ADVANCING HEALTH EQUITY:

LEADING CARE, PAYMENT, AND SYSTEMS TRANSFORMATION

Learning Collaborative Team Profiles

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AHE Advancing Health Equity

Leading care, payment, and systems transformation

Program Background

Launched in 2019, the Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) program Learning Collaborative (LC) strives to align key stakeholders to design and implement equity-focused health care transformation interventions supported by integrated payment models.

Those stakeholders include:

- State Medicaid agencies
- Medicaid managed care organizations
- Health care delivery organizations
- Community-based organizations
- Individuals with lived experience of Medicaid

The first Learning Collaborative cohort was comprised of seven teams that worked with stakeholders to achieve multiple, interconnected goals:

- Convene key Medicaid stakeholders to integrate and synchronize equity goals and activities
- Address at least one health equity focus area
- Diagnose the unique patient, provider, community, organizational, and policy-level factors leading to the health inequities
- Design and implement a tailored, integrated care and payment transformation

The AHE Learning Collaborative hit its stride in the midst of the COVID-19 pandemic. The stark disparities in morbidity and outcomes for COVID-19 by race/ethnicity and socioeconomic status, as well as simultaneous public outrage at police brutality against People of Color heightened awareness of systemic racism. It accelerated the pace at which individuals and organizations became ready to take their work a step further and tackle systemic racism and social drivers of health (SDOH). Those experiences made it clear that de-emphasizing any component of the **Roadmap to Advance Health Equity** diminished the chances of successfully reducing and eliminating health and healthcare inequities. Strengthening the internal and cross-organization cultures of equity in stakeholder organizations and partnering closely with individuals living with the inequities being addressed are key components of the Roadmap that should not be minimized or overlooked.

With continued support from the Robert Wood Johnson Foundation, the AHE LC teams strive to explicitly address systemic racism, oppression, and discrimination to advance health equity and build authentic partnerships with communities and members/patients. In January 2023, **five new teams joined the existing LC cohort**, signaling their commitment to include individuals with lived experience of Medicaid; they also are exploring inviting community-based organizations to become a part of their care transformation initiative. The AHE team recognized that communities must be centered as decision-makers and included as essential stakeholders of our Learning Collaborative. Currently, the AHE program is in the process of substantially revising and updating its curriculum and technical assistance programming.

LEARNING COLLABORATIVE TEAM PROFILES

1 Delaware

Organization Type	Participating Organization Name
State Medicaid Agency	Delaware Health and Social Services, Division of Medicaid & Medical Assistance (DMMA)
Managed Care Organization(s)	AmeriHealth Caritas Delaware (ACDE)
Health Care Delivery Organization(s)	Nemours Children's Health (Nemours)

Identifying and Diagnosing the Problem

The first years of a person's life have a significant impact on their growth, development, and future health yet prevalent **racial and ethnic inequities in pediatric health and healthcare** create barriers for some children to be as healthy as possible. The Delaware team is focused on reducing inequities in preventive care and health among Black and Latine pediatric populations.

First, the team initially reconciled conflicting race, ethnicity, and language (REL) data across AmeriHealth Caritas and Nemours Children's Health and identified four healthcare metrics with inequities: childhood immunization rates; lead screenings; well child visits; and potentially preventable emergency department (ED) admissions. Next, the team conducted a root cause analysis (RCA). The team partnered with Amerihealth Caritas Delaware community health navigators to design a survey that assessed causes for frequent ED/urgent care usage and missed well-child visits. The survey was distributed to Nemours' frontline staff and community partners. The information shared helped the Delaware team identify four primary root causes of missed or late well-child visits and reasons for potentially preventable ED usage:

1. Patient barriers to knowledge about the importance of well-child visits and lead screenings.
2. High ED utilization due to limited and inconvenient access to primary care providers (PCP) and access barriers to health-related social needs (HRSN) such as transportation and childcare.
3. Outdated behavioral health screenings and lack of social drivers of health (SDOH) screening to capture HRSN needs.
4. Provider and staff bias against Medicaid members and lack of cultural competence.

Designing and Implementing Change

In contractual relationships, there can be power imbalances between negotiating parties. For example, a state Medicaid agency can have power over Medicaid MCOs. The state can decide what plans receive bids for Medicaid business, set terms of engagement, and control the flow of fiscal resources to plans. Alternatively, health plans and provider organizations with a large market share can hold power over state agencies because the state Medicaid agency is dependent on those organizations to meet community and patient needs. The DE team has acknowledged and is working to address the ways power and hierarchy play across the three stakeholder organizations. For example, the team's equity-centered processes such as co-creating ACO incentives tied to mutual goals and modifying contract terms based on feedback from frontline healthcare staff have encouraged power sharing among stakeholder organizations.

LEARNING COLLABORATIVE TEAM PROFILES: DELAWARE

In 2020, DMMA authorized Delaware Children's Health Network, which is affiliated with Nemours Children's Health, to establish a Medicaid Accountable Care Organization (ACO) and enter an agreement with the state's two Medicaid MCOs, Amerihealth Caritas Delaware and Highmark Health Options. Delaware Children's Health Network began its ACO contract with Amerihealth Caritas Delaware in 2021, creating an opportunity for a more robust partnership between Nemours Children's and AmeriHealth to advance health equity. The ACO established incentives for its providers to report disparities in care and health outcomes and improve care processes to eliminate specific health disparities. In addition to the ACO incentives, Amerihealth provides **upside-only**, enhanced payment incentives for the four health equity measures the team identified at the start of their initiative. Incremental incentives are earned for the reduction of each of the identified health disparities between Black and Latine pediatric populations and the white pediatric population.

If the identified health disparity gap is reduced by 3% or more over a set period of time, the provider earns the entire incentive outside of shared savings payout. If the health disparity gaps are reduced by 0 to up to 3%, the provider will earn 50% of the incentive. Incentives earned are distributed by Nemours to different provider practices. For SDOH screenings, AmeriHealth awards $10 to the provider per member when one or more diagnosis codes include SDOH, with a cap of $25,000 per measurement period for the provider pool. AmeriHealth provides Nemours with provider-level performance data for SDOH payments so Nemours can use that data to distribute funds among its provider practices.

Initiative Results

Before the ACO agreement, each organization would coordinate and review metrics separately, which resulted in a lack of coordination of quality improvement and health equity efforts across organizations. As part of ACO contract negotiation and implementation, Nemours and Amerihealth established joint meetings to increase opportunities for collaboration and avoid duplication of efforts. For example, the medical management and case management teams from Nemours and AmeriHealth assembled a care management workgroup to jointly review each quality metric of the ACO contract through an equity lens.

In early 2023, the team reviewed ACO performance data from 2022 and preliminary data from 2023 for childhood immunization, potential preventable ER visits, and well-child visit equity measures. All equity measures were stratified by race and ethnicity. The ACO reduced the disparity in two of the four equity measures in 2022; lead screening and flu immunization measures - a significant success. However, the team struggled to pinpoint what care delivery changes were responsible for reducing inequities.

Lessons Learned

By participating in the Learning Collaborative, the DE team learned the importance of embedding equity into all aspects of payer-provider relationships, including the contracting process with providers. AmeriHealth identifies disparities in quality and outcome data and then reviews the data with providers to collaboratively determine which measures to focus on. AmeriHealth now incorporates SDOH screening and health equity metrics in many of their value-based agreements across their network, including other Medicaid value-based agreements in Delaware and across markets in twelve other U.S. states and the District of Columbia.

Looking ahead, the team will be shifting resources to address upstream factors contributing to inequities. The team's equity measures in 2024 and 2025 will be primarily focused on increasing well-child visits and reducing potentially preventable ED visits for Black and Latine pediatric populations. The 2024 ACO agreement between Nemours and Amerihealth has been amended to incorporate these equity measure changes, and changes will also take effect in 2025. Additionally, the team aims to work more closely with Nemours' frontline staff and providers to understand care process changes that effectively address inequities and incorporate process measures into their payment model for the 2025 contract year. Finally, the team also plans to partner with local community-based organizations and Nemours' Patient and Family Advisory Council to inform future iterations of the care and payment model.

LEARNING COLLABORATIVE TEAM PROFILES

2 District of Columbia (DC)

Organization Type	Participating Organization Name
State Medicaid Agency	Department of Health Care Finance (DHCF)
Managed Care Organization(s)	UnitedHealthcare (UHC) Community Plan
Health Care Delivery Organization(s)	MedStar Health (Medstar)
Community Based Organization or Other Partners	DC Primary Care Association (DCPCA)

Identifying and Diagnosing the Problem

People who are enrolled in both Medicaid and Medicare, or dual eligible individuals, report higher rates of chronic conditions, including mental health diagnoses, one or more limitations to activities of daily living, and lower levels of overall health compared to Medicare-only enrollees. In the District of Columbia (DC), about 6% of the population or 37,000 people are dual eligible. In January of 2022, DCHF expanded the district's **Dual Choice** program, which **consolidated Medicaid and Medicare benefits** into a single plan to improve care coordination and reduce administrative burden for dual-eligible Members. United Healthcare (UHC) administers the **Dual Choice program**.

The DC team's focus population is dual-eligible enrollees living with substance use disorder (SUD) and who frequently visit the emergency department (ED). The team reviewed UHC healthcare process and outcome data, which highlighted a need to one, improve patient follow-up after an ED visit for mental illness and/or substance use within 7 and 30 days of discharge and two, increase initiation and engagement of SUD treatment for UHC dual-eligible members with a SUD diagnosis.

Diagnosing Root Causes

The team conducted a literature review on root causes of the inequity of focus. They identified factors that significantly affect the focus population such as lack of access to Medication Assisted Treatment (MAT) providers, lack of timely access to primary care and behavioral health services, and significant health-related social needs.

Partnering with Members and Patients

The team is developing their community and member partnership strategy. They are identifying existing avenues of member engagement at the team's respective partner organizations, including member advisory boards at UHC, a medical care advisory committee at DHCF, and patient focus groups at Medstar. The team was not able to partner with patients and communities to design their initial care model due to time constraints but will use the information to decide how they can partner with—and hold themselves accountable to—Medicaid members for the remainder of the initiative.

LEARNING COLLABORATIVE TEAM PROFILES: DC

Creating Cultures of Equity

AHE encourages teams to begin with creating a team charter that considers challenging norms that reinforce **white supremacy culture**. Those norms could be an ongoing sense of urgency that deters inclusive decision making or fear of open conflict that prioritizes group comfort over addressing tough issues. To help improve team cohesion and increase the potential for long-term success, the D.C. team established operating norms that challenged dominant hierarchies found in work culture. For example, they agreed to embrace conflict to help them uncover and nurture different, potentially overlooked perspectives. The D.C. team also co-created a common definition for health equity that guides their work.

Designing Care and Payment Transformation

To begin designing their care and payment transformation, the team gathered lessons learned from other ED, SUD, and mental health initiatives in DC such as DC Hospital Association's **Emergency Department Medication Assisted Treatment Induction** pilot for individuals with opioid use disorder.

UHC team representatives shared UHC's hospital-initiated MAT value-based care model. The model includes an initial incentive payment to a hospital provider for initiation of **buprenorphine treatment** in a hospital setting or within 3 days of hospital discharge. It provides a second incentive payment for a buprenorphine prescription by a primary care provider outside of the emergency room or inpatient setting within 7-14 days of hospital discharge. The team is using UHC's model as a base framework to begin designing its own payment model and is considering ways to improve access and coordination of primary care services after MAT initiation. The team is beginning to establish a process where key individuals and groups who would be affected by the proposed transformation, such as Medstar's ED doctors and peer recovery coaches, can share feedback with Medstar's administrative staff. Feedback would be used to improve model design and amend the current value-based contract between Medstar and UHC.

Looking Ahead

The team hopes to implement its care and payment transformation. Starting with their AHE initiative as an example, the team hopes to develop a framework for using value-based payment to advance health equity that can be implemented with all MCOs in the District of Columbia across different health conditions and populations.

In the long-term, the team hopes to continue **optimizing the integration** of Medicare and Medicaid benefits to support quality healthcare and health equity for dual-eligible members to reduce and eliminate health inequities for members with SUD and who visit the ED frequently. That integration could include alignment of Medicaid and Medicare financing and coordinated primary care, acute care, behavioral health services, and long-term services.

LEARNING COLLABORATIVE TEAM PROFILES

1 Illinois

Organization Type	Participating Organization Name
State Medicaid Agency	IL Dept. of Human Services (HFS)
Managed Care Organization(s)	CountyCare Health Plan
Health Care Delivery Organization(s)	Cook County Health (CCH)
Community Based Organization or Other Partners	Access Community Health Network (ACCESS) Center for Health and Housing

Identifying and Diagnosing the Problem

In 2023, on any given night in Illinois, an estimated 11,947 people experienced homelessness. In Chicago, that number was 6,139, a 13.9% increase from 2020, when 5,390 people were without adequate shelter. In Cook County, where Chicago is located, it is estimated that **4 out of every 10,000 people experience homelessness**, an issue closely tied to one's gender, race, and ethnicity. The cascading emotional, social, and financial impacts of homelessness have wide-reaching effects on an individual, their families, and the community at large.

People experiencing homelessness have more difficulty obtaining and maintaining primary care, leaving many to rely on high-cost emergency department visits and inpatient stays that can result in added stress to care centers and staff. In 2021, the U.S. government **spent an average of $35,578 per year** for every person experiencing chronic homelessness. Not having a safe place to lay one's head at night can severely impact one's ability to store and create healthy meals to eat, exacerbate rates of depression and other mental health issues, and prevent people from getting necessary preventative care.

The Illinois LC team's initiative serves two groups: CountyCare members experiencing homelessness and severe mental illness (SMI) and/or substance use disorder (SUD) and families with children. The team's goal is to demonstrate that housing can both improve health and create savings by reducing the use of inpatient and emergency department services for needs that can be more effectively met through community-based services.

The IL team's initiative is strengthened by its deep knowledge of structural, racial, social, and economic barriers (among others) that impact one's ability to maintain safe and stable housing. The team's partnering organizations have worked in related upstream health interventions that informed the design and implementation of their initiative. For example, CCH has developed a range of other housing-focused initiatives and HFS has implemented a program to increase behavioral health support for children and families that informed the tenancy support and wrap-around services for Medicaid members and their families in the initiative.

Designing and Implementing Change

The COVID-19 pandemic resulted in HFS directing its annual quality pay-for-performance program toward a community reinvestment fund that encouraged MCOs to invest in resources that addressed social drivers of health; it created a unique opportunity to use Medicaid funds directly toward housing. The Illinois team capitalized on the release of the

pay-for-performance withhold to invest $5 million in a Flexible Housing Pool (FHP) to house 66 CountyCare members and their families for up to 3 years, from 2021-2024.

The FHP focuses on reducing healthcare costs and improving outcomes by providing stable housing and supportive services. It expands how homelessness is defined, facilitates the creation of new affordable housing units, and works closely with landlords.

Creating Cultures of Equity

Illinois' **long history of racial discrimination and segregation** has had a significant impact on homelessness; that history inspired the Illinois team to continually improve their internal cultures of equity. CCH and CountyCare have established equity committees and implemented measures to retain and diversify staff and leadership. They also implemented a Lived Experience Advisory Council (LEAC) and governing board to help center the voices of FHP tenants throughout the duration of the program. The governing board includes Medicaid members and tenants who are voting members and have a role in governing some aspects of the FHP.

The team increased the number of members on the FHP governance board who have lived experience with homelessness to 40 percent. It is a rare example of Medicaid members holding more than just an advisory role in the care that they receive. LEAC members' valuable feedback helped the Illinois team determine which issues were most important to members experiencing homelessness and make necessary changes.

Lessons Learned

A major component of the Illinois team's project is to illustrate how a healthcare organization can look beyond typical measures of success and evaluation, such as relying on timelines to completion, to see the greater impact and value of an investment like their initiative. CountyCare, in conjunction with Cook County Health Center for Health Equity & Innovation; the Center for Housing and Health; the Center for Criminal Justice Research; and the Center for Urban Research and Learning at Loyola University as well as a CountyCare Member with lived experience, presented "Interagency/Cross Systems Collaboration: Housing is Health" at the 2024 Illinois Home Summit.

The panel recounted the FHP's various evaluation activities and important decreases in: emergency department utilization; inpatient hospital utilization; cost of care for housed members; and recidivism in the carceral system. The Loyola team discussed how the FHP can be a catalyst to stabilize and successfully launch younger populations into adulthood.

Looking Ahead

The barriers the IL team have faced are related to sustainability and programmatic challenges, which "can negatively impact outreach efforts, slow down placements to housing, [or] create staffing gaps" the team writes. In response, the IL team increased efforts to retain staff and increased modes of communication across teams to address issues when they arise. Increases in housing costs, the limited number of subsidies to cover rental costs, and challenges in finding new partners to join them in creating long-term sustainability for the program also have been barriers for the team. FHP partners continue to work closely to find new sources of funding and partnerships to support the FHP's longevity. For example, CCH and CountyCare maintain regular communication and have begun sustainability and evaluation workgroups in addition to the LEAC. Having the opportunity to share best practices with the larger AHE

community has helped the team work through questions and roadblocks as it relates to finding partners who will help them expand their initiative.

The Illinois team documented the impact of their initiative in the January 2023 **Flexible Housing Pool Early Impact Evaluation Report**, which details findings since the inception of the FHP in 2018 up to 2022. As the report's authors note: "The cumulative cost offset from reductions in the utilization of the region's crisis system among adult clients was $1.4 million… suggest[ing] that FHP was instrumental in reducing preventable crisis system utilization without sacrificing access to life-saving resources." While there is a strong indication of a high social return on investment (SROI), the program's overall costs currently exceed the cost savings. For the last several months, key members of the Illinois LC team have met with a subset of the AHE team in a small working group to focus on making a business case to stakeholders.

In Spring 2024, the team issued a request for partners (RFP) to identify potential working relationships with organizations to expand their initiative so more housing services could be provided for participants including, but not limited to: eviction prevention services, housing support, legal aid, supportive housing wrap-around services, and workforce development.

2 Louisiana

Organization Type	Participating Organization Name
State Medicaid Agency	Louisiana Department of Health (LDH)
Managed Care Organization(s):	▪ Aetna Better Health ▪ AmeriHealth Caritas ▪ Healthy Blue ▪ Humana Healthy Horizons ▪ Louisiana Healthcare Connections ▪ United Healthcare of Louisiana
Health Care Delivery Organization	TBD
Community-Based Organizations or Other Partners	TBD

Creating Cultures of Equity

Before joining the AHE Learning Collaborative the LDH added the following requirements to contracts with its six managed care organizations (MCOs) to advance health equity for its members:

- Submit health equity plans to LDH that meet key requirements detailed in the MCO contracts.
- Participate in health equity training offered by LDH.
- Provide health equity training for their contracted providers.
- Collect claims and encounter data to identify health and healthcare inequities experienced by Louisiana Medicaid members and inform strategies to reduce and eliminate them.

Care Delivery Transformation and Payment Reform

LDH aims to learn how to best support each MCO in implementing their health equity plan by using claims and claims data to inform potential strategies to address patient-level social needs and establish quality and equity **target withholds and amounts**.

LDH is transforming care delivery by reviewing its model contract with Managed Care Organizations to continue advancing health equity in Louisiana. As the state Medicaid agency, LDH is uniquely positioned to advance health equity state-wide by continuing to **leverage its contracting power** establishing health equity as a core principle and requiring contracted MCOs to adopt practices and operations that align with **LDH's equity goals**.

1 Maine

Organization Type	Participating Organization Name
State Medicaid Agency	MaineCare

Health Equity Focus

People returning to communities after incarceration face significant health challenges, including high rates of mental illness and substance use disorder. They also encounter substantial barriers to health care services access and face difficulty meeting key health-related social needs, like housing. The Maine team is exploring models to improve timely transitional care assistance and intensive case management for adults released from institutional settings such as jails or prisons. They are focused on establishing a connection to care within two days after release from prison or jail when individuals are most at risk. Their goal is to address the immediate need for support for individuals returning to the community including:

- greater continuity of care through care coordination and access to medication pre-and post-release; and
- improved health outcomes and reduced rates of recidivism, emergency department utilization, overdoses, and death.

Partnering with Patients/Members

The Maine team prioritized member engagement from the beginning of their initiative working with organizations such as the **Maine Prisoner Re-entry Network** and the **Maine Prisoner Advocacy Coalition** to better understand the needs of individuals experiencing incarceration. They also coordinated with the Office of Substance Abuse and Mental Health Services and Department of Corrections (DOC) to facilitate three rounds of focus groups with individuals at county jails and a behavioral health center. The focus groups informed both the team's health equity area of focus and their root cause analysis.

Since launching their care delivery transformation pilot at the end of 2023, the team has made additional efforts to partner with members. In 2024, their goal is to hold focus groups across 15 different jails and prisons, compensating participants for their expertise around what's most important for individuals experiencing incarceration upon release. However, state Medicaid policy allows only ongoing advisory council members to receive compensation for their time. In response, the team implemented a strategy to provide payment to Medicaid members via a partner organization.

Care Delivery Transformation and Payment Reform

The Maine team is exploring how to minimize disruptions in care due to termination or suspension of coverage that occur when adults are released from institutional settings—a particularly perilous time for individuals with substance use and mental health challenges and for whom continuity of care is critical. The team has investigated transitional care models that emphasize **whole person approaches** and intensive case management. Their care delivery transformation includes incentive payments to health care providers when they provide an eligible service (e.g., a primary care visit) within two calendar days of release from prison or jail

to motivate timely follow-up and transitions of care. Providers that are *not* eligible to receive incentive payments include: ambulance, child community rehabilitation, early childhood providers, pharmacy, inpatient hospital, school-related services, and transportation providers. MaineCare will reimburse eligible provider claims quarterly from March 2024 through March 2025.

Creating Cultures of Equity

The Department of Human Services (DHS) is developing a diversity, equity, and inclusion (DEI) strategy for each department within DHS, including MaineCare. The DEI initiatives include strategies to improve the quality and availability of data to better analyze disparities; meaningful Medicaid member and community outreach and engagement; and the development of a community health worker model.

Lessons Learned

Getting feedback from any stakeholder who interacts with the system you want to change is critical. The Maine team asked for input on their pilot and strategy from the DOC, leaders across their partnering organizations, residents of jails and prisons, and other groups to apply various perspectives and levels of expertise to their plans. They are now gathering implementation feedback regarding their new care delivery model from members, providers, and other stakeholders.

Looking Ahead

The Maine team has a long-term vision for keeping their work sustained and to iterate on their progress thus far. Their pilot is currently funded via the **American Rescue Plan Act of 2021 Section 9817**. Once the pilot wraps in 2025, the team will apply what they learned to upcoming opportunities related to their work: the Consolidated Appropriations Act (CAA) beginning in January 2025 and the 1115 Re-Entry Waiver. CAA allows states to receive federal payment for allowable medical assistance services provided to Medicaid eligible juveniles while detained. The 1115 reentry waiver offers states an opportunity to improve care transitions for certain individuals who are soon to be former inmates of jail or prison and otherwise eligible for Medicaid. MaineCare plans to apply for the waiver in 2025 and expects to begin participating in 2026.

2 Mississippi

Organization Type	Participating Organization
Other State Agencies	Mississippi State Department of Health (MSDH)
Managed Care Organization(s):	United Healthcare of Mississippi (UHM)
Health Care Delivery Organization(s)	▪ Coastal Family Health Center (CFHC), ▪ Community Health Center Association of Mississippi (CHCAM)

Health Equity Focus

In Mississippi, non-Hispanic African American and Black populations face disproportionately high rates of coronary artery disease, hypertension, obesity, diabetes, and invasive cancer compared to Hispanic and white populations. These health inequities are further exacerbated among individuals with less than a high school education or those earning less than $15,000 annually. The Mississippi team stands out as the only AHE LC team that includes the state Department of Health (MSDH), creating opportunities for innovative and unique strategies to advance health equity. This collaboration has the potential to improve health outcomes for all Mississippians, regardless of their Medicaid status or enrollment.

Care Delivery and Payment Transformation

The MS team is working towards designing and adopting a reimbursement payment model that incentivizes provider organizations to include community health workers (CHWs) as part of their multidisciplinary health care teams. Although the MS team will be funding the pilot for its intervention through grants, they are also working to identify and adopt a long-term and sustainable payment model through other avenues such as State Plan Amendments or a Section 1115 Waiver.

Oftentimes, patients who fall within the MS Team's health equity focus report not understanding the given medical advice or instructions on prescribed medications. Community-based care models can help close those educational barriers and systemic gaps in coverage and care delivery (i.e., patient literacy and engagement), showing promise in improving health outcomes and reducing inequities.

As a result, Coastal Family Health Center's **Patients as Partners** program includes CHWs as part of a multidisciplinary care team whose role will include working with patients and their caretakers to increase:

- health literacy.
- patient engagement with their respective, individual care plans.
- knowledge that would empower patients when they interact with their healthcare providers and healthcare systems.

The CHWs will also focus on assessing patients' social and health-related needs and risks; create an action plan that addresses patient-identified needs; provide necessary referrals; and follow up with patients to provide them with necessary support to facilitate the action plans.

LEARNING COLLABORATIVE TEAM PROFILES

1 New Jersey

Organization Type	Participating Organizations (Phase 1, 2019- 2023)	Participating Organizations (Phase 2, 2023 - present)
State Medicaid Agency	New Jersey Department of Human Services (DHS)	New Jersey Department of Human Services (DHS)
Managed Care Organization(s)	Horizon Blue Cross Blue Shield of New Jersey (Horizon)	Horizon Blue Cross Blue Shield of New Jersey (Horizon)
Health Care Delivery Organization(s)	RWJBarnabas Health Systems (RWJBarnabas)	
Community Based Organization or Other Partners	Partnership for Maternal and Child Health of Northern New Jersey (PMCHNNJ)	Camden Coalition

Health Equity Focus (Phase 1, 2019-2023)

New Jersey ranks 36 out of the 50 U.S. states in overall maternal mortality, with one of the highest maternal mortality rates for Black pregnant individuals in the nation. A Black birthing individual in New Jersey is **seven times** more likely than a white one to die from maternity-related complications. Black women experience **higher rates** of postpartum depression but are **two times** less likely to receive mental health care after delivery compared to white women. After analyzing data for all Medicaid-managed care births from 2016 to 2018, the team identified significant disparities in mood and anxiety disorder diagnoses and treatment between their Black and white populations during perinatal and postnatal periods.

The New Jersey team's initiative focuses on improving perinatal mood and anxiety disorder diagnosis and treatment among Black birthing individuals. They took several steps in planning their initiative, among them:

- **Using a fishbone diagram with an equity lens**, surveying physicians and midwives at RWJBarnabas' Newark and Jersey City hospital sites for their input and expertise.
- **Conducting a patient journey mapping exercise**, which helped them center the patient's journey through the healthcare system.
- **Assessing potential intervention options using a priority matrix** to categorize root causes based on feasibility and importance.
- **Identifying external organizations** that were administering programs designed to advance similar goals, leading to a collaboration with the **Partnership for Maternal and Child Health of Northern New Jersey (PMCHNNJ)**, a community-based organization in Newark with robust perinatal health programming.

Based on their root-cause analysis and patient journey map, the team piloted two intervention components:

1. A training for RWJBarnabas healthcare providers to improve the diagnosis of perinatal mood and anxiety disorders. The training provided recommendations for how to provide culturally relevant screening for Black perinatal patients and emphasized the need to utilize multiple sources of diagnostic information in addition to the **Edinburgh screening scale**.

2. A consolidated resource guide for providers and patients to improve referral processes to sources of care and support for mood and anxiety disorders, which included the promotion of RWJBarnabas' existing perinatal virtual support group.

Partnering with a local community-based organization was key to the initiative's success. The team partnered with PMCHNNJ to craft and deliver the provider training. PMCHNNJ's perinatal health programming and expertise was critical to the training's design and implementation.

Lessons Learned

When implementing provider training, the team experienced low levels of engagement despite multiple adaptations. The COVID-19 pandemic significantly impacted provider capacity to participate in the training; only thirteen providers attended the training and two nurses from RWJBarnabas' Newark Beth Israel Medical Center successfully earned CEU credits. Widespread burnout among health care professionals has impacted provider capacity to complete additional training. The state's behavioral health carve-out was also a significant challenge for the team's care and payment transformation work; providers were not financially incentivized to change behavioral health-related care behaviors through value-based or other alternative payment models, which may have contributed to low levels of provider engagement.

The New Jersey's state Medicaid agency is now **'carving-in' behavioral health** into Medicaid Managed Care delivery. The team will be using what they've learned from participation in the AHE Learning Collaborative to help inform related policy decisions. The team has drafted a case study in partnership with AHE with more detailed lessons learned from the team's Phase 1 initiative. The case study is currently undergoing a legal and compliance approval process at participating organizations for publication.

Health Equity Focus (Phase 2, 2023 to present)

In Phase 2 of its initiative, the New Jersey team is focused on addressing inequities in substance use disorder (SUD) diagnosis and treatment among Black pregnant and parenting individuals. Addressing SUD inequities in perinatal health is a state Medicaid and Horizon BCBS priority and aligns with existing efforts at the state Medicaid agency. The team is currently reviewing SUD diagnosis and treatment data from the SUD component of **NJ FamilyCare's Comprehensive 1115 Demonstration** and claims data from Horizon BCBS. The team has conducted a literature review on best practices for addressing inequities in SUD diagnosis and treatment for pregnant individuals in the United States. The team will consolidate lessons learned from the literature review with Camden Coalition's experiences engaging providers in its **Office-Based Addiction Treatment** initiative in South New Jersey.

Looking Ahead

The team plans to design their care transformation by June 2025. They plan to implement their care transformation first, and subsequently partner with member and community-based organizations to improve the team's care transformation scope and design. The team is also interested in leveraging the state Medicaid agency's behavioral health carve-in to develop a value-based payment model to support the team's care transformation.

2 New York

Organization Type	Participating Organization
State Medicaid Agency	New York State Department of Health, New York State Medicaid
Managed Care Organization(s)	HealthFirst
Health Care Delivery Organization(s)	Sun River Health

Health Equity Focus

In New York state, a Black birthing individual is **nine times** more likely to die from a pregnancy-related complication than a white one. Reducing inequities in maternal health is both a national need and an organizational priority for Sun River Health's patients. The team identified addressing racial inequities between white patients and Black, Latine, and Indigenous patients, respectively, in maternal health and healthcare as its health equity focus.

Designing and Implementing Change

The team is piloting its initiative to advance perinatal health equity for cisgender, pregnant women who are covered by Medicaid at Sun River Health clinics in New York. The care transformation pilot at three of Sun River Health's 56 Federally Qualified Health Centers has three main components:

1. Remote blood pressure monitoring (RPM) for pregnant women in their third trimester up to postpartum, to address preeclampsia and pregnancy-related hypertension.
2. A virtual visit from a nurse practitioner within 48 hours post-discharge that includes a postpartum depression screening and referral to a behavioral health provider if necessary.
3. A social drivers of health (SDOH) screening delivered during patient enrollment and virtual transition of care visit.

The team's pilot began in October 2023 and continued for six months. The team is collecting data on numerous perinatal healthcare process and outcome metrics. Evaluation is ongoing and will inform potential scaling to other clinical sites across the Sun River system. The Sun River informatics team will stratify data by race and ethnicity and determine if disparities in health and healthcare outcomes have been reduced between white patients and Black, Latine, and Indigenous patients, respectively.

Partnering with Members and Patients

Sun River Health will hold two race-specific focus groups for individuals who participated in the pilot: one for Indigenous women and the other for Black and African American women to learn more about their experiences with the program and identify areas for future improvement. Additionally, the team is working with community partners who provide temporary and permanent housing, healthy food deliveries, and other social needs services to improve the inter-organization referral process when health-related social needs are identified for a patient through the initiative's SDOH screening.

Looking Ahead

The team will analyze data from the maternal health pilot to improve care processes, and explore the pilot's potential scaling and sustainability. The team also hopes to create a model for system-wide change initiatives within Sun River Health that incorporates an equity focus in care model dissemination, translation, effective stakeholder communication, and buy-in. The team could use its AHE maternal health pilot as an opportunity to design and test their model. The team is exploring value-based payment models for their RPM maternal health initiative that will also inform future contracting between Sun River Health and HealthFirst.

2 Pennsylvania (Cohort 2)

Organization Type	Participating Organization
State Medicaid Agency	Pennsylvania Department of Human Services (DHS), The Office of Medical Assistance Programs
Managed Care Organization(s)	▪ University of Pittsburgh Medical Center (UPMC) Community Care Behavioral Health Organization ▪ UPMC for You ▪ Geisinger Health Plan
Health Care Delivery Organization(s)	▪ UPMC Magee-Womens Hospital ▪ Geisinger Women and Children's Institute
Community Based Organization or Other Partners	Healthy Start, Inc.

Health Equity Focus

In Pennsylvania, racial inequities in perinatal mortality and morbidity are significant. The Department of Human Services has identified maternal and child health as a policy and public health priority area. According to a January 2022 **report** from the **Pennsylvania Maternal Mortality Review Committee**, the state's pregnancy-associated mortality rate for Black birthing individuals was almost double the overall mortality rate of birthing individuals in 2021. The team is directing their initiative at perinatal health inequities faced by racially/ethnically minoritized birthing individuals and working to establish the parameters of their health equity focus (e.g., specific racial/ethnic groups, geographic regions).

In January 2021, The Department of Health Services (DHS) required all physical health MCOs in the state to implement a maternity care bundled payment model. The model requires MCOs to develop a bundle of services that includes prenatal care, labor and delivery, care coordination services, and services up to sixty days postpartum for the parent and newborn, excluding contraceptive care. Network providers are to assemble a maternity care team to provide prenatal care, labor and delivery services, and postpartum care. The team would be composed of clinicians and at least one doula, one peer support recovery specialist or social worker, and one community health worker.

If fee-for-service payments are lower than an established target price, the difference is allocated to a shared savings pool. Incentive payments are allocated from shared savings based on quality measure performance for SDOH screening, timeliness of prenatal care, postpartum care, prenatal and postpartum depression screening follow-up, and prenatal immunization.

Looking Ahead

The team is working to align health equity data across UPMC and Geisinger integrated plan and health systems to establish baseline data and track perinatal health inequities across both organizations.The team is also creating a toolkit for plans and providers across

LEARNING COLLABORATIVE TEAM PROFILES: **PENNSYLVANIA** (C2)

Pennsylvania, implementing the maternity care bundle with systematic guidelines for all MCOs and providers around addressing perinatal health inequities statewide. They are collecting information on work with care teams to establish short-, mid-, and long-term goals regarding how healthcare can be transformed feasibly and sustainably. The toolkit will address the challenge of scale by attempting to develop an overarching, statewide strategy that supports the flexibility needed to develop and implement tailored, equity-centered interventions for specific regions and communities.

1 Tennessee

Organization Type	Participating Organization Name
State Medicaid Agency	TennCare
Managed Care Organization	UnitedHealthcare Community Health Plan of Tennessee (UHC)
Health Care Delivery Organizations	▪ Tennessee Maternal Fetal Medicine ▪ Meharry Medical College

Identifying and Diagnosing the Problem

Year after year in Tennessee, cardiovascular and coronary conditions are the leading underlying cause of pregnancy-related deaths. Non-Hispanic Black birthing individuals are 3.9 times as likely to die from pregnancy-related causes of death compared to non-Hispanic white birthing individuals. Additionally, Black individuals have a nearly two-fold higher mortality rate than their white peers for hypertension-related heart disease deaths; nearly 58% of Black women have high blood pressure prior to pregnancy. Black women are more likely to be diagnosed with preeclampsia during pregnancy and more likely to have a higher systolic blood pressure. Those statistics led the Tennessee team to focus their efforts on birth outcomes, specifically those related to perinatal hypertension.

The team analyzed UHC claims data to understand disparities in perinatal health outcomes, risk factors, (e.g., hypertension, other forms of heart disease, tobacco use, and drug use) and social drivers of health (e.g., transportation, family support, and access to prenatal care among other social needs and assets). The data helped them focus their efforts on a pilot project within Shelby County at a hospital that serves predominately Black perinatal patients and has one of the highest rates of high-risk pregnancies and the fewest maternal fetal medicine specialists in the state.

Care Delivery Transformation

UHC provided funding to the Tennessee Initiative for Perinatal Quality Care to deliver a provider simulation training to birthing facilities to improve health care providers' ability to recognize and appropriately intervene on high-risk pregnancies.

The team designed and implemented a Remote Patient Monitoring (RPM) initiative to improve access to home blood pressure monitoring equipment and identify pregnancy-related blood pressure issues earlier. They engaged an external vendor that provides remote patient monitoring and education services via a proprietary model. Participating pregnant individuals are supplied with a bluetooth-capable blood pressure cuff to use at home that is paired with an app that logs their blood pressure. The data tracked via the app is viewable by the perinatal health care team, notifying them of concerning or dangerous blood pressure readings. The team is evaluating the RPM pilot using the following Key Performance Indicators (KPIs):

- Enrollment in the app
- App Engagement
  - Total # of active users
  - # Sessions per user
  - Average time per session
  - Most frequently viewed content
- RPM Engagement
  - # and % of RPM members with active participation in the Hypertension Module
  - # and % of RPM members with active participation in the Diabetes Module
  - RPM: Number of notifications to health care providers and interventions

Payment Model

Blood pressure cuffs are not a covered benefit through Medicaid. Thus, UnitedHealthcare is paying for cuffs and the RPM pilot. TennCare will consider covering the cost of blood pressure cuffs for members if the pilot results in earlier identification of hypertension, improved birth and maternal outcomes, and cost savings.

Lessons Learned

The team identified a number of implementation challenges including:

- **Staff education barriers:** It took a great deal of time/resources to train staff and residents about how the RPM technology works and how to enroll patients. Additionally, each time new residents came on board, the training had to be repeated.
- **Provider leadership buy-in:** At the start of implementation, there was clear support for the initiative from providers in leadership positions. However, once those leaders left the health care system, support was lost.
- **EMR integration**: It became infeasible for the patient-recorded blood-pressure data to be viewable in the health system's electronic medical record (EMR) system because of compatibility issues between the health system's EMR and the RPM app.

The team also faced challenges in regard to data management. First, they learned that the RPM care team notification parameters needed to be adjusted; health care providers reported frustration at receiving emergent notifications for patients who did not need intervention. Additionally, patient-recorded blood pressures were not entered into the patient record because of compatibility issues between the RPM technology and the health care provider system's EHR. Finally, the RPM app only included postpartum hypertension engagement for two weeks postpartum. In order to align more closely with American College of Obstetricians and Gynecologists (ACOG) guidelines, the team desired an engagement period of 12 weeks postpartum.

UHC also had difficulty getting quarterly update data from the health system, resulting in delays monitoring KPI outcomes which was complicated by the fact that they only had a verbal agreement for when pilot data would be submitted. Moving forward, the team believes that data requests and completion dates need to be outlined in detail in the project agreement among participating organizations (e.g., the health plan, the health care system, and the vendor providing the RPM service).

LEARNING COLLABORATIVE TEAM PROFILES: TENNESSEE

Value Adds

As a result of their participation in the Learning Collaborative, the Tennessee team has:

- gained insight into issues affecting populations enrolled in Medicaid in other states.
- learned, via AHE Cross-Team Learning Sessions, about what other organizations are doing to create positive outcomes that the TN team could consider (e.g., housing and how other states help to manage resources such as Section 8).
- used information from the Cross Team Learning Sessions to educate front-line staff who interact with members regarding racial equity.

Looking Ahead

Looking ahead, the Tennessee team will explore ways to impact positive birth outcomes, decrease maternal mortality and morbidity, and decrease the newborn mortality rate. They will consider other initiatives (such as those involving UHC, TennCare, and two other Managed Care Organizations).

1 Washington

Organization Type	Participating Organization Name
State Medicaid Agency	Washington State Health Care Authority (HCA)
Managed Care Organization	Community Health Plan of Washington (CHPW)
Health Care Delivery Organization	Community Health Network of Washington (CHNW)

Health Equity Focus

The Washington team identified a range of potential health disparities based on data availability at the plan and state level. After identifying at least six possible options, the team tried to narrow its focus by assessing existing community initiatives and programming that aligned with an area of focus that could be built upon political momentum, such as whether there were state-led initiatives focused on specific areas or recent related legislation, among other metrics.

The team initially focused on equitable perinatal health. However, once they began to assess services provided as well as disparities data by each of the 21 community health centers (CHCs) in the Community Health Network of Washington (CNHW), they found that not all CHCs across the CHNW could participate because of different inequities at the local level and services offered. As a result, the team broadened its health equity focus to include three areas: member experience and access, perinatal health, and depression or other chronic condition management. Their broadened focus allows each CHC to select one or more of the priority areas based on their local disparities data and what their staff, patients, and home communities deem most important. Over time, the Washington team learned that it needed to expand their equity focus even further to accommodate a need for the CHCs to engage in basic capacity-building work that is typically not funded through traditional fee-for-service or incentive-based payment models.

Care Delivery Transformation and Payment Reform

In 2020, CHPW developed a statewide health equity initiative to address the priorities of 21 CHCs. CHCs selected the areas they felt most important to address, including: member/patient experience; maternal health; chronic condition management; internal organizational Diversity, Equity, and Inclusion efforts; and social drivers of health. The initiative used withhold dollars from CHPW's existing pay-for-performance program to provide upfront capacity building funds to participating CHCs. (Typically, funding is only provided after certain quality targets are met. CHCs were invited to participate and received $50,000 to address health disparities in their patient population, taking steps to build capacity and skills to advance health equity. This included activities such as building patient partnership programs; holding focus groups; staff training; revising and updating policies and procedures; and/or IT infrastructure to collect and analyze demographic data.

Over the course of three years, 16 CHCs engaged in regular cross-team learning, training, and skills-building activities facilitated by CHPW, such as workshops on how to conduct a root cause analysis with an equity lens. This included support for the requirement of patient and community engagement to ensure local initiatives were tailored to the priorities of communities served.

LEARNING COLLABORATIVE TEAM PROFILES: WASHINGTON

Creating Cultures of Equity

The Washington team is aligning equity initiatives across organizations. CHPW created an organization-level equity assessment tool to evaluate the health equity implications of all organizational policies and programs. They shared the equity assessment tool with the Washington State Health Care Authority (HCA) and CHNW to be implemented within those respective organizations. HCA, CHPW and CHNW CHCs are developing their own cultures of equity, including hiring new staff dedicated to health equity work, DEI training at all levels of the organization, and improved structures to partner with their communities.

Lessons Learned

The Washington team quickly realized that they couldn't address inequities they were seeing in their communities without doing their own internal equity work at each of the partnering organizations. They have been working to instill that value among participating CHCs as well. So far, the CHCs have been grateful for the prospective payments they have received, which have allowed them to support internal capacity building such as staff training and hiring individuals focused on equity. Many CHCs have stated their work wouldn't be possible without a payment model designed to support them. The importance of internal cultures of equity continues to be a driving force for the WA team.

Value Adds

The Washington team has found that the AHE Learning Collaborative has been a great impetus for its three partnering organizations to work more closely together. They have realized that their work is incredibly interdependent and the more closely they can align their efforts, the better. For example, if CHPW can have greater insight as to what HCA will be requiring from MCOs in terms of performance measures, they can better work with CHCs to plan for how to lay the groundwork for success in achieving high levels of performance.

Looking Ahead

As the initiative enters its fourth year, the Washington team wants to determine how best to account for any policy changes at the state level related to how success will be measured. Additionally, the team wants to better include perspectives of Medicaid members. CHPW is forming member advisory councils and each CHC is further narrowing in on their respective approach to better partner with patients and communities. For example, some CHCs have worked on patient journey mapping to better understand what barriers exist for patients that they may be able to address.

CHPW is partnering with the CHCs to build in payment accountability to reduce health disparities, moving forward. A new model launched in December 2023 that uses a glidepath approach to transition to a payment model with greater provider accountability over the course of three years. CHCs will be paid to complete health equity assessments (2024, develop interventions to address identified disparities (2025, and to have an impact on identified disparities (2026.The team aims to coordinate their activities with state priorities and continue gathering input from CHCs.

AHE Advancing Health Equity

Leading care, payment, and systems transformation

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ABOUT AHE

Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) is a national program supported by the Robert Wood Johnson Foundation and based at the University of Chicago. AHE's mission is to discover best practices for advancing health equity by fostering payment reform and sustainable care models to eliminate health and healthcare inequities.

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