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Leveraging Virtual Health within a Value-Based Care Framework

Advancing Health Equity in the Medicaid Population

A joint report from the Deloitte Public Health Transformation Offering and United States of Care

January 23, 2023

“When we talk about working with stakeholders across the health care ecosystem, this is what we mean. Together, with health care thought leaders like the ones who attended the Greenhouse event convened by Deloitte and United States of Care, we can build a better system for health that meets people's unique needs and treats them as a whole person. I am excited to be working with United States of Care to create a new model aimed at building a set of systems to serve the health and well-being needs of people and works better for them.”

- David Betts

The Deloitte Public Health Transformation Offering

Deloitte’s Public Health Transformation offering is committed to modernizing a community-driven, multi-sector health ecosystem where public health leaders collaborate across sectors and guide systems that influence the nation’s health. We defined a foundational framework that addresses challenges in the public health workforce, data modernization, digital platforms, social determinants of health, and health equity.

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"We're thrilled to be collaborating with people and experts across the system to make sure that new payment models center and increase health equity and meet people's needs. At United States of Care, we know that we, as a country, need to create policy differently and we're so pleased to do so with Deloitte through the Greenhouse experience. Building a better health care system means building solutions differently, with a big tent and a welcoming table.

USofCare is committed to building a system that meets people's needs — one that's affordable, dependable, personalized, and understandable — and a value-based approach in Medicaid payment is a major step that we're excited to be working toward."

- Natalie Davis

United States of Care

United States of Care (USofCare) is a non-partisan, non-profit advocacy organization working to ensure everyone has access to quality, affordable health care. By putting the needs of people at the forefront of our research and policy solutions, we can create a health care system that works for people.

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Executive Summary

On June 21st, 2022, United States of Care and Deloitte Consulting convened a group of influential health care thought leaders to discuss two predominant topics in the industry: health equity and virtual health. The session, a Deloitte Greenhouse® experience, was held in an innovative technology-enabled space led by expert facilitators. This day-long collaborative session focused on opportunities to leverage virtual health tools to advance health equity in the Medicaid population within a value-based care framework. Six major themes surfaced from the session, supported by thirty-six initiatives the participating health care leaders collaboratively identified during the discussion. Three key initiatives were prioritized to support a strong foundation which influenced the creation of a Medicaid-first, value-based care model. The following document shares the journey this work took from initial ideation of the topic to the Greenhouse session and concludes with a synthesis of the model and identification of key initiatives.

Core Framework

Overview

The COVID-19 pandemic both highlighted and exacerbated significant inequities in public health and health care delivery across the US. The pandemic exposed in a clear light the social, structural, and historical factors that have created unequal opportunities for individual and community health and well-being. Health executives and policymakers have increasingly elevated improving health equity and reducing health disparities as priorities. Addressing these challenges will require a collective approach, reflecting inputs across the spectrum of public and private sector services. To drive such a collective response and to facilitate a collaborative approach to improving equity, access and outcomes, United States of Care and Deloitte Consulting convened a group of influential health care thought leaders in June at Deloitte University in a Deloitte Greenhouse Experience® to tackle the following important question: **What are the individual and collective actions participants or other key stakeholders can take to improve access and outcomes and enhance health equity through virtual health in Medicaid populations?**

At the core of this challenging question is the Medicaid population. Far from being a single "population," state Medicaid programs provide care and coverage to an expanding and increasingly diverse group of people across a broad range of programs. State Medicaid programs are partnerships between the federal government and the state wherein each state determines the design of their unique Medicaid coverage plan including the coverage and reimbursement of virtual health services.

Driven in large part by a combination of mandates for continuous coverage under the ongoing Public Health Emergency (PHE), together with increasing economic insecurity, national Medicaid enrollment increased by 25% to 81.2 million people across the United States as of April 2022.[1] This accounts for roughly 25% of the United States population.[2] And, as membership has grown, so too has Medicaid spending, growing to $671.2 billion in 2020, or 16% of the total national health expenditure.[3] Many Medicaid beneficiaries have multiple chronic conditions, increasing their risk for poor outcomes and high-cost services including hospitalizations and emergency room visits, so the opportunity to disrupt this unsustainable growth in spending is clear, as is the need to reduce inequities in access and outcomes. Virtual health represents a strong potential approach for doing so.

For this purpose, virtual health was specifically defined as the intersection of health care delivery and digital technology and includes synchronous and asynchronous modalities, encompassing all communication or transfer of information between two or more entities through technology. Tools that fall under the virtual care heading include video, audio, phone, remote patient monitoring, chat functionality, and even app-based self-management.

Just as the COVID-19 PHE drove an increase in Medicaid membership nationally through its continuous coverage mandates, it also created regulatory and operational flexibility in the provision of virtual health capabilities which supported continued access to care during periods of stay-at-home orders. The results speak for themselves; Medicaid utilization data demonstrated a spike in telehealth delivery. From March 2020 to February 2021, 32.5 million services were delivered via telehealth compared to 2.1 million services the prior year.[4] Given the long-standing systemic challenges with equity and access in the US, virtual care, if not thoughtfully deployed may risk worsening health equity and increase gaps in access (e.g., decreases in access to high-quality in-person care in lieu of virtual care among specific, socially determined patient populations).

Health equity must drive the development of care models that promote access for all through virtual care. The American Medical Association's recently released statement underscores this premise:

"Unless digitally-enabled care models are designed with health equity at the forefront, they can miss opportunities to advance health for and exacerbate inequities impacting historically marginalized populations."

In 2021, United States of Care conducted a survey to understand the level of support various population groups had to continue receiving virtual care. Within the groups that included people of color, people with low income, and rural communities, roughly 83% of respondents communicated a strong level of support.[5] In general, United States of Care found that people want the flexibility to choose when and whether to receive in-person or virtual care, when clinically appropriate. Delivering the flexibility that people want while also addressing the challenges of providing quality, cohesive, connected care requires a multi-stakeholder approach to rethinking the systems of care and coverage available to individuals within the Medicaid program.

Currently, fragmentation of care composed of dependencies and missed interactions across organizations both within and outside of health care, poses a significant challenge to health care

access, quality, and outcomes. Although major organizations across the health care system have a desire to enact change and achieve improvement toward a more equitable health system, each alone does not necessarily have the incentive, resources, or financial capacity to do so. Furthermore, most of these major players – including providers and delivery systems, health plans and payers, social service and community-based organizations, and health technology companies – do not individually hold each piece of the puzzle necessary to support this systemic change. Achieving health equity objectives will require these stakeholders across the health care system to come to the table and contribute each of their unique capabilities, encourage collaboration in areas such as data sharing, and work collectively to align incentives to improve health outcomes. The most important stakeholders to be considered are the people who use the health care system. Patients are often frustrated and confused by the health care system, particularly those in historically marginalized groups.

United States of Care focuses on amplifying the patient voice and putting people at the center of health care. Their Voices of Real Life council brings together a group of people who each represent a variety of backgrounds and have diverse experiences with the health care system. This group comes together on a volunteer basis to guide and advise USofCare's work to influence health care policies that better serve all people. This includes the perspectives of people who are more likely to be affected by policies and practices that keep quality care out of reach for many. USofCare also conducts extensive listening work with people across the country to learn about their interactions with the health care system.

While critical, large adjustments in strategies, partnerships, and technologies in the health care system can also have a destabilizing influence. One person shared their personal experience related to changes within the health care system:

"I think of [healthcare] as a highway that's undergoing a construction project. And if you do a huge change to the system, it will be like driving on a highway that's got construction going on. And it's a mess, and there's no telling how long it will take to get everything smoothed out."

- USofCare Health Equity Focus Group Participant

This sentiment – reflecting uncertainty and insecurity around change in the health care system – is widespread. Centering the patient experience in designing or considering systems changes counteracts this source of disruption through clear and consistent communication, supportive services, and transparency. Enacting change around a topic as extensive and multifaceted as health equity requires dedicated time and a unique set of leaders to activate transformative conversations.

Given the multi-stakeholder, complex, "wicked problem" nature of this issue, the Deloitte Greenhouse Experience® presented an opportunity to serve as an incubator for this type of conversation.

Deloitte Greenhouse® Experience

To drive innovative and productive conversations related to the topic of improving access and outcomes and enhancing health equity for the Medicaid population through virtual care a Deloitte Greenhouse Experience® session was held on June 21st, 2022, at Deloitte University. What do we mean by "Greenhouse?" A greenhouse is a supportive structure for plants to grow. Once the plants are grown, they can be transported into a new home, into nature, or into a grocery store.

The Deloitte Greenhouse® Experience replicates this greenhouse concept by bringing leaders and change-makers together in an innovative space to tackle their biggest challenges. In this case, the challenge spans beyond one organization or even one sector. Instead, it affects traditional health care and other major players within the ecosystem, while also interacting with and being influenced by sectors beyond health care. The session immersed participants in a technology-enabled space led by expert facilitators who guide and challenge the course of conversation to produce transformative outputs. Throughout the session, the group of thought leaders focused specifically on addressing the core question:

What are the individual and collective actions participants or other key stakeholders can take to improve access and outcomes and enhance health equity through virtual health in Medicaid populations?

Figure 1: Greenhouse attendees participating in an activity at Deloitte University

Due to the complexity of this topic and the widespread dependencies across the health care system, thought leaders across traditional and non-traditional health care sectors were strategically selected to come together and participate in the conversation. More than 20 leaders representing sectors including health plans, providers, technology, policy, advocacy, and patient experience attended and contributed to the discussion. This collection of organizations representing varied perspectives, motivations, and resources focused on patient perspectives to ensure the conversation aligned on solutions with real-world experience and needs at the center.

Overview of the Greenhouse Themes

In tackling the core question, the Greenhouse discussions revealed that the actions required to address the challenge align into six major themes as depicted below in Figure 2. There is some natural overlap across the themes which highlights the interwoven nature of the health care ecosystem and further emphasizes the necessity to approach the solution as a collective effort.

At the heart of the participants' discussion was the need to better define a value-based care (VBC) model designed specifically for Medicaid populations. The themes collectively highlight essential components to support a successful such model. Value-based programs support better care for individuals and better health for populations at a lower cost.[6] State Medicaid agencies are increasingly turning to value-based payment as a basic feature of care delivery reform.[7] This approach focuses on preventive and collaborative care through proactive, data-driven care delivery to generate more favorable health outcomes.[8]

Enhanced Data Aggregation

Data uncovers insights and assists in predicting better health outcomes. This is applicable to traditional health data as well as non-clinical, social determinants of health that impact individuals based on their unique situation and health needs; building trust around data and promoting interoperability are just two of the necessary components

Medicaid-First Design

Historically there has been more investment in Medicare and commercial programs in payment model design; if solutions are designed with a particular population in mind, it is more likely to support the beneficiaries unique needs and enhance health equity

Improved Reimbursement & Realigned Incentives

In order to enable change in the system to advance health equity, reimbursement of services and incentives must be aligned with the desired outcomes and ensure the major players in the health care system are working toward the same goals

Community Engagement

It is critical to involve community resources and develop support systems to help individuals feel empowered about their health care journey which builds trust in the system and enhances health equity for populations underserved by the health care system.

Health System & Provider Support

In order to build holistic support throughout the health system, provider groups and systems can play a role in piloting efforts in safety net provider organizations, evolving care teams to support underserved populations, and supporting reimbursement of care coordination efforts. Providers and health systems must have access to the resources necessary to support this type of model

Person-Directed Quality Metrics

Health equity is enhanced through the intentional desire to understand the patient population and work toward reaching their desired health outcomes; furthermore, incorporating these person-directed metrics into more universal drivers such as medical loss ratio and quality-adjusted life year

Figure 2: Greenhouse themes

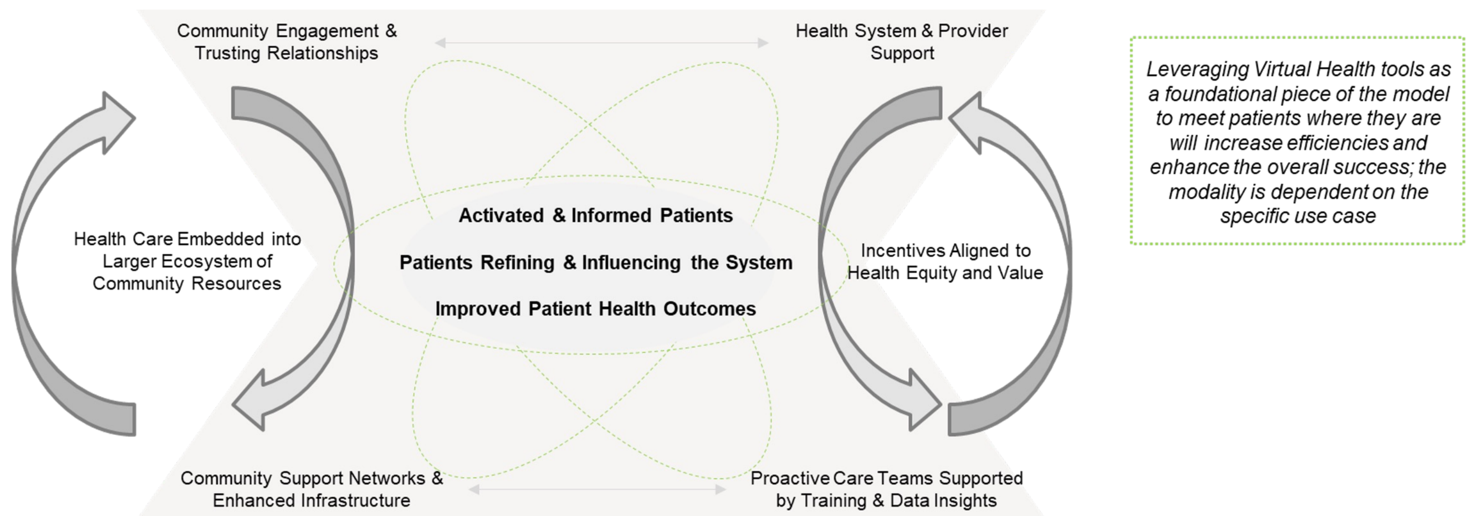

Figure 3: Medicaid-First Value-Based Care model

Figure 3 organizes these themes into a cohesive framework. With the individual at the center, this framework emphasizes the foundational importance of technology in care coordination and continuity and highlights key components needed to support success in VBC. It is designed as a Medicaid-first VBC framework and intends to achieve several goals including:

- Supporting individuals to activate around their health care needs and feel informed about the system
- Helping individuals feel empowered to further refine the system and be active participants in decisions about their health
- Health systems reflecting the needs of individuals and communities, generating improved health outcomes

Embedding communal support, such as community health workers, into the health care ecosystem, and connecting people to adequate resources is critical to this success. This approach also highlights the need to incentivize the achievement of health equity objectives as a component of quality care. Once incentives are aligned, health systems and providers can receive sufficient infrastructural support, training, and data insights to mobilize proactive care teams. Alignment to value encourages follow-up and care coordination across a patient's team of providers to address the holistic needs of the patient to support positive health outcomes and enhance overall health.

The bi-directional arrows spanning the top and bottom of the model, and the cycles outlined on the left and right sides, represent the mutual reinforcement of the four quadrants. Each piece is necessary to support the model and highlights the fluid nature of health care. The left side of the model showcases the important role played by community engagement and support networks in serving Medicaid populations by proactively engaging community members to invest in their health while gaining a deeper understanding of their needs.

A foundational component of the model is virtual health. Virtual health can be a tool for health equity, providing more opportunities for people to access the care they need. However, virtual health is not a one-size-fits-all solution and various modalities should be applied based on preference, access, and quality. This also includes recognizing infrastructural needs among populations long marginalized by the health care system, including rural communities or other medically underserved populations. Technology-driven care runs the risk of exacerbation of existing disparities if not deployed in culturally appropriate ways. Considerations include building and maintaining trust, as people may not trust the privacy, security, and quality of virtual health tools. Building trust in the providers behind the technology as well as the technology itself will further support success.

The concept of "Medicaid first" surfaced throughout the Greenhouse session and became clear as a key driver of effective value-based care design. Meanwhile, commercial payers operate alongside these publicly funded models to provide managed care plans and services in both Medicaid and Medicare settings, in addition to offering plans across markets. These distinctions create inherent complexity in the Medicaid program, underscoring the value of prioritizing standardized, data-driven quality incentives in Medicaid populations. Further, Medicaid programs are a practical starting point for the design and delivery of value-based care because programs operate statewide, have relatively robust provider networks, and can follow representative samples of their population through health care settings, life events, and social needs to assess effectiveness. One of the Greenhouse thought leaders emphasized this point, illuminating that value-based care models that improve outcomes in Medicaid populations may be more likely to be effective in other populations and settings:

"If you specifically design a program with Medicaid in mind at the outset, it will be more likely to support the beneficiaries." To better understand the specific needs of beneficiaries and build value-based care models reflective of the population, "think about working with people with lived experience; approaching this from the lens of the people being impacted."

In addition to leading with the needs of the populations served by the model, another foundational element is determining the process for measuring success of the model over time. Defining initial evaluation criteria is important to support successful and smooth evaluation once the model is in place. Operationalizing the model can be further supported by selecting initial stakeholder groups to engage. The thought leaders agreed the first groups to engage should be Medicaid managed care plans, state Medicaid agencies, and the Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) and Center for Medicaid and CHIP Services (CMCS). Each of these groups has a deep understanding

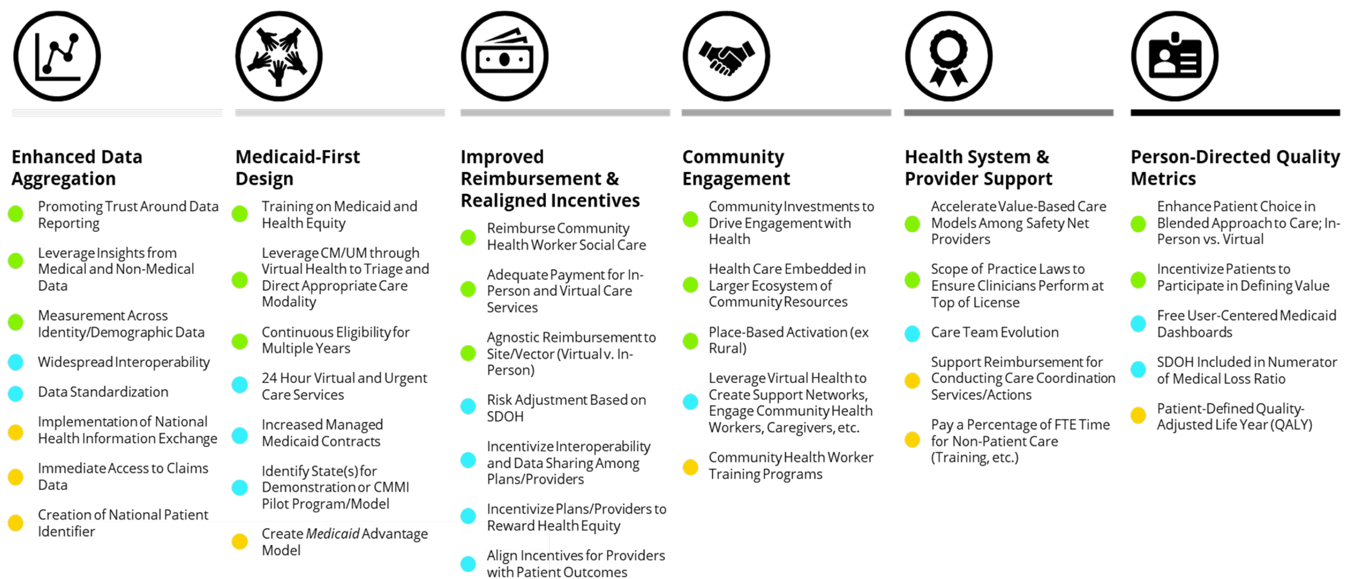

Figure 4: Medicaid-First Value-Based Care initiatives

of and influence around health care payment models, specifically in Medicaid programs. CMMI's vision for the next 10 years includes supporting innovation in Medicaid and has a goal of investing in innovative models to advance primary care and health equity.[9] Building on momentum across these key stakeholders to address health care quality and health equity, a few key initiatives provide a starting point.

Refining Key Initiatives

Throughout the Greenhouse session, thought leaders identified a list of thirty-six initiatives shown in Figure 4, which fall underneath the six themes. This is not an exhaustive list and there are countless others that could also fall under these major themes. These Greenhouse initiatives were further delineated along a timeline based on the feasibility to accomplish and current progress. Green represents the near-term, blue mid-term, and orange long-term. Once the initiatives were synthesized and the themes were developed into a model, the next step involved tactically identifying the key supporting initiatives.

Thought leaders came to a collective agreement on three key initiatives to build the foundation for a Medicaid-first value-based care approach aligned to the unique needs of Medicaid members. The initiatives include: 1) measurement across identity and demographic data, 2) continuous eligibility for multiple years, and 3) acceleration of value-based care models among safety net providers. Although these three have been identified as the first to act upon, there are several others that could supplement or support the efforts to build a strong foundation. Some of the other notable initiatives include enhancing interoperability, building community trust, and enhancing community engagement.

The key initiatives are outlined below, including an overview as well as detail highlighting the importance of each in building a model for the Medicaid populations.

Measurement Across Identity and Demographic Data

Health care data are notoriously fragmented, inconsistent, and incomplete across providers and health systems. Data specifically related to identity and demographic identifiers have not historically been prioritized or systematized. While recognizing the sensitivity of these data and the potential for discrimination, it is critical to acknowledge that these types of data can help policymakers, health systems, and care teams understand the systemic impact of health and social inequity, meet needs of underserved communities, and identify trends to inform investments and care. Medicaid members incorporate a wide diversity of demographics representing unique health-related social needs. In building approaches specific to the Medicaid population, these data are of paramount importance. Although improved data collection alone is not enough to solve long-standing health disparities, it is a critical foundational step in creating a program to redress inequity and improve outcomes. Furthermore, connecting health outcomes to sociodemographic identifiers enhances the move toward value-based care where value is tied to the unique needs of the beneficiaries.

Continuous Eligibility for Multiple Years

"Churn," or frequent enrollment and disenrollment from the Medicaid program due to changing circumstances among individual beneficiaries that affect eligibility (e.g., the acquisition of a seasonal job with employer-sponsored health insurance, a pregnancy) has been a consistent challenge for Medicaid beneficiaries and programs. Inconsistent coverage causes disruption to therapeutic relationships, reductions in patient activation, lack of longitudinal and reliable data across Medicaid-enrolled populations, and other associated ripple effects across health care access, equity, and outcomes. The COVID-19 PHE generated a natural experiment: a component of the federal government's pandemic response was to provide an enhanced federal match to states that maintain continuous Medicaid coverage for anyone enrolled in Medicaid through the end of the last month of the PHE. As a result, Medicaid coverage was much higher and uninsurance rates much lower than under non-PHE circumstances.[10] Under typical eligibility rules, Medicaid members are required to reverify their eligibility and renew enrollment, typically on an annual basis. Medicaid members that do not renew on time, even if they are eligible, can expect to lose coverage - whether they did not have access to the appropriate (often cumbersome) paperwork, never received their renewal notification in the mail, or encountered other purely administrative burdens ("administrative churn").[11] With the end of the PHE and expiration of this requirement in the future, states are bracing for many current Medicaid beneficiaries to lose coverage.

It's predicted that many beneficiaries will lose coverage for a variety of reasons.[12]

Approximately 9.5% of Medicaid enrollees (8.2 million individuals) may leave Medicaid due to loss of eligibility, and based on historical patterns, another 7.9% (6.8 million individuals) may lose Medicaid coverage despite being eligible. Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care.[13] Studies indicate that beneficiaries moving in and out of Medicaid coverage results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.[14] With an approach designed specifically for the Medicaid populations, eligibility could span multiple years and reduce negative impacts of churn on individuals and communities. Furthermore, technology can be used to support and enhance eligibility, enrollment, and retention processes. For example, states that text beneficiaries to notify them of their renewal requirement have higher success rates in reaching beneficiaries than those that exclusively mail these notifications;[15] states and localities have been experimenting with "one-stop-shop" person-facing eligibility and enrollment platforms across multiple public benefits programs; and health systems and social service agencies are collaborating to support community-based care providers in delivering electronic referral and enrollment services.

Accelerate Value-Based Care Models Among Safety Net Providers

"Safety net providers play an essential health equity role in Medicaid by virtue of their location in high-risk communities, their obligation to serve all community residents, and the way in which they have adapted services to meet community and patient needs." The Commonwealth Fund found two key strategies that could strengthen the health care safety net while promoting greater alignment with Medicaid practice and policy. One was related to ensuring safety net providers are consistently in-network for Medicaid managed care organizations and the other was to introduce value-based payment strategies that reward providers for achieving health equity goals for the communities they serve.[16] A pilot program with safety net providers can help build a strong foundation for value-based care strategies before expanding more broadly to other safety net providers. Furthermore, this could present an opportunity to continue to strengthen the relationship between safety net providers and Medicaid programs. When the PHE ends, safety net providers will play an important role in helping to ensure continuity of care for the millions facing potential loss of coverage.[17] Supporting these two initiatives in parallel will enhance synergies which could potentially yield even more fruitful outcomes and strengthen the foundation of the model overall.

Each of the three key initiatives are underway to some extent. Policy levers can provide opportunities to accelerate these efforts, as well as enablers to eliminate barriers that could be slowing potential progress. This supporting piece provides context about the current state of each key initiative as well as the specific impact on the Medicaid population. This additional piece outlines some of the most impactful enablers, policy levers, and accelerators to move the needle for these key initiatives.

Medicaid-first value-based care requires a collective and holistic approach. Although the Greenhouse session at Deloitte University did not solve the problem, it produced strategies for activation and buy-in from a collaborative group of thought leaders across the health care system. There is a lot more work to be done to continue momentum toward the goal of making health care more equitable and accessible.

Three Key Initiatives

A Health Equity and Virtual Health Greenhouse session at Deloitte University convened by Deloitte and United States of Care generated the synthesis of a Medicaid-first value-based care approach. Value-based care supports improved care and outcomes by treating the whole person through a proactive, data-driven approach.[18] This VBC approach was designed specifically from the lens of the Medicaid population with the goal of improving health outcomes among those historically marginalized by the health care system.

Once priorities were defined, the group of thought leaders discussed starting points. Throughout the Greenhouse session, participants identified 36 initiatives, each falling under one of the six themes. The Core Framework provides a deep dive into the Greenhouse session and development of the approach.

The group identified three of the key initiatives to activate first. While each of the 36 initiatives is important to the development of a holistic approach, some initiatives were prioritized to provide a strong foundation and increase the likelihood of long-term success. These key initiatives include: 1) measurement across identity and demographic data, 2) continuous Medicaid eligibility for multiple years, and 3) accelerate value-based care models among safety net providers. These key initiatives align with the overarching goal to support Medicaid populations, with each playing a fundamental role in supporting a more equitable health care system.

The key initiatives are described in detail below, including the current landscape, specific impact to the Medicaid population, and potential barriers.

KI1 - Measurement Across Identity and Demographic Data

1. Current Landscape

a) A recent report co-authored by Deloitte's Health Equity Institute and funded by Elevance Health, a Greenhouse participant, highlighted the momentum to reduce health inequities and, more specifically, identified the need to access high-quality race and ethnicity data as a step toward advancing health equity.[19]

b) Research showed there was more trust in data than initially thought, although there is more work to be done in terms of collecting demographic and equity metrics. The research also highlighted that there are fewer legislative barriers than initially anticipated, but this differs on a state-by-state basis.[20]

c) The Centers for Medicare & Medicaid Services (CMS) highlighted that "collecting standardized patient demographic and language data across health care systems is an important first step toward improving population health" and also mentioned that these data are key to identifying disparities in quality of care.[21] CMS recently announced plans to issue revised guidance on how to improve the quality and completeness of data collection and how to improve measurement of health disparities across a core set of metrics.[22]

2. Impact & Barriers for the Medicaid Populations

a) Race and ethnicity data remain incomplete and inconsistent. These data are not easily shared across the health care sector, let alone other relevant agencies and entities, which makes it difficult to track health inequities and evaluate efforts to reduce them.

b) Medicaid populations have significant demographic diversity, which requires nuanced data and interpretation to contextualize individual and community needs. Measurement and analysis of identity and demographic data would facilitate the design, delivery, and evaluation of effective care plans for in Medicaid.

c) "Negative" or stigmatizing patient descriptors (e.g., words like "resistant" or "noncompliant") were found almost three times more frequently in medical records among Medicaid members compared to patients with private coverage.[23]

KI2 - Continuous Eligibility for Multiple Years

1. Current Landscape

a) Medicaid "churn" is a challenge for Medicaid programs and beneficiaries, creating discontinuity in coverage and care. Prior to the pandemic, most states were working to adopt policies or processes to reduce churn, such as accounting for anticipated income changes or improving communication processes with enrollees.[24]

b) Recently, there has been an uptick in the number of states requesting to expand continuous eligibility through Section 1115 waivers. As of May 2022, five states are in the process of considering or requesting changes that would either expand 12-month continuous eligibility to adults or implement multi-year continuous eligibility.[25]

2. Impact & Barriers for the Medicaid Populations

a) A gap in coverage may lead to gaps in access to aspects of health care such as delayed screenings for chronic illnesses. A study in commercially insured populations showed that "adults with Type 1 diabetes who experience an interruption in coverage used acute care five times more frequently after the interruption than before". Furthermore, studies of Medicaid expenditure data have shown higher costs for individuals enrolled for shorter periods of time.[26]

b) During the Public Health Emergency, eligibility has been maintained for Medicaid beneficiaries, reducing churn, and maintaining continuity of care and coverage. A unique benefit of designing an approach with the Medicaid population in mind is the opportunity to focus on reducing churn and supporting retention of consistent medical coverage while also reducing health care costs over time.

KI3 - Accelerate Value-Based Care Models Among Safety Net Providers

1. Current Landscape

a) Medicaid programs and safety net providers rely on one another for the design and delivery of care for medically underserved populations. Accordingly, "this is a particularly important time to examine [value-based care] given the heightened focus on greater equity in health [care]"[27]

2. Impact & Barriers for the Medicaid Populations

a) Safety net providers share a mission to serve medically vulnerable populations and people underserved by the health care system, oftentimes within under-resourced communities experiencing elevated health risks and shortage of professionals. Safety net systems also may lack funding for upfront investments in infrastructure needed to implement a value-based care approach.

b) Federally Qualified Health Centers & Community Health Centers need to be involved in the creation and foundation of this type of model since they treat the Medicaid population at higher volumes compared to most general hospitals and private providers.

Although these three initial efforts lay a foundation, there are other supplemental and complementary initiatives to support the approach. Some examples include interoperability, community trust, and community engagement. Interoperability supports enhanced data aggregation and analysis goals and would support care coordination and the ability to predict outcomes and proactively treat patients within the Medicaid population. Community trust is another critical aspect to establish early in the creation of a model for Medicaid populations. Trust will enhance the overall success of the model and encourage individuals to feel comfortable and secure in use of the health system. Furthermore, community engagement and activation around health care will establish more secure support networks.

There are several opportunities to positively impact the success of a Medicaid-first VBC model through the key initiatives outlined above. Work is currently being done in these areas, but the trajectory of this work will not lead to a stable foundation of a model in the near future. There are mechanisms, such as enablers, accelerators, and policy levers, to help remove barriers and prioritize completing the work to result in a positive impact for the Medicaid population. In the following section, various mechanisms are outlined related to each of the key initiatives.

"My doctors are really nice. I love them and I see them every month. One of my doctors always starts by saying, 'We have to check and see what you need and what is going on with you.' He checks if I need more medicine and if I am eating the right foods. My doctors take their time."

– Black female, USofCare focus group participant living in Denmark, South Carolina

Accelerators, Enablers, and Policy Levers

A Health Equity and Virtual Health Greenhouse session at Deloitte University convened by Deloitte and United States of Care generated the synthesis of a Medicaid-first value-based care approach. Thought leaders from across health care and public health sectors selected three key initiatives to activate first to build a strong foundation for the approach. The Key Initiatives document outlined these initiatives along with the current state of work for each. Efforts are in motion related to each of the initiatives, and accelerators, enablers, and policy levers will maintain momentum and streamline success. These solutions can range from creating pilot programs to supporting policy waivers to help eliminate barriers.

Engagement of key stakeholder groups serves as an accelerator to guide the Medicaid-first value-based care approach forward from concept to activation. Greenhouse thought leaders identified the below list of groups to engage first because of their deep understanding and influence related to health care payment models, with a specific focus on Medicaid programs:

- **Managed Care Organizations (MCOs):** In states with managed care Medicaid delivery systems, MCOs coordinate the care of attributed beneficiaries to manage cost, utilization, and quality of care.
- **State Medicaid Agencies:** These agencies oversee and implement each state's Medicaid program in partnership with CMS, including any program updates or amendments.
- **CMS Innovation Center:** CMS administers Medicare, Medicaid, and CHIP programs. CMS' strategic vision for the next ten years reflects the priority of innovation and equity in Medicaid programs.[28]

Deloitte and United States of Care have identified several accelerators, enablers, and policy levers related to each of the three key initiatives and outlined them below:

Measurement Across Identity and Demographic Data

1. Accelerators and Enablers

a) Provide adequate resources for providers, health systems, and plans to collect, analyze, share, and apply race and ethnicity data[29] to identify and address inequities in care delivery and outcomes. Require participation in collection efforts for consistency across organizations.

b) Create standard data collection processes and build consensus around roles in collecting and sharing data.[30] Solicit community input around interpreting data, developing inclusive quality metrics and data standards, and reflecting the patient experience in data and outputs.

c) Engage the National Quality Forum (NQF) to help improve and operationalize standards around identity and demographic data.

d) Build consumer trust through enhanced community engagement and communication about data security and privacy, recognizing that there are no state or federal laws that bar stakeholder groups from collecting and sharing race and ethnicity data for a permitted purpose.[31]

2. Policy Levers

a) Guardrails developed by government agencies, with support from health care stakeholders, can ensure data security and patient privacy while using data to drive improved equity and outcomes.

b) State Spotlight: An example of current policy action is the enactment of Colorado's public health insurance option, the Colorado Option. Under the Colorado Option, plan issuers will be required to establish culturally responsive provider networks. A key component of this effort will be to collect voluntarily reported demographic data for both in-network providers and plan enrollees. Data elements that issuers will collect include race and ethnicity, sexual orientation and gender identity, and ability status. Demographic data collected will be confidential and de-identified.[32]

Continuous Eligibility for Multiple Years

1. Accelerators and Enablers

a) The Public Health Emergency (PHE) broadened coverage and protected eligibility, which in turn reduced Medicaid enrollment churn and the attendant negative impacts. This allows health care policymakers and stakeholders to demonstrate the importance and impact of broadening coverage and expanding eligibility and enrollment in Medicaid.

b) Apply virtual health technology and data insights to enhance and streamline more accessible renewal processes for Medicaid enrollment and renewal.

2. Policy Levers

a) Aggregate data demonstrating enhanced quality and patient outcomes to support continuous Medicaid eligibility. These data may be supported by the census or other population-level data sources to help determine the population who were supported throughout the PHE.

b) Allow flexibility for state Medicaid programs to work with contractors, including managed care organizations, to use strategies beyond mail, like text messaging, to message information about eligibility and enrollment.[33]

c) Utilize Medicaid waiver options, including Section 1115 demonstrations, to update eligibility and enrollment processes on a per-state basis to demonstrate feasibility and value of the approach. Roll out successful strategies more widely across the country. For example, as of May 2022, 5 states are in the process of considering or requesting changes that would expand 12-month continuous eligibility to adults or implement multi-year continuous eligibility.[34]

d) State Spotlight: Oregon has requested federal approval for an amendment to its comprehensive 1115 waiver to allow for continuous Medicaid enrollment for children up to age 6 and establish two-year continuous enrollment for Medicaid beneficiaries above age six.[35]

Accelerate Value-Based Care Models Among Safety Net Providers

1. Accelerators and Enablers

a) Determine efficient processes to understand capacity of safety net providers, accommodating distinct types of support for different practices (e.g., technology infrastructure, workflow support, staffing) as each will require different types of support.

b) Provide initial investment to hospitals to supply capabilities needed to stand up value-based care (VBC), sharing the investments and support across providers and across Medicaid

c) Ensure that Medicaid-first VBC approaches are usable by federally qualified health centers (FQHCs) and other community health centers[36]

d) Recognize and mitigate risk associated with moving to VBC approaches by balancing upside and downside risk among providers newer to VBC arrangements and those serving higher-risk populations.

e) Refrain from baselining against historical metrics that are inherently biased; this could be accomplished through organizational-level risk adjustment based on the patient population or technical level related to benchmarks.

2. Policy Levers

a) Establishing sustainable reimbursement rates for safety net providers, including advanced investment payments to support transformed care for medically underserved communities and incorporate safety net providers in VBC.

b) State Spotlight: 18 Massachusetts FQHCs formed a Community Care Cooperative in 2016 to launch the first Medicaid ACO led by FQHCs. It received $19.8 million in startup funds from the state and federal government to pay for population health staff and software. The software enabled the Cooperative to build a tracking system to understand where patients receive care through sharing data across systems. This informs how they deploy field staff, including community health workers. Currently, "Community Care Cooperative's health centers care for 163,000 Medicaid beneficiaries" and contracts directly with the state to receive payments for their patients "which it distributes to member health centers." The health centers receive shared savings or losses depending on their performance against various predefined quality metrics.[37]

Accelerators, enablers, and policy levers can help remove barriers and increase efficiencies to accomplish key initiatives in the near term. An important perspective expressed by health care leaders in the Greenhouse session was that this is a collective effort. Stakeholder groups can identify areas of alignment and leverage their unique resources or perspectives to make an impact on such a vast and complex ecosystem. The list above is a starting point to highlight various ways to further the progress of each of the key initiatives, but now action is needed to start realizing benefits for Medicaid populations.

Endnotes

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