



Value-Based Care:

An essential step
towards achieving
health equity

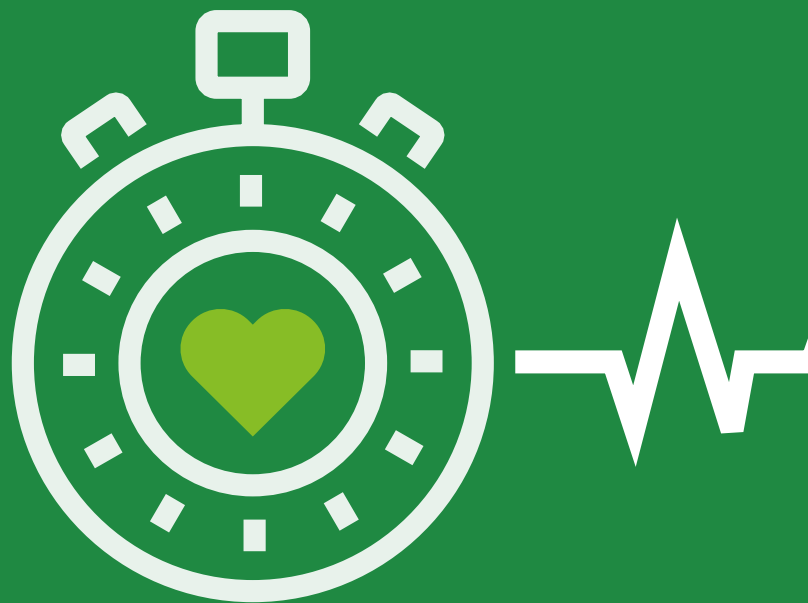
Mark Bethke, Dorrie Guest, and Elizabeth Baca

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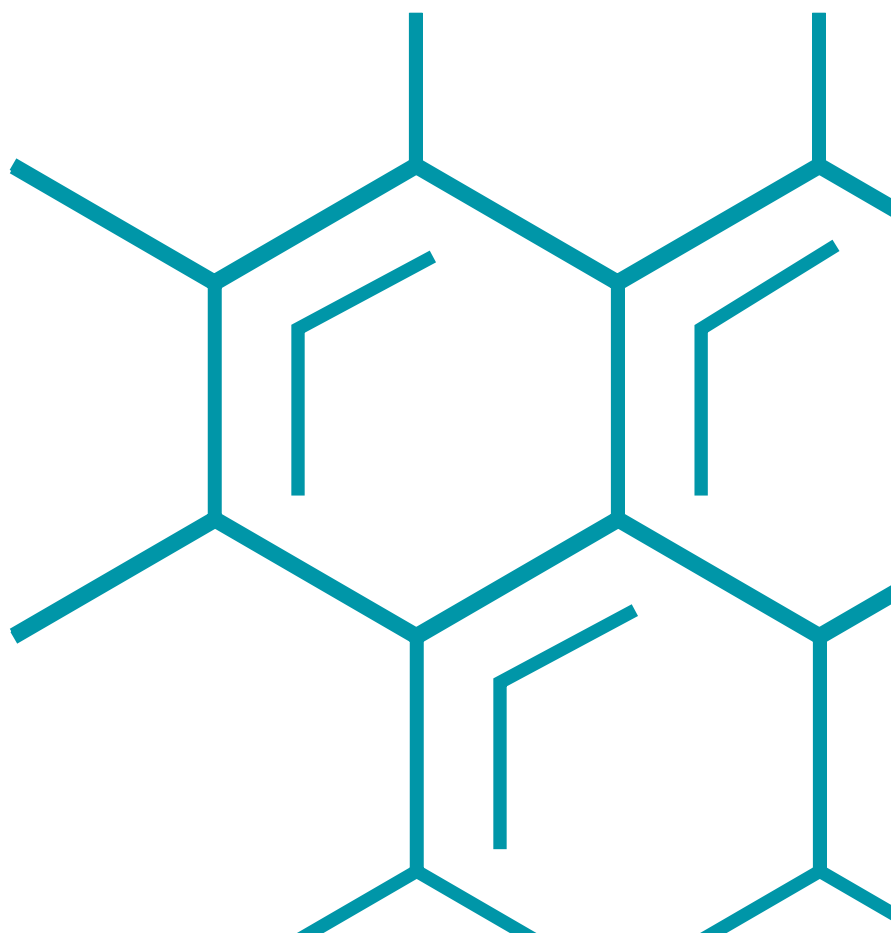
While the causes of disparate health outcomes are incredibly complex and deeply embedded in our broader economic, political, and social systems, there are elements of the health care system which can be targeted to make discernable progress toward achieving greater [health equity](#). Within the realm of value-based care (VBC), this work begins by acknowledging and addressing existing biases in the way payment models and care delivery components have typically been structured.

This article identifies some existing limitations and proposes near-term actions that health care organizations can pursue to drive real change for the patients and communities they exist to serve.



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Existing VBC biases and limitations

Biases in payment models

Current [VBC models](#) were created for provider practices and their insured patients. In the US, this excludes 21% of people who are underinsured¹ and 8% of people who are uninsured entirely.² Health systems may be achieving high quality scores for those groups covered by VBC contracts, but poor health outcomes and inconsistent care may persist for the populations that are most disproportionately impacted by inequities in care.

The variation is exacerbated further by differences between commercial, Medicare, and Medicaid groups. An organization may focus initially on VBC within its Medicare and commercial lines of business; these patients are likely affluent with more resources to navigate our complex health system. Meanwhile Medicaid patients, those in most need of additional support, do not receive the same level of benefits. Regional variation in VBC adoption rates can also leave groups, like rural populations, falling through the cracks.

Current attribution logic is also inherently hindering, as individuals are often attributed only when they have seen a provider for services. Attribution logic does not always account for individuals who are not actively receiving services or individuals who overutilize the emergency room for their primary care needs.

Even if attribution logic were broader, social and environmental risk factors are not commonly accounted for in risk adjustment methodologies, which are primarily based off a patient or member's demographics and diagnoses. Using this design, a patient with poor access may not show a strong correlation between poor health and high cost because they are not accessing the health care system in the first place. With a more comprehensive risk score that reflects broader health care needs, both payers and providers can direct resources and funding to services that address [drivers of health \(DOH\)](#) and improve health care for all.

Biases in care delivery

Biases in the delivery of [care management services](#) also present barriers to equitable care. VBC models often identify target populations for care management efforts based solely on healthcare expenditures and known utilization, which limits the patient pool by failing to incorporate DOH and missing those rising in risk status. Gaps within the data sources typically utilized for identification and stratification are prevalent as well. No claims exist for uninsured patients, and those who do not select or visit primary care physicians (PCPs) may have limited or nonexistent clinical data, thus excluding these patients from registries.

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“Patient engagement and outreach can also be hindered by social and environmental factors”



Patient engagement and outreach can also be hindered by social and environmental factors, including the presence of cultural or language barriers, lack of access to adequate childcare or transportation, food insecurity, lack of physical safety, and more—rendering VBC efforts dependent on traditional methods of patient engagement inherently biased.³ For example, patients in rural communities may not have high-speed internet capabilities, those experiencing homelessness may change addresses frequently, and provider referrals may not take into account the convenience of the service location.

health systems, which usually have more leverage with policymakers and become the driving force behind attribution models. Thus, funding efforts to prepare providers shifting to VBC arrangements have often had limited success in meaningfully including community health providers and social service agencies, which have more regular touchpoints with low-income, high-need community members and are often better equipped to address DOH.

Furthermore, [clinically integrated networks \(CINs\)](#) have cultivated their patient populations via narrowed networks of

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This results in disjointed communication and decreased access to care, which can lead to exclusion from VBC programs if the patient is removed from panels due to inactivity.

Finally, community health providers play an important role in accessing more vulnerable populations, but oftentimes do not receive enough support. VBC efforts have historically centered around large integrated

clinical partners, which can often leave out community health centers, safety-net hospitals, Federally Qualified Health Centers (FQHCs), and perhaps most importantly social service providers—all of whom likely have stronger connections within the communities they serve and are likely better positioned to improve population health in a more equitable way.



Solutions for addressing health equity through VBC

Although biases exist, there are practical next steps health care organizations can take to improve outcomes and provide more equitable care.

Expand the definition of “attributed lives”

For patients who have PCPs, ensure VBC attribution methodologies account for PCP selection in addition to utilization. For those without PCPs, directly analyze patients to assess how care is delivered and provide system-level support. Providers should also include uninsured patients within their attributed lives, promoting delivery of services in lower cost settings, to enhance access, improve health status, and decrease provider investment in charity care. Providers and plans can also consider adding community-based organizations to their VBC networks.

Collect and appropriately utilize additional data

Health care organizations can broaden the types of patient data captured to better assess risk factors and other disparities that may be impacting health status. Layering this data on top of outcomes and process measures can enable better stratification of patients, thereby enhancing the ability to target and address needs.

Additional data points include:

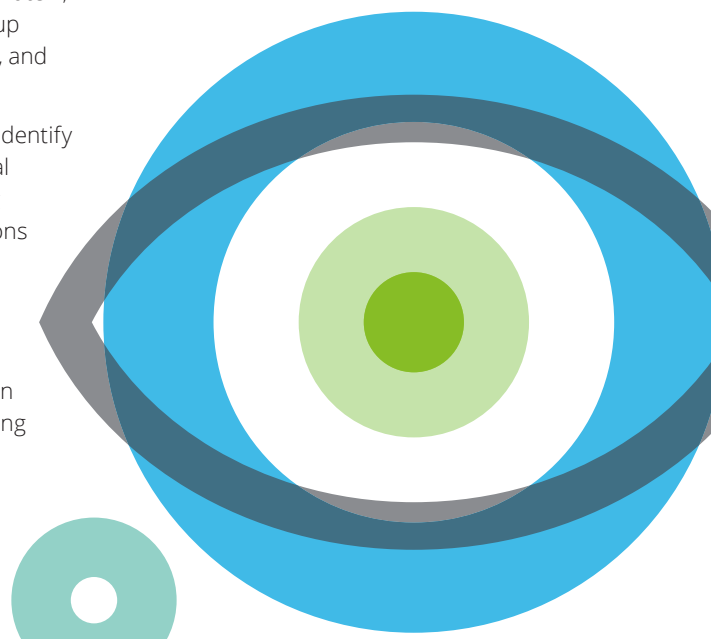
- Race, Ethnicity, and Language (REaL data) Sexual Orientation and Gender Identity (SOGI) data
- Social Risk Factors⁴, such as poverty, minority race and/or ethnicity, social isolation, and availability of community resources⁵
- [Environmental Risk Factors](#), such as air quality, exposure to extreme temperatures, precipitation levels, and infrastructure

In addition to data collection, the application of risk scores must be broadened to incorporate the prediction of health, longevity, or wellbeing to fairly account for patients with poor access and low utilization. Organizations must also be sure to establish appropriate governance mechanisms for responsibly employing and monitoring data usage.

Incorporate additional data into reporting and payment incentives

Health plans and government agencies can require providers to measure and report quality metrics that incorporate social and environmental risk factors, offering rewards to providers who demonstrate reductions in disparities⁴ and increase spending on upstream community benefits, such as housing, nutrition support, and community outreach.⁶ Organizations can coordinate with Centers for Medicare and Medicaid Services (CMS) to incorporate social and environmental risk factors in risk adjustment models where appropriate^{4,7}, as well as for health plans setting up risk adjusted targets, benchmarks, and capitation payments or providers.

CMS maintains ongoing efforts to identify implicit bias and address structural barriers to health equity, including supporting health care organizations through development of the [CMS Framework for Health Equity, analysis](#) of various payment and service delivery models, and continued [updates](#) to its Innovation Center Strategy aimed at embedding health equity in model design, implementation, and evaluation.



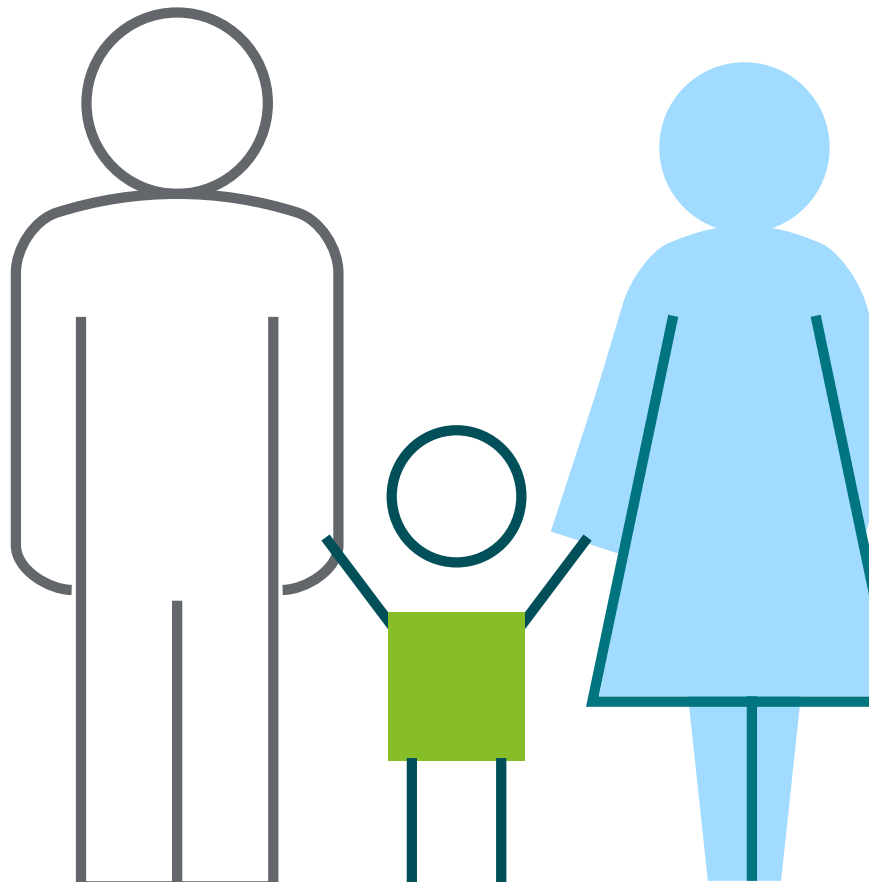
Enhance providers' abilities to track and manage vulnerable populations

There are several approaches that can be pursued to support providers with limited resources:

- To better equip safety net providers to measure and report on social and environmental risk factors, direct health plan payments toward procurement and adoption of tools and alternative reporting methods⁸
- To enable health systems to increase focus on addressing health equity, direct health plan payments toward health system initiatives focused on providing social support benefits or implementing community health worker models⁷
- In instances where providers do not have the staffing levels or expertise to utilize technology or implement social support initiatives, establish partnerships with community-based organizations to pool resources
 - Collaborate with local colleges for data collection and analysis⁹
 - Connect members and patients to resources through community centers, churches, food banks, transportation companies, learning centers, prescription assistance programs, etc.¹⁰

Enhance patient-centered engagement and delivery of services

Health care organizations can increase focus on vulnerable populations by stratifying engagement analytics by social and environmental risk factors or other demographically oriented factors from third-party data. When applying care management approaches, there should be an emphasis on providing language access, health literacy, and culturally tailored services. Barriers and preferences for these patient populations can be better understood through focus groups and other channels that empower individuals to have a voice, so that resources can be deployed most effectively.



Conclusion

VBC models are an essential lever health care organizations can utilize to create true value for all patient populations, regardless of circumstances and underlying risks. Capabilities used to achieve success in these models can be leveraged to support underserved populations by incorporating an equity-focused lens, which will help organizations move closer to achieving the [Quadruple Aim](#) while simultaneously addressing existing health disparities. While these efforts will require commitment and dedication of resources, they are crucial and practical steps for advancing on the path to achieving health equity.

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