Addressing Equity Through Alternative Payment Models

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Physician-Focused Payment Model
Technical Advisory Committee
Public Meeting
September 27, 2021
Context

APMs have played an important role in informing expectations and signaling direction toward value-based care

However, progress in care delivery improvements haven’t necessarily translated into progress in addressing the critical problem of health disparities

There are reasons to worry that APMs could perpetuate or worsen existing disparities facing historically marginalized groups
Questions

How have APMs engaged historically marginalized communities?

How have APMs affected disparities among individuals in those communities?

What are 3 ways to better advance equity through APMs?
Takeaways

Some APMs have excluded historically marginalized communities

Despite encouraging early evidence, there is an overall dearth of data about how APMs impact disparities among historically marginalized populations

Changes to advance equity through APMs include (a) setting national policy intention and goals; (b) incorporating equity into APM evaluation; and (c) convening multistakeholder groups to guide agendas for achieving equity goals
How have APMs engaged historically marginalized communities?
“Markets that were more likely to have a higher burden of adverse outcomes through social risk factors were less likely to be selected for CJR.”

Mandatory APMs:

- Have potential for greater coverage
- Can provide more generalizable estimates of APM impact
- May be less susceptible to provider selection
Physicians’ Participation In ACOs Is Lower In Places With Vulnerable Populations Than In More Affluent Communities

ABSTRACT Early evidence suggested that accountable care organizations (ACOs) could improve health care quality while constraining costs, and ACOs are expanding throughout the United States. However, if disadvantaged patients have unequal access to physicians who participate in ACOs, that expansion may exacerbate health care disparities. We examined the relationship between physicians’ participation in both Medicare and commercial ACOs across the country and the sociodemographic characteristics of their likely patient populations. Physicians’ participation in ACOs varied widely across hospital referral regions, from nearly 0 percent to over 85 percent. After we adjusted for individual physician and practice characteristics, we found that physicians who practiced in ZIP Code Tabulation Areas where a higher percentage of the population was black, living in poverty, uninsured, or disabled or had less than a high school education—compared to other areas—had significantly lower rates of ACO participation than other physicians. Our findings suggest that vulnerable populations’ access to physicians participating in ACOs may not be as great as access for other groups, which could exacerbate existing disparities in health care quality.
Summary

Both voluntary and mandatory APMs may exclude some historically marginalized communities

Participation mechanism – voluntary versus mandatory – may contribute to these dynamics

Social determinants and participation mechanism could be directly considered in the APM design
How have APMs affected disparities among individuals in those communities?
Spending and quality after three years of Medicare’s bundled payments for medical conditions: quasi-experimental difference-in-differences study

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Estimate (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total episode spending</td>
<td>-1.2 (-2.3 to -0.2)</td>
<td>0.02</td>
</tr>
<tr>
<td>Index hospital admission</td>
<td>-0.1 (-0.4 to 0.1)</td>
<td>0.34</td>
</tr>
<tr>
<td>Readmissions</td>
<td>-1.6 (-4.3 to 1.3)</td>
<td>0.28</td>
</tr>
<tr>
<td>All institutional post-acute care</td>
<td>-5.2 (-8.5 to -1.7)</td>
<td>0.004</td>
</tr>
<tr>
<td>Outpatient professional fees</td>
<td>-10.4 (-19.5 to -0.3)</td>
<td>0.04</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>1.7 (-4.1 to 7.7)</td>
<td>0.58</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>-6.3 (-10.0 to -2.5)</td>
<td>0.001</td>
</tr>
<tr>
<td>Home health services</td>
<td>4.4 (1.4 to 7.5)</td>
<td>0.004</td>
</tr>
<tr>
<td>Outpatient hospital care</td>
<td>2.2 (-1.8 to 6.3)</td>
<td>0.29</td>
</tr>
</tbody>
</table>

Spending and quality after three years of Medicare’s bundled payments for medical conditions: quasi-experimental difference-in-differences study

<table>
<thead>
<tr>
<th>Clinical risk</th>
<th>Social risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced age</td>
<td>Black race</td>
</tr>
<tr>
<td>High clinical severity</td>
<td>Medicare/Medicaid dual eligibility</td>
</tr>
<tr>
<td>Frail</td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td></td>
</tr>
<tr>
<td>Prior utilization of SNF/IRF</td>
<td></td>
</tr>
</tbody>
</table>
SNF length of stay

Advanced age: -0.8 days [-1.2, -0.3] 0.001
High Case-Mix: -0.2 days [-0.6, 0.2] 0.38
Frail: -0.4 days [-0.8, -0.1] 0.01
Disabled: 0.8 days [0.4, 1.2] < 0.001
Black: 0.3 days [-0.2, 0.8] 0.29
Dual eligible: -0.4 days [-0.8, 0.1] 0.09
Prior IRF/SNF utilization: -1.1 days [-1.6, -0.6] < 0.001
90-day readmissions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate</th>
<th>[95% CI]</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced age</td>
<td>-0.12 p.p.</td>
<td>[-0.99, 0.75]</td>
<td>0.79</td>
</tr>
<tr>
<td>High Case-Mix</td>
<td>-0.58 p.p.</td>
<td>[-1.59, 0.43]</td>
<td>0.26</td>
</tr>
<tr>
<td>Frail</td>
<td>-0.60 p.p.</td>
<td>[-1.37, 0.18]</td>
<td>0.13</td>
</tr>
<tr>
<td>Disabled</td>
<td>-0.51 p.p.</td>
<td>[-1.71, 0.69]</td>
<td>0.41</td>
</tr>
<tr>
<td>Black</td>
<td>-1.07 p.p.</td>
<td>[-2.22, 0.08]</td>
<td>0.07</td>
</tr>
<tr>
<td>Dual eligible</td>
<td>-0.13 p.p.</td>
<td>[-1.00, 0.75]</td>
<td>0.77</td>
</tr>
<tr>
<td>Prior IRF/SNF utilization</td>
<td>-0.72 p.p.</td>
<td>[-1.77, 0.33]</td>
<td>0.18</td>
</tr>
</tbody>
</table>
Other Outcomes

Differentially lower episode spending: frail, dual-eligible, prior IRF/SNF utilization patient groups

Differentially lower 90-day mortality: disabled patient group

Differentially greater discharge to SNF/IRF: frail patient group
Summary

Under voluntary bundled payments for common medical conditions, there were no widened disparities observed for high-risk patients.

Strategies used in bundled payments did not appear to be applied indiscriminately to high-risk patients.

This early evidence may help allay concerns, though more data are needed.
What are 3 ways to better advance equity through APMs?
# A National Goal to Advance Health Equity Through Value-Based Payment

Joshua M. Liao, MD

Intention matters in health policy. Nearly a decade ago, the clinical community, particularly clinicians who pro-

## Table. Changes to Health Care Payment to Pay for Equity

<table>
<thead>
<tr>
<th>Change</th>
<th>Rationale</th>
<th>Lessons from the value-based payment movement</th>
<th>Example strategies</th>
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<tbody>
<tr>
<td>Set national goals around paying for equity</td>
<td>Policy intention precedes policy implementation, and setting goals is the first step in demonstrating that intention</td>
<td>The US Department of Health and Human Services sped progress toward value-based payment by using bold, unapologetic goals to set direction and expectations for the health care industry</td>
<td>Set a goal of incorporating equity measures into all payment models by 2025</td>
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<td></td>
<td>Set a goal of tying at least 25% of reimbursement in value-based payment models to equity measure performance by 2028</td>
</tr>
<tr>
<td>Revise legislation to incorporate equity into evaluation of value-based payment models</td>
<td>Statute governing payment models does not involve any equity criteria</td>
<td>Section 1115A of the Social Security Act required policy makers to directly consider how payment models affect quality and cost</td>
<td>Require “equity audits” of all payment models independent of quality and cost considerations</td>
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<td></td>
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<td>Add statutory criteria to implement and scale up programs that increase equity</td>
</tr>
<tr>
<td>Convene a multistakeholder group of clinicians, insurers, and community and patient groups to guide an agenda for achieving equity goals</td>
<td>Collaboration is necessary for translating policy intention and statute into real-world programs</td>
<td>Creation of the Health Care Payment Learning &amp; Action Network supported the work of shifting from fee-for-service toward value-based payment</td>
<td>Create a payment equity learning and action network to guide the work of achieving payment equity goals, including collection of nonclinical data, creation of disparities measures, and use of existing measures to quantify disparities</td>
</tr>
</tbody>
</table>

Just for patient illness severity in determining financial bonuses or penalties. But these risk adjustment methods are incomplete for marginalized populations, potentially inducing practice changes that exacerbate disparities.

For example, several bundled payment programs have targeted avoidable utilization of lower extremity joint replacement surgery and post-surgery care. However, related with unexplained disparities. For example, several bundled payment programs have targeted avoidable utilization of lower extremity joint replacement surgery and post-surgery care. However, related with unexplained disparities.
Health Equity and Payment Initiative

A new initiative to use payment to promote equity, rather than perpetuate inequity

Goals are to engaging and working diverse groups of stakeholders to affect change by:

• Setting longitudinal policy goals
• Identifying changes needed in measurement and evaluation methods
• Implementing and evaluating programs
Team & Collaborators

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Amol Navathe, MD, PhD
Takeaways (Revisited)

Some APMs have excluded historically marginalized communities

Despite encouraging early evidence, there is an overall dearth of data about how APMs impact disparities among historically marginalized populations

Changes to advance equity through APMs include (a) setting national policy intention and goals; (b) incorporating equity into APM evaluation; and (c) convening multistakeholder groups to guide agendas for achieving equity goals
Questions?

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