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A Call to Action for Health Equity Leaders:
Health Care Transformation Efforts Must Include a Strong Focus on Health Equity

By Sinsi Hernández-Cancio

Our nation's health care system is rapidly transforming, and the health of people of color and other disadvantaged communities hangs in the balance. Moving to a value-based health care system presents a critical opportunity to achieve health equity. But without particular attention to how disadvantaged communities will be affected and without including these communities in designing these reform efforts, we risk exacerbating disparities in health and health care.

The shift from paying health care providers according to the volume of services they provide (known as "fee for service") to paying them according to the value they provide is already significant, and is gaining momentum.[1] Changes in payment systems to improve quality and reduce costs are essential to the financial sustainability of our health care system and to improving everyone's health outcomes.

The challenge is that it is not possible to reach the goals of better health for all or lower costs without addressing, and ultimately eliminating, the long-standing health and health care disparities that plague communities of color and other disadvantaged populations.[2] Unfortunately, for the most part, the tremendous opportunity to leverage payment and delivery reform to tackle these inequities head-on is being squandered. It is up to health equity advocacy and policy leaders at all levels to actively engage in these efforts before it's too late, and our communities are left behind.

For communities of color, payment and delivery reforms present both risk and opportunity

Ongoing public and private sector efforts to deliver higher quality care at a lower cost offer important pathways to redesigned systems of payment and care delivery that could accelerate the reduction of health disparities.[3] At the same time, however, they also risk exacerbating these same inequities.[4]

On the one hand, payment models could be designed to specifically target reductions in disparities both by incentivizing and paying directly for interventions and services that have a strong track record of improving outcomes for communities of color and other underserved communities. Conversely, payment systems that don't account for diverse patients' needs and experiences, and that don't work to minimize the negative health impacts of socially-determined barriers to good health and high quality health care, could just as easily make things worse.

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More specifically, new payment models could inadvertently create incentives for providers to avoid patients with more complex needs, or to reduce health care utilization among populations for whom underutilization is already a major concern. A related risk is that new payment models could financially undermine safety net and community providers that offer much of the care for communities of color and underserved communities.

Despite these high stakes, payment and delivery reform efforts have mostly overlooked the implications for racial and ethnic minorities who bear a disproportionate burden of health risk.[5] A comprehensive policy and advocacy agenda that would proactively leverage system transformation in the service of health equity remains to be developed. Although some experts have focused on developing payment reform policy options to reduce disparities, their work has not yet been translated into consumer-oriented policy priorities or advocacy agendas, let alone direct advocacy efforts to change policy.[6,7] And to the extent that state and national consumer-focused advocacy groups have been engaging in advocacy on payment and delivery reform policy, remedying racial and ethnic health disparities has largely not been a priority.

An important reason for health equity being overlooked in payment and delivery reform policy and advocacy is that the organizations that have traditionally represented and advocated for the needs of communities of color have not been effectively included in these efforts. Decisions about defining, measuring, and incentivizing value have been made without substantial input from the communities most affected by our dysfunctional health care payment and delivery system.

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Even though health care system transformation is a new frontier for many of the health and health care advocates representing communities of color, we simply can't afford to let delivery and payment reform continue without us. We must rise to the challenge and not only demand inclusion, but also work collaboratively to prepare ourselves to be the most effective advocates possible—despite limited resources, capacity, and technical expertise.

The impact of payment and delivery reform so far

When payment and delivery reform initiatives started to accelerate a few years ago, Families USA was among the few advocacy groups that voiced serious concerns. Among these concerns was the fact that, although the transition to value-based care was necessary, this shift risked widening existing racial and ethnic health disparities.[8]

Additionally, our organization and others were concerned that the definitions of "value" and "quality" that would determine resource allocation under new payment schemes would exclude or undervalue the

services and supports that are most important to low-income, minority, LGBTQ, and rural communities. By definition, these disenfranchised populations are on the margins of society and, as a result, are often overlooked by the architects of payment and delivery reforms on the local, state, and national levels. For example, reorganizing the health care system to improve quality and outcomes for a hypothetical "average" patient would likely miss the mark for people struggling with multiple, intersecting barriers to good health and health care.

We suspected that without a grounded understanding of the factors that increase the risk of poor health in communities of color, and without providing the resources needed to directly minimize the impact of these risk factors and barriers, the results of payment reform for these communities would be mixed, at best. We knew the benefits of health care system transformation wouldn't simply "trickle down" to those who struggle the most to obtain accessible, high-quality care. In order for payment and delivery reform to meet the needs of these communities, the allocation and organization of health care resources, and the structure of payment incentives, both need to be designed with these communities in mind. Unfortunately, these communities have not been adequately considered or represented in payment and delivery reform efforts.

Concerns realized

Today, our concerns about payment and delivery reform aren't just abstract, because some reforms have now been in place long enough to be evaluated—in particular, regarding how they are affecting communities of color. We now know that some payment and delivery reform efforts are having unintended (although not unexpected) negative consequences for people of color and the providers they depend on. For example:

Hospital Readmissions Reduction Program (HRRP)

This program is a striking example of an effort that has had a disparate impact on providers who serve a higher proportion of people of color, even as it is achieving its intended result overall. Created by the Affordable Care Act (ACA), the HRRP's goal is to drive down the number of avoidable hospital readmissions by financially penalizing hospitals that have above-average readmission rates for Medicare patients.[9,10]

The program appears to be succeeding in reducing readmissions, including their occurrence at safety net hospitals. Even so, these hospitals are still more likely to have readmission rates above the average and therefore, to be penalized under the HRRP.[11] An important driver of this disparity is that the risk factors faced by the populations that safety net hospitals serve, such as living in low-resource communities or having limited English proficiency, can make readmissions more likely. Safety net hospitals also serve a higher proportion of people of color,[12] who are more likely than white people to experience potentially avoidable readmissions.[13]

There is growing evidence that the HRRP does not adequately account for these risk factors and, therefore, may be penalizing safety net hospitals simply because of the care they provide people of color and other high-risk groups.[14] Yet, these hospitals are critical sources of care, and financially penalizing them could also further imperil their ability to provide care in already underserved communities,

exacerbating disparities. Concerns about how the HRRP disadvantages safety net hospitals led to legislation requiring different penalty thresholds for hospitals based on the proportion of their patients who are dually eligible for Medicare and Medicaid, which is an indicator of the population's socioeconomic and health status.[15]

Accountable Care Organizations (ACOs)

These organizations are groups of providers that are held responsible, through financial incentives, for improving patient health while lowering health care costs. The ACO model is a popular way to try to shift to a value-based health care system, but is also another example of how, without an explicit focus on equity and inclusion of communities of color, payment and delivery reform will fail to address the needs of these communities.

Though evidence is still mixed regarding the ability of Medicare's ACO programs to drive reductions in health care costs,[16] ACO-affiliated hospitals have reduced readmissions of patients discharged to skilled nursing facilities at a faster rate than other hospitals,[17] and many ACOs have improved quality of care over time.[18] However, not all communities are benefiting equally from these improvements. ACOs serving a high proportion of racial and ethnic minority patients have lower scores on quality measures, a result that affects the amount of financial rewards or penalties they receive.[19] Another challenge is that to become a Medicare ACO, a physician group must also meet a minimum threshold for group size. However, patients of provider groups that meet this threshold are more likely to be white and to live in economically advantaged areas.[20]

Promising progress

As concerned as we are about how payment and delivery reform may be exacerbating health disparities, we also recognize that this transformation of the health care system is an unprecedented opportunity to reduce health disparities. In fact, we are already seeing examples at the state level of how advocates and public officials are leveraging this opportunity to target the reduction of health disparities. Here are two noteworthy examples:

Connecticut's State Innovation Model

Another initiative in the transition to value-based health care is the State Innovation Model (SIM), operated by the Center for Medicare and Medicaid Innovation. This model gives funding and technical assistance to help states design and test new ways to provide and pay for care. In Connecticut, the state decided to include health equity as a primary goal of their SIM process, and established a strategy to increase the integration of community health workers (CHWs).[21] CHWs have a strong track record of improving the health of people of color, those with complex health and social needs, and others who face barriers to good health.[22] The state created a SIM CHW Advisory Committee, which includes actual CHWs.[23] This committee developed recommendations on how to increase CHW integration and laid the foundation for recently-enacted legislation that formally recognizes CHWs.[24]

Oregon's Coordinated Care Organizations (CCOs)

Oregon created CCOs, which are local networks of health care providers, to improve health and control costs for the state's Medicaid program by focusing on prevention and chronic disease management. In

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order to better meet the needs of people of color, Oregon built in key requirements in their contracts with CCOs, such as requiring CCOs to participate in cultural competency training and develop plans to reduce racial and ethnic disparities.[25] Importantly, quality measures that are used to evaluate CCOs are stratified by race and ethnicity and are publically reported, which is a necessary step in identifying and ultimately reducing disparities.

It's time to develop and execute on a health equity advocacy agenda

Payment and delivery reform will continue to move forward—whether or not the needs and perspectives of communities of color and other disadvantaged groups are incorporated into the design of new models. The process will not pause while health equity advocates figure out how to get involved.

For this reason, advocates and experts representing communities of color and committed to achieving health equity must be included in the process. Their active engagement is essential to both the effective redesign of our health care system, and the redistribution of health care resources that will drive it. Our priorities and expertise need to inform and drive how value is defined, measured, and integrated into evolving payment systems and accountability mechanisms.

We must work collaboratively to take the body of expertise and experience that has been developed on disparity-reducing, linguistically-accessible, and culturally-centered care. Together, we can create a shared national policy agenda that encompasses federal, state, and private policy recommendations, and a comprehensive action plan to advocate for those policy solutions that will enable our communities to achieve the best health possible.

This will be a challenging endeavor. The issues are complex and technical, and we will be looking for seats at the table alongside well-resourced stakeholders and decision makers who are unaccustomed to making space for our constituencies. What is more, these stakeholders and decision makers are likely to be unfamiliar with the daily struggles our communities face in what are sometimes increasingly hostile environments.

To succeed, we must garner the resources necessary to support effective representation of our communities in these processes. Most importantly, we need to come together to define our own collective priorities and advocate for them. We cannot squander this opportunity to make a tangible difference in the lives of millions of people. Let's transform our health care system so that every single human being in our nation has an equitable opportunity to receive the highest quality health care, and enjoy the best possible health.

Endnotes

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This publication was written by:

Sinsi Hernández-Cancio, Director of Health Equity, Families USA

The following Families USA staff contributed to this publication (in alphabetical order):

Ellen Albritton, Senior Policy Analyst

Nichole Edralin, Senior Designer

Maria Walawender, Health Equity Intern

Alex Walker, Acting Director of Communications

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1225 New York Avenue NW, Suite 800
Washington, DC 20005
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