear definitions and expectations has an added benefit of facilitating implementation, as has been the case in North Carolina, where the state was able to stand up a new system for delivering social services in Medicaid by delineating roles of various partners and clearly defining a new set of services.

Stakeholder engagement is increasingly prioritized to inform intervention design and facilitate collaboration. Taking time to collect and internalize stakeholder feedback and facilitating good working relationships with key partners are central to the four state initiatives we examined in this study**.** The updates to Minnesota's IHP program and redesign of Ohio's managed care program were both informed by stakeholder engagement process, including listening sessions with Medicaid members and communities in Ohio. While putting up new Medicaid initiatives for public comment is required by federal law, states are increasingly looking for ways to more meaningfully engage Medicaid members and community-based organizations in design and implementation of health care initiatives focused on equity (Crumley, Houston, and Bank, 2023; Everette, Sathasivam, and Siegel 2023; Zhu and Rowland 2020; Zhu et al. 2021). Carefully listening and incorporating feedback from stakeholders and members can enhance program design and support desired goals, and are particularly important when evidence on how to effectively eliminate inequities is inconclusive. For example, introducing population-based payments allowed Minnesota to address providers' concerns about lack of resources to make the necessary practice changes to coordinate care, promoted provider participation, and aligned the IHP program with the state's health equity goals. Effective member engagement is emphasized in Ohio, where managed care plans must recruit members to participate in newly formed Member and Family Advisory Councils and demonstrate that proposed community investment projects are directly informed by and tied to needs and preferences of communities they will serve. The state is in regular communication with health plans to facilitate implementation, collaboration, and ongoing monitoring and improvement of health equity interventions. NC Medicaid is closely monitoring the implementation of Healthy Opportunities Pilots and constantly collecting feedback from all partners and Pilot participants to learn how the intervention is going and what could be improved. Oregon informants give credit for the responsive design of the model to support centers in delivering holistic care, and for the growth and sustainability of the APCM program, to OHA's openness to soliciting and absorbing feedback through effective collaboration with community health centers.

Infrastructure investments are necessary to operationalize and sustain health equity efforts. The success of any initiative is dependent on how well health plans and providers can execute on the design or directive. Moreover, the ability to identify and address health disparities is largely dependent on improvements to Medicaid data systems, including collection and reporting of outcomes by race, ethnicity, and other key characteristics of Medicaid members (GIH 2021; James et al. 2023; MACPAC 2022a). Key informants indicated how important it was that state Medicaid agencies ensure that health plans and providers have the capacity and resources to deliver the intervention. North Carolina began building the infrastructure for addressing patients' social needs with the launch of the NCCARE360 referral platform, which is a public-private venture between the North Carolina Department of Health

and Human Services and the Foundation for Health Leadership & Innovation.[61] In addition, NC Medicaid worked closely with key stakeholders to expand on that infrastructure by developing systems and processes that integrated community-based organizations as Medicaid-enrolled providers. In an example of provider investments, the OHA recognized that community health centers needed a different way of reimbursement to have the flexibility to address underlying problems that contribute to the poor health of Medicaid members. Similarly, Minnesota's IHP program introduced a supplemental up-front payment for providers to support capacity building and promote interventions that go beyond traditional primary care and respond to high-priority community needs. Ohio launched several infrastructure improvements to its underlying technology and information systems to minimize provider burden and improve the ability of Medicaid providers to effectively coordinate patient care.

Evaluation is critical but often missing. While there is promise that Medicaid payment and purchasing strategies can be harnessed to promote health equity (Bailit Health 2023; Kenney et al. 2019; Manatt Health 2022; Smithey, Patel, and McGinnis 2022),[62] the evidence base is lacking to fully quantify the return when investing in models that have the capacity to advance equity. While initiatives in North Carolina and Ohio are brand-new, we do not fully understand the effects of long-standing programs in Oregon and Minnesota beyond anecdotal reports of improved care from patients and providers. While patient stories and provider feedback are valuable in assessing whether the interventions are on the right track, these programs currently lack empirical evidence showing that the investments are associated with equitable health outcomes or reductions in disparities. There are several reasons for this limited evidence base, including a relatively limited focus on health equity in previous interventions, incomplete data to fully assess disparities and progress on closing them, and limited resources and capacity for evaluation. As indicated above and confirmed in our interviews, Medicaid programs are underfunded and often short-staffed and need to prioritize services over data and research.[63] This reality highlights the critical need for greater public and private investments in research and evaluation to grow the evidence base and accelerate implementation of effective strategies that can advance health equity.

Conclusion

Our findings suggest that Medicaid payment and purchasing strategies have the potential to advance equity, even when the term "equity" is not explicitly used. Effective stakeholder engagement and strong partnerships and collaboration seem to be common denominators in promising initiatives. Case-study states have also invested in developing underlying infrastructure and supporting providers in delivering

equitable care. Despite limited evidence on what works, Medicaid programs in this study as well as many others across the country are increasingly pursuing strategies and innovation to tackle longstanding health disparities in their programs. Limited evidence, however, places these health equity initiatives at risk during an unfavorable political climate or economic downturn. Explicitly integrating equity in Medicaid's mission, programming, and operations can help sustain these efforts. Greater emphasis on research, evaluation, and dissemination of effective strategies could accelerate and expand adoption of health equity interventions in Medicaid.

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