

A National Priority Agenda to Advance Health Equity Through System Transformation

The Health Equity Task Force for Delivery
and Payment Transformation's Top 19
Recommendations for 2019 and Beyond

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HEALTH EQUITY ACTION
FOR SYSTEM TRANSFORMATION

AT **FAMILIESUSA**

Our Commitment to Achieving Health Equity

Families USA's core mission is to build a nation where the best health and health care are equally accessible to all, regardless of who you are or where you live. For almost 40 years, we have advanced a vision of social justice at the federal, state, and community levels. Our work is rooted in the conviction that health is foundational to self-actualization and that the opportunity to live a healthy life should be a central focus of our public policy and society as a whole. Fighting for health justice has always been, and will continue to be, our deepest motivation. Given demographic shifts and the importance of health care in our economy, transforming our health care system so that it is more efficient, effective, and equitable is an economic imperative, in addition to a moral one.

We are at a critical point in history. We are coming to terms with how important the full success of communities of color is for the future of our nation. Both the prosperity and the moral standing of our country are inextricably linked to the success of children of color, their families, and their communities. As baby boomers age and retire, our future workforce will be increasingly diverse. In fact, right now, the majority of all children under the age of 10 are from communities of color. By 2020, the majority of all children under 18 will be of color. And by 2045, the majority of our nation will be people of color. Thus, the men, women, and children of color in our nation are critical to our shared prosperity. They are our future labor force, the people whose work will drive our economy; whose incomes will support Social Security, Medicare, and other critical programs; whose hands and hearts will be taking care of the expanding ranks of elders. Achieving equity in health and health care, as well as in other spheres, is not only the right thing to do, it is the smart thing to do.

We are at a critical point in history. We are coming to terms with how important the full success of communities of color is for the future of our nation.

Our dedication to advancing health equity has never been stronger, and we understand that to succeed we all must work collaboratively to ensure that the voices of those most affected are elevated. This is why we are working through a coalition of state and national partners to create a policy agenda to address health inequities by transforming how we deliver and

pay for health care. The Health Equity Task Force for Delivery and Payment Transformation, which launched earlier this year, includes experts and leaders who represent very diverse communities that experience health inequities, including people of color; people with disabilities; rural communities; and lesbian, gay, bisexual, transgender, and queer people, among others.

The drive to transform our health care system into one that is high-performing, efficient, and financially sustainable is a crucial opportunity to accelerate equity by focusing on reducing persistent racial, ethnic, and geographic disparities. However, if the drive toward “value” does not include policy options designed intentionally to narrow these health and health care gaps, there is a considerable risk that some communities will be left behind, and inequities will widen.

To make progress in eliminating historic disparities in health outcomes will require community-based work and engagement with a broad network of stakeholders representing diverse communities and consumers, the health care sector, and the business sector. This policy agenda is the next step in our ongoing efforts to define the path forward. We hope that readers find it a useful resource. We also hope that you find it an urgent call to action. As described in this paper, we as a country are at a turning point on health equity and health system transformation. Families USA will continue to move forward on collaborative efforts to navigate the right path forward to a more just and higher-performing health care system.

—*Frederick Isasi, J.D., MPH, Executive Director,
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The Center on Health Equity Action for System Transformation is the only national entity exclusively dedicated to the development and advancement of patient-centered health system transformation policies designed to reduce racial, ethnic, and geographic inequities.

We focus on advancing equity while improving outcomes, increasing value, and lowering costs. We catalyze and coordinate action to develop and implement health care delivery and payment policies focused on health equity. We make an impact by partnering with and supporting community leaders, health equity experts, and other stakeholders at national, state, and local levels.

The Center on Health Equity Action for System Transformation works to achieve an equitable, high-value, high-quality, and affordable health care system by:

- » **Building a movement for equity-focused health care system transformation by galvanizing and coordinating action among diverse organizations and community leaders** to ensure that a transformed health care system centers on the needs of those most affected by inequities.

- » **Channeling and translating the power of the best ideas and the most innovative thinking from top thought leaders and policy experts into concrete, actionable strategies and recommendations** that community leaders, stakeholders, and decision-makers can use.
- » **Working with leaders who represent communities of color and other underserved groups** to enhance their capacity to engage effectively in system transformation. We provide critical strategic guidance, training, and technical support, while highlighting the urgency of tackling inequities through health system reform.

In addition to being the leading national resource for community leaders, decision-makers, and other stakeholders on equity-focused health care system transformation, the Center on Health Equity Action houses the Health Equity Task Force for Delivery and Payment Transformation and the Community Health Worker Sustainability Collaborative.

The center is made possible by the generous support of the Robert Wood Johnson Foundation and the Patient-Centered Outcomes Research Institute.



FOR DELIVERY & PAYMENT TRANSFORMATION

The Health Equity Task Force for Delivery and Payment Transformation advances health care delivery and payment reform policies that promote health equity and the elimination of racial, ethnic, and geographic health and health care disparities.

The task force brings together the leading health equity and system transformation thought leaders in the nation with national and state-level leaders representing diverse communities dealing with health inequities. We are committed to working together, and with other stakeholders and decision-makers, to ensure that health system transformation maximizes opportunities for good health for those most in need.

While our primary focus is on addressing racial, ethnic, and geographic inequities, we take an intersectional

approach that explicitly incorporates the impact that different identities and experiences have on health inequities, including, but not limited to, sex, gender identity, sexual orientation, disability, English language proficiency, tribal political status, and immigration status. We will create a policy agenda that centers on rectifying racial, ethnic, and geographic inequities, and will develop strategies and tactics that are broader in appeal and impact, including building and participating in larger coalitions, and seeking partnerships with diverse stakeholders.



FOR DELIVERY & PAYMENT TRANSFORMATION

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Executive Summary

Executive Summary

The United States is struggling with an increasingly expensive and inefficient health care system that delivers very uneven outcomes that fuel pervasive health inequities among communities of color, rural communities, and other underserved groups. Efforts underway to improve the cost and quality of health care have centered on transforming our health care system from one that pays for volume to one that rewards value. However, the health system transformation initiatives that have been implemented thus far have failed to significantly reduce health disparities because they have not prioritized solving for equity.

As health system transformation efforts are ongoing, the time is ripe for leaders representing communities that have largely been excluded from health care transformation policy development and decision-making to intervene for the benefit of their communities. Given that for many of these leaders, health system transformation is a relatively new endeavor, Families USA, together with the Health Equity Task Force for Delivery and Payment Transformation, has been working to establish an effective framework for tackling health inequities, develop a menu of policy options and prioritize them, and promote coordinated action in pursuit of health equity. *A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems*, published earlier this year, was the first step. We identified six policy domains that are the key targets for change and presented 86 different policy options to consider specific to federal policy, state policy, the private sector, and some that could be

implemented in any of those spheres. These domains are: payment systems, the safety net and small community providers, community partnerships, the evidence base, measurement, and workforce.

Advancing Health Equity through System Transformation: From a Framework and Policy Options to a Priority Agenda

This national priority agenda is the next step in our collective efforts to ensure that the needs and priorities of communities of color, rural communities, and other underserved groups are purposefully addressed in ongoing and future system transformation efforts. Task force members worked together to arrive at a general consensus on the top policy changes for each of the domains necessary to build a truly equitable and transformed health care system.¹ We identified 19 recommendations considered high priority among the six domains of action.

¹ This is not intended to be an exhaustive list of priorities for each member of the task force, and individual members of the task force likely have additional recommended priorities that are not included.

19 Health Equity and System Transformation Recommendations for 2019 and Beyond

PAYMENT SYSTEMS

Designing and Implementing Payment Systems That Sustain and Reward High-Quality, Equitable Health Care

1. Incorporate health equity into quality measurement and performance-based payment, including paying providers for reducing disparities in quality as a core payment reform package across payers and across state and federal policy.
2. Implement improved, robust risk adjustment methodologies that account for social and medical needs to ensure that providers serving disadvantaged populations are not penalized inappropriately.
3. Require and pay for equity-focused delivery reforms that include mechanisms to pay for care delivery models and activities that have a proven record of reducing inequities, including those that address adverse social determinants of health.

SAFETY NET

Supporting Safety Net and Small Community Providers' Transition to a Value-Based Health Care System

4. The Centers for Medicare & Medicaid Services (CMS) should consider a more targeted Medicaid waiver funding mechanism that is smaller and more accessible to states without large public hospitals.
5. Expand and restructure the technical assistance funded by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that supports practices with fewer than 15 clinicians to better support small practices serving a safety net role, and to incorporate parallel federal funding streams for community health centers

and tribal health systems (including Urban Indian Health Program health centers).

6. States should consider alternatives to make payments to safety net and small community providers to support their transition to value-based health care, such as supplemental payments by insurers under Medicaid managed care, among other options.

COMMUNITY PARTNERSHIPS

Building Robust and Well-Resourced Community Partnerships

7. Provide funding and technical assistance with developing and managing vendor contracts for improving information technology infrastructure for community-based organizations, so that they can maximize their ability to coordinate with health systems and provide services, track clients' progress, and report back to providers.
8. States should require Medicaid managed care programs to contract with community-based organizations that have experience providing services to the populations they cover for needed social services and for outreach, education, assessment, care coordination, and follow-up services for their enrollees.
9. The Center for Medicare and Medicaid Innovation (CMMI) and state Medicaid programs should implement and scale models specifically designed to leverage community partnerships to address the effects of adverse social determinants of health.
10. Strengthen hospital requirements to invest in their communities, both through their business practices and by engaging community residents

directly in identifying problems and identifying and implementing solutions.

EVIDENCE BASE

Ensuring a Transparent and Representative Evidence Base

11. Mandate and incentivize race and ethnicity analysis in clinical and health services research and evaluation, in addition to any other key demographic characteristics that are available, unless statistically inappropriate.
12. Require improved dissemination of high-impact publicly funded research that includes plain-language summaries of all results housed on a user-friendly website so that communities facing a disparate impact of health conditions, their health care providers, clinical guideline developers, and payers can access research results as quickly as possible.
13. Require all publicly funded medical research to report results by key demographic characteristics to ensure evidence is used appropriately, and to indicate where there are significant variations in results by, at a minimum, sex, age group, race, ethnicity, and disability.

MEASUREMENT

Implementing Equity-Focused Measurement That Accelerates Reductions in Health Inequities

14. Require data stratification by age, sex, race, ethnicity, and language, at a minimum, for health care organizations and providers who participate and report performance measures in value-based programs in Medicare, Medicaid, and with commercial insurers.
15. Require and incentivize the collection of patient social and behavioral risk data through value-based payment programs from Medicare,

Medicaid, and commercial insurance, with appropriate privacy and anti-discriminatory protections.

WORKFORCE

Growing a Diverse Health Care Workforce That Drives Equity and Value

16. Invest in and expand K-12 “pipeline” programs and college and postgraduate support to ensure academic readiness and to provide multiple entryways into health care professions for more people from underrepresented groups.
17. Improve education and training for all health care providers to focus on culturally centered care, social determinants of health, the influence of structural racism and discrimination on health, and the implicit biases in the health care system.
18. Build financing streams for community health workers and similar community-based care team members into all payment models, including in fee-for-service, and particularly in Medicaid.
19. Reform scope of practice, licensing, prescribing, and supervision regulations to allow more midlevel providers to practice at their highest level to protect against projected shortages in many communities of primary, mental health, and dental care providers.

As our country becomes more diverse, and health care becomes increasingly expensive, the urgency of eliminating racial, ethnic, geographic, and other health inequities escalates. As policy agendas are being developed for 2019 and beyond across public, private, industry, and community sectors, we urge leaders to prioritize health equity-focused system transformation and utilize these recommendations as a guide toward a healthier and more prosperous nation.

Introduction

In an ongoing effort to create a health care system that produces better quality, improved health outcomes, and lower costs, policymakers, health care industry leaders, and other stakeholders have sought to change how health care is organized and paid for in order to reward value over volume. However, health system transformation (as this effort is often called) has largely left out an important factor: equity.

Our health care system, and our larger society, is riddled with persistent, extensive, severe, and costly health and health care inequities based on race, ethnicity, and geography, among other factors driving social inequities. Yet, even as health system transformation offers a powerful opportunity to tackle these inequities directly, the transformation initiatives that have been promoted and implemented to date have failed to focus on these inequities. There has been little concern for alleviating inequities and little effort to shift resources to where they are needed the most. Indeed, instead of leveraging this opportunity to narrow gaps, health system transformation efforts risk perpetuating, and even increasing, inequities among people and communities that are already struggling.

One important reason the needs of communities of color, rural communities, and other underserved groups have not been the focus of system transformation efforts is that the leaders of these communities have largely been excluded from health care policy development and decision-making. This must end. Earlier this year, we came together as health equity experts and leaders who represent and serve communities of color, rural communities,

and other groups facing health inequities to create the Health Equity Task Force for Delivery and Payment Transformation because we understand the importance and urgency of intervening in system reform initiatives for the benefit of our communities.

We Need a National Priority Agenda for Advancing Health Equity Through System Transformation

In June 2018, Families USA, with the input of the task force, published *A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems*. This framework laid out the components of the health care system that need to be transformed in order to build a truly equitable, efficient, high-value, and affordable health care system that effectively improves and protects everyone's health. We identified six general policy domains that are the key targets for change and presented 86 different policy options to consider. Some of these options are specific to federal policy, some to state policy, some to the private sector, and some could be implemented in any of those spheres.

EQUALITY VERSUS EQUITY



EQUALITY



EQUITY

Equality means that all people receive exactly the same thing, whether they need it or not, and whether it is sufficient for them to succeed. On the other hand, *equity* means that all people receive what they need to succeed.

This priority agenda selects from among these policy options, prioritizes them, and, in some cases, further refines the suggestions in the framework. Especially as we prepare for a new federal Congress and numerous new governors and state legislators, we want to provide guidance on the top priorities for action for health care system transformation focused on health equity in 2019 and beyond. Task force members worked together to arrive at a general consensus on the top policy changes for each domain that are urgently required to build a truly equitable and transformed health care system. (Note: This is not

intended to be an exhaustive list of priorities for each member of the task force, and individual members of the task force likely have additional recommended priorities that are not included.)

**SIX POLICY DOMAINS FOR ACHIEVING HEALTH EQUITY
THROUGH SYSTEM TRANSFORMATION**



1

PAYMENT SYSTEMS

Designing and Implementing Payment Systems That Sustain and Reward High-Quality, Equitable Health Care



2

SAFETY NET

Supporting Safety Net and Small Community Providers' Transition to a Value-Based Health Care System



3

COMMUNITY PARTNERSHIPS

Building Robust and Well-Resourced Community Partnerships



4

EVIDENCE BASE

Ensuring a Transparent and Representative Evidence Base



5

MEASUREMENT

Implementing Equity-Focused Measurement That Accelerates Reductions in Health Inequities



6

WORKFORCE

Growing a Diverse Health Care Workforce That Drives Equity and Value



1 PAYMENT SYSTEMS

Designing and Implementing Payment Systems That Sustain and Reward High-Quality, Equitable Health Care

Traditional fee-for-service health care payment systems are not well-designed for reducing costs, improving overall quality, or narrowing the inequities experienced by communities of color and other underserved groups. Much of the impetus driving payment reform is to fix financial incentives so that they align with the results we seek. However, even as payment reform has been gaining momentum, solving for health equity has not been the focus of this work. Developing payment systems that are specifically designed to support and reward disparity reduction is indispensable to achieving equity. Moreover, these new payment models must not inadvertently undermine those providers who, often under challenging circumstances, care for underserved communities currently affected by inequities.

Our top recommendations to ensure that new and alternative payment models advance equity are:

1. **Incorporate health equity into quality measurement and payment.**

To tackle health equity head-on, direct measurement of health equity must be integrated into all performance-based payment. Paying providers for reducing disparities in quality must be part of the core payment reform package across payers and across state and federal policy. A major step in this direction would be adopting disparity-sensitive and health equity quality

indicators and stratifying performance on these measures by race and ethnicity. The Medicare and Medicaid programs should lead the way by directly incentivizing disparity reductions and explicitly including these measures in their quality measure sets. This should be based on the measures laid out in the National Quality Forum’s 2017 report *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I’s for Health Equity*.¹

What Are Disparity-Sensitive Measures?

The National Quality Forum defines a disparity-sensitive measure as one “that detect[s] differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups.”

What Are Health Equity Measures?

The National Quality Forum defines a health equity measure as “a performance measure that can be linked to an intervention that reduces disparities in health or healthcare.”

2. Implement improved, robust risk

adjustment. To ensure that providers serving disadvantaged populations are not penalized inappropriately, performance-based payment models must include more robust and responsive risk adjustment and stratification. Risk adjustment methodologies currently implemented in public programs using performance-based payment are not able to effectively distinguish between when poor outcomes are the result of poor-quality care and when they have more to do with the many factors related to caring for patients with complex health and social needs. Both medical and social needs must be accounted for in improved risk adjustment methodologies, especially in Medicaid and Medicare. The goal is not adjusting measures so that disparities are not detected, or to reduce accountability for improving outcomes for providers who care for complex populations. Rather, the objective is to ensure that due to inaccurate risk adjustment, new payment methodologies do not result in the net transfer of health care resources from communities struggling with multiple adverse social determinants that undermine their health to communities that face fewer challenges and are better resourced.

3. Require and pay for equity-focused delivery reforms.

Part of payment reform is creating new ways to organize and deliver health care—particularly delivery of primary and preventive care beyond traditional clinic or office visits. Reformed payment systems should include mechanisms to pay for equity-focused care delivery models and activities, including those that address adverse social determinants of health. Good examples of the kinds of models and activities that have been shown to be effective in improving the health of communities dealing with health inequities include integrating community health workers and other bridges to community-based resources, creating telehealth programs that expand access and cultural competence, and integrating behavioral health and primary care, among others.

WHAT ARE SOCIAL DETERMINANTS OF HEALTH?



Social determinants of health are the conditions in which people are born, grow up, live, and work that affect their health and quality of life. Social determinants do not necessarily determine one's health status, but they can have profound and measurable impacts on health, either positively or negatively. For example, higher socioeconomic status tends to increase one's chances of enjoying better health, while experiencing racial and ethnic discrimination tends to reduce it. Many different, often interrelated social determinants of health have been described, including, but not limited to, socioeconomic status, education level, experience with discrimination, exposure to violence, English language proficiency, access to healthy foods, whether one lives in a segregated neighborhood, housing quality, and environmental conditions, including clean air and water. In summary, social inequities have a direct impact on health.

What Should We Do About Fee-for-Service Payment?

Prioritizing reforms to fee-for-service payment is a difficult proposition for advocates of health equity. In the long run, shifting from paying for volume to paying for value is the best way to achieve a transformed health care system that is affordable, high-quality, and equitable, and this shift must be the ultimate goal of health system transformation.

However, our health care system is still in the early stages of transitioning to value-based care, and most of the health care services provided in this country are currently paid for using fee-for-service reimbursement methodologies. As a result, not addressing how to improve equity and quality of care under fee for service could be a critical oversight that would leave behind the communities that most concern us, especially considering that providers in communities of color and other underserved communities face many barriers to entry into value-based payment systems.

In the end, most task force members concluded that even as we work to shift providers to value-based payment systems, it is important that fee-for-service payment systems also evolve to sustain and reward the provision of high-quality, high-value care that concretely addresses long-standing health inequities. We plan to release an issue brief on how to improve fee-for-service payment systems as a follow up to this agenda.



2

SAFETY NET

Supporting Safety Net and Small Community Providers' Transition to a Value-Based Health Care System

Delivery system reform and integrated provider financing involve significant new expenses for health care providers. The upfront costs associated with reforming provider organization and payments are likely to be both larger and more critical for clinicians working with low-income people. At the same time, these clinicians typically have more limited ability to make the financial investments required than other providers do. The providers affected by these costly barriers to entry into health care delivery and payment transformation and in need of financial support include public hospitals and other larger safety net providers; smaller rural hospitals; and small, independent community providers.

Our top recommendations for supporting safety net and small community providers draw on both our framework and a more recent Families USA publication, *Financial Support for Safety Net and Small Community Providers to Participate in Delivery System Reform: Medicaid-Based Options for States.*² These recommendations are:

4. Create a new federal waiver program.

Between 2010 and 2016, the Centers for Medicare & Medicaid Services (CMS) approved \$40 billion in federal and state funding commitments across 12 states targeted at delivery system reform for Medicaid providers, under a rubric called Delivery System Reform Incentive Payment (DSRIP). In most of the 12 states, these programs were closely linked to issues of public hospital financing, which are essentially separate from either system transformation or health equity. CMS should consider a more targeted Medicaid waiver funding mechanism that is both smaller and more accessible to states without large public hospitals. Participating states would still need to fund their share of this program at regular Medicaid match rates, but many states might be able to access provider assessment funds or intergovernmental transfers (IGTs) and certified public expenditures to participate in such a program given the fact that providers would

also benefit from the waiver. A more targeted waiver program would be available to states on a transitional basis to support safety net and small community providers' upfront costs to implement new models of care delivery.

5. Expand technical assistance. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which created a new Medicare physician payment system, also authorized funding for technical assistance entities to support practices with fewer than 15 clinicians, particularly those in rural areas and in health professional shortage areas and medically underserved areas. This technical assistance program should be broadened and restructured to allow also for direct provider support and to include small practices serving a safety net role. Parallel funding streams could also be incorporated into existing federal funding for community health centers and tribal health systems (including Urban Indian Health Program health centers).

The barriers to successful entry into value-based payment programs can be high for safety net and small community providers, even as, in many cases, they have a long history of providing care for communities of color and low-income people. Supporting these trusted, culturally centered, providers' success is critical to advancing health equity.

6. Provide transitional state Medicaid payments to targeted providers.

No change in federal policy is needed for states to make payments to providers to enable a transition to reformed care delivery and payment. States should consider one of the following alternatives depending on whether or not they use Medicaid managed care, among other considerations. First, Medicaid managed care regulations allow for plans to pay providers special payments outside of regular capitation as part of state implementation of value-based purchasing models or delivery system reform or performance improvement initiatives. This flexibility has been used in Rhode Island to route delivery system reform implementation incentives and upfront funds through managed care plans. Second, in states without managed care, similar direct payments can be made to providers as supplemental payments. Third, more limited provider funding tied to overhead is possible with two years of 90 percent federal matching in state Medicaid Health Homes programs.



3

COMMUNITY PARTNERSHIPS

Building Robust and Well-Resourced Community Partnerships

It is well-established that medical care is only one of many factors that shape overall health. In fact, the impact of nonclinical, socially determined factors on health status and outcomes dwarfs that of clinical care, which experts estimate to be less than 20 percent.³ For this reason, payment systems that focus only on health care delivered within the walls of hospitals and clinics are unlikely to move the needle on equity. Some private sector providers, insurers, and government payers⁴ are increasingly acknowledging that providers need to do a much better job of connecting their patients with social and other supports in their communities, beyond simply providing referrals.

However, there are many challenges to achieving the kind of coordinated, collaborative partnerships that are needed to have a consistent and lasting impact. One foundational challenge is that many of the community-based organizations that provide needed services, and are well-known and trusted by their communities, often struggle with funding and lack the infrastructure, including information technology, needed to partner effectively. Additionally, health care systems, as engines of economic activity, should be doing much more to reinvest in the communities in which they are located, which will also help improve some of the underlying social determinants of health.

There are many different approaches to strengthening partnerships between health care systems and communities. Our top recommendations are:

7. Provide funding and technical assistance with developing and managing vendor contracts for improving IT infrastructure for community-based organizations (CBOs).

For CBOs to maximize their ability to coordinate and provide services, track clients' progress, and report back to providers, there has to be a secure, reliable way to share health-related information electronically with providers, insurers, and even government programs, such as state, local, and tribal health departments. However, many of these organizations operate on shoestring budgets and don't have the resources to invest in the IT systems needed to enable this level of coordination. Funding sources must be created to support the establishment of regional IT hubs that CBOs can

plug into to connect with health care providers and payers. This funding should also support the installation of needed technology at the CBO, as well as necessary training.

8. Require Medicaid managed care programs to contract with community-based organizations.

More than 80 percent of people with Medicaid are covered through managed care.⁵ To ensure that these insurance plans support community partnerships, states should require them to contract with CBOs that have experience providing services to the populations they cover, such as communities of color, rural communities, and other underserved groups, for needed social services and for outreach, education, assessment, care coordination, and follow-up services for their enrollees.

9. Prioritize community partnerships through the Center for Medicare & Medicaid Innovation (CMMI) and state Medicaid programs.

CMMI and state Medicaid programs have been developing and testing a variety of different payment and provider organization models. These efforts should prioritize the implementation and scaling of models that are specifically designed to leverage community partnerships to address the effects of adverse social determinants of health.

10. Strengthen hospital requirements to invest in their communities, both through their business practices and by engaging community residents directly in identifying problems and solutions to implement.

Nonprofit hospitals must regularly assess community health needs and develop implementation strategies to address key priorities as a condition of their nonprofit status. The assessment requires them to take input from public health officials and the communities they serve. However, the level of financial investment during implementation can vary greatly, and often does not match the priorities listed in the assessment. States should take steps to improve transparency and accountability for this spending, and to tighten community engagement and investment requirements so they align with broader community needs. In addition, similar community investment requirements should be developed for all hospitals, regardless of tax status, on the basis that they receive federal and state payments.

Moreover, as “anchor institutions” that are often major employers and centers of economic activity, health care systems have the power to make a real difference in their communities’ economies, as well as in diversity and inclusion, through their business practices. For example, health care systems should be required to invest directly in local economies through workforce training, outreach, recruitment, hiring, and contracting for needed services and supplies.



4

EVIDENCE BASE

Ensuring a Transparent and Representative Evidence Base

Evidence-based medicine is a cornerstone of value-based care. Evidence is the foundation of clinical practice guidelines, which inform payment policies and health systems research. The definition of high- and low-value care depends on the available evidence of the costs, risk, and benefits of specific tests, interventions, and treatments. Equity-focused system transformation requires knowing what works and what doesn't work for communities of color and other underserved groups. Unfortunately, people of color are dramatically underrepresented in the current evidence base that is used to inform health care policy and practice. Yet, despite this inherent bias, this evidence is often presented, and usually used, as if it were universally applicable.

To build the equitable, high-value, high-quality health care system we need, these gaps in the evidence base must be addressed. These are our top recommendations:

11. Mandate and incentivize race and ethnicity

analysis in clinical and health services research and evaluation.

Researchers and evaluators must analyze and report, in a timely manner, their data by race and ethnicity (including Asian, Pacific Islander, American Indian, and Alaska Native) in addition to any other key demographic characteristics that are available, unless statistically inappropriate.

12. Require improved dissemination of high-impact publicly funded research.

Many conditions have a disparate impact on communities of color and other marginalized communities. Therefore, there is a particularly urgent need that the results of research on treatments for these conditions and research on health care quality and care delivery related to these conditions are available as quickly as possible to these communities and to the providers who care for them, as well as guideline creators and payers. Publicly funded research on these conditions with a disparate impact must include dissemination plans and plain-language summaries of all results that are housed on a user-friendly website.

13. Require all publicly funded medical research to report results by key demographic characteristics to ensure evidence is used appropriately.

Transparency regarding the demographic characteristics of human test subjects and results is essential to informing how we address health inequities. Therefore, all publicly funded medical research on human subjects must report on the breakdown of their key characteristics by, at a minimum, sex, age group, race, ethnicity, and disability. Moreover, researchers must clearly indicate where there are significant variations in results by sex, age group, race, ethnicity (including Asian, Pacific Islander, American Indian, and Alaska Native), and disability. Researchers also should be required to analyze and report on existing data that may indicate the underlying condition or treatment may be impacted by these demographic factors, and identify additional research questions needed to better understand the impact of the treatment in these populations.



5 MEASUREMENT

Equity-Focused Measurement That Accelerates Reductions in Health Inequities

Measurement is used in various ways in the health care system. Measurement lets us know how we are doing and where we need to improve. It is used to track quality, to capture outcomes, and, increasingly, to influence payments. As the foundation for payment transformation, it is important that measurement be used to identify and monitor health inequities. (For more on payment systems, see Domain 1.)

These are our top measurement recommendations:

14. Require data stratification for health care organizations and providers who participate and report performance measures in value-based programs in Medicare and Medicaid, and with commercial insurers.

This data should be stratified by age, sex, race, ethnicity, (including Asian, Pacific Islander, American Indian, and Alaska Native) and language, at a minimum. Stratification by other demographic factors, such as socioeconomic status, gender identity, sexual orientation, and disability, should be done as data are collected and become available.

15. Require and incentivize the collection of patient social and behavioral risk data through Medicare, Medicaid, and commercial insurance value-based payment programs, with appropriate privacy and anti-discriminatory protections.

Given the importance of nonclinical factors as drivers of health, collecting social and behavioral risk data becomes essential to tailoring interventions and targeting resources. In addition, it will facilitate improved risk adjustment. This should include implementing the Office of National Coordinator for Health Information Technology's 2015 IT standards for collection of patient social and behavioral risk data in electronic health records, with the addition of collecting patient information regarding disabilities. In addition, there must be robust consumer and community engagement in defining the appropriate collection and use of this data, along with protections against potential misuse.



6

WORKFORCE

Growing a Diverse Health Care Workforce That Drives Equity and Value

For delivery and payment transformation to drive improvements in health equity, the health care workforce must be representative of the increasingly diverse U.S. population, provide access to care equitably across and among communities, and be able to deliver care that is responsive to a person’s cultural and social context. The development of a diverse and responsive workforce begins long before any clinical training occurs. In addition, health care systems must support and invest in building care teams that include community-based care team members and allow midlevel practitioners to practice at the highest levels of their licensure. Finally, they must ensure that all care providers are trained to serve diverse patients and to understand implicit biases in health care, as well as the impact of social determinants of health.

These are our top workforce recommendations:

16. Invest in and expand K-12 “pipeline” programs and college and postgraduate support. Federal and state-level government, as well as the private sector, should provide this support to ensure academic readiness and to provide multiple entryways into health care professions for more people from underrepresented groups.

17. Improve education and training for all health care providers. Education and training need to better prepare all providers for serving diverse patients, for providing culturally centered care, and for understanding and addressing the social determinants of health, including the influence of structural racism and discrimination on health, and the implicit biases in the health care system.

18. Build financing streams for community health workers or similar community-based care team members into all payment models, including fee-for-service, and particularly in Medicaid. As trusted members of their communities, these care team members are uniquely positioned to address the social determinants of health and to provide care in a

manner that is responsive to individuals’ social and cultural context. This financing must still ensure that these care team members are firmly rooted in their communities and share lived experiences with the people they serve.

19. Reform scope of practice, licensing, prescribing, and supervision regulations to allow more midlevel providers to practice at their highest level. With current and projected shortages in primary care, mental health, dental, and other providers in many parts of the country, allowing midlevel providers to practice at the highest level allowed by their training, or “at the top of their license,” can help ensure that everyone has access to needed care in their communities.

CONCLUSION

As our country becomes more diverse, and health care becomes increasingly expensive, the urgency of eliminating racial, ethnic, geographic, and other health inequities escalates. As policymakers, providers, researchers, community leaders, and other stakeholders prepare their policy agendas for 2019 and beyond, we urge them to prioritize system transformation focused on health equity. This national priority agenda highlights the top 19 recommendations that, as a group, we consider the most important and urgent. Some will be harder than others to achieve, but we are up for the challenge, and we invite you to join us.

Endnotes

¹National Quality Forum. (2017). A roadmap for promoting health equity and eliminating disparities: The four I's for health equity. Washington, DC. Available online at https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx.

² Fishman, E., Hernández-Cancio, S., & Albritton, E. (2018). Financial support for safety net and small community providers to participate in delivery system reform: Medicaid-based options for states. Washington, DC: Families USA. Available online at <https://familiesusa.org/product/financial-support-safety-net-and-small-community-providers-participate-delivery-system>.

³ Magnan, S. (2017). Social determinants of health 101 for health care: Five plus five. Washington, DC: National Academy of Medicine. Available online at <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>.

⁴ Centers for Medicare & Medicaid Services. (2018). Guide to reducing disparities in readmissions. Available online at https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf.

⁵ Kaiser Family Foundation. (2016). Total Medicaid managed care enrollment. Available online at <https://www.kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

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