

Do the Right Thing: Shifting Health Care Payment Systems to Value-Based Incentives to Achieve Health Equity and Promote Racial Justice

December 2022

All people in the U.S. should have the chance to achieve their fullest health potential and to access adequate, high-quality health care at a price they can afford. The U.S. spends more on health care than any other country, yet hardworking individuals and their families increasingly experience poor health outcomes while shouldering higher and steadily rising health care costs. Broken financial incentives in America's health care system, especially fee-for-service payment, are the main drivers of unaffordable health care. These incentives often encourage high hospital prices and insurance premiums and limit access to high-quality, affordable health care. As a result, millions of Americans are in medical debt, do not receive the care they need to be healthy, and can not seek the health care they need because of the cost.¹ The U.S. fee-for-service health care system, which operates both through traditional health insurance systems and managed care, propels the health care sector to recommend the most profitable procedures and drive up procedure volume. At the same time, these broken financial incentives keep health care inequitable, fragmented, expensive, and far below a gold standard of care, ignoring some of the most important interventions that can keep people healthy and address illness efficiently.²

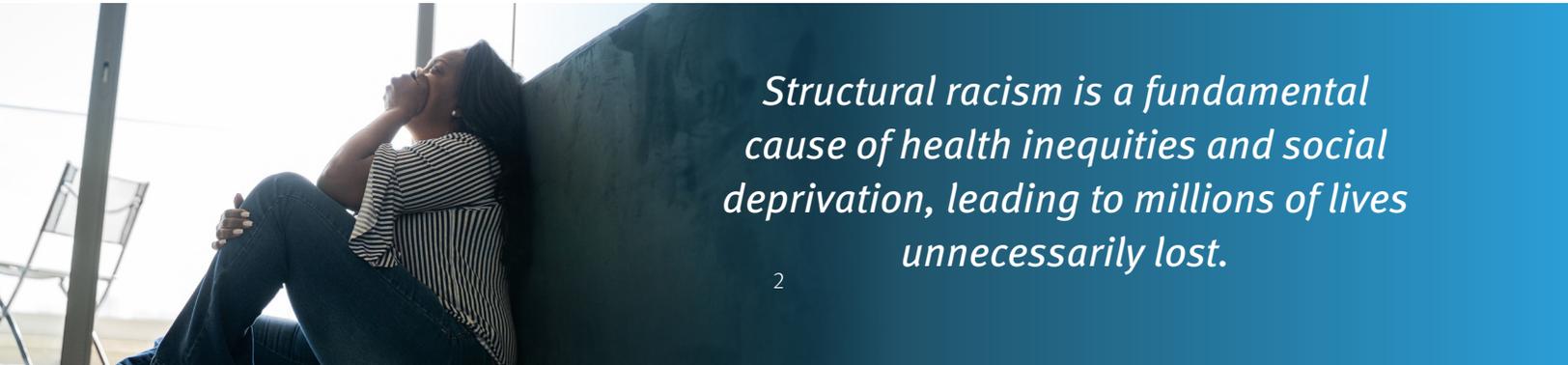
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Structural racism: The root cause of health inequities

The health of individuals and families in the U.S. should not depend on their skin color, their socioeconomic status or where they live, yet it does.^{10,11,12} Racial and ethnic differences in health and overall well-being are not new, coincidental or a result of poor individual choices. These disparate health outcomes are unfair and preventable, yet they persist due to structural racism, socioeconomic deprivation, and implicit and explicit bias.

Structural racism is a fundamental cause of health inequities and social deprivation.¹³ Structural racism has been a key feature of our country since its founding and is deeply embedded in our social, economic and political systems (for example, entrenched in laws, policies, institutional practices and norms). Structural racism refers to the totality of ways in which societies create and maintain white supremacy and reinforce discriminatory beliefs about people of color within and across systems by limiting opportunities for them to be upwardly mobility or to access resources, services and products.^{14,15,16} Structural racism in health care, labor and employment, and housing negatively affects the health and socioeconomic stability of Black people, Indigenous people and other racialized groups. For example, racial residential segregation, a now outlawed form of structural racism in housing, fostered the proliferation of persistent neighborhood disinvestment that drives socioeconomic deprivation experienced by communities of color and low-income communities.¹⁷ The conditions in which people are born, live, learn, work, and play, commonly known as social determinants of health (SDOH), can negatively or positively influence their health and quality of life. For example, higher socioeconomic status often increases one's ability to experience good health, while experiencing socioeconomic deprivation or racism can limit one's chances of enjoying good health. The structural racism deeply embedded in U.S. policies and practices — including in health care, labor and employment, and housing — has negatively affected the health and socioeconomic stability of Black people, Indigenous people and other people of color living in the U.S.

Since the establishment of the U.S. health care financing system in the late 1920s and early 1930s, health care financing policies and practices have advanced structural racism to produce and reinforce profound racial health inequities,^{18,19} including limiting access to quality health care and overall opportunities for health.²⁰ Almost 20 years ago, the Institute of Medicine issued a landmark report identifying U.S. health care financing and delivery system practices as significant barriers to care for Black, Indigenous and people of color.²¹ Moreover, these disparities result in 3.5 million years of life lost, \$93 billion in additional health care spending annually and a total loss of \$135 billion to our nation annually.²²



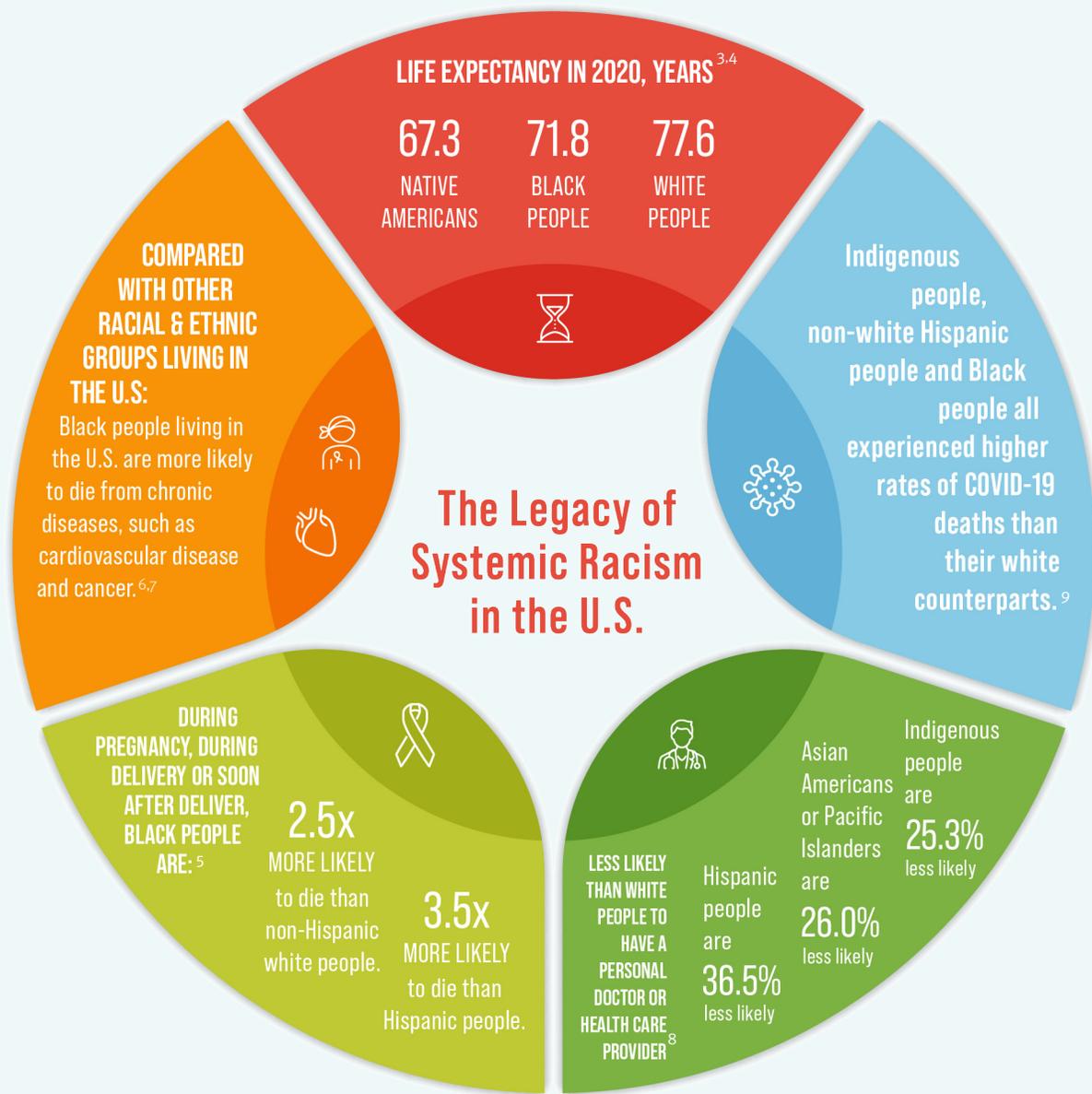
Structural racism is a fundamental cause of health inequities and social deprivation, leading to millions of lives unnecessarily lost.

Today, racial and ethnic diversity is increasing at a rapid rate, and by 2060 over 50% of the total U.S. population is projected to identify as a member of a racial or ethnic group other than white.²³ The future progress of our nation largely depends upon the health of its people, and our health care system has a duty to provide health care that fosters health. Yet persistent structural racism and other forms of structural oppression (for example, economic inequality) continue to drive the lack of affordability, availability and accessibility of health and health care in the U.S., creating profound health inequities.^{24,25,26}

Unfortunately, the health care industry's predominant provider payment system, fee-for-service (FFS), is a main culprit in maintaining the status quo, hurting millions of people of color by severely restricting their access to health as well as high-quality health services and resources. It is critical to note that FFS provider payments predominate in all forms of insurance, from private employer-sponsored coverage and managed care to Medicare and Medicaid, and all forms of insurance have the potential to reorient incentives to move away from FFS provider payments.²⁷

Every individual and family across America must have access to health, not just health care. The U.S. health care payment and delivery system failed millions of individuals and families of color who suffered and died from COVID-19 because it was woefully unprepared to provide tailored whole-person health care that met their particular needs. **As our society becomes increasingly diverse, our health care system must be prepared — and health care providers must be incentivized — to provide whole-person care that is culturally responsive,²⁸ structurally competent²⁹ and linguistically appropriate.** Culturally responsive and linguistically appropriate health care improves patient outcomes³⁰ and is broadly recognized as an important feature of high-quality health care.³¹ Structurally competent health care addresses patients' social needs by considering the myriad ways social structures, such as health care systems, institutional and public policies, neighborhood conditions, and market forces, shape their symptoms and diseases. It is time for the U.S. to do the right thing, to build a health system that produces health, not just health care, for all people, especially the most marginalized. The path is clear: We must shift away from fee-for-service payment and build a payment system that achieves health equity and promotes racial justice.





The U.S. health care financing structure has the most oppressive impact on the health and well-being of Black, Indigenous and Hispanic people, all of whom have persistently been made vulnerable by a legacy of systemic racism in the U.S. The magnitude of this impact is demonstrated by persistent racial and ethnic health disparities. These are some examples.

Fee-for-service payment exacerbates health inequities

The FFS model fuels health inequities and structural racism because, rather than incentivizing improved health outcomes for people of color, it incentivizes increasing the volume of costly and profitable clinical services, including services that are unnecessary and even harmful.³² Incentivizing procedure volume discourages health care providers from addressing patients' nonclinical social needs, which could help address the root causes of health inequities. Furthermore, incentivizing volume means providers are not rewarded for reducing health disparities, providing higher-quality care or improving health outcomes.³³ In addition, FFS prices paid to providers under private health insurance plans are increasing more rapidly than prices paid under government health insurance plans (for example, Medicare and Medicaid), which are often utilized by people who experience vulnerabilities, including seniors.³⁴ As a result, some hospitals and corporate physician groups actively pursue strategies to limit access for patients with government insurance to leverage higher FFS payments from private insurance, only worsening health disparities.³⁵

Under the FFS model, Black and Hispanic people are more likely to be treated at low-quality, high-cost hospitals, significantly increasing their chances of dying.³⁶ In other words, FFS creates and reinforces a segregated, two-tier health care system where the quality of care in effect depends upon what a person looks like and that individual's socioeconomic status.³⁷

FFS Payment: A Hidden Driver of Health Inequities



The FFS model fuels health inequities and structural racism because, rather than incentivizing improved health outcomes for people of color, it incentivizes increasing the volume of costly and profitable clinical

services, including services that are unnecessary and even harmful. Families are forced to ride this economic conveyor belt of poor health outcomes and decreased financial security, furthering inequities.

By definition, FFS payments provide a very narrow view of health and health care by signaling to providers that they can be reimbursed only for delivering the clinical care that drives 10% to 20% of health rather than also being reimbursed for addressing individuals’ health-related social needs associated with social determinants of health (SDOH). SDOH, which includes access to healthy food, affordable and safe housing, transportation and a safe community, drive the majority — 80% to 90% — of people’s ability to achieve their fullest health potential.³⁸

By failing to pay for services that address individuals’ health-related social needs, the economic incentives of FFS work against providers’ professional responsibilities and desires to improve health or reduce health disparities.³⁹ In these ways, the FFS payment system drives high volumes of high-cost specialty care and disincentivizes the delivery of health support services that address the proliferation of SDOH inequities (that is, social deprivation) driven by long-standing racism in the U.S.

Because FFS requires almost no link between the services that providers deliver and the necessity or quality of those services, this payment model does not provide crucial financial incentives to hold the health care system accountable for addressing the impact of structural racism on health outcomes.⁴⁰ FFS also does not align with the idea that addressing individuals’ health and social

Social Determinants of Health



needs can significantly lower health care costs by preventing and mitigating disease incidence rates, disease progression and loss of life.

Furthermore, FFS payments are driving the health care affordability crisis, creating wasteful medical spending that costs the U.S. between \$760 billion and \$935 billion annually.⁴¹ Health care affordability is an issue for many Americans, but especially for people of color. In 2020, average health insurance premiums cost families \$21,342 annually.⁴² For Black and Hispanic families, average annual health insurance premiums were approximately 47% and 39%,⁴³ respectively, of their average household income.⁴⁴

High health care prices impose unnecessary costs on every American, but the impact of high health care prices is most severe for Black people, Indigenous people and other communities of color that experience the compounding effects of racism and economic oppression. These communities experienced economic crisis during the COVID-19 pandemic and continue to suffer from ongoing racial inequities in labor and wealth. According to the Kaiser Family Foundation’s 2022 Health Care Debt Survey, millions of families across the U.S. are unable to pay mounting health care expenses.⁴⁵ As a result, medical debt, a personal debt arising from health care costs, is one of the primary causes of personal bankruptcy. Black and Hispanic adults are 50% and 35%, respectively, more likely to owe money due to copays, deductibles and other out-of-pocket health care costs than their non-Hispanic white counterparts.⁴⁶ Black and Hispanic adults who struggle to pay their medical debt often further compromise their financial stability by increasing their credit card debt draining their savings, or seeking predatory financial services to pay for their medical debt.⁴⁷

Due to the Compounding Effects of Racism and Economic Oppression:



BLACK ADULTS:
50%
MORE LIKELY

↓

to owe money due to copays, deductibles and other out-of-pocket health

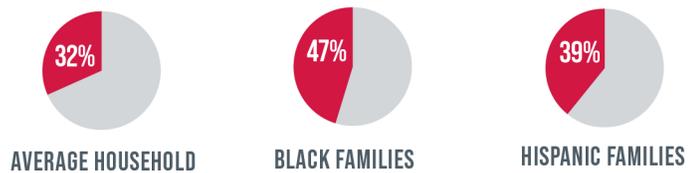
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HISPANIC ADULTS:
35%
MORE LIKELY



Cost of Health Insurance Premiums as a Percentage of Household Income

 HEALTH INSURANCE PREMIUM
 OTHER HOUSEHOLD EXPENSES



High health care prices create and reinforce a vicious cycle of financial instability that limits wealth-building opportunities, especially for people of color. Because of the structural and social factors that contribute to poor health outcomes, Black, Hispanic and Indigenous people are disproportionately burdened by chronic diseases that are costly to treat, and simultaneously have diminished access to financial resources largely due to the racial wealth gap.^{48,49} For various reasons, health insurance costs are not higher for families of color, but the inability to pay for out-of-pocket costs is greater for families of color.

For example, individuals with one or two chronic illnesses often pay two times as much for out-of-pocket costs as Americans without chronic conditions, while individuals with three or more chronic diseases pay four times as much.⁵⁰ These high costs can be devastating for families. Several economists have shown that this cycle of financial insecurity and poor health results in less wealth in the future,⁵¹ creating extreme health and economic disadvantages for Black people and other people of color.^{52,53} Black and Hispanic families are more likely to skip or delay seeking care due to rising health care costs, and this practice produces a domino effect of exacerbated poor health conditions,⁵⁴ increased rates of emergency department visits⁵⁵ and greater medical debt.⁵⁶ FFS fuels high and rising health care prices, reinforcing the pricing practices of big health care corporations and draining our health care system at the expense of individuals' and families' financial stability and, most tragically, their health.

It does not have to stay this way. We can achieve health equity, but it will require deliberate design and intentional action to reduce racial and ethnic health disparities; dismantle root causes of health disparities, such as structural racism; and advance health equity as a key outcome. Health care payment reform can offer a pathway forward in advancing health equity and racial justice as the health care system shifts toward a value-based system that holds the health care industry accountable for delivering health — by addressing health-related social needs — not just clinical services. By design, a quality value-based payment model can potentially shift the economics of health care payment away from FFS and toward a model that pays providers for reducing health disparities and SDOH inequities, eliminating oppressive structural barriers to health, improving population health outcomes, and delivering affordable care.

Importantly, we must be explicit and intentional about imbedding health equity in payment reform efforts or the very dimensions of structural racism that are hurting marginalized populations (for example, lower payment rates, lack of data about disparities, lack of access to services or lack of social programs) will remain embedded in future payment reforms and have the potential to worsen health disparities.

Value-based payment centers on and pays for equity

Payment reform, if structured correctly, has the potential to transform our health care system into one that is just, patient-centered and value-based. Efforts to advance health equity and improve population health will partially depend on payment reforms that dismantle the current economics of our health care system and shift toward models that pay providers for reducing health inequities and hold providers accountable for addressing the impact of systemic racism on health and SDOH.⁵⁷ The purpose of value-based payment system transformation is to create more value for individuals by providing a range of services that improve their health outcomes, which in turn reduces the rate of acute care and lowers their health care costs.^{58,59} This promising pathway can reduce health inequities and advance racial justice by comprehensively providing disenfranchised individuals with the services and resources necessary for health.

Physicians and other health care providers increasingly understand the role nonclinical social needs and the SDOH play in driving individual and community health outcomes.⁶⁰ Adverse social conditions, such as housing instability, food insecurity, a lack of transportation, poverty and economic instability, are associated with higher disease prevalence, poorly managed chronic diseases, increased stress and depressive symptoms, and overall lower quality of life.^{61,62,63,64} As a result, individuals with unmet health-related social needs are more likely to face barriers to health care, such as having to choose between paying rent and obtaining health care. People with unmet health-related social needs also tend to lack a usual source of care, delay needed medical care and medications, have frequent emergency department visits, and have higher rates of inpatient hospital admissions.⁶⁵ The shift to value-based payment offers health care providers the flexibility to coordinate and provide a range of health services that are tailored to meet an individual's broader health needs.



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In addition to offering better health to individuals, a value-based payment system can also help mitigate structural racism and other forms of discrimination in our health care system by requiring providers to report performance data stratified by race, ethnicity, primary language, socioeconomic status, gender identity and sexual orientation. This data will allow health care providers, policymakers and the public to assess the extent to which health services and health supportive resources are available and effective in producing health not just health care — with a focus on addressing health inequities.

Through value-based care, health care providers could also leverage this broad range of data collection systems to assess how a health system's policies impact the fair distribution of health opportunities, including access, quality and affordability of health care services; dignified patient experiences, including anti-bias and anti-discriminatory practices; and good health outcomes among historically marginalized racial and ethnic groups, low-income people, and other excluded groups (for example, LGBTQ+ communities).^{66,67} Such data can guide providers' efforts to identify existing disparities and inequities within their patient population and its broader community as well as appropriately allocate resources and design interventions to reduce unfair differences in health outcomes and opportunities to achieve health. Most importantly, this data can be used to hold health care providers accountable and provide financial incentives for their efforts to implement health equity measures, disrupt bias and racism, and demonstrably reduce racial and ethnic health disparities.

Any effort to reform our health care payment system that does not include robust stratified data requirements will largely reinforce the status quo, miss an opportunity to truly transform our health system and ultimately fail American families. In addition to improving health care outcomes and working to dismantle structural racism in the system, value-based models can potentially lower the burden of health care costs for millions of Americans who experience health inequities, structural racism or other forms of discrimination, and economic oppression.

Value-based payment models also hold promise by prioritizing the growth of a health care workforce that is representative of our population. As our nation becomes more racially and ethnically diverse, persistent racial and ethnic health inequities will increase in magnitude, as illuminated by the COVID-19 pandemic, if we do not build a more diverse and inclusive workforce.⁶⁸ Such culturally competent providers can help ensure improved access to high-quality care for underserved populations, increased patient choice and satisfaction, improved patient-clinician relationships, increased trust and communication, and increased patient likelihood of accepting and receiving evidence-based medical care, all of which would lead to improved health. Increased representation by Black people, Indigenous people and other people of color would foster an understanding of the social and structural barriers that exist for many patients, as well as contribute to more inclusive policies and interventions needed to overcome entrenched barriers to health and health care.

Key policy solutions

As this paper has laid out, advancing health equity and racial justice requires well-defined and deliberate action. Those deliberate actions include creating value-based payment systems that do the following:

- 1. Assess health equity impact.** To advance health equity, health care systems must identify racist and other discriminatory policies, practices and processes deeply embedded within payment systems by answering the following questions:
 - › **Is there a disparate impact on particular communities?** Many payment models result in clear winners and losers. Instead, benefits should be accrued equitably, so that BIPOC populations, populations in rural America, or populations in different geographies have a fair shot at achieving their best health.
 - › **Is risk adjustment effectively accounting for clinical and social risk?** One common critique of some value-based programs is that they use measures to hold providers accountable for factors beyond their control. While a provider may not be able to directly remedy a nonclinical social need, providers should be incentivized to address patients' health-related social needs by ensuring patients are linked to and receive appropriate social resources or services. Clinical care is a relatively small factor in determining health outcomes — social factors often play a much bigger role in driving health outcomes and require the provider's attention when assessing a patient's symptoms and diseases.
 - › **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.
- 2. Reward high-quality and equitable health care.** Value-based payment models, and in particular alternative payment models, by design, must create new economic incentives that allow providers to adopt more holistic, patient-centered approaches to health care delivery, facilitate SDOH equity and improve long-term health outcomes. To effectively reduce health inequities, value-based payment systems can center equity by paying providers to advance equity as well as remedying structural barriers to health and health care within communities served. The goal of payment reform should be to create economic incentives for equitable care, including, but not limited to, more resources for holistic and comprehensive primary care and care coordination that incorporates nonphysician providers. Giving physicians and direct care teams elements of medical risk should be approached carefully and as part of a compensation structure that recognizes and supports their role as care providers, and rewards them for improving health and narrowing disparities.

TWO PROMISING EXAMPLES: States that have built new payment models after assessing health equity impact and incentivizing care that delivers health



Oregon's coordinated care organizations

Oregon's Medicaid delivery system reform efforts, begun in 2012, are centered on [coordinated care organizations](#) (CCOs) that are capitated multisector networks of providers (encompassing physical, behavioral and oral health) that are intended to work collaboratively to improve health outcomes and reduce health care costs in a specific geographic area. Oregon, more so than any other state, incentivizes providers based on equity performance. Incentive measures based on administrative claims data — although not those using medical records — are disaggregated by race, ethnicity, language, sex and disability status, which is a critical step to building health equity performance measures. In addition, Oregon is beginning to designate certain incentive measures as equity measures. The first CCO health equity measure was meaningful language access to culturally responsive health care services, which was developed to measure access for people with limited English proficiency or who communicate using sign language. Beginning in 2020, CCOs have been required to make investments in "[health-related services](#)," including SDOH equity initiatives. Oregon now directs CCOs to use administrative funds — that is, margins after paying for regular covered benefits — to meet health-related social needs, such as food security and stable housing, that are associated with SDOH inequities that exist outside traditional medical services. The state has recently proposed that this spending be counted as medical spending in its filing for federal approval of a five-year extension to the CCO Medicaid waiver. CCO spending on SDOH includes food services and supports, including vouchers or meal delivery; housing services and supports, including temporary housing, utilities assistance or environmental remediation; and education services, including early childhood education, language and literacy education, or support for high school graduation.

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Minnesota's Integrated Health Partnerships

Minnesota's Medicaid provider-based accountable care organizations, referred to in the state as Integrated Health Partnerships (IHP), cover more than 400,000 beneficiaries. The program has an emphasis on SDOH and on IHP accountability for quality outcomes. It brings together health care systems with substance use disorder and mental health services, community health centers, social service agencies, and community-based organizations to implement community-based interventions that respond to medical and health-related problems. Minnesota's IHPs receive a capitated, population-based payment — including some IHPs which are at partial insurance risk — that is adjusted for social risk factors, including deep poverty, homelessness, mental illness, substance use disorder, past incarceration and child protection involvement. Adjusting payment to IHPs based on social risk encourages IHPs to serve patients with greater social needs since the costs associated with addressing these social needs are accounted for in their capitated payment. Minnesota requires IHPs to develop measures and milestones that target health-related social needs as part of their equity-focused interventions, including designated equity measures. IHPs also report their progress in developing tracking systems, contracting with community-based social service providers, and hiring navigators and community health workers. Importantly, Minnesota is increasingly shifting toward stratified measurement by race and ethnicity and toward risk-based payment of accountable care organizations.



Advancing health equity and pursuing racial justice will enable health care providers to deliver health, not solely health care, and more value to the individuals and communities they serve.

Conclusion

At some point in the future, another public health emergency is bound to occur, and our nation cannot afford to lose another million people because of a failed health care system, like what happened during the COVID-19 pandemic. The strength and prosperity of our nation depend on the health and well-being of all its people, not just a select few. It is time for lawmakers to do the right thing and reform our payment system to center on improved health for all, especially the most marginalized individuals living in the U.S., and finally advance health equity. Equitable health care and the elimination of structural racism in the health care system will benefit all individuals while lowering health care costs and improving health care quality in America. Reforming our payment system to center on health equity requires deliberate efforts to redirect dollars to pay for equity, including genuine efforts to unveil inequities; address bias and discrimination; track and reward improved health outcomes for Black people, Indigenous people and other people of color; reduce health disparities; and address SDOH inequities.

Advancing health equity and pursuing racial justice will enable health care providers to deliver health, not solely health care, and more value to the individuals and communities they serve. To achieve this, we must transition away from FFS provider payments, which reinforce and exacerbate health disparities. Value-based payment models hold the promise of ensuring that health care providers are accountable for reducing persistent health inequities, addressing their bias, and dismantling structural and social barriers to health.⁶⁹ Ultimately, payment reform can be one of our health system's primary vehicles for addressing its most persistent problem — inequity — and can lead to better health outcomes and high-quality, equitable health care for all.

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Our health care system has become so focused on dollars that it undermines the best interest of patients. We need to dramatically rethink how we deliver care so that the focus is on positive health outcomes for patients rather than an endless flow of bills.

People First Care is a series of publications over the coming year that addresses the systemic problems in health care payment and delivery that drive unaffordable, low-quality care and poor health, and lays a blueprint for reorienting the health care system to deliver health and affordable, high-quality care for all.

People First Care Series: Publication 4

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