



FOR DELIVERY & PAYMENT TRANSFORMATION

A Framework for Advancing Health Equity and Value

Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems

Sinsi Hernández-Cancio, Ellen Albritton, Eliot Fishman, Sophia Tripoli, and Andrea Callow

A Framework for Advancing Health Equity and Value

Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems

TABLE OF CONTENTS

Our Commitment to Achieving Health Equity	2
The Health Equity Task Force for Delivery and Payment Transformation	3
Executive Summary	4
Introduction	9
Transforming Health Care Systems to Reduce the Negative Impact of Socially-Shaped Barriers	10
Momentum for a Health Transformation Policy Agenda to Drive Health Equity.....	11
Impact of Current Payment Reform Efforts on Communities of Color and Other Disadvantaged Groups	12
The Need to Protect and Support Unique American Indian and Alaska Native Health Care Systems	16
Key Domains for Policies that Advance Health-Equity Focused Transformation.....	17
Six Policy Option Domains for Health Equity-Focused System Transformation	18
1. Payment Systems that Sustain and Reward High-Quality, Equitable Health Care	19
2. Investing to Support Safety Net and Small Community Providers in Delivery System Reform	25
3. Building Robust and Well-Resourced Community Partnerships.....	29
4. Ensuring a Transparent and Representative Evidence Base	32
5. Equity-Focused Measurement that Accelerates Reductions in Health Inequities.....	36
6. Growing a Diverse Health Care Workforce that Drives Equity and Value	40
Overarching Imperative: Include Communities of Color in Delivery and Payment Transformation	45
Two-Sided Strategy for Meaningful Inclusion: Ceding Space and Resourcing Consistent Representation	46
1. Create Inclusive Decision-Making Structures and Practices.....	47
2. Provide Support for Robust Representation.....	50
Endnotes	52

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 more than 30 years, we have advanced a vision of social justice at the state, federal, and community level, rooted in the conviction that health is a fundamental right and a common good. 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.

Our work is aimed at improving the overall health of all in our nation, and a central focus of our work is on the most vulnerable people in our society, often those whose voices are most likely to be silenced or ignored. Thus, 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 document represents the analytical first step down that road. We hope that readers of this analysis 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, JD, MPH*
Executive Director, Families USA



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. 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 these inequities, and develop strategies and tactics that are broader in appeal and impact, including building and participating in larger coalitions, and seeking partnerships with diverse stakeholders.

We thank the Task Force members for their invaluable input and review of this paper, which is intended to be a discussion document to spur dialogue and action to advance health equity through delivery and payment transformation. The members of the Task Force are committed to working together to develop and promote a policy agenda for a health equity-focused system transformation. However, they and their respective organizations do not necessarily endorse each individual policy option presented in this paper.

We also want to thank Maria Walawender for her invaluable research and editorial assistance.

For more information about the task force, visit [Familiesusa.org/HETF](https://familiesusa.org/HETF).

MEMBERS

James Albino, Atlas Research

Charlie Alfero, Southwest Center for Health Innovation

Ignatius Bau, Health Equity Consultant

Ann Marie Benítez, National Latina Institute for Reproductive Health

Regina Benjamin, Bayou La Batre Rural Health Clinic

Joseph Betancourt, Disparities Solution Center

Nimaako Brown, National Urban League

Marshall Chin, Finding Answers: Solving Disparities through Payment and Delivery System Reform

Francys Crevier, National Council on Urban Indian Health

Daniel Dawes, Health Equity Leadership & Exchange Network (HELEN)

Sarah de Guia, California Pan-Ethnic Health Network

Devin Delrow, National Indian Health Board

Tekisha Dwan Everette, Health Equity Solutions

Wandy Hernández, HealthConnect One

Marjorie Innocent, NAACP

Frederick Isasi, Families USA

Kathy Ko Chin, Asian & Pacific Islander American Health Forum

Barbara Kornblau, Coalition for Disability Health Equity

Deborah Riddick, Oregon Nurses Association

Leena Sharma, Community Catalyst

Isaiah Wilson, National Black Justice Coalition

Executive Summary

Introduction

Our health care system is failing us. As a nation, we spend too much and get too little in return. No other industrialized country spends more on health care per capita, yet we consistently rank last among them in access, equity, key health outcomes, and overall performance.¹ By some estimates, up to 30 percent of health care spending is wasted on inefficient or unnecessary care.² Below the surface of these overall statistics, there is an even more troubling reality: the extent and severity of persistent health and health care disparities. These systematic inequities disproportionately affect communities of color, those with low incomes, those with disabilities, and people living in distressed geographic areas.³ Moreover,

The transformed health care system should reduce the negative impact of socially-shaped barriers on people's health, and especially, their access to high-quality care. This means looking beyond the walls of the hospital or clinic and meeting people where they are in their community.

our health care system has not evolved sufficiently to provide high-quality, efficient, and effective services for the large and growing proportion of the U.S. population disadvantaged by these inequities. Given these realities, our current health care system is financially unsustainable for both families and the nation. Large health care inequities undermine people's ability to reach their full potential and the country's ability to stand up a competitive, productive workforce. Moreover, they are fundamentally unjust and morally indefensible.

The good news is that we are in the midst of a transformation of the health care system that offers the opportunity to tackle these challenges. Efforts across the country are underway to shift the health care system from one that pays for the *quantity* of care provided (regardless of whether it's needed) to one that pays for the *quality* of care provided and for improved health. However, even as payment and delivery reform efforts present a valuable opportunity to accelerate the reduction of health and health care inequities, they also pose a serious risk to communities already facing systematic inequities.⁴ The communities most affected by health inequities must be included in the design and implementation of delivery and payment reforms, and policies must be developed with the explicit intent of advancing health equity.⁵

Unfortunately, the needs and interests of communities of color and other communities struggling with health and health care inequities are not adequately represented in health care transformation efforts. So far, health policy makers have not prioritized health equity sufficiently, while health equity advocates have generally not engaged sufficiently in payment and delivery reform efforts at the state or federal levels. To achieve a high-performing, efficient, and equitable health care system, this must change—and the time is now.

This policy options paper represents a collaborative effort among state and national health equity thought leaders to catalyze much needed action to leverage health system transformation for the benefit of those whom the health system is leaving behind. Ensuring that those facing the biggest barriers to good health and high-quality health care are served well by the health care system will improve care for everyone.

The goal of this paper is to create a resource that health equity and health system transformation leaders can use to assist in policy development and prioritization that best serves their communities and constituencies. We begin the paper by reviewing key issues that payment and delivery reform must take into account to advance health equity and improve the health of those currently experiencing disparities including, but not limited to, inequities based on race, ethnicity, sex, sexual orientation, English proficiency, immigration status, income, and geographic location.ⁱ Specifically, we posit that the transformed health care system should reduce the negative impact of socially-shaped barriers on people's health, and especially,

their access to high-quality care. This means looking beyond the walls of the hospital or clinic and meeting people where they are in their community.

In addition, the transformed health care system must be supported by a payment system designed to reward the provision of high-quality, equitable care to all. This is not a simple objective, and neither is it clear that we are headed in the right direction. While existing fee-for-service payment has fostered our unequal health system, new payment models could themselves inadvertently create additional incentives for providers to avoid patients with more complex needs, or to reduce health care utilization among populations whose main challenge is the underutilization of appropriate care. A related risk is that new payment models could financially undermine safety net and trusted, culturally competent community providers upon which underserved communities currently depend.

Assessing the Impact of Payment Reform on Health Equity

To advance understanding of the risks and opportunities of payment and delivery reform on health equity, we developed a rubric, shown below, to review the initial impact of new payment models on communities of color and other disadvantaged groups.

1. Is there a disparate impact on particular communities? The design and evaluation of payment models should attend to which groups or communities are benefiting from the model and which may be bearing the brunt of negative consequences. This requires disaggregated data. Does the model

ⁱThe authors want to make clear that while we use the categories of race, ethnicity, sex, sexual orientation, and gender identity to assess health inequities, in most cases the risk factor is not the specific identity, but current and historical discrimination against and mistreatment of that group that are independent risk factors in health. For example, it is not your “race” but racism.

Risk adjustment is the standard solution for leveling the payment playing field so that providers are fairly compared to each other by adjusting for patient factors that are out of their control.

result in a net redistribution of resources from providers who care for more complex patients with more risk factors (who are more likely to have lower incomes and be people of color) to providers who care for less complex, lower risk patients (who are more likely to be white and have higher incomes)?⁶ Of special note is whether the cumulative impact of provider penalties has the effect of worsening the access to, and quality of, care for communities already struggling with inequities, by shutting down providers where there are no reasonable alternatives.

2. Is risk adjustment effectively accounting for clinical and social risk? Risk adjustment is the standard solution for leveling the payment playing field so that providers are fairly compared to each other by adjusting for patient factors that are out of their control.⁷ However, there is concern that to date, risk adjustment methods are incomplete and “not sophisticated enough to reliably distinguish poor-quality care from high medical and social risk.”⁸ Areas of concern include the appropriate inclusion of individual social risk factors (such as race, ethnicity, functional status), and of neighborhood-level risk factors (such as concentrated poverty and rurality).^{9,10} Yet it is also critical that risk adjustment not mask poor quality care and persistent quality inequities.

3. 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. For example, many safety net, rural, and community hospitals have been systemically underfunded and are operating under financially precarious conditions, with negative margins that leave little room to invest in quality improvement and expanding services that would improve patient outcomes and their metrics.^{11,12} Meanwhile community care capacity may also be limited and lack needed supports.

Using this framework, we review examples of payment and delivery reforms that look promising in terms of reducing inequities, such as Covered California’s active purchasing program that requires the reporting of disaggregated outcomes data on chronic conditions and yearly improvement in disparity reductions. We also describe programs that have more ambiguous outcomes, like the Hospitals Readmissions Reduction Program, which appears to be reducing readmissions and narrowing some inequities, but is also more likely to penalize safety net hospitals, possibly undermining access to care in some communities.

Finally, we underscore the need to protect and support the unique American Indian and Alaska Native health care system. Any payment and delivery reform effort must respect the federal government’s trust responsibility to Tribes, along with their sovereignty. Many of the policy options described in this paper apply to the Indian Health Service, but special care must be taken to ensure that this chronically underfunded system not be further financially strained.

Six Policy Domains for Health Equity-Focused Transformation

In the following section of this paper, we synthesize existing academic research and analysis, and develop a conceptual framework of six specific policy domains that comprise the transformed health care system needed to advance health equity. These conceptual categories interrelate closely, and even overlap. Each domain concludes with a set of potential policy options, flagged by whether they target federal policy, state level policy, and/or the private sector.

1. Payment Systems that Sustain and Reward High-Quality, Equitable Health Care

The financial underpinnings of the health care system must be aligned with the goal of reducing inequities, in addition to increasing quality and reducing costs. Resourcing and rewarding equity must be explicit, so that it is a clear priority and not overlooked.

2. Investments to Support Safety Net and Small Community Providers in Delivery System Reform

Safety net and small community providers face unique barriers to implementing new value-based payment models. Many of these models require significant up front investments that these providers may be unable to make. However, they are often essential sources of culturally centered, geographically and language accessible care that should be supported so they succeed in a value-based health care world.

3. Building Robust and Well-Resourced Community Partnerships

Given the importance of socioeconomic factors and community context in shaping health, providers that want to move the needle on health outcomes will need to work beyond the walls of their institutions.

Especially in the case of communities dealing with the effects of discrimination, and sometimes, historical mistreatment by the health care system, providers should partner with trusted community-based organizations and concretely invest in these relationships.

4. Ensuring a Transparent and Representative Evidence Base

The biases baked into clinical and health system research are well known by experts, yet clinical guidelines are based on this flawed evidence. Improving the evidence base so it reflects the diversity of our population is essential. Similarly, transparency about the limitations of the data used to determine treatment guidelines is needed so that patients, their doctors, and payers can make more appropriate care decisions.

5. Equity-Focused Measurement that Accelerates Reductions in Health Inequities

Measurement is an increasingly important factor in value-based payment as well as quality improvement. For new payment models to effectively reward equity, there must be equity-focused metrics tied to payment. The incorporation of equity-sensitive measures into payment models must be an essential feature of a transformed health care system.

6. Growing a Diverse Health Care Workforce that Drives Equity and Value

Ultimately, no health care system can work without the appropriate workforce to drive it. The overall health care workforce needs to grow to meet burgeoning demand, must be more ethnically and racially diverse, better distributed geographically, and inclusive of a broader array of jobs—from primary care providers, to mid-level providers, to community health workers and peers.

Overarching Imperative: Include Communities of Color in Delivery and Payment Transformation

Finally, there is one overarching priority that cuts across all of the policy domains: ensuring the effective inclusion of the voices and priorities of communities of color, and other disadvantaged groups, in decision-making. This is not only the right thing to do as a matter of equity to support agency and empowerment, but it is also the smart thing to do, because the ultimate output will be of higher quality and more likely to be effective. This inclusion must span policy development, decision-making, implementation, and evaluation for it to be truly meaningful. However, given the complexity of payment and delivery reform and system transformation policy, and the limited experience leaders from communities of color have had in this field, meaningful inclusion will require concerted strategies and dedicated resources.

We identify a two-pronged, interlocking framework for achieving meaningful inclusion of community leaders in health system transformation. On one side,

decision-making structures and practices must be made more inclusive, and on the other, community leaders must be provided support so they can effectively represent their constituencies. Inclusive decision-making structures require: transparency, power balance, diversity, intersectionality, equal decision-making authority, early inclusion, attention to power/hierarchy dynamics, acknowledgment of historical and/or ongoing abuse and discrimination, honoring Tribal consultation, and the recognition of limitations. On the other side, providing support for robust representation requires: commitment to long-term financial support; ongoing training, technical assistance, and support; and a platform for collaboration.

We hope that this paper provides a useful starting point for health equity and health system transformation leaders across the country to begin engaging in this critical policymaking opportunity. The health care system will continue to evolve—whether or not our voices join the discussion. It is up to us to ensure that voices advocating for health equity are heard.

There is one overarching priority that cuts across all of the policy domains: ensuring the effective inclusion of the voices and priorities of communities of color, and other disadvantaged groups, in decision-making.

Introduction

Despite spending more per capita on health care than any other industrialized country, the U.S. health care system is notoriously both inefficient and inequitable.¹³ Up to 30 percent of health care spending is wasted on unneeded or inefficient care.¹⁴ Yet at the same time, there continue to be millions of people who live with the burden of poor health, who systematically cannot access the right care at the right time, and who receive low-quality services. Those facing systematic inequities disproportionately include communities of color, those with low incomes, those with disabilities, and people living in distressed neighborhoods.¹⁵ This is economically unsustainable for families and the nation, and limits the ability of all people in our nation to live to their fullest potential. Therefore it is fundamentally unjust and morally indefensible.

At the root of this ineffective, wasteful, and inequitable maldistribution of health care resources are payment systems—both public and private—that take a narrow, clinical view of health and health care and, among other problems, reward quantity over quality. In response, momentum is growing at the federal, state, and local levels to envision the notion of health and our health care system. More specifically, there are increasing efforts to reform payment and delivery systems to move away from narrow, clinical definitions of health, and from volume-based, fee-for-service payments, and to move toward value-based payments.¹⁶ Although these efforts present an important opportunity for health equity advocates to accelerate the reduction of persistent racial, ethnic, and other health disparities, they also pose a serious risk to communities already facing systematic inequities.¹⁷ Without focused attention on how disadvantaged communities are affected by

broader transformational efforts (including payment reforms), and without inclusion of these communities in designing and implementing these reform efforts, health disparities could widen further and become even more entrenched.¹⁸

Transforming our health care system so that it invests in and incentivizes the health of our nation and the delivery of efficient, high-quality health care that produces better outcomes, at a lower cost, for more people, is essential to its financial sustainability. Given the nation's demographic evolution, it will not be possible to achieve the goals of better health, at lower costs for all, without addressing, and ultimately eliminating, the long-standing health and health care disparities that plague communities of color and other disadvantaged populations.¹⁹

Given the national, state, and local conversations on advancing a broader understanding of health and payment and delivery reform, there is a tremendous opportunity to tackle inequities head-on that communities of color cannot afford to miss. Health policymakers have not adequately prioritized health equity, as reflected in the incentive and measurement design sections of this paper; at the same time, health equity advocates have not significantly engaged with health care transformation, including payment and delivery reform efforts. To adequately address and solve for the health equity issues in our nation and its health care system, and to ensure that no community is left behind, leaders in both health equity advocacy and policy must actively engage in health care transformation and payment and delivery reform; the time is now.

Transforming Health Care Systems to Reduce the Negative Impact of Socially-Shaped Barriers

Socioeconomic factors are significant drivers of health outcomes.²⁰ Those factors include, but are not limited to: race, ethnicity, sex, sexual orientation, English proficiency, immigration status, income, and geographic location.ⁱⁱ To make progress in reducing disparities, health systems need to better account for diverse patients' needs and experiences, and ameliorate the negative health effects of the socially-shaped barriers their patients face. Given that the United States health care system is a business, health care payment systems must be designed such that providing high-quality, equitable care improves health systems' bottom lines, instead of undermining them.

As described in this paper, new transformational efforts, including payment models, have generally not been designed to target reductions in disparities specifically. For example, most payment models do not incentivize or pay directly for interventions and services that have a strong track record of improving outcomes for communities of color, rural areas, and other underserved communities. While it may be unreasonable to expect health systems, alone, to be responsible for eliminating the root causes of inequality, it is reasonable to expect health systems to provide care and support so that these root causes do not compromise patients' ability to get high-quality, timely, affordable care. For example, few would argue that it is the responsibility of hospitals and physicians to teach patients English, provide access to higher education, buy their patients cars, or find them jobs with higher pay and benefits. However,

it is the responsibility of health care providers to ensure that the system in which they work meets their patients where they are, and provides high-quality care and good health including when, for example, patients have zero or limited English proficiency, limited education, no transportation, or low-paying jobs with limited or no health benefits. By identifying and understanding these barriers to care, evolving their delivery systems to better align with community needs, and developing mechanisms and partnerships to ensure appropriate referrals to, and coordination with, social and other services, providers can mitigate the impact of these social factors so they do not undermine their patients' health and well-being.

As described in this paper, payment reforms and new models have mostly overlooked the implications for racial and ethnic minorities, who bear a disproportionate burden of health risk.²¹ For example, the Centers for Medicare and Medicaid Services (CMS) created a Health Care Payment Learning and Action Network to incorporate input from a broad range of stakeholders. However, its Alternative Payment Model Framework mentions disparities only once, noting the need to “ensure that the expansion of population based payments does not lead to disparities in health outcomes.”²² Similarly, major proponents of payment reform such as the Center for Health Care Quality and Payment Reform and America's Physician Groups (formerly CAPG) do not discuss health disparities, health equity, or race and ethnicity in reports on value-based care and alternative payment models.^{23,24}

Nevertheless, new payment models and programs could easily worsen the access to and quality of care for people of color and other disadvantaged groups.

ⁱⁱThe authors want to make clear that while we use the categories of race, ethnicity, sex, sexual orientation, and gender identity to assess health inequities, in most cases the risk factor is not the specific identity, but rather current and historical discrimination against and mistreatment of that group that are independent risk factors in health. For example, it is not your “race,” but racism.

While evaluating and improving the performance of safety net and essential community providers is a vital necessity, implementation of new payment models must account for the specific socioeconomic and clinical challenges their patients face, as well as providers' crucial roles in the specific communities they serve.

For example, new payment models could inadvertently create incentives for providers to avoid patients with more complex needs, or to reduce health care utilization among populations whose main challenge is the underutilization of appropriate care. A related risk is that new payment models could financially undermine safety net and trusted, culturally competent community providers who currently offer a large portion of the care to communities of color and underserved communities. While evaluating and improving the performance of safety net and essential community providers is a vital necessity, implementation of new payment models must account for the specific socioeconomic and clinical challenges their patients face, as well as providers' crucial roles in the specific communities they serve. Many safety net and community providers have extensive experience providing culturally competent care in challenging environments and are critical lifelines that these communities cannot afford to lose. Yet alternative payment models that don't account for socioeconomic and clinical factors can inadvertently penalize safety net providers and exacerbate inequities by "transfer[ing] money from clinicians caring for high-risk patients to ones caring for low-risk patients."²⁵ As a result, the struggle of resource-poor safety net providers would increase and the health of their higher-risk patients would worsen.

Momentum for a Health Transformation Policy Agenda to Drive Health Equity

Health equity advocates and health transformation stakeholders must come together to build a policy agenda and action plan to transform the health care system into one that is high-performing and achieves health equity; indeed, overall system performance depends on improved outcomes for communities of color. Considerable resources have recently been invested into research on models and interventions that improve outcomes for people of color. This research must be synthesized and translated into clear policy goals and implementation strategies that stakeholders and community leaders can pursue.

Communities of color and other disadvantaged communities need policies that will concretely improve their lives. To achieve this goal, these communities must be actively engaged in the development of models and be able to effectively represent themselves in the policy dialogue and decision-making processes.²⁶ Without such engagement, efforts can lead to flawed designs and models that don't align with actual needs, and also undermine communities' agency and trust. Decisions about defining, measuring, and incentivizing value cannot continue to be made without substantial input from the communities most affected by the dysfunctional health care system.

For many in the health equity movement, the universe of health care transformation is a highly complex new frontier, into which many are currently not equipped to venture. Many health consumer organizations are focused on specific diseases and conditions, or specific populations (e.g. seniors, individuals with disabilities, etc.); few have knowledge and expertise on broader health care quality and payment issues. For this reason, it is critical to work collaboratively to be the most effective advocates possible—despite limited resources, capacity, and technical expertise. Given the enormous imbalance in power, resources, experience, and technical expertise between consumer and community advocates on one side, and the providers, payers, and government entities that dominate these conversations on the other, it is important to work together as community leaders, with common goals and priorities that promote collaborative, coordinated action based on a shared blueprint. We must collectively create space for and support the inclusion and leadership of the communities most affected by the inequities in the health care system, and who have been systematically excluded from decision-making. It is critical to understand that the sociopolitical and economic forces that created the health care system are much bigger than individual communities or leaders; success requires working together.

Impact of Current Payment Reform Efforts on Communities of Color and Other Disadvantaged Groups

Using health care payment policy to support reduction in health care disparities has a long history in the United States. Back in 1946, the Hills-Burton Act conditioned funding for the building of hospitals on them later providing a “reasonable volume” of free care to those who couldn’t pay, and serving everyone regardless of

race (although “separate but equal” provisions were an oft-used loophole for many years).²⁷ More broadly, given our market-based health care system, employing financial incentives and penalties to influence provider behavior is an indispensable component of any health system transformation strategy. This is one reason a major theme in delivery and payment reform has focused on “alignment” between payments to providers and the outcomes we want to achieve—whether those outcomes are lower costs, higher quality, improved outcomes, or other goals.

Current payment and delivery reform programs are primarily focused on improving quality and outcomes, and containing costs. Some of the most-discussed reforms are focused on shifting from paying for volume to paying for “value.” Specific payment mechanisms vary, but in broad terms they usually involve some combination of incentives and/or penalties that hinge on meeting specific metrics. In some cases, they simply do not pay for services that are considered markers of low-quality care (such as “never events”²⁸ or care that violates best practices, such as most early-term elected deliveries²⁹).

However, there have been long-standing concerns about potential unintended consequences of new payment systems that do not adequately account for diverse patients’ needs and experiences, and that fail to either address or account for socially determined barriers to good health and high-quality health care. Risks include inadvertently creating incentives for providers to avoid high-risk or complex patients, or pressures to inappropriately reduce utilization. A related risk is that new payment models could financially undermine safety net and community providers that offer much of the care for communities of color and underserved areas.³⁰

Health outcomes are the product of multiple interlocking factors beyond health care,^{31,32} representing a wide spectrum of social determinants. These determinants include economic stability; neighborhood environment; education; availability of safe and healthy food, water, and air;³³ the impact of discrimination;^{34,35} and exposure to “Adverse Childhood Experiences,”³⁶ among others. Disentangling these factors is a difficult challenge for outcome-based payment models, with important implications for health equity.

This is by no means an argument against payment and delivery transformation, or against holding providers accountable for the quality of care they provide. The existing fee-for-service payment system has contributed to health care disparities. Furthermore, we will never achieve health equity if providers in communities of color and other underserved communities are held to lower—separate but unequal—standards. That said, standards must be fair, and the consequences for failing to meet them must serve to improve the health of the disadvantaged communities, rather than putting them even further behind.

A Rubric for Assessing Health Equity Impact

To advance health equity, health system transformation must include assessing the impact of new payment models on communities experiencing health inequities. As a starting point, the following areas should be considered:

1. Is there a disparate impact on particular communities? Many payment models result in clear winners and losers. We should assess whether the benefits are being accrued equitably, not just among providers, but also among populations and communities. This requires the collection of, and access to, disaggregated data. Are there some groups not benefiting from the program? Are some groups

or communities bearing the negative consequences disproportionately? Is the effect of the program a net redistribution of resources from providers who care for more complex patients with more risk factors (who are more likely to have lower incomes and be people of color) to providers who care for less complex, lower-risk patients (who are more likely to be white and have higher incomes)?³⁷ It is particularly important to ensure that the cumulative impact of provider penalties do not inadvertently worsen the access to, and quality of, care for communities already struggling with inequities, by shutting down providers where there are no reasonable alternatives. Moreover, because of the role of many hospitals and health centers as economic anchors of local economies,³⁸ closures are likely to have far-reaching effects beyond access to health care.

2. 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. Clinical care is a relatively small factor in determining health outcomes—social factors often play a much bigger role. The standard solution for leveling the payment playing field is risk adjustment, the goal of which is “to fairly compare providers to one another on patient outcomes, such that the main differences in performance are related to the quality of care provided, rather than to patient factors over which providers have no control, such as clinical conditions.”³⁹ However, there is concern that to date, risk adjustment methods are incomplete and “not sophisticated enough to reliably distinguish poor-quality care from high medical and social risk.”⁴⁰ Areas of concern include the appropriate inclusion of individual social risk factors (such as race, ethnicity, and functional status) and of neighborhood-level risk factors (such as concentrated poverty and rurality).^{41, 42} At the same time, it is critically important that risk adjustment itself not mask poor quality and health inequities.

3. 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. For example, many safety net, rural, and community hospitals have been systemically underfunded and are operating under financially precarious conditions, with negative margins that leave little room to invest in quality improvement and expanding services that would improve patient outcomes and their metrics.^{43,44} Meanwhile, community care capacity may also be limited. No matter how effective the transitional care provided by an inpatient provider, it will not be able to magically eliminate months-long waiting times for appointments at an excellent, culturally competent community behavioral health provider or long waiting lists for placement at community-based organizations that find housing for homeless patients.

Promising Examples

Overall, early evidence on the impact of new payment models on health equity is mixed. The most promising examples can be seen at the state level, where community leaders and public officials are leveraging the payment and delivery reform opportunity to focus on health disparities. For instance:

» **California's Insurance Exchange**, Covered California, is an active purchaser that has prioritized identifying and addressing health disparities in chronic conditions such as diabetes, hypertension, asthma, and mental health. The exchange requires its plans to collect, disaggregate, and report quality data by gender, race, and ethnicity, and to meet year-over-year targets for the reduction of disparities in those subpopulations.⁴⁵

» **Connecticut's State Innovation Model**, the result of a State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI), has prioritized achieving health equity as part of a shift to value-based care. Working with community leaders, the state made health equity a primary goal of its SIM process. An Equity and Access Council was created, as was a Consumer Advisory Board.⁴⁶ To maximize equity, the state also established a strategy to increase the integration of community health workers (CHWs).⁴⁷ CHWs have a strong track record of improving the health of people of color, those with complex health and social needs, and others who face barriers to good health.⁴⁸

» **Oregon's Coordinated Care Organizations (CCOs) Program** built in key health equity-focused contract requirements for its CCOs. CCOs are local networks of health care providers who work on improving health and controlling costs for the state's Medicaid program by focusing on prevention and chronic disease management. The quality measures used to evaluate CCOs are stratified by race and ethnicity and are publically reported, promoting accountability for health equity. Moreover, CCOs are required to participate in cultural competency training and to develop plans to reduce racial and ethnic disparities.⁴⁹

Cause for Concern

On the other hand, there are also indications that the impact of some payment and delivery reform efforts have caused some unintended negative consequences for people of color and other vulnerable groups, and the providers they depend on. A recent analysis across five different value-based payment programs found that providers with high proportions of low-income

patients were significantly more likely to be penalized than others, a fact that may indicate lower quality, or may be a result of the various other factors discussed above.⁵⁰ For example:

» **The Hospital Readmissions Reduction Program (HRRP)**

aims to reduce the number of avoidable hospital readmissions by financially penalizing hospitals that have above-average readmission rates for Medicare patients.^{51,52} There is evidence that the program has reduced avoidable readmissions overall, and has narrowed racial disparities in these readmissions.⁵³ These are important initial outcomes. But at the same time, this is an example of a payment reform that raises concerns about the disparate impact it may have on safety net hospitals and the communities that rely on them, because they are the most likely to be financially penalized.⁵⁴ Moreover, these outcomes may be as much a function of inadequate risk adjustment and disparities in available institutional and community resources as of the actual quality of hospital care. The HRRP may also represent a net transfer of funding from under-resourced hospitals in under-served communities to those that are in much better financial health, further exacerbating inequities rather than improving them.

» **The Medicare Hospital Value-Based Purchasing Program (VBP)**

also presents a tension between capturing true quality problems and unfairly failing to adjust for social risk in safety net institutions, for similar reasons as the HRRP.⁵⁵ Under VBP, components of hospital payment rates for inpatient stays are now determined based on a hospital's performance on a series of measures, and payment rates are either increased

or decreased based on this performance. The entire program is budget-neutral, meaning that any money taken from low-performing hospitals is transferred to higher-performing hospitals. According to a 2017 Government Accountability Office (GAO) report, safety net hospitals' scores, which influence payment rates, were lower compared to hospitals generally. In particular, safety net hospitals had poorer scores on patient outcomes—which measure mortality—as well as patient experience and safety.⁵⁶ As a result, safety net hospitals had a median net financial penalty under VBP. This outcome represents a concerning quality gap, an undetermined element of social and community risk differential, and a resulting net transfer of revenue from less-resourced to more-resourced communities.

» **Accountable Care Organizations (ACOs)** are an increasingly popular approach, with Medicare, Medicaid, and commercial insurance developing different ACO models. However, the impact of ACOs generally on health disparities is not well understood. Though evidence is mixed on whether Medicare's ACO programs are reducing health care costs,⁵⁷ there is evidence of progress in the area of hospital readmissions,⁵⁸ and many providers have improved quality of care over time.⁵⁹ However, not all communities are benefiting equally from these improvements. Recent analysis shows that patients who were already low-risk benefited more from improved outcomes than those who were high-risk, who arguably had higher need.⁶⁰ In terms of racial equity, minimum requirements for physician group size for ACOs make it less likely that providers of color and those working in economically disadvantaged areas participate in these models,

a potential lost opportunity for progress.⁶¹ More concerning is that ACOs serving a high proportion of racial and ethnic minority patients score lower on quality measures (which affects their payment).⁶² As discussed above, quality measures may be capturing factors other than the quality of care delivery by ACO providers.

The Need to Protect and Support Unique American Indian and Alaska Native Health Care Systems

American Indians and Alaska Natives have access to an Indian health care system based on their unique political status and the nation-to-nation political relationship between Tribes and the United States. This includes explicit legal commitments to provide health care made by the federal government in treaties with the Tribes that are the foundation of the federal government's Trust Responsibility to Tribes. These promises also extend to Indians living beyond the borders of the reservation (urban Indians and other populations). This unique health care system consists of services and programs provided directly by the Indian Health Service (IHS), which is a federal agency; Indian Tribes and Tribal organizations that contract with IHS to deliver services for their Tribal citizens; and urban Indian health organizations that receive IHS funding. Collectively, these entities are known as the "Indian health care system," which cares for 2.2 million people. The Indian Health Service carries out the United States' trust responsibility to provide health care services to American Indians and Alaska Natives.

In the following section of this document, we describe the severe financial challenges that safety net providers face in reforming care delivery. These challenges are even more profound for the Indian health care system. This system, as a whole, is dramatically and structurally underfunded, at about 59% of need.⁶³ It lacks the resources and staffing to make needed basic reforms and upgrades, and it is unable to comply with correspondingly greater staffing, reporting, and technology requirements associated with delivery system reform. Furthermore, unlike other health care providers, providers within the Indian health care system often operate in a capped public funding structure. They cannot pass increased compliance costs on to their consumers or commercial payers. Further, given the capping and chronic underfunding of Indian health programs, they are often forced to prioritize emergent crisis care in ways that leave insufficient resources for preventive care and other interventions geared toward improving outcomes and maximizing efficiency, which usually require significant upfront investments.

Many of the policy options and recommendations in this document apply with special urgency to the Indian health care system. It is imperative that delivery and payment reforms not further strain this already-overburdened system, and instead help to ensure that everyone in the United States is the recipient of higher-quality, more efficient health care and improved health outcomes. As detailed below, to achieve this overdue goal, health care transformational work tailored to the particular needs and contexts of these communities must be created in collaboration and accompanied by sufficient resources to implement them.

Key Domains for Policies that Advance Health-Equity Focused Transformation

To build a consensus around a policy agenda for health equity-focused payment and delivery reform, we have reviewed and synthesized existing academic research and analysis. The explicit goal of this paper is to build on the excellent work done so far by the small cadre of health equity and value experts, and lay out a potential rubric of policy domains to help health care and health equity leaders and decision makers understand the complexity of these issues and guide their policy development and prioritization. As a policy options document, its intent is to stimulate discussion and incite action. It describes policy areas, summarizes their health equity ramifications, and points to potential policy recommendations, identified by whether they target policy at the federal or state level, or in the private sector. We strove to create useful conceptual categories, understanding that there is much interrelation between them. Moreover, it is not an exhaustive list of all potential policy recommendations, and surely omits many. The six health equity and value policy domains we identified are:

1. Payment Systems that Sustain and Reward High-Quality, Equitable Health Care
2. Investments to Support Safety Net and Small Community Providers in Delivery System Reform
3. Building Robust and Well-Resourced Community Partnerships
4. Ensuring a Transparent and Representative Evidence Base
5. Equity-Focused Measurement that Accelerates Reductions in Health Inequities
6. Growing a Diverse Health Care Workforce that Drives Equity and Value

In addition to the specific policy domains described above, we have identified a fundamental underlying challenge that spans across all of the domains: the lack of an effective consumer voice that represents the lived experience of the communities that our health care system has left behind. As noted above, excluding the perspectives and needs of the people the system seeks to serve can lead to flawed designs and models that don't align with actual needs, while undermining communities' agency and trust. The following section synthesizes the best practices and important factors to consider to ensure that whatever domain one works in, the voices of those most affected can be included in the decision-making process. We hope that this policy options paper will be thoroughly discussed, debated, dissected, and ultimately, become the foundation for a proactive, actionable health equity and value agenda.

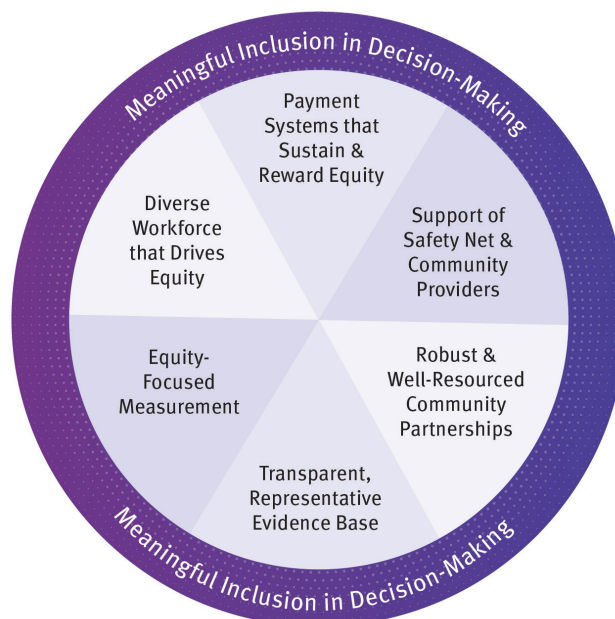
Six Policy Option Domains for Health Equity-Focused System Transformation

We have noted that governmental and industry thinking about value-based care and payment reform has not paid enough attention to health equity, which has resulted in profound gaps in effective policy development. We must ask two critical questions as a starting point. First, who is defining what is valuable, given that what people consider most valuable in health and health care is driven by their particular context? Second, what investments or restructuring efforts are needed to reach a health system that prioritizes health equity? Successful

health care transformation demands prerequisites that are not always present in underserved and disadvantaged communities, such as the necessary workforce, physical infrastructure, and IT infrastructure of health care providers and the community as a whole.

In laying out the policy domains, our goal was to conceptualize the most critical elements for building an efficient, effective, high-quality, and equitable health care system. The domains overlap and intersect, but each has an indispensable role to play.

SIX DOMAINS FOR HEALTH EQUITY HEALTH SYSTEM TRANSFORMATION



Each of the six domains for advancing health equity-focused health care system transformation fit together as interlocking, essential components of a person-, family-, and community-centered health system, and must be informed by the meaningful inclusion of affected communities throughout the decision-making process, including defining priorities, policy development and adoption, implementation, and evaluation.

1. Payment Systems that Sustain and Reward High-Quality, Equitable Health Care

High health care costs are driving much of the focus on payment reform.⁶⁴ However, a focus on shifting risk to providers in order to incentivize reducing costs carries risks. It could lead to providers avoiding patients with complex health and social needs, as they are often the highest-cost patients, or avoiding the delivery of necessary care for fear of exceeding cost targets.⁶⁵ Furthermore, to ensure that efforts to reduce costs do not worsen care for consumers, particularly people of color and other disadvantaged groups, payment reform must be coupled with delivery system reforms that improve the quality of care, improve health outcomes, and reduce health disparities.

The goal of payment reform should be to create economic incentives for the right kinds of care, including (but not limited to) more resources toward thoughtful and comprehensive primary care and care coordination that incorporates non-physician 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.

One major driver of health care costs and poor quality is the current, predominantly fee-for-service payment system. Under this system, payments to providers are based on the volume of services they provide, incentivizing the delivery of *more* services, including some that are unnecessary and even harmful, while not rewarding higher-quality care and improved health outcomes.⁶⁶ Fee-for-service (FFS) payment can contribute to a fragmented health care system because

the underlying economic system creates profound disincentives to coordinate care with other providers, or with social and community-based services that could help address underlying causes of health issues.⁶⁷

The amount of reimbursement for different services also creates challenges to delivering the highest-quality care and the types of care that can be more meaningful to patients. For example, relative to how much specialists are reimbursed, reimbursement rates for preventive and primary care are much lower.⁶⁸ Some important services—such as telehealth to address access barriers, care coordination, or connecting patients with social and community-based services—might not receive any reimbursement at all.^{69,70} These services, which provide immense value to patients by preventing illness, managing chronic disease, and addressing the social determinants of health, are not financially incentivized, and can sometimes even be financially unsustainable for providers to deliver.

All patients are harmed by the distortions caused by economics in the current FFS payment system, including underpayment and non-payment for primary care, prevention, and care coordination—but people of color are particularly harmed. People of color are less likely to have access to a usual source of care⁷¹ but more likely to have a number of chronic conditions,⁷² and people of color with chronic conditions are less likely to have access to primary care.⁷³ There are also racial and ethnic disparities in receipt of preventive services, such as immunizations and cancer screenings.^{74,75,76,77} Because people of color disproportionately face adverse social determinants of health, mainly because of persistent historical

systemic barriers, creating more linkages to social and community services can be an important tool for reducing disparities.⁷⁸

However, simply increasing reimbursement for the important services, described above, will not address the overall incentives to deliver *more* care, as opposed to encouraging higher-quality care and improved health outcomes. The underlying flaws of the FFS economic system must be addressed. A wide array of value-based payments and alternative payment models are being tested and implemented. These come in many forms, but underlying each of them is that providers and/or health systems take on some level of insurance risk paired with quality incentives.

Promising Model 1: Accountable Care Organizations

One popular model is the Accountable Care Organization (ACO). ACOs shift financial risk from payers to a group of providers from across the continuum of care. These providers agree to manage the health of a shared group of patients and, in return, have the opportunity to share in any accrued savings. The Medicare program has made a major commitment to the ACO model, with over 9 million beneficiaries enrolled in the largest Medicare ACO program as of the beginning of 2017.⁷⁹ The Next Generation ACO model, launched in January 2016, is the most recent iteration of multiple Medicare ACO models. It is designed for ACOs with experience in patient care coordination and allows provider groups to assume higher levels of financial risk and reward than were offered in the previous Pioneer ACO Model and Medicare Shared Savings Program ACO model. For an ACO to be eligible to share in any savings, it must meet the established quality performance standards determined by CMS. There are 31 quality measures used to assess ACO quality performance for the Next Generation ACO model. Although there is a great deal of variation among

ACOs in the commercial insurance market, it is notable that there are now more commercial ACOs operating than even the large number in the Medicare program.⁸⁰

ACOs have real potential to advance health equity. One of the first ACO implementations was the Massachusetts Blue Cross Blue Shield “Alternative Quality Contract.” In that program, global payments were tied to quality measures, enrollees in areas with lower socioeconomic status had the highest improvements in quality, and disparities were decreased between more affluent populations and populations with lower socioeconomic status.⁸¹

The specific quality measures chosen for ACOs and their prioritization relative to cost savings as a basis for ACO payment will be key to the success of ACO programs as a tool to advance health equity. However, much of the governmental and academic evaluation of the initial years of the ACO programs has been focused on the binary question of cost savings, with quality improvement a distinct secondary priority, and equity an afterthought at best.⁸² As the next step in the evolution and potential further growth of the ACO model, the program should measure equity-focused improvements in care delivery and health outcomes, and specifically avoid an over-emphasis on cost that encourages rationing of care.

There are also important concerns about the participation of people of color in the ACO program. ACOs serving a high proportion of racial and ethnic minority patients have lower scores on quality measures, a result that affects the amount of financial rewards or penalties they receive.⁸³ One study found that to this point, safety net providers have been slower to participate in ACOs and related programs.⁸⁴ This is likely in part because they lack the resources, analytic capacity, or experience, and in part because ACO payment models do not sufficiently account for social

risk and cost characteristics.⁸⁵ The lack of safety net participation in ACOs is concerning: safety net providers have insight into the types of interventions that can improve outcomes and reduce health disparities because they are embedded in the communities they serve, and are deeply knowledgeable about the populations with which they work.⁸⁶ However, safety net providers also are in a poor position to bear greater financial risk or to fund new investments in care delivery. Safety net providers are challenged in a variety of ways: they generally lack access to large donors and their payer mix includes fewer high-paying insurers, along with a disproportionate share of Medicaid patients and uncompensated care. Due to those reasons, the finances of safety net hospitals are fragile, with most operating at a 0 percent margin compared to a 6 to 8 percent margin for most other hospitals.⁸⁷ Payment reform must not undermine the delicate financial stability of providers who are essential sources of care for their communities in the pursuit of lowering costs.

While Medicaid's movement toward ACOs has been more recent, 10 states currently have active Medicaid ACO programs, and at least 13 more are developing them.⁸⁸ Most of these programs are either just beginning, as in Massachusetts and Rhode Island, or are launching small pilots. Hennepin Health, a successful safety net ACO based in Hennepin County, Minnesota, is the most mature large Medicaid ACO.^{89,90} Hennepin Health focuses on team-based care to reduce costs through preventable emergency department and hospital utilization as well as powerful coordination with behavioral health and social services. Critical to this model is the use of sophisticated algorithms based on shared Electronic Health Records (EHRs) to identify high-cost, high-need patients. Currently, Hennepin Health has made addressing persistent health disparities one of the six goals of its quality management program.⁹¹

Promising Model 2: All-Payer Hospital Global Budgets

A more comprehensive payment model, which was first implemented in Maryland and has now expanded to rural hospitals in Pennsylvania, is the All-Payer Hospital Global Budget model. This model has enormous promise as a tool to advance health equity. An all-payer global budget provides a prospectively set, fixed amount of funding for all medical services for an entire population, through a waiver, to a hospital system for inpatient and outpatient care, rather than providing FFS reimbursement.⁹² The global budget is set year-over-year, based on the costs of a selected cohort of patients, known as the "reference group." The way a reference group is selected is determined based on a variety of factors, and can include geography, provider affiliation, or health status of patients.⁹³ The hospital system is strongly incentivized to spend within its budget using a focus on prevention, care coordination, and community-based integration. However, the global budget does not have a hard cap like a block grant, and the model has safeguards built through its governance structure. For example, if a hospital is not meeting quality metrics or otherwise seems to be compromising quality, the program can revert to the prior reimbursement arrangement. If it succeeds, the global budget may be renewed for the following year, with payment adjustments based on utilization patterns, market shifts, and other trends.

Promising Model 3: Connecting Health Care and Social Services through Accountable Communities

In community-level initiatives around the United States, a broad structure called Accountable Communities of Health has sought to bring together clinical and community-based organizations, around the health

and social needs “to achieve equity, better population health outcomes, reach a higher quality of health care, and reduce costs.”⁹⁴ A prominent and promising example is the California Accountable Communities for Health Initiative (CACHI), supporting community-level initiatives in 15 locations in the state.⁹⁵

At the national level, the Center for Medicare and Medicaid Innovation’s Accountable Health Communities (AHC) model is similarly focused on social determinants of health.⁹⁶ The AHC model attempts to address the current gaps between health care delivery and community services. The AHC program is a five-year model, launched in the spring of 2017, that tests whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts health care quality, utilization, and costs. The AHC model funds awardees called *Bridge Organizations* to serve as “hubs” that are responsible for coordinating AHC efforts to:

- » Identify and partner with clinical delivery sites.
- » Conduct systematic health-related social needs screenings and make referrals.
- » Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers who might be able to address those needs.
- » Align model partners to optimize community capacity to address health-related social needs.

Notably—given the potential of the model to reduce disparities—the metrics used to evaluate the AHC model performance, described by Gottlieb et al. in the *Journal of General Internal Medicine*, are broad and generic.⁹⁷

- » Health care utilization: emergency department visits, inpatient admissions, readmissions, and utilization of outpatient services.
- » Total cost of care.
- » Provider and beneficiary experience.

The metrics used to evaluate the AHC model performance are focused on health care utilization and major cost drivers, missing an opportunity to include measures sensitive to health disparity and give deeper understanding of the impact of new models on communities of color. In addition, the model performance metrics only look at utilization, total cost of care, and provider/beneficiary experience, none of which account for improved health outcomes of the patient population.

POLICY OPTION 1.1

Reform New Medicare, Private Insurance, and Medicaid Payment Models

To ensure that new financial incentives, including those described above, do not harm people of color or the providers who serve them, ***an overall recommendation is that programs must have a fundamental framing and day-to-day operational focus on health outcomes and health equity.*** The following more specific policy options should be considered as steps toward that more foundational goal:⁹⁸

OPTION 1.1A Incorporate robust risk adjustment for social risk factors into all or some risk-based payment programs, so that providers are not penalized for caring for patients with more complex health and social needs. To the extent that they are not already developed, direct the U.S. Department of Health and Human Services (HHS) to prioritize the development and continued refinement of risk adjustment methods to account for social risk factors. **F S P**ⁱⁱⁱ

OPTION 1.1B Incentivize or require that payment models' quality and cost incentives explicitly include equity measures, both in Medicare and in Medicaid. **F S**

OPTION 1.1C Ensure that cost reduction is not overly emphasized; and prioritize access, quality, and, in particular, equity for Medicaid value-based payments and other models that disproportionately serve people of color and other disadvantaged populations. **F S**

OPTION 1.1D Make changes to ACO requirements at the federal and state level, including requiring input from communities of color in state planning processes of ACOs, and require ACOs to have a disparities reduction plan with corresponding metrics.⁹⁹ **F S**

OPTION 1.1E Encourage the spread of All-Payer Hospital Global Budget models, with strong incentives for health equity and an emphasis in governance on communities of color. **S P**

OPTION 1.1F CMMI should issue a call for proposals linked to technical assistance support for Medicaid models, multi-payer models including Medicaid, and/or models driven/led by Federally Qualified Health Centers (FQHCs) and other essential community providers. Technical support could follow the model of the Medicare Access and CHIP Reauthorization Act (MACRA) Physician-Focused Payment Model Technical Advisory Committee. **F**

POLICY OPTION 1.2

Build Improvements to Care Delivery into New Payment Models

The following policy options seek to ensure that payment models are always built on a foundation of improved care delivery that can address health disparities:

OPTION 1.2A Incentivize or require that payment models include a minimum mandatory set of equity-focused care delivery reforms, when appropriate, such as requiring that federal and state programs: **F S**

- » Implement or improve clinical-community linkages.
- » Use community health workers and similar community care team members.
- » Implement some or all patient-centered medical home criteria.

OPTION 1.2B Require CMMI and state-level Medicaid or multi-payer payment reform initiatives to collect input from a diverse group of consumer advocates, community providers, and other key stakeholders during the Request for Information/early design phase, the Technical Expert Panel/application phase, and the evaluation design phase of new models to ensure that health disparities experienced by communities of color are appropriately accounted for in the efforts to move toward value-based payment models. **F S P**

OPTION 1.2C Direct CMMI and state-level Medicaid or multi-payer payment reform initiatives to prioritize the scaling of existing models, and continuous development of new models, involving delivery system reforms focused on primary care, medical homes, and the integration of physical health with behavioral health and/or oral health. **F S P**

OPTION 1.2D Direct CMMI and state-level Medicaid or multi-payer payment reform initiatives to prioritize the implementation and scaling of models specifically designed to minimize the health impacts of adverse social determinants of health (e.g. housing, food insecurity), such as the Accountable Health Communities model or the Oregon CCO program. **F S P**

OPTION 1.2E Encourage state Medicaid programs to take advantage of existing opportunities to fund supportive housing services and evidence-based housing-first models.¹⁰⁰ (F) (S)

OPTION 1.2F Incentivize or require ACOs and similar entities to seek out and include representation from communities of color in governance structures and patient or community advisory boards. (F) (S) (P)

OPTION 1.2G Incentivize or require ACOs and similar entities to include safety net and key community providers in their structures so that these providers' unique and important perspectives are not left out of health system transformation efforts. (F) (S) (P)

POLICY OPTION 1.3 _____

Incentivize Needed Care within Fee-For-Service

To better remove barriers to and prioritize preventive care, primary care, care coordination, and connections with social and community services within a fee-for-service system, the following policies could be considered:

OPTION 1.3A Establish equity in reimbursement for these services, including by reducing payment for specialist services and by increasing payment for primary care or expanding the types of these services that can be reimbursed by Medicare, Medicaid, and Qualified Health Plans (QHPs). One specific element of this option could be to restore and make permanent the requirement on states for Medicaid-Medicare parity in payment for primary care. (Under the Health Care Education and Reconciliation Act section 1202, the federal government fully funded a requirement on states that Medicaid primary care providers receive at least Medicare rates for two years, 2013 and 2014.)

(F) (S) (P)

OPTION 1.3B Address the barriers to greater uptake (for both providers and patients) of chronic care management, transitional care management, and similar existing reimbursable services. (F) (S) (P)

OPTION 1.3C Expand the geographic areas and services eligible for telehealth reimbursement across all payers and remove other regulatory barriers to using telehealth. (F) (S) (P)

OPTION 1.3D Remove regulatory and administrative barriers to integrating physical health care with behavioral health and oral health care, such as billing and electronic health records. (F) (S)

OPTION 1.3E Move to fee-for-service payment and provider organization systems in which a single organization and provider is identified as a health or medical "home," responsible for coordination of services across primary care and specialty settings including oral and behavioral health, patient education regarding management of chronic or post-acute conditions, and connection to social service agencies as needed for benefits and eligibility support, housing, and food insecurity. (F) (S) (P)

2. Investing to Support Safety Net and Small Community Providers in Delivery System Reform

Delivery system reform and integrated provider financing, such as ACOs, involve significant new expenses for health care providers. Although these investments are important for any provider preparing to manage health outcomes for a whole population, upfront costs are likely to be larger, more mission-critical, and potentially out of the financial reach of providers working with low-income people, including safety net providers and small, independent community providers.¹⁰¹ Small physician practices play a particularly important role in caring for racial and ethnic minorities, and face distinctive challenges under MACRA and other new payment models.¹⁰²

Providers trying to adapt to new payment models will need to hire or contract with mid-level and non-clinical staff to deliver preventive and educational services in clinics, at home visits, or in other community settings. New staff may also be needed to deliver behavioral and physical health services together, screen for social risk factors, and coordinate the medical care and social services that patients need to ameliorate the impact of negative social determinants of health, such as obtaining stable housing and healthy food.^{103,104} In order to engage in effective interventions with people in crisis, providers serving low-income patients must be able to work with providers of social services and tie those social service providers into their primary care delivery.¹⁰⁵ For effective chronic illness and prevention services, safety net providers will need to be able to deliver care management in non-traditional settings. New delivery system models

also require providers to invest in health information systems to track how an entire population is using health care and to manage chronic conditions effectively in between formal office visits.

All of these new requirements involve multiple types of upfront investment. More specifically, these expenses can include:

- » Hiring and/or training of care coordination staff and community-based and peer health workers (an out-of-pocket cost in advance of care coordination reimbursement streams becoming fully available).
- » Developing new clinical services like palliative care programs, and non-clinical services, like community health worker programs, including training and consulting services and initial staffing costs.
- » Training and technical assistance to transition to team-based care, including all members of the care team to practice at “the top” of their education, training, and license.
- » Physically modifying clinical spaces.
- » Acquiring, deploying, maintaining, and training staff on sophisticated data systems to support new types of care delivery and new types of payment focused on population health, including:
 - » Management tools such as clinical data repositories, registries, and tools for analytics, decision support, and reporting.

- › Software for the point of care, such as health information exchange systems and care management records, with the capacity to track and measure quality performance for new reimbursement methodologies.
- › Training for “non traditional” providers who have not worked with clinical providers before or billed health insurance before, such as social service providers being integrated into new delivery frameworks.
- › Implementing new billing/claims systems for non traditional providers.

These significant upfront costs are a major barrier for safety net and small community providers to participate in new, integrated payment and delivery models and succeed in a value-based financial environment. Looking at the formation of ACOs specifically, there are four principal barriers that safety net providers face, most of which tie into financial limitations:

1. Lack of capitalization (for non-hospital safety net providers).
2. Lack of size (for non-hospital safety net providers).
3. Limited access to management information.
4. Financial imperatives on hospitals to keep beds filled (also known as the “hospital conundrum”).¹⁰⁶

Providing upfront funding to safety net and small community providers can help overcome these barriers, and there are multiple pathways to secure this support.

A. Center for Medicare and Medicaid Innovation

In principle, the Center for Medicare and Medicaid Innovation (CMMI) could help to finance these upfront safety net and small community provider costs as part of its broader goal of funding innovation across the health care system. But CMMI’s total budget allows for only modest upfront financial awards and/or grant funds, which are not usually sufficient to finance the entire provider investment needed to implement a comprehensive new care delivery and payment change. Participation in CMMI pilots has for that reason generally attracted providers with the resources to fund some of their implementation costs and/or who have already made some of the investments described above—in other words, well-capitalized, non-safety net provider systems rather than safety net providers.¹⁰⁷

B. Medicare MACRA-Related Funding

The MACRA law creating a new Medicare physician payment system also authorized technical assistance funding, with a focus on physician practices in rural and underserved areas and small physician practices.¹⁰⁸ This funding could be a basis for targeted support to small practices and community health centers serving in a safety net role for their broader upfront costs in MACRA implementation.

C. State Medicaid Funding

Medicaid is another potential source of financing for safety net providers’ and small community providers’ upfront delivery system reform costs. Medicaid is a very large source of funding for states and is relatively flexible because of its broad waiver authority. Medicaid waivers can allow states to fund payments to providers or other non-claims based payments if they are in support of Medicaid objectives and if they are part of an overall

package that includes offsetting savings—that is, if the waiver is projected to be “budget-neutral.”¹⁰⁹

Both CMS and states moved quickly to develop Medicaid avenues for investment shortly after delivery system reform was identified as a national priority in 2009 and 2010. CMS, together with several state Medicaid agencies and large safety net health providers, formulated an approach involving special Medicaid investments in improved health care delivery using Medicaid waivers. (Note that Medicaid waivers have also been used to create new payment systems such as Accountable Care Organizations—these are discussed above in this paper, in the section on payment.) These investments were typically known as Delivery System Reform Incentive Programs, or DSRIPs. DSRIPs involved pools of funding made available to providers as

incentives to engage in reforming how they deliver care. In more recent DSRIP states, these incentives have also been tied to a move to advanced value-based payment methodologies such as ACOs.¹¹⁰ Funding is placed partly at risk, based on providers achieving measurable gains in key program areas identified by the state.

Example of State Medicaid Funding: Washington State

CMS recently approved a DSRIP in Washington state, which included health equity as its first stated goal.¹¹¹ Funding will be distributed through multi-stakeholder regional entities called Accountable Communities of Health, or ACHs, focused on achieving health equity by preparing safety net providers to manage population health and value-based payment. The key clinical focus areas are laid out in the table below.

CARE DELIVERY REDESIGN
Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
Community-Based Care Coordination
Transitional Care
Diversions Interventions
PREVENTION AND HEALTH PROMOTION
Addressing the Opioid Use Public Health Crisis (required)
Reproductive and Maternal and Child Health
Access to Oral Health Services
Chronic Disease Prevention and Control

Source: Washington State Health Care Authority.

Between 2010 and January 2017, DSRIP or other Medicaid-finance delivery system reform investment pools for providers were approved in 12 states.¹¹² The DSRIP model has a great deal of appeal, given the needs described in this paper. Funding to providers is targeted at either population-level clinical priorities or developing specific new services, and can be partly conditional on achieving quality and/or health equity goals.

However, an important limitation to the DSRIP model is that it has been dependent in many of the 12 states mentioned above on a specific Medicaid funding context, in that it preserves hospital payments (many involving public hospitals) that would otherwise be disallowed when states move to Medicaid managed care.¹¹³ CMS gives special Medicaid waiver authority to maintain this flow of funds. This results in a kind of DSRIP quid pro quo: states pursue DSRIP as a way to preserve supplemental funding that would otherwise be disallowed, and CMS and state Medicaid agencies leverage that waiver funding stream to achieve federal and state delivery system reform priorities.¹¹⁴ However, only a subset of states have this particular reason to even pursue a DSRIP. The model may have limited appeal for states, particularly states without large public hospital systems. Another limitation is that DSRIP funding is also particularly dependent on a completely discretionary federal executive branch decision.

POLICY OPTION 2.1

Continue DSRIP with Safety Net and Small Community Provider Requirements

OPTION 2.1A Continue large DSRIP options for states and create mechanisms for states without public hospital networks to participate. **F**

OPTION 2.1B Require DSRIP programs to incorporate the same requirements as outlined above for other payment models for measurement and inclusion of communities of color and safety net and community providers. **F** **S**

POLICY OPTION 2.2

Establish a Targeted Medicaid Waiver to Support Safety Net and Small Community Providers

CMS could establish a more modest, and therefore more easily replicated, Medicaid waiver program to fund DSRIP-style safety net and small community provider support. **F**

POLICY OPTION 2.3

Establish a New CMMI Program to Support Safety Net and Small Community Providers

This would require additional funding for CMMI, which would require federal legislation. **F**

OPTION 2.4

Expand Medicare MACRA Implementation Support for Small, Underserved, and Rural Practices

As of May 2018, CMS offers support in implementing MACRA for small physician practices, with a broad mandate to provide technical assistance with various aspects of the Quality Payment Program.¹¹⁵ This change would dedicate more targeted implementation support funds specifically to the support needs of practices seeking to implement team-based care and community-based, social determinants-focused clinical services.¹¹⁶ This change could be done administratively by CMS, through new rule-making under the current law authorizing technical assistance funding. Alternatively, Congress could expand funding for the MACRA assistance program to support interventions to reduce disparities. **F**

3. Building Robust and Well-Resourced Community Partnerships

With socioeconomic and behavioral factors being such significant drivers of health outcomes, hospitals and other health care providers cannot improve health by themselves. Moreover, as people of color and other disadvantaged communities disproportionately face adverse social risk factors, building and maintaining strong community partnerships with social service providers, faith-based organizations, schools, local public health departments, and other community-based organizations is essential for achieving health equity. These partnerships can be effective for preventing illness and injury in the first place, and for ensuring that patients have the necessary resources and supports to recover and manage their condition following a diagnosis or a discharge from the hospital. What's more, given that health systems are often the economic anchors of the communities in which they are located, by partnering with community organizations and businesses they can leverage their investment, create jobs, partner on training and employment, spark economic development, and immediately begin to redress underlying inequities.

Despite the potential for improved health and health equity that can come from community partnerships, current fee-for-service payment systems do not incentivize providers to keep people healthy—let alone develop robust community partnerships to do so. As discussed above, when providers are paid based on the volume of clinical services they provide, there are strong financial incentives to increase the number of clinical services they provide, and for hospitals to maintain or increase inpatient volumes. On the other hand, social services and community-based organizations (CBOs) often have their own funding

challenges. In addition, partnerships often have to overcome a lack of existing framework or structure for collaboration, differing organizational cultures, and challenges associated with data collection, storage, and sharing.¹¹⁷

The move to more value-based health care, along with changes to community benefit requirements under the Affordable Care Act (ACA), is putting new pressures on hospitals and other health care providers to be more accountable for the overall health of their patients and communities.¹¹⁸ As the health care system increasingly recognizes the role of the social determinants of health, there is much it can learn from community partners and the expertise these partners have regarding the risks facing the community. Health systems can leverage their resources by helping to build community capacity, as opposed to replicating it, or taking it over.

POLICY OPTION 3.1

Focus Payment and Delivery Reform Models/ Waivers on Incentivizing Community Partnerships

With an increasing number of providers engaged in new payment and delivery models to improve health outcomes and reduce costs, robust community partnerships should be an integral part of these models. Partnering with CBOs that have the history, cultural understanding, and trust relationships with the communities struggling with health disparities and barriers to health can be key to achieving the goals of the payment model and can help ensure that the design and implementation of the model are targeted to reduce health disparities.

To focus the development of these models on supporting community partnerships, the following policies should be considered:

OPTION 3.1A Direct CMMI to prioritize the implementation and scaling of models specifically designed to minimize the health impacts of negative social determinants of health (e.g. housing, food insecurity) and that prioritize community partnerships as a key feature of the model, such as the Accountable Health Communities model’s “Alignment Track.”¹¹⁹ **F**

OPTION 3.1B Incentivize or require ACOs and similar entities to seek out and include representation from communities of color in governance structures and patient or community advisory boards. **F S P**

OPTION 3.1C Require Medicaid managed care plans to contract with CBOs for appropriate social services, and for outreach, engagement, education, assessment, and follow-up services. **F S**

OPTION 3.1D Independently from federal or state requirements, work with local Medicaid Managed Care Plans so they collaborate with CBOs in providing a broad range of services to their members. **P**

OPTION 3.1E Direct CMMI to develop a State Innovation Model (SIM)-like model that is explicitly focused on health equity to assist in the creation of regional planning organizations or other infrastructure to help health systems and community-based organizations coordinate their efforts. **F**

OPTION 3.1F Require state Medicaid offices to develop, pilot, and scale models that require significant input and engagement with CBOs. **F S**

POLICY OPTION 3.2

Strengthen and Expand Community Benefit Requirements

The ACA added new requirements for nonprofit hospitals to increase transparency regarding their investments in Community Benefit programs and to formalize how these hospitals should conduct community health needs assessments (CHNAs) and implement community health improvement programs that respond to the findings of CHNAs. However, much of these investments are still dedicated to increasing access to clinical services, with very little going toward more “upstream” causes of poor health outcomes and health disparities.¹²⁰ Moreover, currently Community Benefit requirements apply only to nonprofit hospitals, and not to other entities that also should be partnering with community organizations.

To strengthen the Community Benefit provision and ensure it is being fully utilized to advance health equity, the following policies should be considered:¹²¹

OPTION 3.2A Require all nonprofit hospitals and health plans, including Medicaid managed care organizations, to meet Community Benefit requirements. **F S**

OPTION 3.2B Require adopting Community Benefit programs as a condition for state Medicaid Disproportionate Share Hospital (DSH) participation. **F S**

OPTION 3.2C Establish a minimum percentage of a nonprofit hospital’s Community Benefit OR, for all hospitals, a total budget that must be invested in programs specifically targeted at reducing health disparities by addressing root causes. **F S**

OPTION 3.2D Strengthen requirements for the inclusion of community members, particularly those from marginalized communities, in the CHNA process and implementation of Community Benefit programs. **F S**

POLICY OPTION 3.3

Incentivize/Resource Infrastructure Required to Enable Seamless Coordination between Health Systems and Providers and Community-Based Resources

OPTION 3.3A Building on the Beacon Communities,¹²² Community Interoperability and Health Information Exchange grants,¹²³ and other now-closed federal grant opportunities, set up regional IT hubs that under-resourced CBOs providing services can plug into. Include grants for the installation and deployment of these systems and training. (F) (S)

OPTION 3.3B Incentivize the multi-purposing and leveraging of existing community infrastructure in addition to CBOs, such as faith-based organizations, schools, and recreation centers. (F) (S)

As people of color and other disadvantaged communities disproportionately face adverse social risk factors, building and maintaining strong community partnerships with social service providers, faith-based organizations, schools, local public health departments, and other community-based organizations is essential for achieving health equity.

POLICY OPTION 3.4

Incentivize/Require Health Care Providers to Recruit Actively from Their Communities and Contract with Businesses in Their Communities to Provide Needed Services and Supplies

In addition to partnering with community organizations that provide the support services individuals and families need to improve their health, health care provider systems have a valuable role to play in supporting the economic advancement of communities where they are located. Hospital systems and large FQHCs are often economic anchors in their communities, not just as employers, but also as purchasers of good and services.

OPTION 3.4A Establish local business contracting programs for health systems. (S) (P)

OPTION 3.4B Create outreach/recruiting programs to hire from the community. (S) (P)

OPTION 3.4C Create workforce development partnerships with schools, community colleges, owners/managers of affordable housing, etc. (S) (P)

4. Ensuring a Transparent and Representative Evidence Base

Building an evidence-based health care delivery and payment system that is oriented toward high value care and reducing health disparities requires policymakers, insurers, and providers to have and use reliable evidence in making decisions about resource allocation and payment. However, when it comes to understanding the efficacy of medications, treatments, care models, and other interventions for people of color and other groups affected by disparities, there are enormous gaps, and significant biases in the evidence base.

The gaps in clinical research have been known for a long time. For example, although racial and ethnic minorities make up more than 30 percent of the U.S. population, less than 2 percent of more than 10,000 cancer clinical trials funded by the National Cancer Institute, and less than 5 percent of NIH-funded respiratory research included racial/ethnic minorities.^{124,125,126} This means that evidence for treatments and other interventions comes from study participants who are overwhelmingly white, in addition to disproportionately male. This evidence is then generalized and applied to the much more diverse population of the U.S. and forms the basis of medical treatment guidelines and federal prevention recommendations, and also influences insurers' treatment coverage decisions.

Increased representation of communities of color in clinical research enables researchers to examine the relationship between ancestry, environmental exposures, social factors, and an individual's genomic profile to better understand disease pathology and to create medical treatments and prevention

programs that are most effective in improving health for communities of color. It also allows researchers to uncover where current guidelines are inadequate for specific populations, allowing providers to adjust treatment and researchers to seek better treatments. For example, compared to the rest of the population, Puerto Ricans with asthma respond less favorably to albuterol, the standard first-line treatment for an asthma attack.¹²⁷ But even though Puerto Ricans have a much higher prevalence and mortality rate from asthma than any other group in the country, a

Despite efforts by agencies and institutions...research on the most effective ways to organize health systems, deliver, and pay for accessible, culturally competent care to diverse communities is lagging.

treatment that is more effective for Puerto Ricans has not yet been developed.¹²⁸ Structural and systemic factors restrict the effectiveness of new diagnostic and therapeutic approaches for communities of color, and as new medical discoveries emerge, the benefits are not distributed equitably.

Recent advances in medicine and technology offer an opportunity to disentangle the social and genetic factors that contribute to health disparities. Precision medicine, for example, is a new approach used for disease prevention, early detection, and treatment that considers genetic variability, the environment, demographic factors, social determinants, and lifestyle.¹²⁹ Advancements in precision medicine and other medical technologies, such as genomics, promise to improve patient care and reduce health disparities.¹³⁰ However, the ability of new medical technology to achieve both those goals for communities of colors depends on the improved understanding of the interplay between various biological, behavioral, social, and environmental factors specific to communities of color, in addition to improved representation of communities of color in ongoing research about precision medicine and other new medical advances.

The Food and Drug Administration, the National Institutes of Health, and the Centers for Disease Control and Prevention have each developed recommendations and launched important initiatives and campaigns to diversify clinical trials; therefore, we will not address that issue in this paper. However, given these gaps in the clinical evidence base, it is imperative that payment models take these gaps into account. For example, where payment models rely on quality measures tied to adhering to prevention and treatment guidelines derived from this incomplete evidence, there must be “guardrails” and “safety valves” to ensure that patients can get the care that is right for them, when that care deviates from such guidelines.

In addition to the gaps in the clinical evidence base, there are also significant gaps in research on the most effective ways to organize, deliver, and pay for accessible, culturally competent care for specific

populations. Despite efforts by agencies and institutions, such as the Agency for Healthcare Research and Quality and the Patient-Centered Outcomes Research Institute (PCORI), research on the most effective ways to organize health systems and to deliver and pay for accessible, culturally competent care to diverse communities is lagging. To be sure, progress has been made, particularly by the National Quality Forum, Finding Answers: Solving Disparities through Payment and Delivery Reform, the Disparities Solutions Center, and the National Institute on Minority Health and Health Disparities’ precision medicine initiative. Still, strengthening research and evidence on the best models of care and interventions will be key to building a health care system that can narrow disparities.

POLICY OPTION 4.1

Mandate Improved Reporting and Analysis of Demographic Characteristics in Clinical and Delivery Systems Research and Evaluation

Providers, patients, payers, and policymakers need accurate information about the demographic characteristics of research and evaluation subjects to inform clinical guidelines, treatment recommendations, and reimbursement decisions.

OPTION 4.1A Require public reporting of the racial and ethnic composition of people enrolled in clinical trials and other research. **F**

OPTION 4.1B Require additional notice be given if the effectiveness of any given treatment or intervention was determined based on studies involving homogenous groups. **F**

OPTION 4.1C Incentivize researchers and evaluators to analyze their data by race and ethnicity in addition to any other key demographic characteristics that are available, unless statistically inappropriate. **F**

POLICY OPTION 4.2

Support the Generation of More Community-Specific Health System and Delivery Research

Community members should be equitable partners in collaborative research design, as they are directly affected by the health and health care issues facing their community. Community-based participatory research is one model that incorporates community members and/or patients throughout the research process, so that research is better informed by the community, and returns results to that community. A community can be defined as a physical community, such as neighborhood, or as a community of individuals with similar characteristics, experiences, health conditions, disabilities, or other such features.

Patient-centered outcomes research is another model that incorporates patient input throughout the research process, generally organized around and with patients with similar characteristics or conditions under study. PCORI was established by the Affordable Care Act to conduct and evaluate the “relative health outcomes, clinical effectiveness, and appropriateness” of different treatments from the perspective of what is important to patients,¹³¹ and addressing disparities is one of PCORI’s “priority areas.”¹³²

OPTION 4.2A Reauthorize PCORI and strengthen its mandate to address health inequities, including prioritizing the evaluation of non-clinical, complementary, and community-driven interventions. **F**

POLICY OPTION 4.3

Improve the Translation and Dissemination of Evidence to Decision Makers, Practitioners, and Communities

Producing better evidence is only the first step in building an evidence-based, effective health care system primed to reduce disparities. The evidence must get into the hands of those who can use it: policymakers, health systems, payers, providers, communities, and consumers. However, studies indicate that it can take 17 years or more for new medical knowledge to be incorporated into clinical practice—let alone reach policymakers and consumers.¹³³ Ensuring that actionable evidence regarding what works well, how, when, and for whom gets to the right end users requires proactive and tailored translation and dissemination strategies. Although dissemination and implementation science has significantly progressed in recent years, it is not clear how effective it has been in serving diverse stakeholders and communities.

OPTION 4.3A Require all federally funded research into health outcomes, new treatments for conditions that disproportionately affect and are high priorities for communities of color and other disparity groups, health care quality, and delivery reform to create dissemination plans and plain-language summaries of all results that are housed in a user-friendly website. **F**

OPTION 4.3B Establish funding streams to support community and consumer groups as partners in evidence translation and dissemination in their communities. **F S P**

POLICY OPTION 4.4

Ensure Appropriate Use of Evidence in Treatment Guidelines and Reimbursement

Private and public payers, the U.S. Preventive Services Task Force, and other bodies that develop and disseminate clinical practice guidelines should consider the potential differential impacts of specific treatments on diverse patients in the development of guidelines and payment systems.

OPTION 4.4A Require all federally funded medical research on human subjects to indicate the breakdown of their key characteristics by, at a minimum: sex, age group, race, ethnicity, and disability. **F**

OPTION 4.4B Require all federally funded medical research on human subjects to clearly indicate where there are significant variations in results by sex, age group, race, ethnicity, and disability, and identify additional research questions needed to better understand them. **F**

OPTION 4.4C Require clinical guidelines to clearly indicate when there are significant variations in outcomes based on sex, age group, race, ethnicity, and disability to allow for the appropriate and precise application of the guideline, and also to indicate the need for the development of guidelines specific to the group in question. **F P**

Ensuring that actionable evidence regarding what works well, how, when, and for whom gets to the right end users requires proactive and tailored translation and dissemination strategies.

OPTION 4.4D Require all payers to incorporate into medical necessity determinations any exceptions or evidence-based alternatives developed by treating providers or other appropriate health professionals. This is especially important when the underlying research supporting the guideline was based on studies that did not represent the patients' sex, age group, race, ethnicity, and disability, or when evidence clearly indicates variations based on these or other relevant characteristics. Moreover, the process for this should be patient-friendly and not overly lengthy. **F S P**

5. Equity-Focused Measurement that Accelerates Reductions in Health Inequities

Measures are used throughout the health care system in several ways, including to evaluate the performance of a wide array of processes, clinical outcomes, patient experiences, and the efficiency of care delivery. Public and commercial insurers, hospitals and other health care organizations, and individual providers all participate in quality measurement and reporting programs, some of which are voluntary, while others are required by various federal and state laws and regulations. All large health care organizations (and many smaller ones) use quality measures to design new processes or systems intended to improve the quality of care and health outcomes and, through public reporting, to provide health care consumers with information that can be used to determine where they want to receive care.^{134,135}

Increasingly, as health care moves away from fee-for-service and to a more value-based system, quality measures are being used to adjust the payments that health care providers receive.¹³⁶ For example, under the Quality Payment Program established by MACRA, providers' performance on a set of quality measures helps determine the percent bonus or penalty they receive on their Medicare Part B payments.¹³⁷ State Medicaid programs also employ a variety of approaches that hold Medicaid managed care organizations and/or providers financially accountable for meeting certain quality targets.¹³⁸

Measurement is also an important, yet underused, tool for reducing health care disparities. Measurement can allow policymakers, providers, consumers, and other stakeholders to identify disparities in their communities, target resources and interventions that can reduce those disparities, and monitor the improvement or worsening

of disparities in response to these interventions or other changes.¹³⁹ However, in order to be an effective tool for advancing health equity, performance measurement must be implemented in a way that specifically accounts for disparities in risk factors, experiences, quality of care, and health outcomes.

Below are several ways to structure performance measurement to promote health equity.

POLICY OPTION 5.1

Require Health Care Organizations to Report Performance Data Stratified by Race, Ethnicity, Language, Socioeconomic Status, Sex, Gender Identity, Sexual Orientation, Disability, and Other Demographic Factors¹⁴⁰

If performance measures are not stratified by race, ethnicity, language, socioeconomic status, sex, gender identity, and other demographic factors, then providers, consumers, and policymakers are not able to pinpoint disparities and evaluate the impact of specific payment and delivery changes on outcomes for communities of color and whether they are reducing or widening disparities. Even though the ACA requires population health surveys in national health insurance programs to collect and report stratified data when possible, multiple major operational data sets in Medicare, Medicaid, and commercial insurance do not stratify on race, ethnicity, and language. These include the Healthcare Effectiveness Data and Information Set (HEDIS) data set used for managed care performance measurement and incentive payments in Medicare and Medicaid, the new measure sets associated with physician incentives under MACRA, and state-level core quality measures implemented for children and adults in Medicaid.¹⁴¹

Increased stratification of performance measures can be achieved through the following policies:

OPTION 5.1A Require the stratification of this data for health care organizations and providers who participate in and report performance measures in value-based programs in Medicare, Medicaid, and with commercial insurers. This data should be stratified by age, sex, race, ethnicity, and language (at a minimum) and by other demographic factors as data becomes collected and available. **F S P**

OPTION 5.1B Require stratification of data as a condition for participating in CMMI demonstrations or grant programs. **F**

OPTION 5.1C Provide financial incentives for health care organizations, providers, and commercial insurers who collect and report on stratified measures. **F S P**

OPTION 5.1D Provide upfront financial support and technical assistance to help organizations and providers build necessary capacity to collect and report stratified data. **F S P**

POLICY OPTION 5.2

Require and Incentivize Collection and Reporting of Social Risk Factor Data

Though our system has persistent racial and ethnic disparities in clinical care quality, health disparities are also rooted in the social determinants of health. For health care organizations and providers, understanding that the social and behavioral risks experienced by the population they serve, such as financial strain or social isolation, can lead to three helpful outcomes:

- » Selecting performance measures that are sensitive to the negative health impacts caused by these social and behavioral risks.

- » Tailoring quality or care delivery improvement initiatives that target and mitigate the negative impacts of these risks.
- » Identifying the social and community services that the organization or provider should prioritize for partnership and collaboration.¹⁴²

Standardized collection of such data can also be useful for better design and implementation of payment reform efforts—first, by identifying the infrastructure needs of health care organizations and providers; and, second by allowing for improved methods of risk adjustment. However, any collection or exchange of such data must be done in a way that still recognizes patients’ right to privacy, particularly that concerning sensitive information such as immigration status or mental health diagnoses or treatment.

Multiple opportunities exist for incentivizing or requiring the collection of standardized patient social and behavioral risk data:¹⁴³

OPTION 5.2A Implement the Office of National Coordinator for Health’s 2015 IT standards for collection of patient social and behavioral risk data in EHRs, with the addition of collecting patient information regarding disabilities. **F**

OPTION 5.2B Incentivize or require collection of patient social and behavioral risk data through Medicare, Medicaid, and commercial insurance value-based payment programs (e.g. pay-for-reporting in MACRA, CMMI demonstrations, state Medicaid requirements, etc.). **F S P**

OPTION 5.2C Include patient social and behavioral risk data in electronic health information exchanges. **F S P**

OPTION 5.2D Support electronic health information exchange with other public assistance programs (SNAP, WIC, housing assistance, etc.) to streamline eligibility decisions and share appropriate information to support comprehensive patient-centered services. **(F S)**

POLICY OPTION 5.3

Prioritize the Development and Use of Disparities-Sensitive and Health Equity Measures

Policy option 5.1 references stratification of broader measures, and option 5.2 describes measurement of the social determinants of health. Option 5.3 prioritizes the direct measurement of disparities and inequities. The National Quality Forum (NQF) has defined disparities-sensitive measures as those that can detect disparities, and these measures can be identified based on the following criteria:

- » A condition’s prevalence among populations with social risk factors.
- » The size of the disparity.
- » The strength of the evidence linking improvement on the measure to improvement in health outcomes for populations with social risk factors.
- » The “actionability” of the measure.¹⁴⁴

Health equity measures are those that assess whether interventions that increase health equity are being utilized. NQF has identified existing measures in these areas, as well as gaps that remain. Within health

equity measures, the Partnerships and Collaboration domain described in this document may be particularly important for prioritization, given how heavily factors outside the health care system contribute to a person’s health. For example, measures in this domain could include linkages with schools, childcare providers, and other non-health sectors.¹⁴⁵

In order to prioritize the development and use of these measures, policy options include the following:

OPTION 5.3A Increase the number of disparities-sensitive and health equity measures that providers and plans can choose to report on in accreditation programs and in value-based programs in Medicare and Medicaid, as well as in the commercial market.

(F S P)

Directly measuring inequities and progress toward eliminating them requires using disparities-sensitive measures that detect disparities in populations, and health equity measures that assess whether interventions that increase health equity are being implemented.

Just as providers are incentivized and rewarded for achieving high-quality care overall or for improving their performance on quality measures, providers should be similarly rewarded for decreasing health disparities.

OPTION 5.3B Require and incentivize providers participating in all or a subset of Medicare and Medicaid value-based programs to report on a certain number of these measures. **F S**

OPTION 5.3C Require CMMI to use a minimum number of these measures to evaluate the success of demonstration projects. **F**

OPTION 5.3D Target existing resources, and allocate additional ones as necessary, to the development of measures in the identified gaps, with a particular focus on improving patient experience measures. **F S P**

OPTION 5.3E Prioritize the inclusion of disparities-sensitive and health equity measures in the development of core measure sets used by various public and private initiatives.¹⁴⁶ **F S P**

OPTION 5.3F Prioritize the addition of disparities-sensitive and health equity measures when other measures become “topped-out” because of high performance and little variation, or when they are decommissioned for other reasons. **F S P**

POLICY OPTION 5.4

Directly Incentivize Providers to Reduce Disparities in Performance Measures

Just as providers are incentivized and rewarded for achieving high-quality care overall or for improving their performance on quality measures, providers should be similarly rewarded for decreasing health disparities.¹⁴⁷

This could be done through the following policies:

OPTION 5.4A Incorporate decreases in health disparities into the evaluation or “scoring” for providers participating in pay-for-performance or other value-based programs. **F S P**

OPTION 5.4B Establish a financial bonus (in addition to normal scoring and payment adjustment methodologies) for providers who perform exceptionally well at reducing disparities. **F S P**

6. Growing a Diverse Health Care Workforce that Drives Equity and Value

In the coming years, it is projected that there will be an increased demand for primary care services in the United States, due mostly to a large aging population.¹⁴⁸ If trends continue, there will be a shortage of primary care practitioners, as the number of primary care physicians, physician assistants, and nurse practitioners will not be enough to care for the number of people seeking services.¹⁴⁹ Another important shift in the coming decades is that non-Hispanic whites will no longer make up the majority of the population.¹⁵⁰ The needed growth in primary care practitioners presents an opportunity to improve and diversify the health care workforce to match an increasingly diverse United States. For payment and delivery reform to be successful in achieving health equity, the health care workforce must be representative of the increasingly diverse population in the United States, provide access to care equitably across and between communities, and deliver care that is responsive to a person's culture and social context.

The development of a diverse and representative workforce begins in training. Currently, only about 30 percent of medical school faculty who responded to an Association of American Medical Colleges survey are from a racial and/or ethnic minority.¹⁵¹ The percentage

is even smaller for physical therapist faculty, as less than 20 percent identified as persons of color.¹⁵² Instructors in training and education programs for physicians, nurses, physician assistants, physical and occupational therapists, dentists, dental hygienists, psychologists, community health workers, and all health care practitioners should be representative of the population. Curricula in these programs must also reflect the diversity of potential future patients. This includes case studies and literature focused on people of color, diseases with particularly high impact on racial and ethnic minorities, and culturally competent care.

POLICY OPTION 6.1

Increasing the Diversity of Health Care Providers and Health System Leaders

Though people of color are projected to be a majority of the population within a few decades, only 11 percent of the physician workforce and 15 percent of registered nurses are African American, Hispanic, or American Indian and Alaska Native.¹⁵³ Additionally, only about 20 percent of physical and occupational therapists are from these racial and ethnic groups.¹⁵⁴ Some groups of Asian Americans, Native Hawaiians, and Pacific Islanders are also greatly underrepresented

For payment and delivery reform to be successful in achieving health equity, the health care workforce must be representative of the increasingly diverse population in the United States, provide access to care equitably across and between communities, and deliver care that is responsive to a person's culture and social context.

in health care professions.¹⁵⁵ The substantial underrepresentation of these groups in the health care workforce has significant implications for health equity. People of color who receive care from a provider of the same race or ethnicity report receiving higher-quality care and higher levels of satisfaction with their care.¹⁵⁶ Health disparities can be traced in part to language and cultural barriers that can deter people from getting care or result in lower-quality care.¹⁵⁷ More than one in five African Americans, and roughly one in six Latinos and American Indian and Alaska Natives, report avoiding needed medical care out of fear of facing discrimination.^{158,159,160} A related finding is that, when given a choice, people of color are more likely to choose providers of their same race or ethnicity.¹⁶¹

Increasing the diversity of the workforce can also help alleviate health care access challenges that result from shortages of providers located in a particular community, or who do not serve low-income patients. African American and Hispanic physicians are more likely to treat people who are low-income and on Medicaid, and along with American Indian and Alaska Native physicians, are much more likely to practice in underserved communities than are white physicians.¹⁶² A more diverse health care workforce can also help address the underrepresentation of people of color in medical research by asking research questions of importance to communities of color and improving outreach and engagement with these communities.¹⁶³ Finally, more people of color serving as health care providers will also pave the way for greater diversity among the leadership of health care systems,¹⁶⁴ which will have significant influence over the transformation of a health system in which 98 percent of senior managers currently in health care organizations are white.¹⁶⁵

The following policy options should be considered to increase the diversity of health care providers and health system leaders. Each of these options could be directed at health care professionals broadly, or targeted at specific fields (e.g. mental health, nursing, etc.).

OPTION 6.1A Expand K-12 “pipeline” programs to ensure academic readiness and entryways into health care professions for more people from underrepresented groups. **F S P**

OPTION 6.1B Increase the amount of loan repayment, loan forgiveness, and other financial incentives available for health care providers from underrepresented groups and/or to providers who practice in health professional shortage areas, such as through the National Health Service Corps and various state initiatives. **F S**

OPTION 6.1C Increase availability of Graduate Medical Education or other support for Teaching Health Centers¹⁶⁶ and other training opportunities in underserved communities to train medical residents. **F S**

OPTION 6.1D Require state health profession licensing boards (for physicians, nurses, dentists, etc.) to collect demographic data on recipients of licenses. **S P**

OPTION 6.1E Require health care organizations to publically report on the diversity of their workforce, leadership, and board. **F S**

OPTION 6.1F Provide direct financial incentives for health care organizations to hire and retain health care providers and organizational leaders from underrepresented groups, with a particular focus on hiring those individuals from the health organization’s own community. **F S**

OPTION 6.1G Require or incentivize health care systems to have members of underrepresented groups serve in senior leadership positions and as board members. (F) (S)

OPTION 6.1H Establish leadership development programs for clinicians of color to be prepared for trustee board and executive positions in the systems that serve their communities. (P)

POLICY OPTION 6.2

Promoting the Sustainable Use and Integration of Community Health Workers (CHWs) and Similar Community Care Team Members¹⁶⁷

Increasing the diversity of health care providers alone is not sufficient for building a health care workforce that achieves health equity. The health care workforce must also be equipped to address the broad array of factors that influence a person’s health, and be able to provide sufficient access for all people. Social factors are huge drivers of health outcomes—and for many people, these factors are even more important than clinical care. It is imperative to the goal of reducing inequities that the health care workforce be designed to help people and communities address the social factors that are negatively affecting health. As people of color are more likely to experience adverse risk factors, it is important that health care teams include individuals who understand and can help mitigate the effects of these factors.

Utilizing CHWs is an example of how health care organizations and providers can ensure that they are building care teams that are well-suited for addressing such risk factors. CHWs are trusted members of the communities they serve who, because of their relationships and training, are able to serve

as frontline public health workers who effectively provide education and support to improve the health of individuals, their families, and their communities as a whole. In alignment with the American Public Health Association’s definition,¹⁶⁸ the term “community health workers,” as used in this document, refers to all those who serve in this capacity. They work under numerous job titles, including *promotores de salud*, community health representatives, patient navigators, and peer educators, to name just a few. While all of these frontline health workers are similar in their relationships with their communities and many will undergo some type of training, the success of these individuals stems from the way they cater to their communities’ specific needs. As such, it is imperative that CHWs be involved in defining their role in each region, state, or Tribe.

There is ample evidence that CHWs can improve outcomes, produce cost savings, and reduce disparities. The approach embodied by CHWs is also present in the use of community-based doula and peer health workers in the mental and behavioral field.¹⁶⁹ A similar approach is being tested through other models, such as community paramedics.¹⁷⁰ Community paramedics and emergency medical technicians (EMTs) have been able to meet some of the needs of rural populations that do not have access to primary care.¹⁷¹ Unfortunately, the use of CHWs and similar community-based care team members is often limited by a lack of sustainable funding. Many of these programs are grant-funded or are supported by an organization’s general administrative or community benefit budgets, meaning that when grants end or budgets tighten, these programs are often scaled back or ended. Establishing separate, sustainable funding streams and incorporating these individuals into broader value-based payments present opportunities to reduce health disparities.

The following policy options should be considered for increasing the sustainable funding and integration of CHWs and similar community-based care team members:

OPTION 6.2A Remove regulatory barriers at the state level that may be an impediment to increasing the growth and reach of this workforce, or integrating them into the health care system. **(S)**

OPTION 6.2B Establish claims payment for CHWs and similar community-based care team members for effective services in traditional fee-for-service Medicaid, Medicare and/or other payment models. **(F)(S)(P)**

OPTION 6.2C Require Medicaid managed care plans (in state contracting) and/or QHPs (in federal or state contracting, depending on the state) to make CHWs and similar community-based care team members and their highly effective services available to their members, by, for example: **(F)(S)**

- » Specifying which services, at a minimum, they must be available to provide.
- » Including provisions that ensure that contracted CHWs or similar community-based care team members are true to the community-based approach, including spending a significant percentage of their time in the community, outside of the clinic or hospital setting (i.e., not telephonic case managers who are unconnected to the community).

- » Establishing a minimum ratio of CHWs or similar community-based care team members to people enrolled in their plan, as well as standards for geographic coverage and distribution.

OPTION 6.2D Build CHWs or similar community-based care team members into the design of Medicaid waivers or other Medicaid value-based payment programs. **(F)(S)**

OPTION 6.2E Build CHWs or similar community-based care team members into the design of broad CMMI value-based models. **(F)**

OPTION 6.2F Design a CMMI model to specifically test the best models for integrating CHWs and other community-based care team members into the health care system. **(F)**

POLICY OPTION 6.3

Promoting the Use and Integration of Mid-Level Providers^{iv}

Among the barriers to accessing care that marginalized communities face is a lack of sufficient medical, dental, and mental health care providers in their communities. Nationally, about one in four people live in primary care health professional shortage areas, one in three live in mental health professional shortage areas, and one in six live in dental health professional shortage areas.¹⁷² Communities of all incomes, racial and ethnic backgrounds, and levels of urbanization experience health professional shortages—but rural areas, lower-income neighborhoods, and communities of color are disproportionately affected.¹⁷³

^{iv}We acknowledge that the term “Mid-Level Providers” is not accepted by all non-physician clinical providers. However, for the purposes of this discussion, we have resorted to using it because we have not found a term that better encompasses this category of practitioners across the medical, behavioral, and dental fields.

Especially with the predicted scarcity of primary care physicians,¹⁷⁴ allowing mid-level providers to practice at the highest level allowed by their training or “at the top of their license” can help address these shortages. This approach also requires the training of mid-level providers in primary care, as currently only about one-third of physician assistants are working in primary care.¹⁷⁵ Mid-level providers can include advanced practice nurses, physician assistants, dental therapists or hygienists, and midwives. The following policy options should be considered for increasing the supply and integration of these providers. Each of these options could be directed at mid-level providers broadly, or targeted at specific types.

OPTION 6.3A Change state legislation and regulations regarding scope of practice, licensing, prescribing, and supervision to allow more mid-level providers to practice at their highest level. **(S)**

OPTION 6.3B Establish or increase payment rates for these providers in traditional fee-for-service payment models. **(F)(S)(P)**

OPTION 6.3C Require Medicaid managed care plans (in state contracting) and/or QHPs (in federal or state contracting, depending on the state) to include these providers in their networks. **(F)(S)**

OPTION 6.3D Build mid-level providers into the design of Medicaid waivers or other Medicaid value-based payment programs. **(F)(S)**

OPTION 6.3E Build mid-level providers into the design of broad CMMI value-based models. **(F)**

OPTION 6.3F Design a CMMI model to specifically test the best models for integrating more mid-level providers into care teams. **(F)**

OPTION 6.3G Increase the amount of loan repayment, loan forgiveness, and other financial incentives available for mid-level providers from under-represented groups and/or to providers who practice primary care in health professional shortage areas, such as through the National Health Service Corps and various state initiatives. **(F)(S)**

Overarching Imperative: Include Communities of Color in Delivery and Payment Transformation

One overarching priority cuts across all of the specific policy domains: facilitating and resourcing the meaningful inclusion of the voices and priorities of communities of color, and other disadvantaged groups, in policy development and decision-making writ large. This is a key ingredient to success, both in terms of following a process that empowers communities, and in terms of the quality of the outcomes.

Health system transformation efforts to date have largely overlooked reducing the impact of persistent racial and ethnic health disparities and advancing health equity. Even though the system is performing most poorly for these populations and their needs are more likely to go unmet, there is a risk that new payment models may actually cause them harm.^{176,177,178,179} In part, this can be explained by market forces. These communities often represent a small fraction of patients and, since they are more likely to be uninsured, underinsured, or covered by Medicaid

(which historically has provided reimbursement at lower rates than Medicare or commercial insurance),¹⁸⁰ they provide a smaller percentage of providers' revenue and margin. Moreover, as we have described already, they may be seen as challenges because of the complexity of their needs, particularly given their higher levels of social risk. Importantly, there is another reason for the lack of focus on the communities most in need of higher quality care that effectively meets their needs: they simply have not been included in the decision-making processes.¹⁸¹

Powerful, well-resourced, and well-connected interests—who have a limited understanding of the needs and challenges of communities of color, and minimal incentives to address them—have dominated these processes. Meanwhile, consumer perspectives are often missing from these spaces, and when they are included, they rarely represent communities of color and other disadvantaged groups. Therefore, it is no surprise that decisions about defining, measuring, and incentivizing value have not taken into account the needs, priorities, and resources of those communities. The expertise, vision, values, and voices of the most affected must be meaningfully integrated and centered in health transformation policy development, decision-making, implementation, and evaluation. Without the active participation of the most affected communities, we will lack mechanisms to prevent decisions that actually widen disparities, and to hold decision makers accountable. Moreover, this active inclusion must occur at all levels of decision-making power: national, state, local, and community levels.

Health system transformation efforts to date have largely overlooked reducing the impact of persistent racial and ethnic health disparities and advancing health equity.

Consumer and civil rights groups have worked to improve community and consumer engagement and authentic community representation in payment and delivery reform policy decision-making for a long time. In addition to Families USA,¹⁸² organizations like the National Partnership for Women and Families,^{183,184} Community Catalyst,^{185,186,187} and New America,¹⁸⁸ among others, have developed guides and best practices for inclusion in different aspects of health or social policy development that provide a useful foundation. Some organizations, like Families USA¹⁸⁹, the Health Care Value Hub,¹⁹⁰ and Community Catalyst,¹⁹¹ have also invested in building both “grasstops” and grassroots capacity to engage in delivery system reform generally. It is important to keep in mind that, in addition to the challenges community and consumer groups face generally, leaders from communities of color face additional, intersecting challenges arising from the experiences of interpersonal, institutional, and structural racism and marginalization that also must be addressed in order to ensure their authentic voice is a part of health care transformation efforts. Even at the level of national and state organizations that represent communities of color, we must account for how these dynamics shape access to the resources, relationships, and power needed to succeed in advancing effective policies.

Meaningful inclusion of leaders from communities of color in these decision-making processes will require a multifaceted approach that seriously grapples with structural imbalances in power, technical expertise, experience in the field, and dedicated resources. Ensuring that inclusion and equity are structurally “baked in” to policymaking processes is a critical prerequisite to ensuring that the policies themselves are inclusive and equitable.

Two-Sided Strategy for Meaningful Inclusion: Ceding Space and Resourcing Consistent Representation

While health care advocates and organizations representing communities of color have been deeply involved in efforts to expand health coverage and community health promotion, they have brought to light a variety of concerns and limitations with regard to their role in policy work related to health care transformation. These include:

- » Multi-issue organizations are grappling with many high-priority, urgent issues and attacks on multiple fronts (especially in the current political environment), and have limited bandwidth and resources to dedicate to health care payment policy.
- » There is limited grant or philanthropic funding dedicated specifically to supporting their organizations to work on policy development and advocacy around health equity-focused payment and delivery reform.
- » The complex, highly technical, and rapidly-evolving nature of this field makes it challenging to quickly build and maintain the technical expertise in the financial underpinnings of payment systems necessary to formulate and evaluate the effective policy solutions that they feel will do their constituents justice.
- » It is often difficult to ensure authentic, ongoing, meaningful inclusion and representation that is not reductionist or tokenized. There is limited interest in investing time and resources to be “included” in committees and tables where their role will be limited to raising concerns that the actual decision makers will “consider” but

not address, while their participation may help legitimize a process that does not serve the interests of their constituencies. This includes activities like focus groups, town halls, listening sessions, etc., which can be useful in spotlighting interests and priorities, but should not be confused with actual decision-making.

- » There is concern about the ability to continue engagement in the issue over time and avoid ending up with “orphan” projects in their organizations.

Addressing these concerns and barriers will require a double-pronged strategy, not unlike supply and demand. On the demand side, decision-making structures must be opened up to both create the opportunity for community leaders to participate, and require inclusion and representation. On the supply side, community leaders must be actively and concretely supported so they can consistently and robustly represent their constituencies. Sending out an invitation to a committee or network that leaders cannot meaningfully participate in is not sufficient, and neither is training leaders to elevate community priorities if there is nowhere to raise them effectively.

Meaningful inclusion of leaders from communities of color...will require a multifaceted approach that seriously grapples with structural imbalances in power, technical expertise, experience in the field, and dedicated resources.

1. Create Inclusive Decision-Making Structures and Practices

Creating space for representation at the decision-making table and in related processes, at the national, state, and local levels requires:

- » **Transparency:** The objectives, role of the representatives, and decision-making process must be clear from the beginning. Leaders need to know what is expected of them, what will be done with their input, and how it all fits into actual decision-making.
- » **Balance:** There must be balance between those who make their livelihood from the health care industry (providers, insurers, pharmaceutical companies, etc.) and those who represent people. Community and individual consumer representation cannot be limited to just one or two slots. Moreover, beyond the numbers, it is important that consumer and community leaders and the concerns they raise be valued equally with those of technical experts and industry representatives.
- » **Diversity:** A corollary to having multiple slots to represent consumers and communities is that the leaders must represent diverse communities authentically. A representative from one particular community of color cannot represent ALL communities of color, and key decision-making entities must resist the temptation to seek only “umbrella” organizations that allow them to “cover the bases” with just one representative.
- » **Intersectionality:** Another corollary to diversity is understanding and respecting that racial, ethnic, geographic, and other groups contain great diversity within themselves. There are

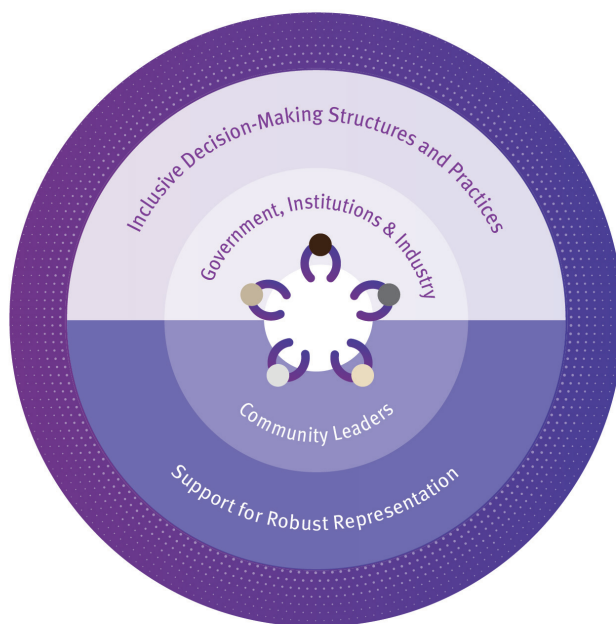
Hispanics of all “races.” Lesbian, gay, bisexual, transgender, and queer people are racially and ethnically diverse as well. “Rural America” is not monolithically white. Disabilities affect all groups. Additionally, it is important to recognize how these multiple identities can multiply the barriers some may face in terms of their health, and in terms of participating at the decision-making table.

» **Equal Decision-Making Authority:** Community leaders and individual consumers must have the same formal power and authority as other stakeholders. Separate consumer panels or advisory councils that report to the decision-

making body can be good structures for incubating ideas, but they are not sufficient in terms of representation. Segregating representation to a parallel process or side conversation can be a form of “ghettoization” of the communities’ concerns.

» **Early Inclusion:** Inclusion should happen as early as possible in the process so all parties can engage in determining priorities and the agenda on an equal basis. Bringing in community representatives after key decisions have been made only to provide “feedback” late in the process is inadequate and disrespectful.

TWO-SIDED STRATEGY FOR MEANINGFUL INCLUSION: CEDING SPACE AND RESOURCING CONSISTENT REPRESENTATION



Meaningful inclusion of community leaders in decision-making requires a dual strategy to shift the status quo of power dynamics. On one side, traditional decision makers must consistently make space for these leaders at the decision-making table and invite them in, and on the other, the leaders need resources and support to be able to sit at the table and effectively represent their constituents.

The knowledge, experience, expertise, and trust relationships that community leaders bring to the table are invaluable assets to any effort to transform health care to produce better and more equitable outcomes.

» **Attention to Power/Hierarchy Dynamics:**

Even when attempts are made to fully include community members and balance representation from various groups, there are still deeply-ingrained power dynamics at play that might inhibit full and authentic community engagement. Committees and boards should make a conscious and concrete effort to combat these dynamics. Factors such as the meeting location, overuse of jargon, or meeting structures that allow certain participants to dominate the conversation can serve to reinforce class, race, or gender power imbalances. These dynamics can make community members less likely to actively participate or speak honestly. They also affect the value that decision makers give to community members' contributions. Taking steps such as limiting the use of technical terms or acronyms, relaxing meeting dress codes, or rotating meeting locations can help balance the power dynamics. Meeting location is a particularly powerful tool, as community members shouldn't always be expected to travel outside their communities to be engaged in these efforts, and decision makers would benefit greatly from getting an on-the-ground view of what life is like for others.

» **Acknowledgment and Understanding of Health Care Systems' Historical, and in Some Cases, Ongoing, Abuses against Marginalized Populations:**

Examples of this issue include abuses against women, communities of color, people with disabilities, lesbian, gay, bisexual, and transgender people, and other groups. One specific power dynamic that merits particular attention is that many different communities have suffered greatly over decades at the hands of the medical system, and in some cases, continue to suffer discrimination and mistreatment. In engaging people from communities that have suffered this kind of historical, or continuous, trauma, this reality must be acknowledged, and time and effort must be invested in building trust.

» **Honor Tribal Consultation:** Because of the unique political status that Tribes have with the United States government, federal agencies "undertaking to formulate and implement policies" affecting Tribes should, to the extent possible, defer to Indian Tribes to establish standards. In determining whether to establish federal standards, they should consult with Tribal officials as to the need for federal standards

and any alternatives that would limit the scope of federal standards or otherwise preserve the prerogatives and authority of Indian Tribes.

- » **Recognition of Limitations:** Logistics and timelines matter. Processes need to be structured so there is ample time and opportunity for community representatives to engage, taking into account that doing so is not their full-time job, and that they likely do not have support staff, excess capacity, or time and money for travel. It is important that consumer and community representatives can meaningfully contribute, and that their input and particular expertise is recognized and carries equal weight, even though they may not focus on the issue 100 percent of the time. They need to be able to “come to the table,” and have their expertise be valued even when they are unable to “live at the table” and engage in these processes every day.

2. Provide Support for Robust Representation

While Tribes, community, and consumer leaders must ultimately determine the issue areas, priorities, and solutions that work best for their communities, they will need training and technical support to succeed. They cannot be expected to train themselves, considering their nascent experience in payment and delivery reform policy and limited resources. To support meaningful inclusion, they will need tools, training, and financial resources to enable their efforts, including:

- » **Commitment to Long-Term Financial Support:** Other stakeholders have significant financial resources to help them participate in payment and delivery reform. Community leaders not only need the money to support this work, but also need to know that those financial resources

will still be there down the road. It is unfair to encourage organizations to make an investment of their staff time and resources, develop important expertise and relationships, and then leave them without the resources to continue the work. Needed financial resources should account for staff time for the full range of activities they engage in to represent their communities at the highest level—not just time at meetings and traveling to them. This can include time spent training, meeting with community members, conducting research, reviewing materials, and drafting documents and talking points, among other activities. In addition to staff time, there are the direct costs of training, travel, meals, childcare, etc.

- » **Ongoing Training, Technical Assistance, and Support:** For most organizations and leaders from communities of color, the complexities of payment and delivery reform are a brand-new policy area. To support truly meaningful representation, they will need initial training on both the policy content and decision-making processes of payment reform, particularly during early onboarding. This needs to include not just the issues at stake and the policy options, but also information on who the players are, where the decision points are, the background of power dynamics in the group, and the political and financial context, among other key pieces of information. To support continued engagement, they need to have a reliable and trusted source of ongoing technical assistance and strategic guidance, and even coaching. In addition, leaders have identified that part of the support they need is the monitoring of opportunities for

leverage and engagement, and guidance in the form of talking points, clear policy options, model legislative or regulatory language, and the like.

- » **Platform for Collaboration:** Coordinating and mutually supporting the voices of communities of color is an important way to maximize their impact, and to counterbalance the interests of other stakeholders. Establishing a platform where leaders can exchange ideas, coordinate agendas, divide tasks and delegate, answer questions, and

provide moral support will encourage robust representation and continued engagement.

The knowledge, experience, expertise, and trust relationships that community leaders bring to the table are invaluable assets to any effort to transform health care to produce better and more equitable outcomes. Creating the conditions for them to be part of the decision-making process will require investment in time and resources, and also a willingness to share power.

CONCLUSION

Health Equity-Focused Health System Transformation Cannot Wait

As a nation, we need a transformed health care system that is efficient, affordable, and provides high-quality care for everyone, regardless of their background, their income, or where they live. To achieve this, health system transformation cannot just be about cutting costs or improving overall quality. Achieving a transformed and equitable health care system requires concrete strategies designed to reduce health and health care inequities. We hope this paper catalyzes a much needed national policy dialogue about resolving health disparities, but more importantly, that it propels leaders across the country to work together to achieve a health care system that works well for everyone.

Endnotes

¹ Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah, and Michelle M. Doty, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care* (New York, NY: The Commonwealth Fund, July 2017), available online at <http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/>.

² Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Washington, DC: The National Academies Press, 2013), available online at <https://www.nap.edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning>.

³ Kenan Fikri and John Lettieri, *The 2017 Distressed Communities Index* (Washington, DC: Economic Innovation Group, 2017), available online at <http://eig.org/wp-content/uploads/2017/09/2017-Distressed-Communities-Index.pdf>.

⁴ Melinda Buntin and John Ayanian, “Social Risk Factors and Equity in Medicare Payment,” *New England Journal of Medicine* 376 (February 2017): 507-510, available online at <http://www.nejm.org/doi/full/10.1056/NEJMp1700081#t=article>.

⁵ Andrew M. Ryan, “Will Value-Based Purchasing Increase Disparities in Care?” *New England Journal of Medicine* 369, (December 2013): 2472-2474, available online at <http://www.nejm.org/doi/ref/10.1056/NEJMp1312654#t=article>.

⁶ Karen Joynt Maddox, “Financial Incentives and Vulnerable Populations—Will Alternative Payment Models Help or Hurt?” *New England Journal of Medicine* 378 (March 15, 2018): 977-979, available online at <http://www.nejm.org/doi/full/10.1056/NEJMp1715455>.

⁷ Office of the Assistant Secretary for Planning and Evaluation, “Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs” (Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, December, 2016): p. 10, available online at <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.

⁸ Joynt Maddox, *op cit*.

⁹ Office of the Assistant Secretary for Planning and Evaluation, *op cit*.

¹⁰ National Quality Forum, *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I’s for Health Equity* (Washington, DC: National Quality Forum, September 14, 2017), available online at http://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx.

¹¹ Office of the Assistant Secretary for Planning and Evaluation, *op cit*.

¹² Karen E. Joynt, M.D., M.P.H., Nancy De Lew, M.A., Steven H. Sheingold, Ph.D., Patrick H. Conway, M.D., Kate Goodrich, M.D., and Arnold M. Epstein, M.D., “Should Medicare Value-Based Purchasing Take Social Risk into Account?,” *New England Journal of Medicine* 376 (February 9, 2017): 510-514, available online at <http://www.nejm.org/doi/full/10.1056/NEJMp1616278>.

¹³ Joseph Dielman et al., “Evolution and Patterns of Global Health Financing 1995–2014: Development Assistance for Health, and Government, Prepaid Private, and Out-of-pocket Health Spending in 184 Countries,” *Lancet* no. 389 (April 2017): 1981-2004, available online at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30874-7/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30874-7/abstract).

¹⁴ Institute of Medicine, *op cit*.

¹⁵ Fikri and Lettieri, *op cit*.

¹⁶ Buntin and Ayanian, *op cit*.

¹⁷ Ibid.

¹⁸ Ryan, *op cit*.

¹⁹ Rachel DeMeester, Lucy Xu, Robert Nocon, Scott Cook, Andrea Ducas, and Marshall Chin, “Solving Disparities through Payment and Delivery System Reform: A Program to Achieve Health Equity,” *Health Affairs* 36, no. 6 (June 2017): 1133-1139, available online at <http://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0979>.

²⁰ John Walton Senterfitt, Anna Long, Margaret Shih, and Steven Teutsch, *Social Determinants of Health: How Social and Economic Factors Affect Health* (Los Angeles, Los Angeles County Department of Public Health, January 2013), available online at http://publichealth.lacounty.gov/epi/docs/SocialD_Final_Web.pdf.

²¹ National Center for Health Statistics, *Health, United States, 2016* (Hyattsville, MD: U.S. Department of Health and Human Services, May 2017), available online at <https://www.cdc.gov/nchs/data/abus/abus16.pdf>.

²² Health Care Payment Learning & Action Network (HCPLAN), *Alternative Payment Model (APM) Framework: Final White Paper* (Washington, DC: HCPLAN, 2016), available online at <http://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

²³ See Harold Miller, *Why Value-Based Payment Isn’t Working and How to Fix It* (Pittsburgh, PA: Center for Health Care Quality and Payment Reform, October 2017), available online at <http://www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf>, and Harold Miller and Sandra Marks, *A Guide to Physician-Focused Alternative Payment Models* (Pittsburgh, PA: American Medical Association

and the Center for Health Care Quality and Payment Reform), available online at <http://www.chqpr.org/downloads/Physician-FocusedAlternativePaymentModels.pdf>.

²⁴ CAPG, *CAPG's Guide to Alternative Payment Models* (Los Angeles, CA: CAPG, 2017), available online at <http://capg.org/Modules/ShowDocument.aspx?documentid=3832>.

²⁵ Joynt Maddox, *op cit*.

²⁶ Tanjala Purnell, Elizabeth Calhoun, et al., "Achieving Health Equity: Closing The Gaps In Health Care Disparities, Interventions, And Research," *Health Affairs* 35 no. 8 (August 2016), available online at www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0158.

²⁷ Health Resources and Services Administration, *Hill-Burton Free and Reduced-Cost Health Care* web page (Washington, DC: Health Resources and Services Administration, March 2018), available online at <https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html>.

²⁸ Agency for Healthcare Research and Quality (AHRQ), *Patient Safety Primer: Never Events* web page (Rockville, MD: AHRQ, June, 2017), available online at <https://psnet.ahrq.gov/primers/primer/3/never-events>.

²⁹ American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice, and Society for Maternal–Fetal Medicine, *Nonmedically Indicated Early-Term Deliveries: Committee Opinion No. 561* (Washington, DC: ACOG, April 2013), available online at <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Nonmedically-Indicated-Early-Term-Deliveries>.

³⁰ Joynt, et al., *op cit*.

³¹ National Quality Forum (NQF), *op cit*.

³² Steven Woolf, "Progress In Achieving Health Equity Requires Attention To Root Causes," *Health Affairs* 36, no.6 (June 2017): 984-991, available online at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0197>.

³³ Samantha Artiga and Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* (Washington, DC: Kaiser Family Foundation, May 10, 2018), available online at <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

³⁴ David Williams and Selina Mohammed, "Racism and Health I: Pathways and Scientific Evidence," *American Behavioral Scientist* 57(8) (May 8, 2013): 1152–1173, available online at <http://journals.sagepub.com/doi/pdf/10.1177/0002764213487340>.

³⁵ Zinzi Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, and Mary Bassett, "Structural racism and health inequities in the USA: evidence and interventions," *Lancet* 389 (April 8, 2017): 1453–63, available online at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30569-X/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30569-X/abstract).

³⁶ Centers for Disease Control and Prevention (CDC), *Adverse Childhood Experiences* (Atlanta, GA: CDC, April 1, 2016), available online at <https://www.cdc.gov/violenceprevention/acesstudy/index.html>.

³⁷ Joynt Maddox, *op cit*.

³⁸ American Hospital Association (AHA), *Hospitals are Economic Anchors in Their Communities*, (Washington, DC: AHA, January 2017), available online at <https://www.aha.org/system/files/2018-03/17econcontribution.pdf>.

³⁹ Office of the Assistant Secretary for Planning and Evaluation, *op cit*.

⁴⁰ Joynt Maddox, *op cit*.

⁴¹ Office of the Assistant Secretary for Planning and Evaluation, *op cit*.

⁴² National Quality Forum, *op cit*.

⁴³ Office of the Assistant Secretary for Planning and Evaluation, *op cit*.

⁴⁴ Joynt, et al., *op cit*.

⁴⁵ Covered California, *Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy* (Covered California, 2018), available online at <http://hbex.coveredca.com/insurance-companies/PDFs/Att-7-QHP-Update-for-2018.pdf>.

⁴⁶ Connecticut State Innovation Model (CSIM) Equity and Access Council, *Draft Report on Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements* (Hartford, CT: CSIM, June 2015), available online at http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-07-16/eac_phase_i_draft_report_062015.pdf.

⁴⁷ Connecticut State Innovation Model (CSIM), *SIM at a Glance* (Hartford, CT: CSIM), available online at http://www.healthreform.ct.gov/ohri/lib/ohri/general_documents/sim_ataglance_20161018.pdf.

⁴⁸ Institute for Clinical and Economic Review (ICER), *Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England* draft report (Boston, MA: ICER, May 2013), available online at <http://icer-review.org/wp-content/uploads/2011/04/CHW-Draft-Report-05-24-13-MASTER1.pdf>.

⁴⁹ Ignatius Bau, *Oregon Health Authority Transformation Center: Opportunities for Oregon's Coordinated Care Organizations to Advance Health Equity* (ignatiusbau.com: August 2017), available online at <http://www.oregon.gov/oha/HPA/CSI-TC/Documents/CCO-Opportunities-to-Advance-Health-Equity.pdf>.

⁵⁰ Joynt Maddox, *op cit*.

⁵¹ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010) available online at <https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap157-subchapl-sec18001.pdf>.

⁵² Centers for Medicare and Medicaid Services (CMS), *Hospital Readmissions Reduction Program (HRRP): Fiscal Year (FY) 2015 Fact Sheet* (Washington, DC: CMS, July 2014), available online at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/HRRP-2015-Fact-Sheet.pdf>.

⁵³ José Figueroa, Jie Zheng, E. John Orav, Arnold Epstein, and Ashish Jha, "Medicare Program Associated with Narrowing Hospital Readmission Disparities Between Black And White Patients," *Health Affairs* 37, no. 4. (April 2018), available online at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1034>.

⁵⁴ Colleen McIlvennan, Zubin Eapen, and Larry Allen, "Hospital Readmissions Reduction Program," *Circulation* 131, no. 20 (May 2015): 1796-1803, available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4439931/>.

⁵⁵ Centers for Medicare and Medicaid Services (CMS) Medicare Learning Network, *Hospital Value-Based Purchasing* (Baltimore, MD: CMS, September 2017), available online at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf.

⁵⁶ U.S. Government Accountability Office (GAO), *Hospital Value-Based Purchasing: CMS Should Take Steps to Ensure Lower Quality Hospitals Do Not Qualify for Bonuses* (Washington, DC: GAO, June 2017), available online at <https://www.gao.gov/assets/690/685586.pdf>.

⁵⁷ Len Nichols, Alison Cuellar, Lorens Helmchen, Gilbert Gimm, and Jay Want, "What Should We Conclude From 'Mixed' Results In Payment Reform Evaluations?," *Health Affairs* blog (August 14, 2017), available online at <http://healthaffairs.org/blog/2017/08/14/what-should-we-conclude-from-mixed-results-in-payment-reform-evaluations/>.

⁵⁸ Ulrika Winblad, Vincent Mor, John McHugh, and Momotazur Rahman, "ACO-Affiliated Hospitals Reduced Rehospitalizations from

Skilled Nursing Facilities Faster Than Other Hospitals," *Health Affairs* 36, no. 1 (January 2017): 67-73, available online at <http://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0759>.

⁵⁹ Centers for Medicare and Medicaid Services (CMS), *Medicare Accountable Care Organizations 2015 Performance Year Quality and Financial Results* (Baltimore, MD: CMS, August 2016), available online at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html>.

⁶⁰ J. Michael McWilliams, Michael Chermew, and Bruce Landon, "Medicare ACO Program Savings Not Tied To Preventable Hospitalizations Or Concentrated Among High-Risk Patients," *Health Affairs* 36, no. 12 (December 2017) available online at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0814>.

⁶¹ Ryan Anderson, John Ayanian, Alan Zaslavsky, and Michael McWilliams, "Quality of Care and Racial Disparities in Medicare Among Potential ACOs," *Journal of General Internal Medicine* 29, no. 9 (May 31, 2014): 1296-1304, available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4139518/>.

⁶² Valerie Lewis, Taressa Frazee, Elliott Fisher, Stephen Shortell, and Carrie Colla, "ACOs Serving High Proportions Of Racial And Ethnic Minorities Lag In Quality Performance," *Health Affairs* 36, no.1 (January 2017): 57-66, available online at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0626>.

⁶³ National Indian Health Board (NIHB), *National Tribal Budget Formulation Workgroup's Recommendation on the Indian Health Service Fiscal Year 2017 Budget*, p. 8 (Washington, DC: NIHB, May 2015), available online at <https://www.nihb.org/docs/06242015/Final%20FY%202017%20IHS%20budget%20full%20report.pdf>.

⁶⁴ David Squires and Chloe Anderson, *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries* (Washington, DC: The Commonwealth Fund, October 8, 2015), available online at <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>.

⁶⁵ Melissa Hansen, *Payment Reform: Health Care Safety-Net Toolkit for Legislators* (Denver, CO: National Conference of State Legislatures, 2013), available online at <http://www.ncsl.org/documents/health/PaymentRTK13.pdf>.

⁶⁶ Rushika Fernandopulle, "Breaking the Fee-For-Service Addiction: Let's Move to a Comprehensive Primary Care Payment Model," *Health Affairs* blog (August 17, 2015), available online at <http://www.healthaffairs.org/doi/10.1377/hblog20150817.049985/full/>.

⁶⁷ Bipartisan Policy Center (BPC), *What is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth*

(Washington, DC: BPC, September 2012), available online at https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401339.

⁶⁸ Medicare Payment Advisory Commission (MPAC), *Report to the Congress* (Washington, DC: MPAC, March 15, 2017), available online at http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.

⁶⁹ Jodi Summers Holtrop, Zhehui Luo, and Lynn Alexanders, "Inadequate Reimbursement for Care Management to Primary Care Offices," *Journal of the American Board of Family Medicine* 28, no. 2 (March-April 2015): 271-279, available online at <http://www.jabfm.org/content/28/2/271.full>.

⁷⁰ Ellen Albritton, *How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities* (Washington, DC: Families USA, July 2016), available online at http://familiesusa.org/sites/default/files/product_documents/HE_HST_Community_Health_Workers_Brief_v4.pdf.

⁷¹ Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Quality and Disparities Report: Chartbook on Access to Health Care* (Rockville, MD: AHRQ, May 2016), available online at <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd/2015-chartbook-access.pdf>.

⁷² Families USA, "Racial and Ethnic Health Disparities among Communities of Color Compared to Non-Hispanic Whites" infographic (Washington, DC: Families USA, August 2014), available online at <http://familiesusa.org/health-disparities>.

⁷³ Leyu Shi, Chien-Chou Chen, Xiaoyu Nie, Jinsheng Zhu, and Ruwei Hu, "Racial and Socioeconomic Disparities in Access to Primary Care Among People with Chronic Conditions," *Journal of the American Board of Family Medicine* 27, no. 2 (March-April 2014): 189-198, available online at <http://www.jabfm.org/content/27/2/189.long#ref-19>.

⁷⁴ Megan Multack, "Use of Clinical Preventative Services and Prevalence of Health Risk Factors among Adults Aged 50-64," (Washington, DC: AARP, August 2013), available online at <https://www.aarp.org/health/health-insurance/info-08-2013/use-of-clinical-preventive-services-and-prevalence-AARP-ppi-health.html>.

⁷⁵ Matthew O'Brien, Chanita Hughes Halbert, Rebecca Bixby, Susana Pimentel, and Judy Shea, "Community Health Worker Intervention to Decrease Cervical Cancer Disparities in Hispanic Women," *Journal of General Internal Medicine* 25, no. 11 (November 2010): 1186-1192, available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2947642/>.

⁷⁶ X. Cheng, M. Lee, and R. Salloum, "Racial and Ethnic Differences in the Use of Preventive Services among Cancer Survivors in the Medicare Program," *The Journal of the International Society for Pharmacoeconomics and Outcomes Research* 19, no. 3 (May 2016): A25-A26, available online at [http://www.valueinhealthjournal.com/article/S1098-3015\(16\)00395-8/fulltext](http://www.valueinhealthjournal.com/article/S1098-3015(16)00395-8/fulltext).

⁷⁷ Amanda Gelman, Elizabeth Miller, Eleanor Bimla Schwarz, Aletha Akers, Kwonho Jeong, and Sonya Borrero, "Racial Disparities in Human Papillomavirus Vaccination: Does Access Matter?," *Journal of Adolescent Health* 53, no. 6 (December 2013): 756-762, available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4058822/>.

⁷⁸ National Academies of Sciences, Engineering, and Medicine, *Systems Practices for the Care of Socially At-Risk Populations* (Washington, DC: The National Academies Press, 2016), available online at <https://www.nap.edu/catalog/21914/systems-practices-for-the-care-of-socially-at-risk-populations>.

⁷⁹ Centers for Medicare and Medicaid Services (CMS), "All Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)" (Baltimore, MD: CMS, January 2017), available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>.

⁸⁰ David Muhlestein, Robert Saunders, and Mark McClellan, "Growth Of ACOs And Alternative Payment Models In 2017", *Health Affairs* blog (June 2017), <http://www.healthaffairs.org/doi/10.1377/hblog20170628.060719/full/>.

⁸¹ Zirui Song, Sherri Rose, Michael Chernew, and Dana Gelb Safran, "Lower- Versus Higher-Income Populations In The Alternative Quality Contract: Improved Quality And Similar Spending," *Health Affairs* 36, no. 1 (January 1, 2017): 74-82, available online at <https://www.ncbi.nlm.nih.gov/pubmed/28069849>.

⁸² For example, see Centers for Medicare and Medicaid Services (CMS) Office of the Inspector General, "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality: 2017, available online at <https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf>; see also Robert Saunders, David Muhlestein, and Mark McClellan, "Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time," *Health Affairs* blog, November 21, 2017, available online at <https://www.healthaffairs.org/doi/10.1377/hblog20171120.211043/full/>.

⁸³ Valerie Lewis, et al., *op. cit.*

⁸⁴ Michael Bailit and Beth Waldman, *Safety-Net Provider ACOs: Considerations for State Medicaid Purchasers* (Princeton, NJ: Robert

Wood Johnson Foundation, January 2016), available online at <https://www.statenetwork.org/wp-content/uploads/2016/01/SHVS-Bailit-Safety-Net-Provider-ACOs-Considerations-for-State-Medicaid-Purchasers-January-2016.pdf>.

⁸⁵ Ibid; also National Quality Forum, *op cit*.

⁸⁶ Purnell, et al., *op cit*.

⁸⁷ Dave Chokshi, Ji Chang, and Ross Wilson, “Health Reform and the Changing Safety Net in the United States,” *The New England Journal of Medicine Catalyst* (October 18, 2017), available online at <https://catalyst.nejm.org/health-reform-changing-safety-net/>.

⁸⁸ The Center for Health Strategies Inc., “Medicaid Accountable Care Organizations: State Update” (Hamilton, NJ: The Center for Health Strategies Inc., June 2017), available online at <https://www.chcs.org/media/ACO-Fact-Sheet-06-13-17.pdf>.

⁸⁹ Martha Hostetter, Sarah Klein, and Douglas McCarthy, *Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries* web page (Washington, DC: The Commonwealth Fund, October 7, 2016), available online at <http://www.commonwealthfund.org/publications/case-studies/2016/oct/hennepin-health>.

⁹⁰ Hennepin Health, Presentation at National Health Policy Forum (Minneapolis, MN: Hennepin Health, January 30, 2015), available online at https://www.nhpf.org/uploads/Handouts/Owen-slides_01-30-15.pdf.

⁹¹ Hennepin Health, “Quality Management Program” web page, (Minneapolis, MN: Hennepin Health), available online at <https://www.hennepinhealth.org/quality>.

⁹² Nelson Sabatini, Joseph Antos, Howard Haft, and Donna Kinzer, “Maryland’s All-Payer Model—Achievements, Challenges, and Next Steps,” *Health Affairs* blog (January 31, 2017), available online at <https://www.healthaffairs.org/doi/10.1377/hblog20170131.058550/full/>.

⁹³ Ibid.

⁹⁴ Marie Mongeon, Jeffrey Levi, and Janet Heinrich, “Elements of accountable communities for health: A review of the literature,” *NAM Perspectives* web page (Washington, DC, National Academy of Medicine, 2017), available online at <https://nam.edu/elements-of-accountable-communities-for-health-a-review-of-the-literature>.

⁹⁵ California Accountable Communities for Health Initiative (CACHI), *Modernizing Our Health System* web page (CACHI), available online at www.cachi.org.

⁹⁶ Chisara Asomugha, Susan Jackson, and Louise Amburgey, “Accountable Health Communities: Model Overview and

Requirements” presentation (Baltimore, MD: Centers for Medicare and Medicaid Services), available online at <https://innovation.cms.gov/Files/slides/ahcm-appreqslides.pdf>.

⁹⁷ Laura Gottlieb, et al., “Evaluating the Accountable Health Communities Demonstration Project,” *Journal of General Internal Medicine* 32(3): 345-9, available online at <http://link.springer.com/content/pdf/10.1007%2Fs11606-016-3920-y.pdf>.

⁹⁸ U.S. Department of Health and Human Services (HHS) Advisory Committee on Minority Health, *Sustaining and Advancing the Healthcare Safety Net: Ensuring that the Healthcare Safety Net is Not Left Behind Recommendation Report* (Rockville, MD: HHS, September 2013), available online at https://minorityhealth.hhs.gov/Assets/pdf/ACMH_Healthcare_Safety_Net_Report_Sep_2013_final_508.pdf.

⁹⁹ Henry Ford Health System (HFHS), *Health Disparities Research Collaborative* web page (Detroit, MI: HFHS), available online at <https://www.henryford.com/hcp/research/hdrc>.

¹⁰⁰ Flora Arabo, Sandra Wilkniss, Sally Malone, and Frederick Isasi, *Housing as Health Care: A Road Map for States* (Washington, DC: National Governors Association Center for Best Practices, September 2016), available online at <https://www.nga.org/files/live/sites/NGA/files/pdf/2016/1609HousingRoadmap.pdf>.

¹⁰¹ Justin Timbie, Peter Hussey, Claude Messan Setodji, Amii Kress, Rosalie Malsberger, et al., “Association Between Patient-Centered Medical Home Capabilities and Outcomes for Medicare Beneficiaries Seeking Care from Federally Qualified Health Centers,” *Journal of General Internal Medicine* (May 2017), available online at https://www.rand.org/pubs/external_publications/EP67197.html.

¹⁰² Comments on Proposed Rule on Medicare Program; CY 2018 Updates to Quality Payment Program, National Council Of Asian Pacific Islander Physicians (August 21, 2017), available online at <https://www.regulations.gov/document?D=CMS-2017-0082-0863>.

¹⁰³ Missouri Department of Social and Health Services (MDSHS), et al., *Missouri CMHC Healthcare Homes Progress Report 2012-2015* (Jefferson City, MO: MDSHS, 2016), available online at <https://dmh.mo.gov/mentalillness/docs/cmhchch2016report.pdf>.

¹⁰⁴ Albritton, *How States Can Fund Community Health Workers*, *op cit*.

¹⁰⁵ Thomas Bodenheimer, *Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs*, Center for Health Care Strategies (October 2013), available online at http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_e211389.pdf?refer=provider.

¹⁰⁶ Bailit and Waldman, *op cit*.

- ¹⁰⁷ Craig Pollack and Karen Katrina, “Accountable Care Organizations and Health Care Disparities,” *Journal of the American Medical Association* 305, no. 16 (April 27, 2011): 1706–1707, available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696383/>.
- ¹⁰⁸ Centers for Medicare and Medicaid Services (CMS) Quality Payment Program, *Support for Small, Underserved, and Rural Practices* web page (Baltimore, MD: CMS), available online at <https://qpp.cms.gov/about/small-underserved-rural-practices>.
- ¹⁰⁹ MaryBeth Musumeci, Robin Rudowitz, Elizabeth Hinton, Larisa Antonisse, and Cornelia Hall, *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers* (Washington, DC: The Henry J. Kaiser Family Foundation, March 2018), available online at <https://www.kff.org/medicaid/issue-brief/section-1115-medicare-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/>.
- ¹¹⁰ Julia Baller, Mariel Finucane, Marian Wrobel, Carol Irvin, and Natalya Verbitsky Savitz, *Delivery System Reform Incentive Payments* (Mathematica Policy Research, June 2017), available online at <https://www.medicare.gov/medicaid/section-1115-demo/downloads/evaluation-reports/eval-dsgn-dlvry-incntv-pymnts.pdf>.
- ¹¹¹ See Washington State Health Care Authority (WSHCA), *Accountable Communities of Health (ACH)* web page (Olympia, WA: WSHCA), available online at <https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach>.
- ¹¹² Center for Health Care Strategies (CHCS), *Delivery System Reform Incentive Payment (DSRIP): State Program Tracking* (Hamilton, NJ: CHCS, December 2016), available online at <http://www.chcs.org/media/DSRIP-State-Program-Tracking-120516-FINAL.pdf>.
- ¹¹³ For more detail on this point, see: Melanie Schoenberg, Felicia Heider, Jill Rosenthal, Claudine Schwartz, and Neva Kaye, “State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools” report (Portland, ME: National Academy for State Health Policy, March 2015), available online at <https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf>.
- ¹¹⁴ Ibid.
- ¹¹⁵ CMS Quality Payment Program, *op cit*.
- ¹¹⁶ Comments on Proposed Rule on Medicare Program; CY 2018, *op cit*.
- ¹¹⁷ Health Research and Educational Trust (HRET), *Creating Effective Hospital-Community Partnerships to Build a Culture of Health*. (Chicago, IL: HRET, August 2016), available online at <http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf>.
- ¹¹⁸ Ibid.
- ¹¹⁹ Tomi Ogundimu and Darby Sullivan, “3 ways CMS is incentivizing community partnerships,” *Advisory Board Care Transformations* blog (May 30, 2017), available online at <https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2017/05/community-partnerships>.
- ¹²⁰ Jessica Curtis, *Transforming Hospital Community Benefit: Increasing Community Engagement and Health Equity Investment in Connecticut* (Boston, MA: Community Catalyst, October 2017), available online at https://www.communitycatalyst.org/resources/publications/document/Community-Benefit-in-CT_Final.pdf.
- ¹²¹ Ibid.
- ¹²² U.S. Department of Health and Human Services (HHS) The Office of the National Coordinator of Health Information Technology, *Beacon Community Program* web page (Washington, DC: HHS, 2017), available online at <https://www.healthit.gov/topic/onc-programs/beacon-community-program>.
- ¹²³ U.S. Department of Health and Human Services (HHS) Office of the National Coordinator of Health Information Technology, *Community Interoperability and Health Information Exchange Cooperative Agreement Program* (Washington, DC: HHS, 2017), available online at <https://www.healthit.gov/topic/grants-contracts/community-interoperability-and-health-information-exchange-cooperative>.
- ¹²⁴ James Williams, “Eliminating Disparities in Clinical Trials (EDICT) Project” presentation, available online at https://deainfo.nci.nih.gov/advisory/ctac/archive/0309/presentations/Williams_030409.pdf.
- ¹²⁵ Moon Chen, Primo Lara, Julie Dang, Debora Paterniti, and Karen Kelly, “Twenty Years Post-NIH Revitalization Act: Enhancing Minority Participation in Clinical Trials (EMPaCT): Laying the Groundwork for Improving Minority Clinical Trial Accrual: Renewing the Case for Enhancing Minority Participation in Cancer Clinical Trials,” *Cancer* 120, no. 7 (April 1, 2014): 1091–1096, available online at <http://onlinelibrary.wiley.com/doi/10.1002/cncr.28575/abstract;jsessionid=993A3978E6F886FBD951AD3048E68DC8.f01?systemMessage=Wiley+Online+Library+usage+report+download+page+will+be+unavailable+on+Friday+24th+November+2017+at+21%3A00+EST+%2F+02.00+GMT+%2F+10%3A00+SGT+%28Saturday+25th+Nov+for+SGT+>.
- ¹²⁶ Esteban Burchard, Sam Oh, Marilyn Foreman, and Juan Celedón, “Moving toward True Inclusion of Racial/Ethnic Minorities in Federally Funded Studies. A Key Step for Achieving Respiratory Health Equality in the United States,” *American Journal of Respiratory and Critical Care Medicine* 191, no. 5 (March 1, 2015): 514–521, available online at <http://www.atsjournals.org/doi/abs/10.1164/rccm.201410->

1944PP?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&

¹²⁷ Mariam Naqvi, Shannon Thyne, Shweta Choudhry, Hui-ju Tsai, Daniel Navarro, et al., “Ethnic-Specific Differences in Bronchodilator Responsiveness Among African Americans, Puerto Ricans, and Mexicans with Asthma,” *Journal of Asthma* 44, no. 8 (July 2, 2009): 639-648, available online at <http://www.tandfonline.com/doi/abs/10.1080/02770900701554441?journalCode=ijas20>.

¹²⁸ U.S. Department of Health and Human Services (HHS) Office of Minority Health, “Asthma and Hispanic Americans” web page, (Washington, DC: HHS, March 13, 2017), available online at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=60>.

¹²⁹ National Institutes of Health (NIH), “NIH Funds Precision Medicine Research with Focus on Health Disparities” news release, (Bethesda, MS: NIH, July 28, 2016), available online at <https://www.nih.gov/news-events/news-releases/nih-funds-precision-medicine-research-focus-health-disparities>.

¹³⁰ Ibid.

¹³¹ Patient-Centered Outcomes Research Institute (PCORI), *About Us* web page (Washington, DC: PCORI), available online at <https://www.pcori.org/about-us>.

¹³² Patient-Centered Outcomes Research Institute (PCORI), *Explore Our Portfolio* web page (Washington, DC: PCORI), available online at https://www.pcori.org/research-results?f%5B0%5D=field_project_type%3A298&f%5B1%5D=field_award_research_priority%3A162&f%255B0%255D=field_project_type%3A298#search-results.

¹³³ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: The National Academies Press: 2001), available online at <http://www.nationalacademies.org/hmd/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx>.

¹³⁴ Caitlin Morris and Kim Bailey, *Measuring Health Care Quality: An Introduction* (Washington, DC: Families USA, 2014), available online at http://familiesusa.org/sites/default/files/product_documents/HSI%20Quality%20Measurement%20Intro_factsheet_final_web.pdf.

¹³⁵ Ibid.

¹³⁶ National Quality Forum, *op cit*.

¹³⁷ Ellen Albritton, “Paying for Value: First Glance at the New MACRA Rule,” Families USA blog (Washington, DC: Families USA, May 3, 2016), available online at <http://familiesusa.org/blog/2016/05/paying-value-first-glance-new-macra-rule>.

¹³⁸ National Association of Medicaid Directors (NAMd), *The Role of State Medicaid Programs in Improving the Value of the Health Care System* web page (Washington, DC: NAMd, March 22, 2016), available online at http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf.

¹³⁹ National Quality Forum, *op cit*.

¹⁴⁰ Marshall Chin, “Creating the Business Case for Achieving Health Equity,” *Journal of General Internal Medicine* 31, no. 7 (July 2016): 792-796, available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4907942/>.

¹⁴¹ Judy Ng, Faye Ye, Lauren Ward, Samuel Haffer, and Sarah Hudson Scholle, “Data on Race, Ethnicity, and Language Largely Incomplete for Managed Care Plan Members,” *Health Affairs* 36, no. 3 (March 2017), available online at <https://doi.org/10.1377/hlthaff.2016.1044>.

¹⁴² National Quality Forum, *op cit*.

¹⁴³ National Academies of Sciences, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment* (Washington, DC: The National Academies Press, January 10, 2017), available online at <http://nationalacademies.org/hmd/reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx>.

¹⁴⁴ National Quality Forum, *op cit*.

¹⁴⁵ Ibid.

¹⁴⁶ Examples of these initiatives include: the Core Quality Measure Collaborative (CMS, NQF, AHIP), available online at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>; Vital Signs (National Academies of Sciences, Engineering, and Medicine), available online at <http://nationalacademies.org/HMD/reports/2015/vital-signs-core-metrics.aspx>; and the Measures Application Partnership (NQF, CMS), available online at http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx.

¹⁴⁷ National Quality Forum, *op cit*.

¹⁴⁸ U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020* web page (Rockville, MD: HHS, 2013), available online at <https://bhw.hrsa.gov/health-workforce-analysis/primary-care-2020>.

¹⁴⁹ Ibid.

¹⁵⁰ Sandra Colby and Jennifer Ortman, *Projections of the Size and Composition of the U.S. Population: 2014-2060* (Washington, DC: U.S. Census Bureau, March 2015), available online at <https://census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf>.

- ¹⁵¹ Association of American Medical Colleges (AAMC), “Table 10. Distribution of U.S. Medical School Faculty by Sex and Race/Ethnicity,” U.S. Medical School Faculty, 2017 (Washington, DC: AAMC, December 31, 2017), available online at <https://www.aamc.org/download/486096/data/17table10.pdf>.
- ¹⁵² Data USA, “Physical Therapists: Race and Ethnicity” web page (Data USA, 2015), available online at <https://datausa.io/profile/soc/291123/#demographics>.
- ¹⁵³ U.S. Department of Health Human Services (HHS) National Center for Health Workforce Analysis, *The U.S. Health Workforce Chartbook* (Rockville, MD: HHS, 2013), available online at <https://bhwh.hrsa.gov/sites/default/files/bhw/nchwa/chartbookpart1.pdf>.
- ¹⁵⁴ U.S. Department of Labor (DOL) Bureau of Labor Statistics, *Labor Force Statistics from the Current Population Survey: Employed Persons by Detailed Occupation, Sex, Race, and Hispanic or Latino Ethnicity* web page (Washington, DC: DOL, January 19, 2018), available online at <https://www.bls.gov/cps/cpsaat11.htm>.
- ¹⁵⁵ U.S. Department of Health and Human Services (HHS) Office of Minority Health, *HHS Plan for Asian American, Native Hawaiian, and Pacific Islander (AANHPI) Health* web page (Rockville, MD: HHS, 2016), available online at <https://minorityhealth.hhs.gov/omh/content.aspx?ID=8805&vl=3&vlid=63>.
- ¹⁵⁶ Health Professionals for Diversity Coalition (HPDC), *Fact Sheet: The Need for Diversity in the Health Care Workforce* (HPDC), available online at <http://www.aapcho.org/wp/wp-content/uploads/2012/11/NeedForDiversityHealthCareWorkforce.pdf>.
- ¹⁵⁷ Julia Fantacone, “Looking to the Future: Improving the Diversity of the Health Care Workforce,” *Altarum* (May 6, 2014), available online at <https://altarum.org/health-policy-blog/looking-to-the-future-improving-the-diversity-of-the-health-care-workforce>.
- ¹⁵⁸ Harvard Opinion Research Program, *Discrimination in America: Experiences and Views of African Americans* (Boston, MA: Harvard T.H. Chan School of Public Health, October 2017), available online at <https://www.npr.org/assets/img/2017/10/23/discriminationpoll-african-americans.pdf>.
- ¹⁵⁹ Harvard Opinion Research Program, *Discrimination in America: Experiences and Views of Latinos* (Boston, MA: Harvard T.H. Chan School of Public Health, October 2017), available online at <https://www.npr.org/documents/2017/oct/discrimination-latinos-final.pdf>.
- ¹⁶⁰ Harvard Opinion Research Program, *Discrimination in America: Experiences and Views of Native Americans* (Boston, MA: Harvard T.H. Chan School of Public Health, October 2017), available online at https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf441678.
- ¹⁶¹ Health Professionals for Diversity Coalition, *op cit*.
- ¹⁶² *Ibid*.
- ¹⁶³ National Conference of State Legislatures, *Racial and Ethnic Health Disparities: Workforce Diversity* (Washington, DC: National Conference of State Legislatures, August 2014), available online at <http://www.ncsl.org/documents/health/workforcediversity814.pdf>.
- ¹⁶⁴ *Ibid*.
- ¹⁶⁵ Suzuho Shimasaki, *Health Equity and Racial and Ethnic Workforce Diversity* (Denver, CO: The Colorado Trust, October 2013), available online at http://www.coloradotrust.org/sites/default/files/CT_Workforce_Diversity_Brief_FINAL.pdf.
- ¹⁶⁶ U.S. Department of Health and Human Services (HHS) Health Resources & Services Administration, *Teaching Health Center Graduate Medical Education (THCGME) Program* web page (Rockville, MD: HHS, 2018), available online at <https://bhwh.hrsa.gov/grants/medicine/thcgme>.
- ¹⁶⁷ Albritton, *How States Can Fund Community Health Workers*, *op cit*.
- ¹⁶⁸ American Public Health Association (APHA), “Community Health Workers” web page (Washington, DC: APHA), available online at <https://www.apha.org/apha-communities/member-sections/community-health-workers>.
- ¹⁶⁹ Christine Vestal, “Peers’ Seen Easing Mental Health Worker Shortage,” *Stateline* blog (Washington, DC: The Pew Charitable Trusts, September 11, 2013), available online at <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage>.
- ¹⁷⁰ Meryl Schulman, “Community Paramedicine: Taking Care into the Home for Complex Populations” (Hamilton, NJ: Center for Health Care Strategies, May 9, 2017), available online at https://www.chcs.org/community-paramedicine-taking-care-home-complex-populations/?utm_source=CHCS+Email+Updates&utm_campaign=81e89419d0-Community+Paramedicine+Blog+-+05/09/17&utm_medium=email&utm_term=0_bbc451bf-81e89419d0-152144945.
- ¹⁷¹ Rural Health Information Hub (RHIH), “Community Paramedicine: Introduction” (Grand Forks, ND: RHIH, February 3, 2017), available online at <https://www.ruralhealthinfo.org/topics/community-paramedicine>.
- ¹⁷² U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration, *Data Warehouse: Shortage Areas* web page (Rockville, MD: HHS), available online at <https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx>.

¹⁷³ Lydia Mitts and Sinsi Hernández-Cancio, *Dental Therapists Can Improve Access to Dental Care for Underserved Communities* (Washington, DC: Families USA, November 2016), available online at http://familiesusa.org/sites/default/files/product_documents/HE%26HST_DentalTherapist_Brief_web.pdf.

¹⁷⁴ U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020* web page (Rockville, MD: HHS, 2013), available online at <https://bhwh.hrsa.gov/health-workforce-analysis/primary-care-2020>.

¹⁷⁵ Bettie Coplan, James Cawley, and James Stoehr, “Physician Assistants in Primary Care: Trends and Characteristics,” *Annals of Family Medicine* 11, no. 1 (January/February 2013): 75-79, available online at <http://www.annfam.org/content/11/1/75.full#sec-5>.

¹⁷⁶ Joynt Maddox, *op cit*.

¹⁷⁷ National Quality Forum, *op cit*.

¹⁷⁸ Chin, *op cit*.

¹⁷⁹ Joseph R. Betancourt, “Ushering in a New Era of Health Equity,” *Health Affairs* blog (October 31, 2016), available online at <https://www.healthaffairs.org/doi/10.1377/hblog20161031.057296/full/>.

¹⁸⁰ Samantha Artiga, Julia Foutz, and Anthony Damico, *Health Coverage by Race and Ethnicity: Changes under the ACA* issue brief (Washington, DC: Kaiser Family Foundation, January, 2018), available online at <http://files.kff.org/attachment/Issue-Brief-Health-Coverage-by-Race-and-Ethnicity-Changes-Under-the-ACA>.

¹⁸¹ National Academies of Sciences, Engineering, and Medicine, *op cit*.

¹⁸² Families USA, *Guiding Principles for Consumer-Friendly Health System Transformation* (Washington, DC: Families USA, January 2016), available online at http://familiesusa.org/sites/default/files/product_documents/HST_Principles_web.pdf.

¹⁸³ National Partnership for Women and Families (NPWF), *Steps for Achieving Meaningful Consumer Engagement in Health IT Initiatives* fact sheet (Washington, DC: NPWF, March 2012), available online at <http://www.nationalpartnership.org/research-library/health-care/HIT/steps-for-engaging-consumers.pdf>.

¹⁸⁴ *Ibid*.

¹⁸⁵ Center for Consumer Engagement in Health Innovation, *Recommendations to Improve Consumer Engagement in Quality Measurement* (Boston, MA: Community Catalyst, 2017), available online at <https://www.communitycatalyst.org/resources/publications/document/Resource-for-Advocates-on-Quality-Measurement-Recommendations-Final.pdf>.

¹⁸⁶ Center for Consumer Engagement in Health Innovation, *Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups, and Communities*, (Boston, MA, Community Catalyst) available online at <https://www.healthinnovation.org/resources/toolkits/meaningful-consumer-engagement>.

¹⁸⁷ Kris Wiitala, Margaret Ann Metzger, and Ann Hwang, *Consumer Engagement in Medicaid Accountable Care Organizations: A Review of Practices in Six States* (Boston, MA: Community Catalyst, September 2016), available online at <https://www.communitycatalyst.org/resources/publications/document/ConsumerEngagementMedicaidACOs.pdf?1474915709>.

¹⁸⁸ Rachel Black and Sabeel Rahman, *Centering the Margins: A Framework for Equitable and Inclusive Social Policy* (Washington, DC: New America, January 2017), available online at <https://www.newamerica.org/family-centered-social-policy/policy-papers/centering-margins/>.

¹⁸⁹ Families USA, *Health System Transformation* web page (Washington, DC: Families USA), available online at <http://familiesusa.org/issues/health-system-transformation>.

¹⁹⁰ Altarum, *Healthcare Value Hub* web page (Washington, DC: Altarum), available online at <https://altarum.org/focus-areas/Healthcare-Value-Hub>.

¹⁹¹ Center for Consumer Engagement in Health Innovation, *Building Advocacy Capacity* web page (Boston, MA: Community Catalyst), available online at <https://www.healthinnovation.org/work/building-advocacy-capacity>.

Publication ID: HEV061218

This publication was written by:

Sinsi Hernández-Cancio,

Director of Health Equity, Families USA

Ellen Albritton,

Senior Policy Analyst, Families USA

Eliot Fishman,

Senior Director of Health Policy, Families USA

Sophia Tripoli,

State Campaigns Manager, Families USA

Andrea Callow,

Associate Director of Medicaid Initiatives, Families USA

The following Families USA staff contributed to this publication (in alphabetical order):

Nichole Edralin, Senior Designer

Denisse Sanchez, Health Equity Intern

Maria Walawender, Health Equity Intern

For more information about the Health Equity Task Force, visit [Familiesusa.org/HETF](https://familiesusa.org/HETF).

To download a PDF of this report, visit [Familiesusa.org/HETFreport](https://familiesusa.org/HETFreport).



1225 New York Avenue NW, Suite 800 | Washington, DC 20005 | 202-628-3030 | info@familiesusa.org
FamiliesUSA.org | [facebook / FamiliesUSA](https://www.facebook.com/FamiliesUSA) | [twitter / @FamiliesUSA](https://twitter.com/FamiliesUSA)