



FOR DELIVERY & PAYMENT TRANSFORMATION

A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems

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Executive Summary

Introduction

Our health care system is failing us. As a nation, we spend too much and get too little in return. No other industrialized country spends more on health care per capita, yet we consistently rank last among them in access, equity, key health outcomes, and overall performance.¹ By some estimates, up to 30 percent of health care spending is wasted on inefficient or unnecessary care.² Below the surface of these overall statistics, there is an even more troubling reality: the extent and severity of persistent health and health care disparities. These systematic inequities disproportionately affect communities of color, those with low incomes, those with disabilities, and people living in distressed geographic areas.³ However, our health care system has not evolved sufficiently to provide high-quality, efficient, and effective services for the large and growing proportion of the U.S. population disadvantaged by these inequities. Given these

realities, our current health care system is financially unsustainable for both families and the nation. Large health care inequities undermine people's ability to reach their full potential and the country's ability to stand up a competitive, productive workforce. Moreover, they are fundamentally unjust and morally indefensible.

The good news is that we are in the midst of a transformation of the health care system that offers the opportunity to tackle these challenges. Efforts across the country are underway to shift the health care system from one that pays for the *quantity* of care provided (regardless of whether it's needed) to one that pays for the *quality* of care provided and for improved health. However, even as payment and delivery reform efforts present a valuable opportunity to accelerate the reduction of health and health care inequities, they also pose a serious risk to communities already facing systematic inequities.⁴ The communities

most affected by health inequities must be included in the design and implementation of delivery and payment reforms, and policies must be developed with the explicit intent of advancing health equity.⁵

Unfortunately, the needs and interests of communities of color and other communities struggling with health and health care inequities are not adequately represented in health care transformation efforts. So far, health policy makers have not prioritized health equity sufficiently, while health equity advocates have generally not engaged sufficiently in payment and delivery reform efforts at the state or federal levels. To achieve a high-performing, efficient, and equitable health care system, this must change and the time is now.

This policy options paper represents a collaborative effort among state and national health equity thought leaders to catalyze much needed action to leverage health system transformation for the benefit of those whom the health system is leaving behind. Ensuring that those facing the biggest barriers to good health and high-quality health care are served well by the health care system will improve care for everyone.

The goal of this paper is to create a resource that health equity and health system transformation leaders can use to assist in policy development and prioritization that best serves their communities and constituencies. We begin the paper by reviewing key issues that payment and delivery reform must take into account to advance health equity and improve the health of those currently experiencing disparities including, but not limited to, inequities based on race, ethnicity, sex, sexual orientation, English proficiency,

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immigration status, income, and geographic location.ⁱ Specifically, we posit that the transformed health care system should reduce the negative impact of socially shaped barriers on people's health, and especially, their access to high-quality care. This means looking beyond the walls of the hospital or clinic and meeting people where they are in their community.

In addition, the transformed health care system must be supported by a payment system designed to reward the provision of high-quality, equitable care to all. This is not a simple objective, and neither is it clear that we are headed in the right direction. While existing fee-for-service payment has fostered our unequal health system, new payment models could themselves inadvertently create additional incentives for providers to avoid patients with more complex needs, or to reduce health care utilization among populations whose main challenge is the underutilization of appropriate care. A related risk is that new payment models could financially undermine safety net and trusted, culturally competent community providers upon which underserved communities currently depend.

ⁱThe authors want to make clear that while we use the categories of race, ethnicity, sex, sexual orientation, and gender identity to assess health inequities, in most cases the risk factor is not the specific identity, but current and historical discrimination against and mistreatment of that group that are independent risk factors in health. For example, it is not your "race" but racism.

Assessing the Impact of Payment Reform on Health Equity

To advance understanding of the risks and opportunities of payment and delivery reform on health equity, we developed a rubric to review the initial impact of new payment models on communities of color and other disadvantaged groups.

1. Is there a disparate impact on particular communities? The design and evaluation of payment models should attend to which groups or communities are benefiting from the model and which may be bearing the brunt of negative consequences. This requires disaggregated data. Does the model result in a net redistribution of resources from providers who care for more complex patients with more risk factors (who are more likely to have lower incomes and be people of color) to providers who care for less complex, lower risk patients (who are more likely to be white and have higher incomes)?⁶ Of special note is whether the cumulative impact of provider penalties has the effect of worsening the access to, and quality of, care for communities already struggling with inequities, by shutting down providers where there are no reasonable alternatives.

2. Is risk adjustment effectively accounting for clinical and social risk? Risk adjustment is the standard solution for leveling the payment playing field so that providers are fairly compared to each other by adjusting for patient factors that are out of their control.⁷ However, there is concern that to date, risk adjustment methods are incomplete and “not sophisticated enough to reliably distinguish poor-quality care from high medical and social risk.”⁸ Areas of concern include the appropriate inclusion of individual social risk factors (such as race, ethnicity,

functional status), and of neighborhood-level risk factors (such as concentrated poverty and rurality).^{9,10} Yet it is also critical that risk adjustment not mask poor quality care and persistent quality inequities.

3. Are underlying resource inequities taken into account? Another challenge in ensuring a level playing field in the application of payment reform models is accounting for wide disparities in the resources providers have at their disposal, both within their institutions and in their communities. For example, many safety net, rural, and community hospitals have been systemically underfunded and are operating under financially precarious conditions, with negative margins that leave little room to invest in quality improvement and expanding services that would improve patient outcomes and their metrics.^{11,12} Meanwhile community care capacity may also be limited such that needed supports are not available.

Using this framework, we review examples of payment and delivery reforms that look promising in terms of reducing inequities, such as Covered California’s active purchasing program that requires the reporting of disaggregated outcomes data on chronic conditions and yearly improvement in disparity reductions. We also describe programs that have more ambiguous outcomes, like the Hospitals Readmissions Reduction Program, which appears to be reducing readmissions and narrowing some inequities, but is also more likely to penalize safety net hospitals, possibly undermining access to care in some communities.

Finally, we underscore the need to protect and support the unique American Indian and Alaska Native health care system. Any payment and delivery reform effort must respect the federal government’s trust

responsibility to tribes, along with their sovereignty. Many of the policy options described in this paper apply to the Indian Health Service, but special care must be taken to ensure that this chronically underfunded system not be further financially strained.

Six Policy Domains for Health Equity-Focused Transformation

In the next section of the paper, we synthesize existing academic research and analysis, and develop a conceptual framework of six specific policy domains that comprise the transformed health care system needed to advance health equity. These conceptual categories interrelate closely, and even overlap. Each domain concludes with a set of potential policy options, flagged by whether they target federal policy, state level policy, and/or the private sector.

1. Payment Systems that Sustain and Reward High Quality, Equitable Health Care

The financial underpinnings of the health care system must be aligned with the goal of reducing inequities, in addition to increasing quality and reducing costs. Resourcing and rewarding equity must be explicit so it is a clear priority and not overlooked.

2. Investments to Support Safety Net and Small Community Providers in Delivery System Reform

Safety net and small community providers face unique barriers to implementing new value-based payment models. Many of these models require significant up front investments that these providers may be unable to make. However, they are often essential sources of culturally centered, geographically and language

accessible care that should be supported so they succeed in a value-based health care world.

3. Building Robust and Well-Resourced Community Partnerships

Given the importance of socioeconomic factors and community context in shaping health, providers that want to move the needle on health outcomes will need to work beyond the walls of their institutions. Especially in the case of communities dealing with the effects of discrimination, and sometimes, historical mistreatment by the health care system, providers should partner with trusted community-based organizations and concretely invest in these relationships.

4. Ensuring a Transparent and Representative Evidence Base

The biases baked into clinical and health system research are well known by experts, yet clinical guidelines are based on this flawed evidence. Improving the evidence base so it reflects the diversity of our population is essential. Similarly, transparency about the limitations of the data used to determine treatment guidelines is needed so that patients, their doctors, and payers can make more appropriate care decisions.

5. Equity-Focused Measurement that Accelerates Reductions in Health Inequities

Measurement is an increasingly important factor in value based payment as well as quality improvement. For new payment models to effectively reward equity there must be equity-focused metrics tied to payment. The incorporation of equity-sensitive measures into payment models must be an essential feature of a transformed health care system.

6. Growing a Diverse Health Care Workforce that Drives Equity and Value

Ultimately, no health care system can work without the appropriate workforce to drive it. The overall health care workforce needs to grow to meet burgeoning demand, must be more ethnically and racially diverse, better distributed geographically, and inclusive of a broader array of jobs—from primary care providers, to mid-level providers, to community health workers and peers.

Overarching Imperative: Include Communities of Color in Delivery and Payment Transformation

Finally, there is one overarching priority that cuts across all of the policy domains: ensuring the effective inclusion of the voices and priorities of communities of color, and other disadvantaged groups, in decision-making. This is not only the right thing to do as a matter of equity to support agency and empowerment, but it is the smart thing to do because the ultimate output will be of higher quality and more likely to be effective. This inclusion must span policy development, decision-making, implementation, and evaluation for it to be truly meaningful. However, given the complexity of payment and delivery reform and system transformation policy, and the limited experience leaders from communities of color have had in this field, meaningful inclusion will require concerted strategies and dedicated resources.

We identify a two-pronged, interlocking framework for achieving meaningful inclusion of community leaders in health system transformation. On one side, decision-making structures and practices must be made more

inclusive, and on the other, community leaders must be provided support so they can effectively represent their constituencies. Inclusive decision-making structures require: transparency, power balance, diversity, intersectionality, equal decision-making authority, early inclusion, attention to power/hierarchy dynamics, acknowledgment of historical and/or ongoing abuse and discrimination, honoring Tribal consultation, and the recognition of limitations. On the other side, providing support for robust representation requires: commitment to long-term financial support; ongoing training, technical assistance, and support; and a platform for collaboration.

We hope that this paper provides a useful starting point for health equity and health system transformation leaders across the country to begin engaging in this critical policymaking opportunity. The health care system will continue to evolve—whether or not our voices join the discussion. It is up to us to ensure that voices advocating for health equity are heard.

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Endnotes

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