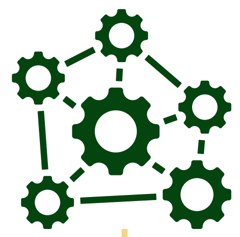
Sustaining a Community-Designed Model of Care:

Existing Payment Landscape and Opportunities to Address Structural Drivers of Inequities

February 2024



A Report by the Tubman Center for Health & Freedom in Collaboration with Byrd Barr Place

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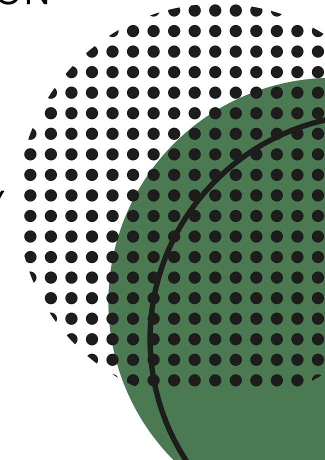
SUMMARY



Executive Summary

In Brief: The payment landscape profoundly impacts the design and delivery of care. While promising in theory, value-based purchasing and care in practice has not lived up to its equity aspirations in transforming healthcare and instead contributed to the further medical marginalization of populations most impacted by existing health disparities. Structure shifts in policies and accountability measures between CMS, health plans, health systems, and individual clinicians are necessary to address these negative outcomes. Through an anti-racist lens, this report explores potential structural interventions that can shift the course of value-based care to integrate health equity at its core.

- Community-based integrated care programs have successfully reached medically marginalized patients and demonstrated positive outcomes,[1,2] yet the structure of the payment environment makes implementation and upscaling difficult. Sustaining quality, equitable models of care is almost infeasible given the current payment landscape, except in rare exceptions where health delivery systems and individual clinicians have intentionally threaded the needle to provide whole person care with aligned incentives. However, these rare instances are burdensome for all involved and can only become the standard of care if the payment landscape structurally shifts to create space for health delivery systems and individual clinicians to deliver person-centered, equitable, and sustainable care.

- There remains limited structural dedication to addressing health disparities at different levels of the healthcare system. This is evidenced by the findings from the Health Care Payment Learning & Action Network's (LAN) 2021 Measurement Effort, which reviews payment activity, implementation of alternative payment models (APMs), and delivery on health equity goals.[3] In 2021, LAN recognized the need for more robust approaches to advance health equity. However, LAN's findings indicate limited leveraging of Value-Based Purchasing (VBP) to reduce health disparities.[4]

- VBP, with APMs, in its current iteration has had no effect on health disparities at its best and exacerbated health disparities at its worst when looking at hospital-based payment mechanisms.[5,6] Outcomes data has demonstrated that VBP's current implementation creates a systemic disparity, by limiting support for safety net hospitals that serve more socioeconomically diverse patient populations who already face greater medical marginalization.[7] This is in part attributed to the existing definitions of VBP, in which value is equated to cost effectiveness and progress on incomplete quality measures. A major challenge to these standards is who defines value; generally, value is defined not by the patient nor community but instead by non-inclusive bodies that set quality measures.

- The foundational architecture of the payment landscape further stymies VBP with its base building blocks – reimbursement rates – remaining focused on and validated by encounter-based data. Core, supplementary, and organizational models, as classified by the American Medical Association, demonstrate the clear ties that remain between payment and utilization.[8] Supplemental models, including Pay-for-Performance, Shared Savings, Retainer-Based Payment, and Pathways, are models that must co-exist with at least one core model, such as Fee-for-Service. Supplementary models in practice support integrated, coordinated care in ways that VBP intends to, but falls short in doing. Supplemental models are promising for health equity with the inclusion of benchmark payment systems that monitor outcomes that are inclusive of the needs of medically marginalized patients. However, the potential opportunity within these innovative, more equitable supplemental models is currently lost as they are overlaid onto volume-based structures.

- Complementing this review of payment models is a focus on specific barriers impacting the delivery of equitable care and recommendations to support an enabling environment for equitable whole person care delivery that community has envisioned for themselves. Barriers and recommendations are identified within three spheres of accountability: (1) CMS to Private Health Plans, (2) Health Plans to Contracted Health Delivery Systems and (3) Health Delivery Systems to Individual Clinicians. Opportunities for progress toward health equity exist at both the macro level with the implementation of VBP and at the more micro level in relationships between key stakeholders.

A bipartisan call to action in 2023 to improve healthcare structures and systems...

"Health does not occur in the doctor's office, or in the hospitals alone. It is where we live, where we learn, where we work, where we play, and pray, everything that we do, so we have to take our health care where people are."

– **Dr. Regina Benjamin**, Former Surgeon General under President Barack Obama

"The one thing you're supposed to do as a parent is leave your children a better world than the world that was handed to you. I have to look at my three teenagers every day and know that I'm not handing them a better world, and I'm not handing them a better world that was left to me. And a lot of that is because of our failure to really focus on mental health and to do the hard things that it's actually going to take to overcome this mental health crisis that we're in."

– **Dr. Jerome Adams,** Former Surgeon General under President Donald Trump

"If we truly want to go far, we truly want to build things that will last, if we truly want to lift up everyone, we have to move together."

– **Dr. Vivek Murthy,** Current Surgeon General under President Joe Biden

Over the past three years, community has envisioned a model of care for the Tubman Center for Health & Freedom (Tubman Health).

Through thousands of touchpoints via a variety of research engagement efforts, including community design sessions, interviews, and surveys, medically marginalized communities in the Puget Sound region have worked together to design a new standard of healthcare.

Community design goes beyond inclusion to shift true decision-making power in design and implementation to ultimately lie with our community, which includes our current and future patients and providers. Starting with community design is a crucial part of Tubman Health's model; visioning with providers and patients from community to intentionally build from the ground up allows us to collectively dream of and explore opportunities to improve upon the existing strengths in medicine and address inequities that harm our health.

Uniquely, Tubman Health is building a 40,000 square foot community health clinic, slated to open in 2027, from the ground up with community design and community-directed research. All components of the clinic, from the built environment to the care arrangements and model of care have been iterated through the community design process to create a culture of health and wellness.

As a community-created, community-led, and community-owned organization, Tubman Health is distinctively positioned to deliver on new arrangements and systems of community-designed care to shift healthcare in its core design to be more equitable and anti-racist.

Definition of Medically Marginalized

Individuals and communities who:
(1) have been excluded from the design of healthcare historically and currently
(2) are not served by mainstream medicine
(3) continue to face the highest proportion of health disparities and differential outcomes across healthcare.

Medically marginalized communities include, but are not limited to, patients who are Black and Brown, and identify as LGBTQIA+, disabled, LEP/ESP, and immigrant.

Existing Inequitable Arrangements Within Healthcare

Whole-person, patient-centered care that recognizes the tailored needs of each patient, supports the creation of trusted relationships between patients and their care teams, and incorporates integrative medicine is crucial for the health and wellbeing of medically marginalized communities and must be central to efforts towards health equity.

Historically and currently, our communities have relied upon trusted modalities of care, including ancestral medicine that emphasizes the connection between mind, body, and spirit. In the Wellness Equity by Lifting up Local Underreporting Solutions (WELL US) Study, we found that 100% of participants, all of whom self-identified with at least one medically marginalized identity, utilized care modalities considered as complementary or alternative medicine (CAM).[9] WELL US also reaffirmed that members of our communities have preferred methods of care and healthcare modalities that are utilized, including the prioritization of communal care networks centering relationships.

Relationship-centered care (RCC) has been recognized not only in our work, but in other healthcare conceptual frameworks that recognize that "the nature and the quality of relationships are central to health care and the broader health care delivery system."[10] However, despite leaps in healthcare innovation, expanded insurance coverage,[11] and increased recognition of the importance of whole person health care,[12] our communities continue to face medical marginalization and significant barriers, including cost and racism, when attempting to access the types of care that support whole person health within mainstream medicine.[9] These continued inequities contribute to expanding health disparities for marginalized communities.

Insurance access, specifically "having health insurance," is historically cited as a major contributor to utilization of health services and better health outcomes,[13,14] yet barriers to access remain prevalent even after our community members have been enrolled in coverage.[15] The conversation must not stop with insurance access – a lack of health insurance is not the only contributor to health disparities. **Focus must also be dedicated to reviewing the systems, structures, and policies within the payment and reimbursement landscape that keep our communities unwell.** The Washington State Health Insurance Plans Comparison Report found that health insurance plans continue to prioritize the biomedical model, while excluding complementary and alternative medicine (CAM) through blatant exclusion, visit limitations, in-network requirements, tricky wording and fine print, and lack of details in the health insurance plan shopping process.[16] Across the board, the plans researched for the report scored low to medium on metrics for "access to alternative care" and "coverage of relationally driven services."

To increase access to equitable whole person care, more comprehensive and community-inclusive investments in payment model transformation are needed from federal bodies like the Centers for Medicare & Medicaid Services (CMS), which set fee schedules and reimbursement rates for health services as a de facto standard. Paradigm shifts in the payment and billing environment come top down from CMS and alike bodies like the National Academy of Medicine (NAM) and Institute of Medicine (IOM), including (1) the movement toward value-based purchasing (VBP) and value-based care (VBC) from the traditional fee-for-service (FFS) model and (2) the transformation of the United States healthcare utilizing the six domains of healthcare quality – safe, effective, patient-centered, timely, efficient, and equitable.[17,18] **Equity is listed as a core consideration as part of healthcare transformation, yet in practice and implementation, has not been a major area of success, accountability, nor financial investment.**

The desired direction for VBP/VBC specifically has been undercut by the utilization-dependent system that ultimately informs overall rate development. Without a shift in the core foundation of the payment landscape away from the restrictive service-utilization frameworks, specifically the use of encounter-based data for payment validation, the architecture will remain focused on fee-for-service and other volume-driven practices that directly undermine VBP/VBC. The Health Care Payment Learning & Action Network's (HCPLAN) 2021 Measurement Effort, reviewing payment activity, shifts to alternative payment models (APMs), and delivery on health equity goals, demonstrates the limited structural dedication to addressing health disparities at different levels of the healthcare system (Figure 1).[3] The HCPLAN's existing metrics for Health Equity are also equity floors rather than ceilings; the expectations of VBC and standard for healthcare as a whole should be higher.

Despite NAM's dedication to "accelerating health equity" put forward in their 2018-2023

Strategic Plan,[19] and aspirational statements made among other peer bodies for health equity, **efforts for reform have fallen flat as they have continually failed to include patients with medically marginalized identities in decision-making circles and excluded the experiences of members of medically marginalized communities during the design of policies that govern health delivery systems.**[17] Evidence and research into VBP has specifically demonstrated varied to negative impacts on health disparities,[5,6] with trends pointing towards VBP exacerbating health disparities due to its structural design favoring health delivery systems serving advantaged populations over safety net hospitals with more socioeconomically diverse patient populations who face higher levels of medical marginalization.[7]

This report explores potential structural interventions that can shift the course of value-based healthcare to integrate health equity at its core. Future work from the Tubman Center for Health & Freedom will focus on the feasibility and implementation of innovative billing models in community health, primary care, and integrative medicine settings.

Figure 1: APM Measurement Effort 2021 Infographic by the Health Care Payment Learning & Action Network (HCPLAN)

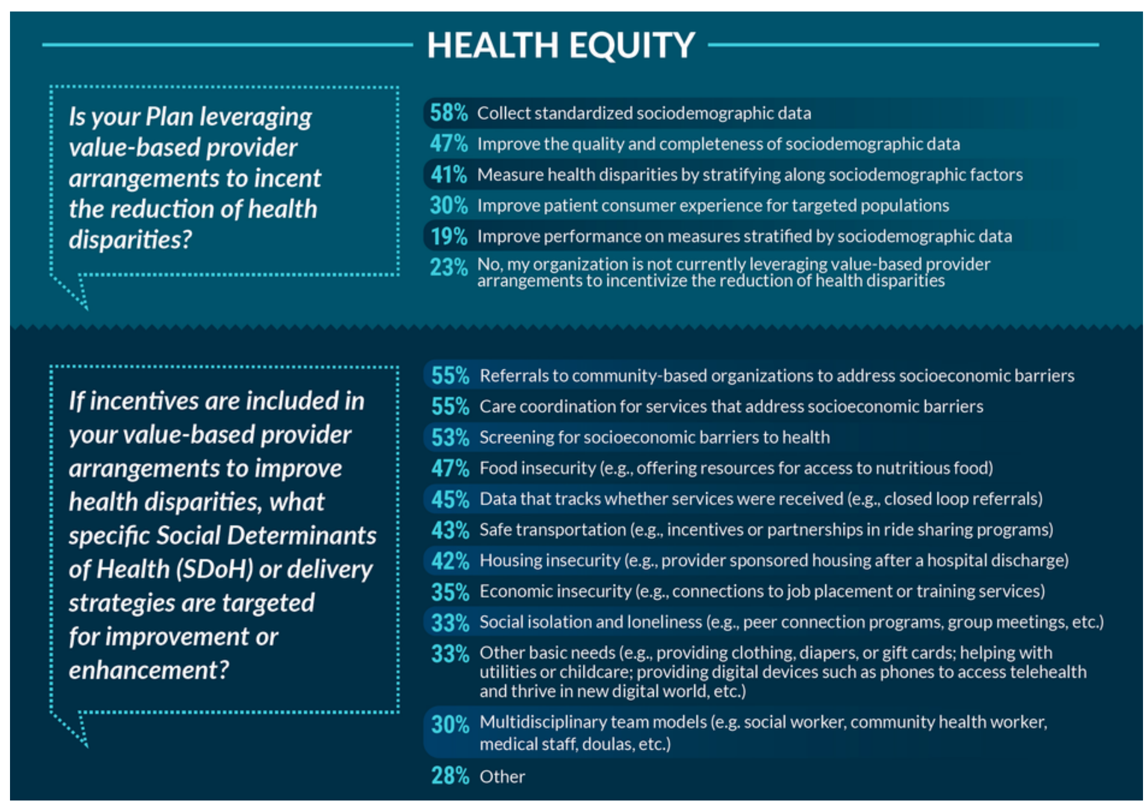


Figure 1: APM Measurement Effort 2021 Infographic by the Health Care Payment Learning & Action Network (HCPLAN).[3] *HCPLAN, a multi-stakeholder group working to accelerate the adoption of APMs in the healthcare system, provides a common framework for measurement. These definitions, such as "value-based provider arrangement", are set forth by HCPLAN and raw payment data received by HCPLAN is analyzed using standard, objective methods across plans.*

The Tubman Difference

At the Tubman Center for Health & Freedom, we will be tracking sociodemographic data, making patient- and data-driven decisions, and including SDOHs in our screening & referrals as part of measurement-based care. Care for patients will be coordinated through our multi-disciplinary, integrated care teams and will include health-related social needs and community resources – recognizing that health does not start and stop at the clinic doors.

Aligning Definitions Within Healthcare & the Payment Landscape

Within healthcare, there are a variety of definitions put forth related to payment models depending on which stakeholders are sitting at the table; within the payment landscape specifically, delineations are no different and a wide range of definitions exist.

Value-based purchasing (VBP) was introduced by CMS in 2010 under the Affordable Care Act as a program to incentivize hospitals to provide quality care to Medicaid and Medicare beneficiaries and shift away from the existing quantity care to quality care.[20] In its implementation, VBP has attempted to shift the standard of healthcare to focus on "value," another term in healthcare that remains loosely defined depending on the audience.[21] With incentive from CMS to shift to VBP in the last decade, health plans and health delivery systems have taken the cue to also attempt shifts to value-based care (VBC).[22] These shifts have not included medically marginalized communities in decision-making roles nor in the creation of definitions. Continuing to design without diverse lived experience and in homogeneous spaces, despite potential positive intent, further increases the risk of medical marginalization and differential outcomes.

The myriad of definitions that exist directly conflict with goals to standardize language, data, and measurement.[23] The ambiguity foundationally contributes to systemic fragmentation – seen through an unclear vision for VBC.[24] Definitions within care that only focus on efficiency and lose sight on the patient drive healthcare further away from its primary user and away from equity in design.

The definitions utilized in this report, displayed in Figure 2, come from an equity and anti-racism lens and a holistic view that includes systems and structures that contribute to and/or mitigate health disparities and health inequities. Utilizing targeted universalism in the baseline definition of terms supports more equitable interpretation; interpretations of these definitions must happen in different settings depending on the audience.[25]

Figure 2: Common Definitions for the Healthcare and Payment Landscape

Integrated Care:
Health services and wraparound care that is driven by the patient, includes partnership and care delivered by a multi-disciplinary care team specializing across healthcare and health-related social needs, and is structurally supported by community, healthcare organizations, delivery systems, and reimbursement structures. Strong integration and power sharing enables equitable care.

Health Delivery System:
Arrangements and organization of institutional providers, including hospitals, community health clinics, physicians groups, healthcare centers, or in partnership/combination/ network, that deliver care to patients.

Value:
Positive experiences and outcomes for patients, including improvements in physical, mental, social, emotional, and spiritual health, measured against costs for these experiences and outcomes for the patient, providers, community health system, and payors.

Value-Based Care (VBC):
In this brief, we utilize the definition put forth in The Commonwealth Fund's 2023 Explainer Value-Based Care: What it is and Why it's Needed.[9]

"Value-based care ties the amount health care providers earn for their services to the results they deliver for their patients, such as the quality, equity, and cost of care. Through financial incentives and other methods, value-based care programs aim to hold providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time."

Value-Based Purchasing (VBP:
In this brief, we utilize the definition put forth in Health Affairs' 2022 Research Brief Value-Based Payment as a Tool to Address Excess US Health Spending.[13]

"These terms refer to a variety of arrangements, all of which are best defined by what they are not: open-ended fee-for-service payments, or straight pay for volume. Value-based payment models can exist at multiple levels within the health care system: the health plan. the delivery system (here used to include institutional providers, such as hospitals, physician groups, or combinations thereof), and the individual clinician."

Figure 2: Equitable common definitions for the healthcare and payment landscape are presented based on community-generated research and sources from strong health policy resources. Select CMS definitions are provided below our equitable common definitions as a point of comparison.

Available Models: Core vs. Supplementary

The American Medical Association (AMA) classifies billing models using three main categories: core payment models, supplementary payment models, and organizational models.[8]

- **Core payment models**, also known as underlying payments models, function alone without additional types of payment methods. Common examples of core payment models are fee-for-service (FFS), capitation, and bundled payments.
- **Supplementary payment models** are models that must coexist with at least one core payment model. They are dependent on the functionality of core payment models in their current design as additional payment methods are still needed to support health delivery systems utilizing supplementary payment models. Popular examples of supplementary models are pay for performance (P4P), shared savings program, and retainer-based payment.
- **Organizational models** function as a system that combines and braids in both core payment models and supplementary models to create an alternative payment model (APM). Some examples of organizational models are the patient-centered medical home and accountable care organization.

The AMA's classifications were chosen over the HCPLAN framework to organize this report as they categorized models based on whether they could exist alone without other payment types (core) or could not exist on their own (supplementary) in the current landscape. The HCPLAN framework (Figure 4) has been leveraged by CMS and numerous states and has many beneficial definitions across the framework. However, HCPLAN utilizes pre-determined categorizations based on foundational architecture that continues to drive quantity over quality care by tying rates and payment back to encounters and volume. HCPLAN's framework was also not conceived with community at the table. Ultimately, as a community-led and -owned health delivery system building from the ground up, the AMA classifications were most appropriate in our analysis and directly applicable to the design of our reimbursement infrastructure.

These models, outlined in Table 1, can be viewed along a continuum, displayed below in Figure 3, starting at FFS and moving toward VBC programs that have various levels of risk and reward. Traditionally, and in Figure 3, the spectrum of payment models has focused on financial risk, which encompasses the likelihood of adverse financial consequences on stakeholder(s). Financial risk is a major area of focus in healthcare, with stakeholder(s) carrying various levels of risk aversion. Understanding financial risk is important to the implementation and adoption of innovative healthcare reform but should not be the sole determinant for reform nor overweighted in cost-benefit analyses. In our analysis in Table 1, we include both the traditional financial risk burden and an additional, complementary, and crucial assessment of risks to patients and health equity for each payment model.

Figure 3: Payment Model Spectrum

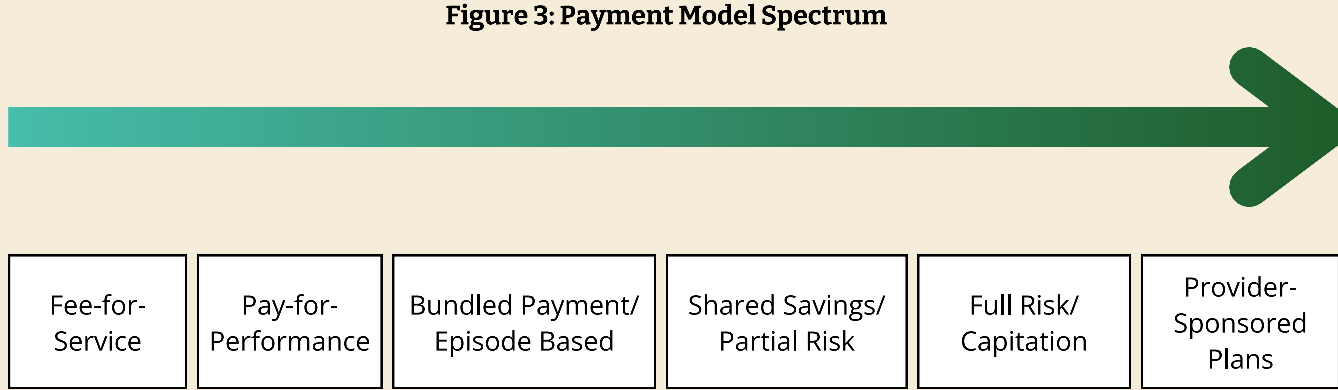


Figure 3: From Chee, et al. demonstrating a traditional payment model spectrum that moves toward higher financial risk and more comprehensive programs.[6] This Payment Model Spectrum does not include considerations for health equity nor impact on patients outside of financial risk.

Table 1: Existing Core vs. Supplementary Payment Models & Their Upsides/Downsides		
Model Type	Model Name	Model Description
Core Models	Fee-for-Service (FFS)	Function: Patients and health plans pay health delivery systems (or individual clinicians) separately for each service they deliver.[26] Who bears financial risk? Financial risk on patients because this model does not consider the cost of treatment for chronic conditions or intensive surgical procedures with recovery. In practice, this model incentivizes health delivery systems (or individual clinicians) to overservice patients and to treat many patients prioritizing volume and quantity over quality of services. What are the risks to patients and health equity? Care risks to patients due to unnecessary care, which increases the risk of harm to patients through inappropriate care and increased burden of care coordination and logistics. For patients of lower socioeconomic status, with limited resources and time, unnecessary care disproportionately carries a negative impact. Takeaways: Volume over quality leads to uncoordinated, fragmented care with repeated services in the delivery of healthcare.[27]
	Capitation	Function: Health delivery system receives payment per patient per set time. Payment covers all or a subset of services. Who bears financial risk? Health delivery systems are exposed to financial risk if services are not properly predicted during prospective time intervals and patients need more than expected care. What are the risks to patients and health equity? Increased barriers to care for patients with chronic illnesses or higher complexity medical needs. Disproportionate chronic diseases rates in the United States exist among racial/ethnic minorities, especially Black and Native communities,[28] meaning this model would increase barriers to care for these medically marginalized patients. Takeaways: Concern of incentivizing underutilization of care. Payments may be risk-adjusted for patient characteristics and are adjusted to the quality of care that physician provides.[26]
	Bundled Care	Function: Health delivery systems paid up front for the cost of care for a specific condition over a set time/episode. Traditionally used for heart surgery, hip or knee replacement. Instead of the patient paying for each service, the patient pays for a period of care. If costs exceed the patient's bundled payment, the health delivery system is still responsible for the remaining costs of the grouped services. Often in practice, the bundle is paid by the health plan on behalf of the patient to the provider. There is usually an accountable provider, as there may be several providers within the model.

Core Models	Bundled Care (cont.)	Who bears financial risk? Providers assume financial risk which incentivizes them to prevent catastrophic or episodic care and coordinate care more effectively. What are the risks to patients and health equity? Patients can receive shortened or incomplete visits, with the underuse of effective services within the bundle, resulting in a decrease in quality care and limited relationship building. The result is a negative impact on trust between patients and their care team because care feels rushed.[29] High-risk patients can also be underserved, as health delivery systems avoid high-risk patients if the risk stratification is not appropriate.[30] Patients can be viewed as non-compliant afterwards with shifts in their health seeking behaviors, perpetuating a cycle of low-quality care. Takeaways: Providers will employ more preventative and collaborative care to minimize the financial risk.[26,27]
Supplementary Models	Pay-for-Performance (P4P)	Function: Health delivery system (or individual clinician) receives bonus or is penalized based on the completion of specific performance goals/value metrics. Who bears financial risk? Health delivery systems (or individual clinicians) bear upside risk with bonus, and potentially downside risk when penalized for not meeting performance goals.[26] What are the risks to patients and health equity? Existing performance-based metrics are non-responsive to actual patient needs and are checklists that have neutral to negative impacts on health equity. Takeaways: Performance improvements are heavily dependent on quality informed incentives. Can be an introductory model for physicians into key aspects of APMs, including value metrics, performance measurement/improvement, incentives, and risk.[6]
	Shared Savings	Function: Health delivery systems (or individual clinicians) receive a bonus that is tied to quality and cost performance benchmarks. Benchmarks are set on a yearly basis or in retroactive periods. Different from capitation and bundled care as bonuses are a share of the total savings relative to a set cost benchmark.[26] Who bears financial risk? Like P4P, health delivery systems (or individual clinicians) bear risk with bonuses or fines. What are the risks to patients and health equity? Increased malalignment in care coordination within this model is burdensome and confusing to patients. Patients are at risk of being labeled non-compliant and further disconnected from their care teams/individual clinicians. Takeaways: Quality care is incentivized over volume of services.

Supplementary Models	Retainer-Based Payment	Function: Patients pay a fee which covers all primary care costs or separate services not billed to insurance companies. Who bears financial risk? Shared risk between patient and provider because the fee does not translate to the cost of direct service. Patients may bear the risk because they are paying without yet receiving services. What are the risks to patients and health equity? Quality is sometimes replaced by the idea of "easier access to providers." Care outcomes have not necessarily seen improvements in this model. Takeaways: Providers do not bill based on volume of visits so that quality can be prioritized. Providers have more time to spend with patients.[26]
	Pathways	Function: Patients pay fees which contribute to structured coordinated care and meetings with patients, caregivers, and providers to define consistent pathways for care that prioritize cost-effective treatment regimens. Traditionally associated with oncology care and geriatric rehabilitation. [31,32] Who bears financial risk? Like retainer-based payment, there is shared risk between the care team and patient. What are the risks to patients and health equity? Differential implementation of the model that depends on the health delivery system (i.e. academic health center vs. community health center) and the drivers of the effort. Has not fully incorporated patient experience, outcomes, or care quality into the model, but focused on providers. Takeaways: Pathways minimize unnecessary variation in treatment patterns and improve quality of care while reducing costs. [26]

Organizational Models & Their Points of Tension

Supplementary models are not able to stand alone, but must coexist with at least one other core model, resulting in their appearance in organizational models solely in supportive roles. Organizational models integrate multiple types of core and supplementary models to create Alternative Payment Models (APMs). Two popular organizational models are the Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO), which can co-exist together or separately.

While limited, the adoption of APMs to date has provided a variety of positive contributions to the field of VBC. These include new learnings, investments in data and analytics systems for collection and management, expanded incentive models for individual clinicians that include both financial and nonfinancial options, and increased diversity in the types of roles included within care management models.[26,32]

Challenges and learning opportunities that have arisen in implementing APMs include: managing the increase in the volume of nonclinical activities and associated documentation; conflicts for health delivery systems incentivized by different incentive structures from different health plans in their shift from volume to value; and difficulty negotiating contracts with health plans still focused on FFS.[26] In 2018, 43% of physicians in the U.S. said their compensation plan included some form of VBP, but 50% of these respondents said that the VBP amounted to less than 10% of their income.[26]

The Health Care Payment Learning & Action Network's 2021 Measurement Effort found that provider interest/readiness remained a top barrier to the adoption of APMs, with 22% of health plans reporting that they did not have a strategy for contracting with providers to use population-based APMs (Category 4 in Figure 4).[3]

Figure 4: Organizational Models & Their Points of Tension

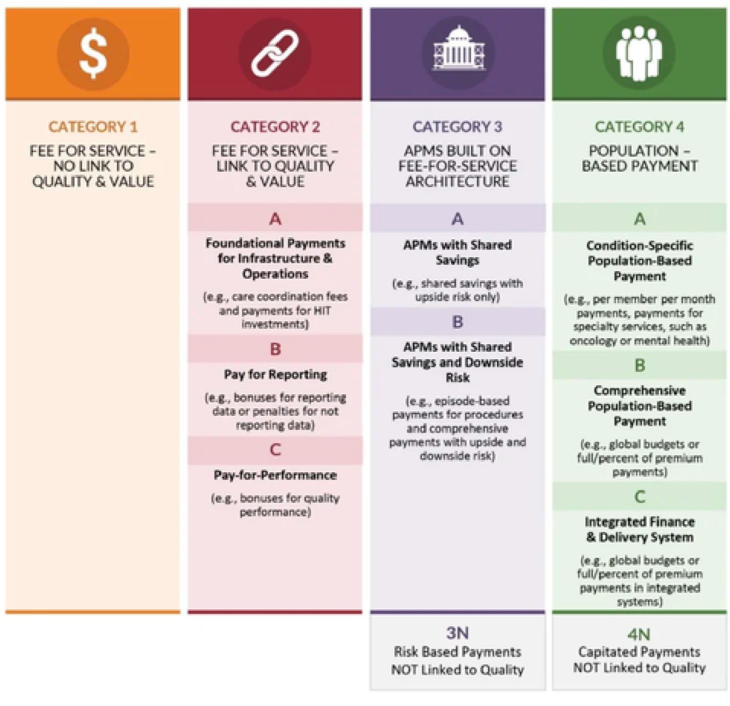


Figure 4: A comprehensive APM framework provided by the Health Care Payment & Learning Action Network (HCPLAN).[10] HCPLAN does not believe that all providers should/can be at the most advanced payment model.

Patient-Centered Medical Home Models (PCMH)

Patient-Centered Medical Home Models (PCMH) consists of a health delivery system with a highly coordinated team based around the primary care physician as the core clinician. Collaborative in nature, this model prioritizes preventive whole person integrated care with strong, trusted relationships between the clinicians and patients.[33,34] This model allows for increased risk stratification to better identify patients in need of more resources and expand the access patients have.[26]

In practice, PCMH models have shown to improve quality and satisfaction among both patients and clinicians, while generating cost savings.[35] However, **both quantitative and qualitative studies reviewing the impacts on addressing health disparities have demonstrated that PCMH models have further exacerbated inequities.**

Specifically, PCMH enrollment was shown to increase racial disparities among Black patients when compared to their White counterparts.[36] This could be due to the lack of intentional design for medically marginalized communities and turning a blind eye to the impact of racism in healthcare; original PCMH recognition standards did not reflect equity criteria.[36] Stakeholders across healthcare, including health plans, health delivery systems, and clinicians shared that PCMH in its current state had "minimal or indirect influence on health care disparities."[37]

Accountable Care Organizations

Accountable Care Organizations (ACO) consist of a collective of providers from different specialties that work together to support a large patient population. Providers can function as individuals (i.e., specialty physicians, family doctors) or as institutions (i.e., hospitals, clinics). Coordinated care is an expectation of ACOs as the affiliated providers come from diverse specialties with a baseline understanding of the consequences of fragmented care, such as overservicing and costly care.

With ACOs, there are quality and cost benchmarks that help to manage the care of the collective organizations and penalties for underperformance on targeted measures. When ACO targets are met, providers share the savings; providers incentivized not to overservice with benchmarks focused on limiting cost.[27] In their design, ACOs can "reinforce racial/ethnic differences in sites of care by further concentrating patients from certain/ethnic groups within particular health care organizations," which may be "associated with the historic, systemic, and social barriers that African American patients face around discrimination, access to quality care, [and] trust in the healthcare system"[38]; **ACOs can increase medical segregation for medically marginalized populations.**

Continued research has demonstrated the need for patient-centered design with varying outcomes and responsiveness to strategies for preventable hospitalizations for patients with different race/ethnicities within the ACO model.[39] For effective patient-centered design, it is important that local communities lead the efforts to support geographic, racial/ethnic, and cultural concordance.

The Case for Supplementary Models Standing Alone

Currently, many health delivery systems rely on core payment models to bill patients; CMS programs utilize Fee-for-Service (FFS) core models, or organizational models like the Patient-Centered Medical Home (PCMH) and/or Accountable Care Organization (ACO). Within these arrangements, supplementary models have demonstrated their various strengths that core models do not have, including strengths in measurement and benchmark incentivization, yet they are still unable to exist on their own. Supplementary models address failures of core models as they are (1) supportive of integrated and collaborative models of care, (2) equitable in design and accountable in meeting the needs of medically marginalized populations with the inclusion of benchmark payment systems monitoring outcomes, (3) able to be sustainable from a financial standpoint. However, there is minimal research focused on supplementary models standing alone to support the delivery of integrated care. As supplementary models cannot exist without a core payment model, health delivery systems are limited in their potential pathways for reimbursement and sustainability.

Core payment models fail to support major components of integrated, coordinated care despite recent progress and improvement. For example, FFS often results in uncoordinated care, fragmentation, and repeated services, leading to health disparities and poor performance in equity-specific quality measures. FFS does not work well with many of the longitudinal, team-based care models, especially in reimbursement covering critical integrative medicine care team roles (i.e., care coordinators, community health workers, patient navigators, and community outreach workers).[27] This failure of FFS has been demonstrated during the implementation of the collaborative care model, which is "a systematic strategy for treating behavioral health conditions in primary care through the integration of care managers and psychiatric consultants".[40] FFS also limits office visit times, causing rushed treatment planning, and incentives directly against appropriate treatment, which has a magnified negative impact on patients with chronic conditions.[41]

Key Takeaways

Supplementary payment models are seen solely in support roles to core models but have the potential to stand alone as more equitable APMs that better serve all patients, including medically marginalized patients.

- Core models fail to support integrated, coordinated care models, such as the collaborative care model, in their current iteration directly incentivizing against coordinated, quality care and leading to poor performance in equity-specific quality measures.
- Supplementary models help create an internal environment that is focused on building trusted relationships between team-based clinicians and between clinicians and patients – improving clinician satisfaction and trusted, quality care for medically marginalized patients.
- Supplementary models better support medically marginalized communities, especially patients with higher-risk and multiple co-morbidities, with patient-centered cost-effectiveness and quality measures adapted to these specific communities.
- Supplementary payment models can stand alone financially with promising cost-effectiveness and cost-utility after immediate investments in infrastructure to observe quality measurements and additional providers to facilitate collaborative care.

Further equity-driven research, specifically focused on implementation, piloting, and the inclusion/ partnership of patients from medically marginalized communities, is needed among the various supplementary models to create evidence for scale.

Core models that can better address chronic conditions include bundled care and capitation, yet these models are hindered by a lack of widespread implementation support and underutilization of appropriate incentives. Bundled care has only been utilized for a minimal number of health services, such as surgeries or technology-intensive treatments and maternal care. The UW AIMS Center is at the forefront of the conversation to expand the definition of bundled care to incorporate collaborative care in the behavioral health field. However, only including collaborative care in the expansion of bundled care misses other medical models and opportunities for innovation in the delivery of care.[27,42,43] Similarly troubling, although capitation supports collaborative care, health delivery systems no longer incentivize increasing the volume of visits for the total patient population, which consequently negatively affects care for chronic patients needing continuing care over episodic treatment.[26,41]

Supplementary payment models provide stronger backbones for integrated, coordinated care, structurally supporting the development of trusted relationships between the care team clinicians and the clinicians and patients. Retainer-based payment is utilized in select primary care settings, but is slow in adoption among specialists.[26] Longitudinal, trusted relationships between providers-patient and primary care provider-specialist are essential components of quality integrated medicine and can lead to more productive team relationships among clinicians and a decrease in average healthcare utilization.[44] Retainer-based payment creates the structural space for the creation of these longitudinal relationships to develop, leading to these beneficial outcomes. Additionally, the supplementary models of pathways and shared savings embrace collaboration. ACOs rely heavily on the shared savings models in their billing procedures in which care is provided through a collection of practices; this reliance was heavily encouraged by CMS through rules that were adopted in 2011, revised extensively in 2016, and continue to be updated.[26,45,46] Within the shared savings model, coordinated resources work to complement the shared agreement among providers to provide quality care. Through the shared agreement and benchmarks set, providers come together to build relationships and find solutions to meet targets, while having the potential for increased financial sustainability.[47] The pathways model improves continuity and coordination of care by encouraging collaboration on the predicted clinical trajectories of patients, especially in oncology and geriatric care.[31] Collaborative care is essential for integrated medicine in primary cancer treatment, supportive care, and geriatric rehabilitation. Specific to pathways, physician buy-in and satisfaction have been higher when the pathways are provider-driven compared to payer-driven.[32]

Supplementary models are more equitable in supporting medically marginalized patients compared to core payment models. Health plans that use capitation apply attribution rules that intentionally exclude patients.[8] There is a high likelihood that medically complex patients are excluded in bundled care models if payments are not appropriately risk-adjusted. Patients with comorbidities or chronic conditions pay more out of pocket which decreases access to care for these high-risk populations; 94% of providers worried that bundled payments create disincentives to operate on high-risk patients.[26] Alternatively, a subset of the supplementary retainer-based payment model - direct primary care - charges lower retainer fees and does not bill by volume which attracts more socioeconomically diverse patients. Pay-for-Performance (P4P) incentivizes providers to meet quality measures (i.e. productivity, quality of care, cost reduction, patient outcomes, coordination of care, care transitions, equity, reduction in disparities) where health delivery systems can direct providers to support patients, especially medically marginalized patients that face the most extensive health inequities and disparities. Similarly, with another supplementary model – shared savings – health delivery systems can intentionally choose quality measures to observe how the payment model is affecting racial and socioeconomic disparities and reward health services that promote health equity.

Supplementary models can stand alone after initial financial investment. Healthcare has invested for decades in core models, especially FFS. Due to this historical, structural design, necessary and equitable innovation in healthcare requires high levels of initial investment. For example, shared savings can be

considered costly upfront when prioritizing quality benchmarks where it is hard to recoup investment, while other supplementary models carry costly membership fees and funding to support the setup of systems for triage, tailored electronic health records to track appropriate outcomes, and management of additional collaborative specialties and healthcare workers. After the initial investment, strong risk-adjustment methods and back-end savings from preventative care delivered in these integrated settings relieve upfront costs.[26] In a study with the pathways supplementary model in the Netherlands, a country that leads in piloting this model, economic savings from shorter hospital stays and decreased overutilization addressed the implementation barrier of costs. Total costs in the care pathway were significantly lower than their counterparts (€57,350 usual cohort vs. €42,516 pathways cohort). When adjusting for patients with incomplete cases and those who died, the pathway model remained a cost-effective intervention.[31]

Supplementary models have the potential to shift the healthcare landscape to better serve patients and providers, address health equity as a core outcome, and create long-term cost savings. With the demonstration of theoretical and early implementation benefits of supplementary models, a necessary next step to prove the standalone value of these models is to engage in equity-centered health services research studies focused on feasibility, implementation, and outcomes. These studies should be carried out outside of the limitations of current models and systems to enable innovation and equity.

Additional Barriers & Opportunities Impacting the Delivery of Equitable Care

Further exacerbating the inequities driven by the structural design of available payment models are a multitude of barriers in the payment landscape between (1) CMS and health plans, (2) health plans and health delivery systems, and (3) health delivery systems and individual clinicians. In these spheres of accountability, health services research on VBP and VBC has focused on the relationship between health plans and health delivery systems.[20] The additional barriers highlighted in this section follow these spheres of accountability, but equally look at the three levels of relationships. Barriers were determined through a scoping review of the existing literature, including current healthcare policies & practices, and discussion with experienced healthcare administrators, clinicians, and policymakers. They build on the policy design tools for equity proposed in June 2023 in Health Affairs by Navathe, et al. that review organizational participation, payment rules, risk adjustment, performance measurement, spending targets, performance-based incentives, and care redesign and the six implementation recommendations for antiracist payment reform put forth in January 2023 in the AMA Journal of Ethics by Singletary and Chin that address insurance access and coverage, managed-care contracts, the safety-net system, nonprofit hospital tax status, and payment incentives.[5,48]

Due to intersecting, layered relationships in the payment landscape, barriers and recommendations may touch multiple stakeholders. In our review, barriers and their associated recommendations were categorized under the sphere of accountability in which the implementation of recommendations would carry the greatest impact. An overview of these barriers and recommendations is provided in Table 2.

Table 2: Overview of Barriers to Equity in the Payment Landscape & Recommendations

Spheres of Accountability	Existing Barrier	Recommendations
CMS to Private Health Plans	Lack of Support for Health Delivery Systems Serving Medically Marginalized Communities	Evaluate the Shared Savings Program (SSP) to understand the full scope of impact, including the inequities in its design, and make appropriate adjustments.
		Adjust social risk payments to incentivize APMs to care for medically marginalized communities and have quality verified by the patients.
		Increase accountability with charity care practices and community benefit – focusing on the nonprofit hospital tax benefit, collection practices, and bad debt.
	Design of Core Quality Measures	Shift the makeup of decision-making bodies that determine measures for payment programs to create majority representation from members of medically marginalized communities.
		Adopt a robust definition of “equity” that comes from medically marginalized communities.
	Exclusion of Equitable Diagnostic & Treatment Codes	Standardize coding requirements for health plans and update codes for extended treatment, especially for mental health.
		Hold health plans accountable to existing health parity laws.
		Use authority of CMS to advocate for the increased inclusion and recognition of diagnoses around trauma, racialized weathering, and traumatic stress.

CMS to Private Health Plans	Disproportionate Cost Burden/ Undervaluation of All Care Team Members	Standardize sustainable reimbursement across different types of clinicians, especially those who are patient-centered and community-engaged.
		Increase reimbursement rates and coverage for care modalities medically marginalized communities rely on, including complementary & alterative care and services addressing health-related social needs.
		Review implementation costs and support opportunities to make piloting APMs and other innovative models, including investment in capacity development, more accessible to health delivery systems.
Health Plans to Contracted Health Delivery Systems	One-Size-Fits-All Approach to Quality Measures & Required Reporting	Include social needs assessments and tracked outcomes for social determinants of health (SDOH)/health-related social needs.
		Disaggregate data beyond existing sociodemographic standards to address erasure – data can always be reaggregated for power but cannot be disaggregated after collection.
		Pilot more explanatory reporting metrics, including measures that can be drawn from rigorous qualitative methods, to understand mechanisms driving health disparities.
	Missing Behavioral Health Parity for Whole Person Care	Incentivize health delivery systems to include a wide suite of mental and behavioral health services, including health promotion/education, preventative care, early intervention, and social services.
		Hold health systems accountable to existing parity laws.
		Support piloting and feasibility studies among community-led organizations that focus on whole person interventions specific to medically marginalized communities.
		Increase access to telehealth services for mental and behavioral health through structural support and insurance coverage.

Health Plans to Contracted Health Delivery Systems	Health Delivery System Transparency & Accountability	Track referrals for SDOH and health-related social needs among health delivery systems against patient outcomes.
		Work in collaboration with other public agencies to provide oversight into health delivery system practices.
	Lack of Partnership with Clinicians & Communities on the Ground	Fund programs that encourage clinicians to build relationships and work with patients outside the clinic doors.
		Provide opportunities for clinicians who are engaged in equitable, community-driven work to be part of decision-making tables.
		Increase opportunities for feedback and iteration, transparently showing the changes made based on feedback.
	Ineffective Incentives & Speed Prioritized Over Quality	Hold foundational trainings for all clinicians to create shared understandings of health and health-related social needs, trauma-informed care, and community-centered care.
		Build in longer time horizons for major payment/ reimbursement transitions to garner clinician buy-in and partnership.
	Reliance on Screening Tools that Exclude	Fund community-directed research into priorities set by community.
		Create transition tools that can support diagnosis and understanding of diverse presentation of health needs across differing communities.

Sphere of Accountability: CMS to Private Health Plans

Barrier: Lack of Support for Health Delivery Systems Serving Medically Marginalized Communities

Safety-net hospitals traditionally care for a higher percentage of patients from medically marginalized communities. The design of the Medicare Shared Savings Program has pushed out ACOs that are safety-net hospitals and serve more medically marginalized populations – namely "patients with greater disease severity and complexity." [49] The structural exclusion in the participation of providers that work directly with more socioeconomically and racially diverse patient populations increases the reliance of health plans on FFS and other quality metrics that directly drive against equitable care and the goals of VBC.

Recommendation(s):

- Evaluate the SSP using mixed-methods approaches, focusing specifically on the drivers that push out ACOs serving medically marginalized communities. With the findings, update the structure, policies, and design of the SSP program to move toward health equity. Transparently share the findings and learnings for progress toward more equitable VBC. This evaluation process can support current changes for newer programs launched by the CMS Innovation Center, such as the Making Care Primary (MCP) 10.5-year model launched in 2023 across eight states including Washington.[50]
- Adjust social risk for payment to make additional APMs like ACOs more likely to enroll and care for medically marginalized communities. As an additional layer of accountability, have quality verified by actual patients and value defined by community.
- Modify the nonprofit hospital tax benefit by redefining community benefit and charity care to be more equitable and accountable. Be accountable with charity care laws and measure the actual impact and follow-through with care for medically marginalized patients, reviewing bad debt and collection practices.

Barrier: Design of Core Quality Measures

In their design, current core quality measures do not support health equity, with an overly centralized, top-down definition of the goal of equity and an overemphasis on metrics that, when implemented, drive down quality of care and reproduce health disparities.

Recommendation(s):

- Evaluate and shift the makeup, including sociodemographic identities, of the Core Quality Measures Collaborative (CQMC),[51] a public-private partnership between American's Health Insurance Plans (AHIP) and CMS that sets core quality measures, and other similar entities. The CQMC sets the core quality measures to align public and private payors and create systems efficiency. These are measures that health plans are required to report yet have continued to drive health disparities and quantity over quality in care because they continue to exclude lived experience, and the unique considerations that come from heterogeneous groups, in their design. CQMC and related bodies do not present as truly diverse public-private partnerships and coalitions, but rather as top-down entities that make decisions without patients and community. Specifically, shifts in the makeup should be made to create majority representation from medically marginalized communities.
- Adopt a definition of health equity from medically marginalized communities most impacted by health disparities and provide opportunities for seats at the table and true decision-making process during the design process for patients from medically marginalized communities to integrate this definition into quality measures.

Barrier: Exclusion of Equitable Diagnostic & Treatment Codes

As of 2023, codes for extended therapy sessions were removed by CMS and the AMA. Specifically, the extension codes 99354 and 99355, which were used commonly with 90837 (psychotherapy for 53+ minutes), were to be replaced by 99417. However, 99417 is only allowed to be billed with 99245, 99345, and 99350, which are all evaluation and management outpatient codes that lack the mental health focus.[52] The extended codes that were sunsetted were previously used for extended therapy sessions, including effective trauma therapy techniques like Eye Movement Desensitization and Reprocessing (EMDR) Therapy. This compounds the fact that diagnoses for Complex Post Trauma Stress Disorder (C-PTSD) are not recognized in the United States in the DSM-5, despite its recognition by the World Health Organization and inclusion in the ICD-11.[53] These shifts are problematic for patients from medically marginalized communities, especially those identifying as Black and/or Indigenous, who have been repeatedly traumatized due to the impacts of racism and the disparate impacts from COVID-19 which is compounded by existing underdiagnosis and treatment for mental health conditions.[54]

Recommendation(s):

- Standardize coding and update codes for extended sessions that all health plans must follow, which has the potential to improve transitions when patients switch health plans and are navigating their benefits, support trust-building in the relationship between patients and their individual clinicians, decrease out of pocket costs for patients, increase preventative care use over emergency care, and support in addressing impacts of trauma and the ongoing mental health crisis in this country.
- To support mental health parity, CMS can hold health plans accountable to existing parity laws through a fine and punish strategy – in the form of a stick incentive – by focusing on effective oversight strategies. The emphasis should build on the progress in 2023 focused on compliance in respect to nonquantitative treatment limitations (NQTLs), including prior authorization requirements, that have hampered efforts to ensure parity.[55] For any future parity task forces, there should be a clear understanding of the experience of multiple users within the system, and analysis of the implementation of enforcement.
- Using the authority of CMS, move other institutions to recognize the impacts of trauma, traumatic stress, and racialized weathering; whole person care must be considerate of the differential baselines that patients walk in the door with.

Barrier: Disproportionate Cost Burden/Undervaluation of All Care Team Members

Not all roles in any given care team are equitably supported, with differential to no reimbursement for certain roles. Many preferred modalities for care among medically marginalized communities, such as complementary and alternative medicine (CAM), have seen cuts in reimbursement rates over time. The Collaborative Care Model (CoCM), a strong integrated care example, stresses community engagement, but only medical interventions are reimbursable. Care coordinators, CHW, and outreach are not reimbursable roles under FFS. To financially sustain this model, the health delivery system bears the cost of a full billing team to advocate with payors and track denials. Billing scenarios are further complicated when attempting to include support systems/families for pediatric patients. For smaller health care systems, the cost burden deters even piloting the CoCM model, despite its success across outcomes.

Recommendation(s):

- Standardize reimbursement rates across community-engaged practices, making sure that diverse care roles are also equitably reimbursed and included as a core part of clinical teams. Ensure that all health plans follow the standard, equitable reimbursement rates and decrease the administrative burden for health delivery systems. For example, with the Collaborative Care Model (CoCM), there are a set of codes and payments for Medicaid reimbursement that have been standardized across a series of states including Washington. These additional codes have supported the effective implementation of CoCM, a successful integrated care delivery model, as they cover the whole team of clinicians and care managers.[42]
- Increase reimbursement rates and coverage for care that medically marginalized communities utilize, including CAM modalities, like massage therapy and acupuncture, and services addressing health-related social needs.
- Review available APM implementation and startup funding opportunities, associated incentives, and accessibility of these capacity development opportunities, focusing on health delivery systems that work with medically marginalized patients.

Sphere of Accountability: Health Plans to Contracted Health Delivery Systems

Barrier: One-Size Fits All Approach to Quality Measures & Required Reporting

The current quality measures and mandated reporting that health plans require from health delivery systems do not support health equity, as they often exclude health-related social needs, overly aggregate data which supports cultural erasure and disparities within groupings, and do not encapsulate the mechanisms through which disparities are happening within the health delivery system. Definitions of qualities should meet patients where they are; one rigid set of measures across different geographics, sociodemographic groups, and health delivery systems does not recognize these distinctions.

Recommendation(s):

- Be more inclusive of health-related social needs — which can be reflected within quality measures and required reporting from health delivery systems that carry metrics from social needs assessments and tracked outcomes for SDOHs.
- Prioritize quality measures and reporting from health delivery systems that observe how the payment model is affecting racial disparities among patients — specifically disaggregating data within overarching racial ethnic groups. The disaggregation of Asian American Pacific Islander (AAPI) communities has supported a clearer understanding of health disparities.[56] For other identity groups, including Black/African American and American Indian/Alaska Native (AIAN), further granularity and disaggregation, such as into country of origin and tribal affiliations, can support decision-making with stronger, patient-centered approaches.
- Pilot qualitative and mixed-methods indicators within reporting from health delivery systems that can explain the mechanisms driving health disparities and create concrete strategies for action.

Barrier: Missing Behavioral Health Parity for Whole Person Care

Behavioral health parity is in namesake and not in practice and implementation in many circumstances, despite protections in the Affordable Care Act (ACA). Incentives that do not consider whole person health care further perpetuate the lack of consideration and inclusion of mental health needs.

Recommendation(s):

- Health plans should incentivize health delivery systems to include more mental and behavioral health promotion, education, preventative care, early intervention services, and social services.
- Health plans should hold health delivery systems accountable to existing health parity laws through a fine and punish strategy to complement the existing carrot incentives that have been given to delivery systems.
- Health plans should support community-designed, patient-centered pilots and feasibility studies for whole person interventions that are market/region-specific and center medically marginalized patients.
- Increase access to telehealth by providing coverage and support for initial costs to accessing telehealth services for members (i.e. internet-enabled device, internet services).

Barrier: Health Delivery System Transparency & Accountability

Some health delivery systems have murky practices that are profit-driven, harming the patient – including in cases when health plans and patients are overbilled together, and others in which patients are improperly denied charity care. These practices do not only impact health plans, but also impact public funding and public agencies, and ultimately health seeking behaviors among patients.[57] Certain health delivery systems have been documented patient dumping low-income, medically complex patients and frequent flyers out of their emergency departments rather than coordinating their care; in Washington, there are several charity care lawsuits ongoing, where the health delivery system benefited from charity care laws from the state but sent low-income patients to collections for unpaid hospital bills.[58,59]

Recommendation(s):

- Track closed-loop referrals for SDOH and health-related social needs against patient outcomes to see which health delivery systems support continuity of care compared to delivery systems receiving funding without creating change for their patients.
- Work with other state agencies to require transparency with billing practices to prevent overbilling, patient dumping, and health delivery systems keeping charity care dollars.

Sphere of Accountability: Health Delivery Systems to Individual Clinicians

Barrier: Lack of Partnership with Clinicians & Communities on the Ground

Health delivery systems have the opportunity to integrate their care with the resources that exists within the communities that they function within, but fail to create the power sharing relationships that are necessary to facilitate these partnerships. Individual clinicians and other members of the care team who are actively engaged in the community, especially in roles that look at whole person health, carry a wealth of understanding and knowledge that those more distant from direct care and community can benefit from. Major barriers to future APM adoption include "provider willingness to take on financial risk," "provider ability to operationalize," and "provider interest/readiness;"[3] understanding why clinicians are hesitant is important to stronger implementation.

Recommendation(s):

- Funds for incentives should be redistributed to support relationship building between individual clinicians and their patients, rewarding clinicians who have been engaged in the community and encouraging others to begin thinking of care outside just the clinic doors. For example, a few joint programs that could be funded are patient mobility, health literacy and education, needs assessments, and finance/social supports. There could also be incentives targeting care teams that have the ability to increase coordination and provide these joint programs.
- Including individual clinicians who are innovating and leading health equity work in decision-making circles could benefit the health delivery system as a whole and improve the relationship and understanding between the administration and clinicians.
- Increase opportunities for all staff within the health delivery system to give feedback and inform their job function to support progress and innovation, while improving the relationship between employer and employee.

Barrier: Ineffective Incentives & Speed Prioritized Over Quality

Existing financial incentives to change individual clinician behavior have been short-lived band-aid solutions that are tied to performance and process measures that shift away from long-term impact by incentivizing against outcome measures and long-term patient outcomes. In 2018, 43% of physicians in US said their compensation plan included some VBP but 50% of these respondents said that the VBP amounted to less than 10% of their income.[26] The incorrect use of financial incentives over non-aligned time frames increases excessive, inefficient spending by wasting resources that could be better utilized.

Recommendation(s):

- Design, with the patients, foundational training for the individual clinicians. Hold foundational training for all individual clinicians, where there is clear guidance on community-based collaboration, a shared understanding of SDOHs, focus on trauma-informed and culturally responsive care, knowledge on how to refer for health-related social needs, and shared definition of health equity. Change actions by changing hearts and minds.[24]
- Build in longer time horizons for major shifts and space for engagement, questions, and iteration. APMs that have allotted for the longer time horizon have been more successful, even "with the more advanced models that shift greater accountability onto providers."

Barrier: Reliance on Screening Tools that Exclude

Gold standard diagnostic tools that are not designed for medically marginalized communities and diverse patient bases are the basis for diagnosis and treatment across the board, which leads to insurance reimbursement and service coverage. Research has historically excluded or extracted from medically marginalized communities, including medical interventions and clinical trials. The lack of diagnosis and appropriate treatment causes worse health outcomes for medically marginalized patients. This can be seen among the underdiagnosis of ADHD among women of color and the high rates of autoimmune conditions among women.

Recommendation(s):

- Fund research that is inclusive and in partnership with communities most impacted and who have been historically excluded in the design of screening tools. Look specifically at the cultural relevance and implementation of gold standard tools that are commonly used in clinical settings, including the Patient Health Questionnaire-9 (PHQ-9) and General Anxiety Disorder-7 (GAD-7), as well as criteria put forth in the Diagnostic Statistical Manual of Mental Disorders (DSM-5) that are used to diagnosis other conditions like ADHD.
- Create translation tools that are culturally relevant, incorporate targeted universalism, and are designed with patients from medically marginalized communities for diagnoses and to better understand the diverse presentation and symptomology of conditions and needs that exist. With the underrepresentation of medically marginalized communities in clinical trials[60] and in the creation of tools, rating scales, screeners, and other diagnostic devices, it is important to shift the design process to be truly inclusive and equitable to address health disparities.

Implementation of these recommendations within the different spheres of accountability can support shifts toward a more equitable healthcare landscape. Utilizing levers in the payment environment that do not lose sight of the patient, and especially those from medically marginalized communities, is crucial in forward movement to address health disparities.

Summary

Centering specific levers within spheres of accountability is one step among many needed to full address barriers of healthcare in the United States. Health justice requires us to connect the barriers that we see to a larger systemic issue: **current reimbursement policies uphold and reinforce a structurally racist healthcare system that directly harms Black and Brown patients by perpetuating differential health outcomes.** Medically marginalized individuals are overrepresented in the Medicaid system yet have the greatest difficulty accessing quality care.[48] These patients are expected to receive impactful care in a one-size fits-all model that does not account for their diverse medical and social needs: a standard of care that continues to utilize cost benchmark measures and rates based on volume that directly incentivize against quality care.

Racism within the structural design of the payment landscape further perpetuates existing health disparities driven by medical racism, bias, mistreatment, and marginalization. Research from early 2023 continues to highlight the widening disparities, despite the myriad of health equity initiatives.

Healthcare is shifting toward whole person care with a focus on addressing the mental health crisis, but the benefits of innovation and investment are not shared, despite the shared cost. During a primary care visit, Black patients are still 40% less likely than their White counterparts to have a mental health concern addressed.[61]

Integrated medicine has been a proven solution to address mental health and other health needs, but is financially unsustainable in the current climate, especially for health delivery systems that serve medically marginalized communities. There should be a payment environment that provides enough flexibility that cost is not restrictive to quality care. To create such an environment, the payment landscape needs drastic shifts. Supplementary models can provide a pathway forward if they are given adequate resources and attention. These models have been essential in highlighting quality care measurements, centering conversations with patients, and prioritizing the components needs for integrated, coordinated care as supplements to core models. There is minimal research that supports supplementary models functioning as the singular payment model backing models of care – further piloting and feasibility research into supplementary models functioning alone without the aid of core payment models could support ushering in value-based care (VBC) that is more equitable and accessible.

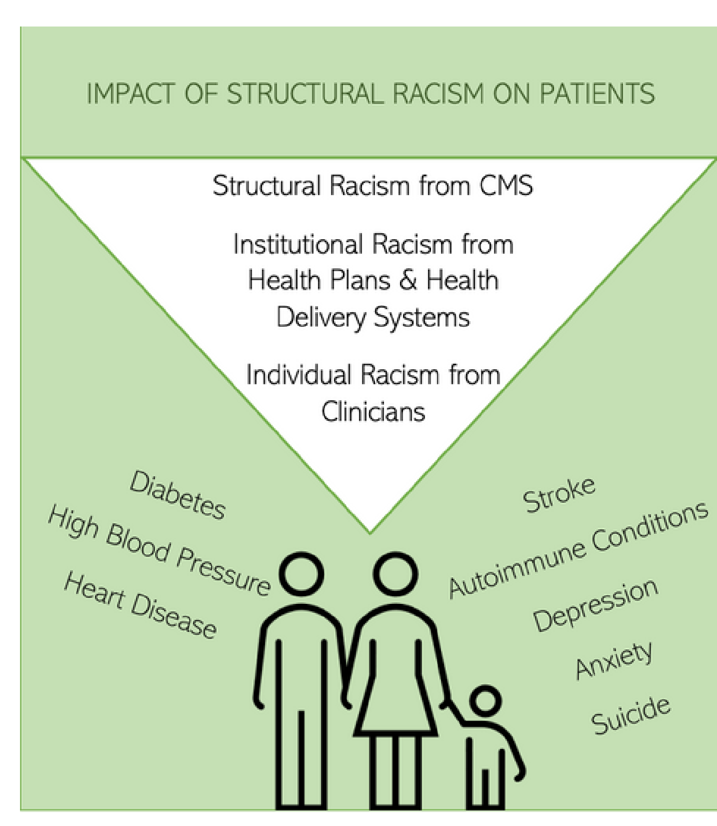
Healthcare in the United States is expansive, at time confusing, and above all, a deeply interwoven structure with pre-arranged positions for power and accountability. This report is only the tip of the iceberg in focusing on opportunities for increasing health equity in the environment.

Firmly, as progress is made, it will be important to remember these core tenets:

1. Redefine who is at the table with the power to make systemic changes.
2. Include and prioritize the concerns of patients and providers from community who are most negatively impacted.
3. Rectify impact of those structures on providers and workforce development.
4. Prioritize health justice in future plans for implementation.

Above all else, it is essential that the solutions and re-design be community-driven to recognize the innate expertise of lived experience.

At the Tubman Center for Health & Freedom, these tenets drive our work forward and inspire our work. As community members working within a community-owned organization, we are uniquely positioned to collaborate with our peers and communities to understand and prioritize our health needs through our research, our clinical delivery, and the design of our model of care. **Community-driven priorities and design in healthcare, including research, is the gold standard for health equity.**



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