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Value-Based Payment to Support Health Equity

To help hospitals on their journey to value, the American Hospital Association's *The Value Initiative* has been virtually convening leaders from diverse hospital types and locations to discuss opportunities and challenges in implementing value-based payment models. Over a series of meetings, the Insights on the Transition to Value group is exploring what it will take for hospitals to enter and thrive in value-based payment contracts. Based on these discussions, the AHA is developing additional resources to help hospitals develop the skills and capabilities to take on value-based payment.

Amol Navathe, M.D., Ph.D.
Assistant Professor, Medical Ethics and Health Policy
Perelman School of Medicine at the University of Pennsylvania

Mai Pham, M.D., MPH
President and CEO
Institute for Exceptional Care

The February 2022 series focused on using value-based payment to improve health equity and featured a conversation among two experts in the field: **Amol Navathe, M.D., Ph.D., assistant professor, medical ethics and health policy, Perelman School of Medicine at the University of Pennsylvania** and **Mai Pham, M.D., MPH, president and CEO, Institute for Exceptional Care.** *The conversation transcribed below has been condensed and edited for clarity.*

What is your vision for the future of value-based payment?

Dr. Navathe: We have a vision of a health care system that pays in a prospective way and pays for outcomes. Yet, the mechanics of how we get there are nothing short of challenging. Numerous factors are at odds with that goal. We are in a transitional state. While most provider groups are engaged in some form of value-based payments, we are still a predominantly a fee-for-service system. To take a leap forward, we have to find a way to address some of these core habits and processes for care, documentation and billing.

Dr. Pham: Value-based payment is going to hit a wall in terms of how much return either providers or the system or patients can get from the current paradigm in the absence of the policy levers to make the counterfactual to value-based payment a lot less attractive. And by that, I mean, there are two canoes – fee-for-service and value-based payment – let's remove fee-for-service. Or let's put a hole in one of them so that the business proposition for value-based care actually looks a lot better.

We're just playing at the margins of our vision for the future. Health care has to take a hard look at itself – how do we justify eating up 20% of the GDP? This is about how we produce health. Providers can't produce health without deep, meaningful and long-term collaborations with their community-based partners, government, employers and schools.

Where are we as a field on value-based payment models, especially as it relates to health equity?

Dr. Navathe: As we move into the second decade of reforms trying to shift us towards value, we should take a hard look at what this means for equity. High-value care, as it is defined in the context of how much quality we get in relation to how much we spend, does not equal equity. In fact, many of the core vehicles that are a fundamental

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part of value-based care and value-based payment may even be at odds with equity.

We are at this critical juncture. Nobody at the national level wants to take their foot off the pedal to drive our system towards value. But at the same time, I think there is this very salient recognition that we have to do something about equity and reducing disparities. And these two goals are not necessarily fully aligned.

Dr. Pham: We are at a tender pivot point. We now have the benefit of 10 years of experimentation with alternative payment models to look back on. In terms of health equity, it cannot be a more poignant time. Even before the pandemic, we were all aware of the terrible non-clinical burdens that have led to stagnating life expectancy in the U.S. And that's a real disgrace. No matter how much utilization we may cut under a value-based approach, we are not yet thinking about what actually produces health or how reducing health inequities, in the context of value-based arrangements, will be a key lever for getting us there.

In what situations can value-based payment improve health equity?

Dr. Navathe: We're now seeing that participation in value-based payment programs is disproportionately moving away from communities that are predominantly low-income. One of the fundamental reasons that troubles me is that those innovations and benefits are accruing disproportionately to our populations that don't face disparities. So we're just driving a wedge further between the "haves" and the "have nots" when it comes to our health care system. This highlights that we have to make equity a centerpiece of our value-based strategy. We need a reorientation of priorities so that we move our practice transformation in a direction that directly considers the equity effects and includes the closing of disparities gaps as a core goal.

Dr. Pham: A high-value system doesn't necessarily mean that you squeeze costs out of every single component of that system. The system is, in part, not high-value because there are parts of it where you have underinvested.

If we open ourselves to thinking about right sizing the value-based approach for a particular community, I think we open up a lot of possibilities to focus on somewhat different outcomes for different communities. A community could say that they are more worried about clinical outcomes than cost accountability and choose to focus on that. And once they reach some threshold, then they can look to see whether there are efficiencies that could be gotten out of the system.

It takes courage to experiment because it may not be perfect and we may get it wrong the first time. But the current state is one where we've not gotten it right. So we have to actually do worse than we are currently doing to justify not experimenting in this way.

How much progress are we making in value-based care?

Dr. Navathe: We've been making modest steps in fits and starts, but not in any kind of uniform way. I would say we have some nuggets to be proud of, but that's still only nuggets. We need more of a systematic effort. I think the best way to judge progress is in terms of what's happening to the outcomes. Are we actually closing gaps or not? And then the interim as a process measure – how many different initiatives do we have out there from private and public payers that are directly driving toward this goal? We don't yet have that systematic approach. And hopefully, that's where we're going to make progress now.

Dr. Pham: We're certainly not behaving as if we are in a crisis moment. When COVID hit, the entire system had to improvise and figure out how to respond to a crisis. Hospital systems completely changed their processes for everything from intake and triage to resource allocation. Insurers had to keep up with literally hundreds of regulatory changes at federal, state and local levels. And they did it. It just doesn't feel to me like we have ignited ourselves in that way yet around disparities.

How can we use data to help make the case for value-based payment models as a tool to address health equity?

Dr. Pham: Waiting for perfect data is a convenient excuse. We have plenty of data to get started looking at disparities and actually trying to tackle them. You can start asking within your own organizations how to better collect and track data and be consistent in the way that we grade ourselves.

As an industry, health care has been very proactive in adopting new technologies and analytic approaches. But we have not brought that kind of data savvy to the art of predicting broader outcomes. Knowing that 80%, of health outcomes are actually more predictive by nonclinical factors than by clinical factors, it feels very archaic that we are relying primarily on clinical data in order to do our work. I think that we need to have the humility to recognize that we have blinded ourselves to the rest of a person's life circumstance when we're thinking about what leads to health outcomes. We need to see those factors more clearly – whether it be in predictive analytics, or in the way that we collect data from patients about their life, or in the way that we set care goals for them. I think that if we were capable of opening ourselves up to viewing that broader landscape of a person's life, many things that seem like mysterious and intractable problems in health care would become less so.

Dr. Navathe: I just wanted to double down on this idea that as a system we are guilty of scapegoating incomplete or unreliable data as a reason to kick the can down the road. We can't hold the whole thing hostage because we don't have great individual-level social determinants of health data.

What do you think the next 10 years will look like for value-based payment and health equity?

Dr. Pham: I think there will be some incremental steps to tackle some key ingredients of the solution. And I think we will start to see programs from CMS that more explicitly address disparities. But when I talk about disparities, I mean a much broader bucket of issues than just racial/ethnic disparities. It applies to rural versus urban location, people with disabilities and socioeconomic status. I do think we will see more investment and explicit policy attention to that through real programs, and change some refinements to current programs.

I think the most necessary change is policy that would explicitly shift resources from "haves" to "have nots." I think it's something that can happen gradually but that can still send clear, long-term signals so that health systems feel like it's a long-term goal and that they can invest their time and resources in this effort as well. And that is what will really allow these communities to receive the kind of sustained support and attention that they need to turn around these outcomes.

Dr. Navathe: The big challenge with value-based payment is that it is not perfectly aligned with equity. At the same time, there's just a fundamental recognition that our prevailing system for the past 40 years is not going to get anything done. So I think part of the reason to be very optimistic around value-based payments, is it may be our golden opportunity to really make progress in the health care equity space. But that doesn't mean it's going to be easy.

So I think my prediction for the next 10 years is continued somewhat steady progress. Nothing dramatic. If there is not going to be some sort of either policy or exogenous shift that really suddenly drives adoption of value-based arrangements, I think it's going to be really hard to just bust this open and make a lot of progress. But I think we can at least get oriented in the right direction. Where I'm optimistic is that we are shifting the Titanic a little bit in the right place.

Dr. Pham: I'll offer one ray of hope. In some communities, they are recognizing that they need to improve the health of their citizens with much more holistic approach. Even if it's on the level of a single metropolitan area or state, that is important progress because it starts to change the cultural expectation around health care. I think just for people to see what is possible will be a really powerful thing.

Explore more AHA resources about the transition to value at www.aha.org/TheValueInitiative.