Health Care Transformation Task Force
Partners in Promoting Value

ADVANCING HEALTH EQUITY WITHIN VALUE-BASED CARE

OVERVIEW

The Health Care Transformation Task Force is committed to promoting health equity in the United States. Value-based care (VBC) offers a key opportunity to promote equity by influencing quality measurement and payment policies. The Task Force assessed current federal policies related to health equity in VBC to identify gaps and opportunities. Based on this assessment, the Task Force identified the following principles to increase multi-payer alignment around health equity within current and future VBC models. These principles provide a roadmap for policymakers, payers, and providers – including health systems and physician medical groups – to work toward a more equitable health care system.

1. Care Delivery for Health-Related Social Needs

HCTTF strongly supports clinical care and wrap-around services that address health-related social needs (HRSNs). VBC arrangements should offer providers and payers support to screen for and address HRSNs, while also reducing patient financial barriers.

2. Risk Adjustment for Clinical and Social Risk

VBC arrangements should use financial methodologies that do not penalize those caring for higher-risk patients, including both clinical and social risk. Quality measurement should identify gaps related to patient demographics and social risk, and payment methodologies should provide bonuses for gap closure.

3. Data Collection for Demographics & HRSNs

CMS and other payers should invest in collecting and validating patient-reported data on demographics and HRSNs. CMS should align with organizations that are establishing coding and documentations standards for these data.

4. Multi-Payer Alignment for Increased Consistency

CMS and other payers should align health equity policies across programs and plans, to support providers and improve the applicability of data that is collected.

CARE DELIVERY FOR HEALTH-RELATED SOCIAL NEEDS

1. HCTTF strongly supports clinical care and wrap-around services that address HRSNs. Patient's perspectives and participation should be central to identifying and delivering needed services. These services may be provided through a diverse range of care delivery options, including:
   a. Team-based care in the clinical setting, including nurse coordinators, social workers, pharmacists, and/or physical and occupational therapists.
   b. Community health integration, with the inclusion of Community Health Workers and other peer support specialists as members of the care team.
   c. Additional resources to address HRSNs, such as transportation, food insecurity, and housing instability. These needs may be addressed in collaboration with Community-Based Organizations (CBOs).

2. Value-based care arrangements should offer providers and payers flexibility to address HRSNs.
   a. In MSSP and other CMMI models, providers can invest shared savings into resources to address patients' needs holistically, including both clinical needs and HRSNs.
   b. Under Medicare Advantage, available supplemental benefits allow payers to deliver wrap-around services to enrollees to address HRSNs.

3. HRSN screening is essential and should be combined with interventions to address patient needs.
   a. Payers and/or providers should screen patients for HRSNs. Payers and providers should understand the social support resources available within their communities and connect patients to resources to address identified needs. While some health care organizations face barriers due to limited social supports in their communities, payers, and providers should prioritize addressing identified patient needs to the extent possible. Payers and providers may support patients through their own care teams or by connecting patients with CBOs.
   b. Providers should work to develop and disseminate best practices related to identifying and addressing HRSNs. Best practices should include recommendations for work flows, such as: what questions are used to collect demographic and HRSN data, what medical professionals ask the questions, when the questions are asked during the visit or inpatient stay, and how this is standardized across care settings. Best practices should also include information on the tools used to collect and share the data, as discussed further below.

c. In addition, CMS and other payers should support providers by paying separately to screen for and address HRSNs. This payment would help providers establish and maintain the staff and data infrastructure needed to collect HRSN data and address these needs. For example, beginning in 2024, CMS began reimbursing for Community Health Integration (CHI) services (HCSPCS G00019 and G0022), including payment for providing tailored support and system navigation after identifying an HRSN that significantly limits the physician's ability to carry out a treatment plan. However, there is not currently a separate reimbursement code for the screening. While Medicare covers CHI services and screening for social drivers of health in certain situations (G0136), there is not widespread use of these payment codes among private payers. Consistent coverage and payment for these services by all public and private payers is essential to ensuring patients have access to needed supports to address HRSN.

d. To drive continuous improvement, both payers and providers should evaluate the effectiveness of these interventions. For example, in 2023 CMS adopted two pay-for-reporting measures for Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health (SDOH-02).

4. **Payers should waive – or allow providers to waive – cost-sharing for patients with HRSNs.** Out-of-pocket costs are a critical concern for many patients, particularly those with HRSNs, which contributes to delayed care that results in higher future disease burden.

   a. Payers should waive patient cost, either by the payer directly (e.g., through a value-based insurance design) or by offering provider waivers (e.g., such as the patient cost-sharing waivers offered in CMMI models). Note that provider waivers typically come out of practice's revenue, while value-based insurance design keeps the provider whole because the payer does not assess patient cost-sharing.

   b. As an example, CMS began paying for CHI services beginning in 2024, as described above. However, if providers bill for these services, it triggers patient cost sharing. This would be a prime opportunity for CMS to waive patient cost-sharing to better address HRSNs.

RISK ADJUSTMENT FOR CLINICAL AND SOCIAL RISK

1. Value-based care arrangements should use financial methodologies that do not penalize providers that care for higher-risk patients, including both clinical and social risk factors.

    a. To the extent that validated data are available, CMS and other payers should risk-adjust benchmarks and other payment methodologies to account for clinical and social risks. This will ensure that providers are not penalized for caring for higher-risk patients, while also avoiding the unintended consequence of having providers avoid high-risk populations.

    b. In the short term, CMS and other payers may be limited to risk adjustment using claims-based data or validated population-level data. Under Medicare, claims-based data typically includes patients with dual eligibility, low-income subsidies, and enrollment due to disability. Medicare has also begun incorporating population-level data from the Area Deprivation Index. Payers can also consider other population-level data such as the Social Vulnerability Index.

    c. In the longer term, CMS and other payers should collect, validate, and use patient-reported data on HRSNs, as discussed below.

    d. Payment arrangements that include risk adjustment for social risk should not be a zero-sum game. For example, under ACO REACH, providers whose patient population is below the median in terms of social risk have their benchmarks reduced, and that money is redistributed to providers with patient populations in the highest 10th percentile of social risk. In contrast, the AHEAD Model increases global budgets for hospitals treating patients with more HRSNs, without penalizing other hospitals.

2. Quality measurement should identify gaps related to patient demographics and social risk data, and payment methodologies should incentivize gap closure.

    a. Quality measures should be stratified by validated demographic and social risk data, to identify gaps in care between different patient populations. Quality measures should include patient outcomes and experience measures, in addition to clinical quality measures. This will allow payers and providers to target additional resources where they are needed to address these social needs.

    b. Financial methodologies should support providers to address and close these gaps in care. For example, payers could provide upside-only incentives for closing gaps. CMS has precedent for this in the ESRD Treatment Choices Model.

DATA COLLECTION FOR DEMOGRAPHICS & HEALTH RELATED SOCIAL NEEDS

1. **Payers should invest in collecting patient-reported data on HRSNs.** While collecting this data presents technical and operational challenges, patient-reported data is the gold standard.
   a. Payers may collect the data directly from patients, or they can support providers in collecting this data. As described above, HCTTF recommends that payers separately pay for data collection and screening.
   b. Once collected, this data should be incorporated to risk adjust financial methodologies and stratify quality measures, as discussed above.
   c. Organizations that collect patient-level data should support data-sharing arrangements with relevant payers, providers, CBOs, and caregivers, in accordance with privacy policies and applicable law. This includes CMS and state Medicaid agencies, who may collect patient-reported demographic data during enrollment processes. In addition, health information exchanges should also share health equity data if it is available.

2. **Payers and/or providers should collect both demographic data and HRSNs,** because both types of data are pertinent to patient-level risks.
   a. *Demographic data*: Demographic data represents patient-level characteristics (e.g., race, ethnicity, language, sexual orientation, gender identity). While demographics themselves are not a risk, they may be associated with risks due to factors such as systemic inequalities.
   b. *Health-related social needs:* HRSNs represent risks that can potentially be addressed by payers and providers.

3. **CMS should align with organizations that are establishing coding and documentation standards for HRSN data,** such as the Gravity Project and United States Core Data for Interoperability (USCDI).
   a. If CMS mandates the use of any one standard, payers and providers should be given sufficient time to implement changes to the data infrastructure and work flows.
   b. In addition. CMS can support the adoption of these standards by working with electronic health record (EHR) vendors to advance the adoption of USCDI Version 3, which includes categories of data elements that capture health status (including health concerns, functional status, disability status, and mental function), demographics (including race, ethnicity, tribal affiliation, sexual orientation, gender identity and preferred language), and other HRSNs, so these data can be appropriately requested via the Application Programming Interfaces (APIs) from EHRs.

MULTI-PAYER ALIGNMENT FOR INCREASED CONSISTENCY

1. CMS and other payers should align health equity policies across programs and plans, to the extent possible.

    a. CMS and other payers should align data collection requirements across their own programs. In addition, payers should work toward multi-payer alignment on demographic and HRSNs data. Payers should define clear and consistent data elements, keeping these definitions consistent across payment arrangements. However, payers should not require the use of specific tools, to allow flexibility for different patient populations.

    b. If payers require or incentivize providers to collect demographic and health-related social need data, they should commit to validating this data and incorporating it into financial methodologies and quality measurement.

    c. Payers should also align health equity quality measures across their own programs, and work toward multi-payer alignment on these measures. Currently, CMS uses only two health equity measures related to screening for HRSNs, and these measures are currently pay for reporting. CMS should work to validate these measures and move toward pay for performance, using upside-only incentives for gap closure, as described above. In addition, CMS should evaluate the ability of physicians and other providers to successfully address identified HRSNs by connecting patients to community-based resources, while bearing in mind that providers' ability to do so is limited by the degree to which these resources exist in the communities where their patients live.

    d. Since 2022, CMS has required providers to develop health equity plans as part of value-based payment arrangements. CMS can make these plans more meaningful by requesting annual progress updates.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.