Aligning Value-Based Payments With Health Equity
A Framework for Reforming Payment Reforms

A decade of value-based payment policy has done little to reduce health inequity in the US. Despite modest successes in improving quality and cost efficiency, value-based models and alternative payment models can also unintentionally exacerbate inequities encountered by historically marginalized communities.

Although consensus about the need to reform payment policy around equity has grown, effective reforms must reconcile existing tensions between financial incentives and equity goals. For instance, holding clinicians accountable for total spending (a core mechanism for achieving cost-efficiency through value-based payment) could inadvertently discourage clinicians from caring for historically marginalized populations for whom spending can be more challenging to control.

Policy makers must systematically address such issues to translate moral imperative into policy reform. This Viewpoint presents a potential guiding framework of strategies that align payment model components with equity goals (eTable in the Supplement).

Organizational Participation
Organizational participation in value-based payments has been uneven and has prevented historically marginalized groups from accessing benefits under payment models. For instance, accountable care organizations (ACOs) have demonstrated evidence of quality improvements and small but significant cost savings. However, early physician participation was higher in affluent communities than in communities with more Black individuals and those who were poor, uninsured, less educated, or had disabilities. Limited participation by safety-net centers and rural organizations has also restricted access to model-associated improvements among lower-income and nonurban populations.

One approach is to require participation. Mandating that certain organizations enroll in payment models can address selective participation and ensure that models encompass different populations within and across regions. For example, communities with higher proportions of individuals from racial and ethnic minority groups were more likely to be included in mandatory joint replacement bundles. Mandates that lead to payment models with broad geographic coverage could also reduce the ability to cherry pick favorable patients (eg, those facing adverse social drivers of health) or otherwise game the system (eg, excluding specific clinicians who care for less favorable patients) in ways that entrench inequity.

However, selective participation is only 1 factor when considering mandates that should be implemented in the broader context of their benefits and drawbacks. Requiring participation may sometimes be infeasible, such as when payment models target less common conditions or involve highly specialized services that are geographically regionalized (eg, bariatric surgery). Mandates may also be undesirable if they require extensive financial investments from safety-net organizations or force them to compete against other organizations.

These issues have been observed in mandatory hospital readmission penalty and joint replacement programs, in which safety-net organizations have shouldered disproportionate penalties vs other organizations. Mandatory participation should be considered, implemented with appropriate safeguards and monitoring, and closely coupled with other payment model reforms to support rather than disadvantage safety-net institutions.

When mandates are less advantageous, policy makers could create targeted programs for specific organizations and patient populations. For example, Medicare’s ACO investment model was explicitly designed to support infrastructure investments and participation among organizations in rural and underserved areas. Other programs have expanded participation beyond traditional health organizations to include community bridge organizations because of the critical gap between clinical and community services. Future policy could extend early exemplars and ensure that any proposed participation strategy leads to the inclusion of organizations serving historically marginalized populations. Mandatory participation and targeted, voluntary programs represent components of a comprehensive participation-based strategy for promoting equity by including all community segments in payment models and the resulting care improvement efforts.

Spending Targets
Spending targets designed to drive cost efficiency should encourage participating health care organizations and clinicians to take actions that support, rather than undercut, equity. Doing so may require acknowledgment that lower spending, particularly for marginalized groups, is not always desirable. Lower spending may reflect underuse and insufficient access, rather than appropriate cost-efficiency efforts. Cost-efficient processes (eg, reducing hospital discharges to skilled nursing facilities) may also create undue difficulties for patients (eg, those who need for postsurgical care support).

Spending targets should comprehensively account for patients’ clinical and social needs. One approach is to implement models that increase spending targets based on social drivers of health. In a forthcoming ACO program, financial spending benchmarks will be increased based on social drivers in patients’ lived environments and calculated using area level deprivation measures.
on such examples, future policy should mitigate the possibility that risk adjustment methods exacerbate inequity.

Another strategy is to decouple spending incurred for historically marginalized populations from overall spending calculations; this represents a possible approach for resolving tension between clinically appropriate care and financial disincentives. For example, ongoing Medicare bundled payments exclude high-value cardiac rehabilitation services from spending target calculations. In a forthcoming oncology model, Medicare intends to provide additional payments to care for Medicare and Medicaid dual-eligible individuals, while excluding those payments from total spending targets.7

Quality Measurement
Value-based payment arrangements invariably involve quality, but seldom involve measurement of inequity. Despite longstanding racial disparities for conditions such as hypertension, organizational performance has not been race-stratified to measure disparities nor how they change under payment incentives. Future policy could rectify this issue, building on early work from states and private payers to measure and report quality metrics for conditions stratified by race, ethnicity, and indicators of socioeconomic status.8

Similarly, awareness about social drivers of health has not translated into metrics that reflect inequity arising from health-related social needs. However, early examples have demonstrated the feasibility of standardized screening for health-related social needs and navigation for connecting individuals with community resources.5 Payment models could build on these lessons by using quality metrics for completing social needs screening, and among patients with identified needs, placing referrals to community services.

Performance-Based Incentives
Performance-based incentives are a critical element of value-based payment models that can undercuts equity. For instance, clinicians caring for marginalized populations could be disproportionately penalized if incentives are based on direct comparisons between safety net and other organization types. Comparisons can be even more problematic if they require participants to outperform other organizations to even become eligible for incentives.

Several strategies could help resolve these tensions. First, policy makers could use stratification to create more appropriate comparisons, a method that has been used to reduce disproportionate readmission penalties on safety-net hospitals. Approaches are also being used in the End-Stage Renal Disease Treatment Choices Model to stratify performance benchmarks based on the volume of Medicare and Medicaid dual-eligible or low-income subsidy patients.

Second, performance-based incentives could involve standard performance thresholds across all participants, but reward relative improvements toward those thresholds for each participant. Third, payment models could use standard thresholds and incentive definitions to reward participants, but vary the size of incentive pools based on the population served. For example, all participants that meet absolute performance thresholds (eg, 80% quality performance) could be eligible for a predefined proportion of incentives (eg, 80% of the incentive pool). However, payment models could allocate and pay incentives out of larger pools for participants that provide care for a large proportion of lower-income individuals, and smaller pools to participants that primarily serve affluent populations. These models would effectively reward the same level of achievement, but with larger incentive amounts for participants serving marginalized populations.

Both approaches could harness financial incentives and reward organizations that care for historically marginalized populations while underscoring critical equity goals to (1) avoid setting lower standards for different populations and (2) acknowledge efforts made by participants given different populations and starting at different levels of performance. Stronger future steps could include directly incorporating equity requirements into performance incentives. For instance, eligibility for financial bonuses could be directly contingent on improvements in reducing disparities.

Conclusions
Payment reform alone cannot overcome the root causes of health inequity, but it is nonetheless an important tool for helping to achieve health equity. Because no strategy is a panacea, progress will require the collective effects of systematic reforms enacted under a guiding framework to align payment and equity goals.

REFERENCES

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