Group Medicare Insights: Industry news and trends

Three CMS initiatives for equity in value-based care

The benefits of a value-based care and payment model over a fee-for-service model are well-documented when it comes to measures such as quality of care, coordination among providers, and improved patient outcomes. But the value-based model also has great potential for reducing health disparities among different populations, helping to achieve health equity goals.

Historically, value-based care programs and payment models did not necessarily prioritize equity-related outcomes.

"The original value-based payment models were focused on population health, and that doesn't necessarily mean improving equity," says Dr. William Bleser, Research Director of Health Care Transformation for Social Needs and Health Equity at the Duke-Margolis Institute for Health Policy.

However, this is changing with the introduction of new CMS initiativesv that promote alignment between health equity outcomes and care delivery and payment models.

"CMS is pushing plans to get more data-driven and become more specific in how we address social needs and health equity," says Stephanie Franklin, Director of Health Equity Strategy at Humana. She adds that value-based care has demonstrated "an ability to align the whole continuum of care around a shared cause and shared values."

Some of the new CMS initiatives are coming into effect soon or are already being implemented. This makes it important for Medicare Advantage organizations to become familiar with the new rules and determine how they will incorporate them into their health equity strategies.

What is health equity?

Before changing any policies, updating strategy, or refining a plan's design, it's important to first understand what is meant by the term health equity. This means defining it within the context of health disparity and health equality (or inequality), according to Dr. Bleser.

A health disparity refers to a difference in a particular health outcome or process measure between two different populations, but without attributing any value or reason to that disparity. "Health inequality brings in the connotation that this difference is unjust, and it's not supposed to be that way," explains Dr. Bleser.

Health equity goes one step further, drawing a link to structural and systemic causes, such as differences in the environment that people grow up in, socio-demographic status, employment, race and ethnicity, and how different people are treated within societal structures.

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"A health inequity is an unjust difference between two populations in some health metric that matters for quality, or value, or experience in healthcare, and this is caused by structural and systemic differences in society," says Dr. Bleser. According to Franklin, "Health equity eliminates the unjust and avoidable barriers to everyone achieving their optimal health."

Striving for equity: Value-based care vs. fee-for-service

There are several reasons why the fee-for-service model is misaligned with achieving health equity goals. For example, services that promote health equity, such as community health workers, may not be covered by the fee schedule. "Fee-for-service doesn't foster accountability for the quality of services, or the value, or who is getting them," says Dr. Bleser. "And if something isn't on the fee schedule, even if it's important for equity, it's not paid for."

In contrast, value-based models are conducive to achieving health equity goals.

Value-based payment models offer a "natural entry point" for health equity.

- Shilpa Patel, PhD, Director of Population Health and Health Equity at the Center for Health Care Strategies

Value-based payment models offer a "natural entry point" for health equity, according to Shilpa Patel, PhD, Director of Population Health and Health Equity at the Center for Health Care Strategies. "The focus from volume to value offers an entry point and approach to understanding how VBP models can be a potential lever to reduce health disparities and address inequities," she says.

However, for this to happen, health equity objectives need to be embedded within the design and implementation of value-based payment models. Providers also need to be empowered and incentivized to leverage population health data, develop partnerships within communities, and bring in services such as behavioral health and social needs programs, in addition to comprehensive clinical care.

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"If value-based models do not have health equity as an explicit goal, we're not going to achieve the full potential," says Franklin. She adds that it's also important to define what is meant by value. "We can define value as reducing disparities between populations or improving the performance of a particularly vulnerable population," she says.

How new CMS initiatives aim to advance health equity

Over the last five years, CMS has expanded the types of supplemental benefits that Medicare Advantage plans can offer, to include services that are not primarily health related. For example, special supplemental benefits for the chronically ill (SSBCI) enables plans to address health related social needs in ways that differ from what's permitted within the standard supplemental benefits framework. This allows plans to customize benefits for members who have specific clinical and social needs, an important step toward achieving health equity.

More recently, CMS released an updated framework with specific initiatives geared toward achieving health equity and reducing health disparities. Medicare Advantage organizations should assess their health equity strategies to ensure alignment with the new CMS requirements and make any changes needed. This could include changes to plan design, implementation, incentive structures, forging new partnerships with healthcare practitioners, ensuring proper resourcing, or moving providers to a value-based care and payment model.
Here's an in-depth look at the health equity-focused CMS initiatives.

CMS initiative #1: Health equity index in Star Ratings

Star Ratings are an important part of Medicare Advantage organizations' strategy because they impact plan revenue. The Star Ratings system is undergoing a major change: CMS is incorporating a health equity index that will reward contracts that improve care for populations with social risk factors. This will go into effect beginning with the 2027 Star Ratings, based on data collected in 2024 and 2025.

"CMS is trying to incentivize Medicare Advantage plans to align our incentives around strong quality attainment for members with social risk factors," says Franklin. "The Stars health equity index is a huge lever."

The health equity index is meant to encourage Medicare Advantage organizations to enroll and better serve beneficiaries with social risk factors (e.g. low-income, dual-eligible, and disabled populations.) Medicare Advantage organizations must meet the minimum threshold of beneficiaries with social risk factors to be eligible for rewards.

CMS initiative #2: New physician payment rules

To help advance a value-based care strategy that prioritizes equity, CMS is refining the physician fee schedule. This rule, which went into effect on Jan. 1, 2024, includes separate coding and payment for certain services that facilitate access to community-based social services to address unmet social determinants of health (SDOH) needs. For example:

- Separate payment for community health integration and care navigation services for people with serious illnesses. This takes into account clinicians who involve healthcare support staff, such as community health workers.

- New coding and payment for SDOH risk assessments to account for practitioners who spend time and resources assessing SDOH that may impact their ability to treat a patient. This is also being added to the annual wellness visit.

These new rules are good news for fee-for-service providers who are looking to transition to a value-based model.

"There are providers who are on a path to value and are starting to make those investments in social needs care," says Franklin. "And now we have a way to code and bill for that part of care."

When it comes to Medicare Advantage, Dr. Bleser says plans can use value-based contracting with providers, including equity designs within their contracts.

"There's no reason they can't incentivize disparity reduction. Medicare Advantage plans within value-based contracts can pursue those pieces," he says, adding that Medicare Advantage organizations should also look at their provider networks and ensure they're not leaving out providers who have a history of working with marginalized communities.

CMS initiative #3: Annual health equity analysis

To help ensure equitable access to benefits and to reduce the task of seeking prior authorizations, CMS has issued the following requirements:

By Jan. 1, 2025, Medicare Advantage plans must include on their utilization management committee an individual who has health equity expertise. The utilization management committee is a group of clinicians who review protocols for prior authorization.

The utilization management committee must conduct an annual plan-level health equity analysis on the impact that prior authorization policies have on beneficiaries with social risk factors (e.g. low income or disabled) versus those without.

All Medicare Advantage organizations offering Part D benefits are included in this new CMS rule. The purpose is to provide a mechanism that allows Medicare Advantage organizations and CMS to determine whether prior authorization requirements may be contributing to disparities among beneficiaries with certain social risk factors.

A winning strategy for everyone

To ensure the success of value-based models that incorporate health equity objectives, it's important to get buy-in from different stakeholder groups.

"You need to get buy-in from those who will be engaging with this model," says Dr. Patel. "One of the opportunities is stronger engagement with providers, members, and communities as part of this work."

While moving to a value-based model and embedding equity-focused goals may entail a lot of work, it's worth the effort for a number of reasons. Chief among these is that pursuing equity is simply the right thing to do from a moral and ethical standpoint, according to Dr. Bleser. It also benefits everyone, including members, payers, providers, plan sponsors, and society as a whole.

"From a plan perspective this is a way to engage populations that the plan may not have been good at engaging before," he says. "It's moving to a better system for everyone."