AMERICA'S ESSENTIAL HOSPITALS

Engaging Essential Hospitals in Value-Based Care Models

Recommendations to CMMI on Improving Equity Through Broader Model Participation

Value-based health care is a delivery model in which providers are paid based on patient health outcomes, versus a fee-for-service (FFS) approach based on the amount of health care services delivered. Cost and quality metrics are used to evaluate success and determine "value" in value-based payment models. The potential benefits of value-based care include improved health for patients, reduced effects and incidence of chronic disease, and lower overall costs to the health care system.[i] Further, organizations participating in value-based payment models have benefited from the flexibility to adapt care models to their patients' needs and circumstances during the COVID-19 pandemic.

Given the benefits of value-based care to patients, providers, payers, and society as a whole, it is critical a broad array of stakeholders participates in value-based payment reforms—particularly providers that serve low-income, medically complex, marginalized, and underrepresented communities. A disproportionate number of essential hospitals' patients face sociodemographic challenges to accessing care, including homelessness, language barriers, and low health literacy. In communities served by essential hospitals, approximately 10 million people struggle with food insecurity and nearly 22.3 million live below the poverty line.[ii]

Medical care cannot exist in silos. Essential hospitals are engrained in their community as a trusted and central resource for care. They often serve as community anchors, with deep ties to the residents; this leads to a clear understanding of the nonclinical influences on patients and population health. A coordinated approach to patient care—involving clinical and nonclinical partners—can lead to better outcomes, higher patient satisfaction, and less care duplication. However, care coordination is resource intensive for essential hospitals that serve a population with complex social needs. Significant challenges exist in developing partnerships, building needed infrastructure, engaging patients, measuring progress, and creating sustainable funding models.

Additionally, quality metrics—used in Medicare value-based payment models to evaluate performance and determine shared savings or incentive payments—do not yet incorporate social determinants of health (SDOH) such as food insecurity, housing instability, and lack of transportation. By ignoring these factors, value-based payment models disproportionately penalize providers seeking to support patients' broader health and social needs. Essential hospitals disproportionately care for a segment of the population that faces complex challenges requiring unique solutions to achieve improved population health, better patient experience, and reduced costs.

Movement from Volume to Value

Under traditional FFS, Medicare payments are tied only to volume without any connection to quality or outcomes. With the passage of the Affordable Care Act (ACA), the U.S. health care

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delivery system embarked on a path of reform, both in delivery of care and payment models. At its core, the movement from volume to value is about improving quality and outcomes for patients by focusing on overall wellness and preventive treatments. Value-based payment reforms seek to hold providers accountable for outcomes and create a financial incentive to coordinate care.

Under the hospital Inpatient Quality Reporting (IQR) Program, hospitals must submit data on quality measures (e.g., morbidity/mortality, readmissions, patient satisfaction) designated by the Centers for Medicare & Medicaid Services (CMS). Those measures then are publicly reported on CMS' Care Compare website. Hospitals that fail to meet IQR requirements are subject to a reduction in their annual Medicare payment update. The ACA also established "pay- for-performance" programs that reduce Medicare reimbursement to hospitals that score below national performance benchmarks on selected quality measures. These value-based initiatives include the Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Condition Reduction Program. The ACA also established the Center for Medicare and Medicaid Innovation (CMMI) to implement and study new payment and care delivery models. CMMI since has developed a portfolio of alternative payment models (APMs) that test the impact of adequate payment for care coordination combined with accountability for costs and quality.

In 2015, Health and Human Services (HHS) Secretary Sylvia Burwell set a goal of tying 30 percent of traditional FFS Medicare payments to quality or value through APMs by 2016 and increasing to 50 percent by 2018.[iii,iv] Essential hospitals developed innovative care delivery models and participated in a variety of initiatives at the federal, state, and local levels in response to these goals. Our members are well-situated to do so because of the comprehensive, integrated nature of their delivery systems, their strong primary care base, and their historic need to provide high-quality care on a shoestring budget; however, they face high barriers to system transformation because of financial challenges. More can be done to advance the movement to value—in particular, ensuring health equity is a central feature and goal of value-based payment models and essential hospitals are incentivized to participate more fully in payment reforms.

Role of CMMI in Advancing Health Equity

Care often is fragmented under Medicare FFS, which pays for services piecemeal. This fragmentation can lead to unintended consequences, such as inefficiency, ineffectiveness, and inequality. For patients with chronic conditions—those disproportionately served by essential hospitals—fragmentation can lead to poorer outcomes, including higher rates of hospital admission and excess emergency department visits.[v] These patients tend to require more care, have multiple comorbidities, and benefit from having a multidisciplinary care team. Value-based payment reforms have the ability to incentivize integration across the care continuum, which in turn promotes efficiency and creates an opportunity to develop comprehensive care plans that meet individuals' needs.

CMMI oversees 12 APMs offering 25 distinct tracks with distinct payment options and risk arrangements. These models are designed to enable providers to focus on whole-person care and proactively manage care for populations. However, according to CMS officials and other stakeholders, providers in rural locations and in medically underserved or provider shortage areas face financial, technological, and other challenges in transitioning to APMs.[vi] Further, the extent to which essential hospitals are represented in these models is unknown, nor is it clear which of these models are relevant for or directly target essential hospitals and their unique patient population.[vii]

We are at a pivotal point in the movement to value—a point in which we have the opportunity to elevate the health and well-being of communities negatively impacted by policies and programs rooted in structural racism. CMMI should ensure value-based payment models do not

inadvertently exacerbate health disparities by rewarding providers that cherry-pick healthier, less diverse patients to achieve better quality scores and financial success. Additionally, CMMI should empower health care organizations through policies and payment models that address the underlying, contributing factors of health inequities (e.g., poverty, unequal access to care, lack of education, and racism).

Under the Biden administration, CMMI has set forth a 10-year vision that places health equity as a central goal in all stages of model design, operation, and evaluation.[viii] CMMI has the potential to mitigate health inequities through care models that:

- include incentives for better outcomes related to SDOH and improving equity;
- adjust outcome measures, such as cost and quality, to account for factors outside the control of the hospital or provider;
- provide upfront funding for safety net providers;
- account for the unique needs of safety net providers and the patients and communities they serve; and
- leverage data to improve outcomes and overcome health inequities.

Policy Recommendations

As providers of care for marginalized and underrepresented communities, essential hospitals deeply understand the need to identify gaps in care quality and eliminate disparities. In designing new value-based payment models, CMMI should support providers who disproportionately deliver care to disadvantaged populations impacted by historical inequities.

The following federal policy recommendations seek to ensure essential hospitals can more fully participate, and thrive, in value-based payment reforms.

INCORPORATE SDOH AND EQUITY

Recognizing the effect of upstream factors outside a hospital's control, essential hospitals increasingly work to mitigate SDOH in various ways. In most cases, the first step is to identify the needs of the patient population. Many essential hospitals screen patients for food insecurity, housing instability, and other SDOH and refer affected patients to community resources to help meet their social needs. We recommend incorporating SDOH in risk-adjustment methodologies and incentivizing hospitals to close gaps in care quality.

Include Appropriate Risk-Adjustment

The design and performance metrics used in value-based payment models, as well as efforts to address inequities in the health care system and society as a whole, are critical on the path from volume to value. Current quality metrics used in Medicare payment models to evaluate performance and determine shared savings or incentive payments do not incorporate social risk factors.

It is critical that essential hospitals are not disadvantaged for serving medically and socially complex beneficiaries and that they have the resources to continue providing vital services to their communities. Performance measures must account for the socioeconomic and sociodemographic complexities of patient populations to ensure a level playing field across all hospitals.

A large and growing body of evidence shows sociodemographic factors—age, race, ethnicity, and language, for example—and socioeconomic status, including income and education, can influence health outcomes.[ix, x] These factors can skew results on certain quality measures, such as those for readmissions, and make it difficult for certain hospitals to obtain incentives or share in savings under value-based models. Further, when performance measures in value-based payment programs do not account for providers serving complex patients, these programs can exacerbate health care

disparities by depleting resources necessary to treat adverse health outcomes caused by social barriers to care.

Incentivize Improvements in Equity

Equity must be at the forefront of design, development, implementation, and evaluation of value-based payment models. These models should reward relative improvement by providers working to overcome SDOH and improve equity at their organizations—for example, for increasing screening of SDOH and referral of patients to wraparound services. This type of incentive helps ensure disparities are better identified, documented, and addressed as part of a model's implementation and evaluation.

Further, SDOH are not static; they continually change and therefore require dynamic data exchange and nimbleness. Payment methodologies and quality metrics should account for differences among communities and populations and provide flexibility for essential hospitals to design, and be evaluated on, strategies that are responsive and meaningful.

PROVIDE UPFRONT FUNDING

Members of America's Essential Hospitals understand the critical contribution social services make to achieving effective care transitions and improved outcomes, including reduced readmissions. They continuously work to develop innovative strategies to overcome potential barriers to accessing care and learn how to best engage patients in their own care. However, as noted by the National Academy of Medicine, achievement of good outcomes might be costly for providers caring for patients with social risk factors "owing to additional costs required to tailor care appropriately or because these patients have fewer resources outside the health systems available to contribute to outcomes."[xi]

For example, infrastructure, staff time, community engagement, health information technology and data—factors key to success under value-based payment models—require resources that are especially scarce for essential hospitals that serve the marginalized populations most in need of this assistance. Further, the social needs screening and referral process is resource intensive. Hospital staff must undergo training and dedicate time to performing the screenings, information technology systems might require updates to incorporate new screening tools and referral systems, and hospitals must build and maintain referral relationships with an array of local organizations.

Essential hospitals operate on slim margins due to their safety net, community-driven mission of providing high-quality care to all. Many struggle to find upfront funding to invest in the infrastructure to execute value-based strategies, including activities that mitigate SDOH. Upfront funding would help essential hospitals build a solid foundation to help them thrive in new models, including in activities generally not reimbursed by Medicare (e.g., housing).[xii]

Upfront funding would enable essential hospitals to:

- update technology and electronic health records (EHRs) to support collection of SDOH data;
- provide training to staff for SDOH screening activities;
- recruit specialists for multidisciplinary teams (e.g., social workers, behavioral health providers);
- support the provision of language and cultural consultation services;
- partner with community organizations to increase access to nonmedical services; and
- leverage data to reduce disparities in patient outcomes.

Future value-based payment models should provide upfront funding to encourage and sustain participation among organizations caring for socially disadvantaged populations.

ADDRESS THE NEEDS OF ESSENTIAL HOSPITALS AND THEIR PATIENTS

To date, CMMI models have largely focused on Medicare with limited reach to the Medicaid population and essential hospitals that serve these patients. CMMI has expressed a desire to "refresh" their strategy to ensure participation from a diverse group of providers, including those that care for underserved communities.[xiii] Future CMMI models should reflect the full diversity of beneficiaries in Medicare and Medicaid, as well as the increasing number of uninsured individuals. This will require an understanding of underserved communities, disparities that impact their health, and their specific medical and nonmedical needs. Additionally, CMMI should examine, and incorporate into future models, the unique characteristics of providers that serve as anchor institutions for their communities.

Tailor to Individual and Community Needs

Efforts to address SDOH are inherently shaped by local context and individual patient needs. There is no "one-size-fits-all" solution and incentives should align with community need. Further, just as hospitals continue to adapt and respond to an evolving health care payment and delivery landscape, there will there be an evolution of community-level needs. Value-based payment reforms should account for differences in community needs and provide flexibility for essential hospitals to design strategies that are responsive and meaningful. Additionally, value-based payment models should include incentives that drive all providers along the care continuum to collaborate and take responsibility for delivering high-quality, cost effective health care.

Models also should account for a potential lack of nonhealth, community-based services in a particular geographic area that might limit an essential hospital's ability to meet the needs of a patient and is beyond their control. Further, essential hospitals might face difficulty tracking patients attributable to APMs and other value-based strategies due to housing instability and other SDOH, compounded by the effects of natural disasters that disproportionately impact at-risk populations.

It also is critical that at-risk populations—the incarcerated and those in need of quality mental health service, for example—are not left out of value-based payment strategies. Patients with behavioral health issues often turn to local emergency departments for treatment and episodic care, contributing to rising health care costs and fragmented care. They also are among populations most likely to have limited access to continuous behavioral health services for long-term condition management. These factors can drive higher readmission rates and poorer outcomes.[xiv] Value-based payment models should support interventions that address the unique needs of these populations.

Account for Hospital-Level Characteristics

Essential hospitals take on the provision of services vital to the community, such as trauma or behavioral health care, which are likely to have higher costs. These hospitals provide services often not otherwise available, including, but not limited to, community clinics; neonatal services; wraparound services, such as social services and interpretation; and coordination of access to food and shelter. Essential hospitals also train three times more physician residents than other U.S. teaching hospitals and meet public health needs by preparing for and responding to natural disasters and other crises, as shown throughout the COVID-19 pandemic.[xv] CMMI should consider the unique characteristics of essential hospitals when designing models to address inequities.

Additionally, essential hospitals care for disadvantaged people, who often are uninsured. Three-quarters of essential hospitals' patients are uninsured or covered by Medicaid or Medicare; nearly 15 percent are eligible for both Medicaid and Medicare.

Just one in five inpatient discharges and one in four outpatient visits at essential hospitals are covered by commercial insurance.[xvi] Further, data show that, for the third year in a row, the number of uninsured nationwide increased in 2019.[xvii] It is important to incorporate payer mix into the design of value-based payment models to enable the participation of essential hospitals that serve a high proportion of Medicaid or dual-eligible beneficiaries, in addition to the uninsured. In doing so, CMMI can better address issues of inequity that disproportionately impact these patients.

ADDRESS DATA CHALLENGES

Data is a key driver in health care delivery, informing providers of patient needs while engaging patients in their own care. To fully realize the potential of data within value-based payment models, CMMI must address challenges to data collection, particularly among providers serving marginalized people and people of color. Collection efforts should ensure users can efficiently access, analyze, and apply data meaningfully to improve patients' circumstances.

Data Completeness and Accuracy

CMMI should encourage the collection of patient demographic data, across all models, in a culturally sensitive and linguistically appropriate manner. The unconscionable rates of COVID-19 infections and deaths among Black, Latino, and other minority populations have emphasized the need for collection and analysis of data by race, ethnicity, and preferred spoken and written language (REL) of patients. The collection of REL data in an EHR is necessary to empower providers to identify and address health disparities and to support further research on the health effects of SDOH.

Improving efforts to collect SDOH data can provide a better understanding of how these factors impact outcomes. This work also is important in identifying the needs of our nation's most underrepresented patients and designing incentives that directly tackle those needs. A 2014 National Academy of Medicine report suggested standardized use of EHRs that include social and behavioral domains could "provide better patient care, improve population health, and enable more informative research."[xviii]

The collection and reporting of data that provides a more comprehensive picture of patients and their community requires accuracy and validity to ensure appropriate use in Medicare programs. To the extent providers collect SDOH data, it is important to establish standards by which collection methods—and the data—are validated.

A subset of ICD-10-CM codes, known as Z codes, present an opportunity to capture social determinants data. Z codes related to SDOH cover education and literacy, employment, housing, and lack of adequate food or water. Despite the availability of Z codes, CMS reports these codes are used on fewer than 2 percent of Medicare FFS claims.[xix, xx]

Challenges to collecting SDOH data include the sensitive nature of these conversations, a lack of alignment across screening tools, data collection silos, and a need to link data from medical and nonmedical sources (i.e., community services).

CMMI should include the collection of SDOH data in a standardized manner across its value-based payment models. Further, the agency should direct technical assistance, including learning collaboratives, at essential hospitals to leverage existing data infrastructures to collect information on patient needs and share best practices for addressing those needs.

Interoperability

While multiple private- and public-sector initiatives exist to improve interoperability, more work remains to allow providers to easily exchange information. Further,

providers serving marginalized populations face tangible barriers in EHR adoption and use, whether due to financial constraints, infrastructure challenges, or reasons outside their control (e.g., vendor issues or unique patient populations). Improved interoperability is critical in enabling providers to use certified EHR technology to seamlessly exchange health information. This is particularly true as it relates to data sharing between health care systems and community-level providers.

Data sharing between clinical and nonclinical partners is integral to achieving health equity. Shared data can uncover trends or illuminate other challenges and opportunities that could be missed in the absence of review by multiple stakeholders with different perspectives. Further, the ability to monitor and share data (including data stratified by REL) could help to identify disparities and standardize efforts across hospitals and community-based partners. CMMI should examine ways to incorporate real-time data into value-based payment models to allow participants to identify gaps more quickly and develop and implement quality improvement efforts.

Conclusion

CMMI Director Liz Fowler, in remarks October 20, noted the agency is "fully engaged in the effort to drive our delivery system toward meaningful transformation and in particular, driving a focus on health equity."[xxi] For essential hospitals to fully engage in value-based care strategies, CMMI should focus on the design, implementation, and evaluation of models that incorporate SDOH, include upfront funding, and promote tailored interventions based on patient need, not payer status. Future payment models should mitigate unintended consequences, such as incentives to selectively treat lower-acuity patients or avoid treating the uninsured or dual-eligible population, which could exacerbate disparities. Adoption of these recommendations will support the nation's efforts to address health equity through value-based payment reforms.

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