Opportunities to Address Health Disparities in Performance-Based Accountability and Payment Programs
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Disparities in health care and health outcomes are a pressing policy problem in the United States. Recent attention has focused on the role of social risk factors in disparities in health care quality and the ramifications of not accounting for social risk factors in value-based payment and accountability initiatives. In this issue of JAMA Health Forum, Meyers and colleagues report findings from a study in which they constructed simulated star ratings for Medicare Advantage health plans (ie, contracts). These simulated star ratings were based on 22 Medicare Advantage quality measures estimated for subgroups of enrollees in each contract, specifically those who were Black, Hispanic, or White individuals, and those with low or high socioeconomic status (SES). The authors found lower simulated star ratings associated with low SES among Black and Hispanic enrollees compared with high SES and White enrollees. As in prior studies, they found variation in performance and disparities by the sociodemographic composition of contract enrollees. The authors also report estimated contract-level associations in performance across subgroups that likely understate true associations, being attenuated by the limited reliability of some measurements.

The study by Meyers and colleagues adds to the growing body of studies describing quality-performance disparities for individuals with greater burdens of social risk factors. The authors found evidence of disparities in 1 of the largest quality-incentive programs in the United States, consistent with prior findings reported by Joynt and colleagues in 9 federal performance-based payment systems. The evidence prompts consideration of potential actions to address disparities in the context of performance accountability and value-based payment programs. We propose a 4-part approach to aligning measurement, reporting, and incentive payments with equity goals in such programs. Each component addresses a different facet of this pressing problem, and their complementary effects may offset the limitations that each component might have in isolation.

Measure Performance Accurately to Reduce Provider Incentives to Avoid Disadvantaged Patients

Performance measurement and incentive programs can have unintended consequences if better health care providers (ie, physicians, physician groups, hospitals, health systems, skilled nursing facilities) and health plans avoid caring for individuals at greater social risk because the scoring approach does not accurately measure the value a clinician or health care institution or a health plan adds. When measuring performance, it is important to remove bias in provider or health plan scores that does not reflect provider performance but is instead associated with patient or beneficiary characteristics outside of the control of providers or health plans. Disparities are composed of within-provider disparities (eg, the extent to which patients of low SES receive worse care than patients of high SES from the same clinician or health care institution) and between-provider differences (the extent to which all patients of a clinician or health care institution receive worse care).

Improving measurement accuracy requires adjusting for the mean within-provider differences associated with factors appropriate for adjustment, but not adjusting for between-provider differences. Case-mix adjustment may be implemented in regression models, with fixed effects for reporting units (providers, hospitals, or health plans), producing the scores that providers would receive if they all served the same patients.

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differences related to social risk factors gives providers credit for caring for higher-risk patients without masking between-provider differences in performance. The Medicare Advantage Star Ratings Program adjusts for within-contract differences via the Categorical Adjustment Index, indirectly approximating the effect of case-mix adjustment for low income (ie, dual eligibility for Medicare and Medicaid or receipt of the low-income subsidy) and disability as the reason for Medicare entitlement. The adjustment factor assigned is based on the contract’s percentage of beneficiaries with low income and/or disability and is added to or subtracted from a contract’s overall star rating. The Categorical Adjustment Index is intended to improve care indirectly for beneficiaries with low income and/or disability by removing a disincentive to enroll them that high-performing contracts may have.

**Make Disparities Visible Through Public Reporting of Stratified Performance**

Increasing the visibility of performance in patient subgroups promotes awareness of where disparities exist and may motivate providers and health plans to address disparities through reputational effects. One such example has been developed by the Centers for Medicare & Medicaid Services’ Office of Minority Health, which has stratified reporting of clinical and patient experience performance measures by race/ethnicity and by gender for Medicare Advantage contracts. To accurately differentiate subgroup performance, these stratified performance reports pool data over 2 years, require a minimum of 100 cases per subgroup, and enforce minimum reliability standards of 0.6 to report results.

**Specifically Incentivize Providers and Health Plans to Improve Care for Disadvantaged Patients**

As recommended by Meyers and colleagues, financially incentivizing providers and health plans to improve care for enrollees with a greater burden of social risk factor through an equity measure in value-based payment schemes could provide the impetus for providers and health plans to invest quality improvement resources in enrollees who may be more costly to treat. Such measures could include measures of performance for groups at greater social risk. Agniel and colleagues describe the development of a Health Equity Summary Score, including a proof-of-concept application to Medicare Advantage plans that could be extended to other settings, social risk factors, and measures. The Health Equity Summary Score focuses on stratified measurement of each plan’s performance for beneficiaries at greater social risk to highlight and incentivize good performance for social risk factor groups. The summary score directly measures and incentivizes high performance for beneficiaries who are dually eligible for Medicaid, Black, Hispanic, and Asian or Pacific Islander. This score incorporates cross-sectional performance to recognize good care provided to those with social risk burden, somewhat like the stratified star ratings recommended by Meyers and colleagues, and it accounts for within-plan and overall improvement to incentivize low-performing but improving plans.

**Modify Performance-Based Payment Systems to Avoid Redistributing Resources Away From Providers Who Care for Disadvantaged Patients**

Most performance-based incentive schemes are structured as zero-sum games, where financial rewards for high performers come at the expense of low performers. As such, they can create unintended effects because providers who care for disproportionate numbers of disadvantaged patients tend to perform less well than other providers, even when quality is measured accurately, reflecting persistent between-provider and between-plan disparities. Under some performance-based payment systems, these between-provider disparities may redistribute resources away from the providers who most need them to improve care. To keep resources from being transferred away
from providers who care for disadvantaged patients, it is necessary to act on the distribution of the incentive payments that are themselves based on unbiased measures of performance, as described in our first recommendation.

In a prior study, we tested an alternative incentive payment approach that started with a standard incentive payment allocation but then "postadjusted" provider payments using predefined patient or provider characteristics. The approach held the mean incentive payout constant across subgroups while providing larger incentives for better performers within all subgroups. In 1 application, this approach nearly doubled payments to providers caring for disadvantaged patients and reduced payment differentials across providers according to patients' income, race/ethnicity, and region.

Health equity is a high priority for policy makers and is crucial to the nation's health. The study by Meyers and colleagues contributes to a body of evidence-based tools to advance this aim. A piecemeal approach might address within-provider or within-plan differences, but not between-provider or between-plan differences, or such an approach might not address cost obstacles to improving equity. Only by advancing a coordinated, complementary set of strategies, such as those described herein, can we ensure accurate measurement that spotlights high performance and areas requiring improvement, along with payment systems that most effectively promote better care for all patients, particularly for those who are disadvantaged.

**ARTICLE INFORMATION**


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**REFERENCES**


