

Collecting Better Data I: Incentives, Framework, Mission

RAISE Community Workshop 2

Thursday, February 2, 2023, 2 – 3 PM ET

Summary

Overview of RAISE Community Workshop II


During RAISE workshop II, we had welcome remarks from Susan Winckler, CEO of the Reagan-Udall Foundation, and RDML Richardae Araojo, FDA Associate Commissioner for Minority Health and Director of the Office of Minority Health and Health Equity. During the session we heard two presentations. First, Dr. Leo Russo of Pfizer, Inc., provided a framework on improving diversity in clinical trial recruitment. Next, Kate de Lisle of Leavitt Partners, presented an overview of how the value-based payment system advances health equity. The session was closed with a discussion moderated by Dr. Amy Abernethy.


Connecting the Dots: From Opportunities → Incentives & Framework

Carla Rodriguez-Watson, PhD, MPH

Director of Research, Reagan-Udall Foundation for the FDA

The presentations of Workshop I: “Improving Race and Ethnicity Data in Health Care” showed that infrastructure changes are needed to increase the capture, curation and transfer of race and ethnicity data. Additionally, workshop I explored the pairing of measuring and reducing inequities and how to build and keep patients’ trust. This session built upon the last to discuss the incentives to spur and support infrastructure redesign, the structure of value-based payment (VBP) models in adding health equity and keeping patients at the center of all investments.

 Connecting the Dots: From Opportunities (Workshop 1) to Incentives and Framework (Workshop 2)	
Workshop 1	Workshop 2
Infrastructure Needs to ↑ capture of race/ethnicity <ul style="list-style-type: none"> • Workflow friendly user interface (redesign) • Staff training • \$\$ 	Incentives for investment <ul style="list-style-type: none"> • Clinical/Epidemiologic studies that better represent the population at risk • Pay for equity
Measuring Inequities + Reducing Inequities	Structure of Value-Based Payment Models (VBPM)
Trust: How to Get It / How to Keep It	Keeping Patients at the Center of the Investment

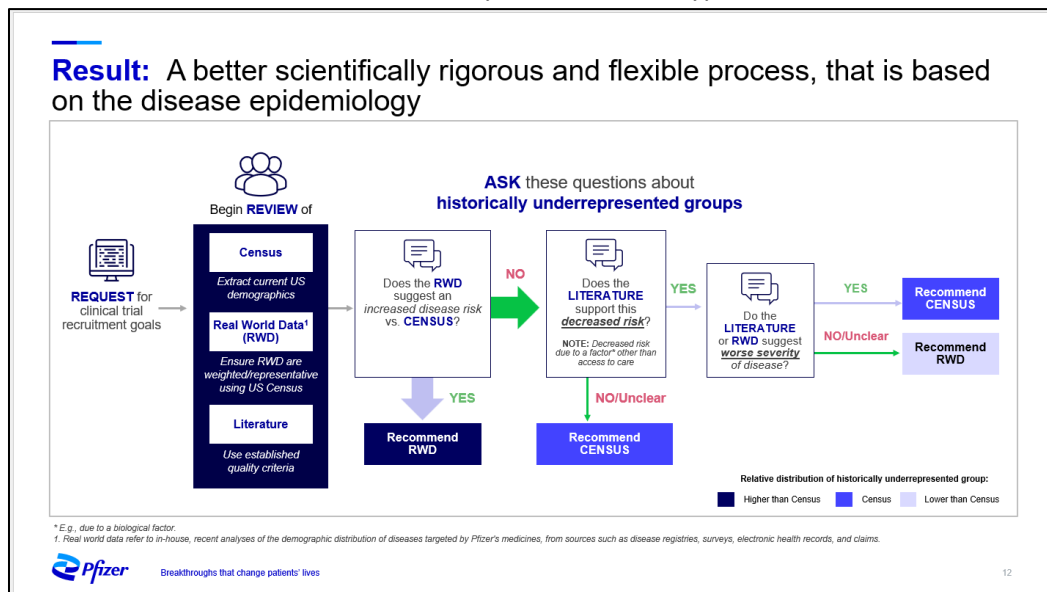


Better Healthcare Data on Race and Ethnicity Needed to Progress Clinical Trial Diversity

Leo J. Russo, PhD, Head of Global Medical Epidemiology
Pfizer, Inc.

Pfizer made a public commitment to including racially and ethnically diverse participation in all their clinical trials.

- In 2021, [Pfizer published enrollment data from all trials in the United States from 2011-2020](#) using the census as the gold standard that showed where the company was currently in regard to clinical trial diversity and decided it needed to do better,
 - recognizing disease epidemiology had to be the benchmark; and
 - needing a better transparent and reproducible process for setting clinical trial enrollment goals.
- Pfizer built a framework using (1) epidemiologic expertise and (2) the evaluation and endorsement of advisory boards around ethics, social determinants of health and equity in trials. The framework has been submitted for peer review to be shared, improved, and expanded upon by others for quantitative accountability.
- The framework includes using census data as a base, medical and epidemiology literature, and real-world data including electronic health records and health care claims, surveillance and registries, surveillance systems, and national surveys. Real-world data sources typically used are SEER (for cancer), EHR and NHANES.
- The framework is not straightforward:
 - Limitations had to be addressed; for example, weighing EHR data to make them more representative;
 - It was designed to address the under representation in the medical literature for historically underserved groups; and
 - It had to consider access to care, severity of disease and type of clinical trial.



- The resulting framework starts with this question: Does the real-world data suggest an increased disease risk to historically underrepresented groups vs the general population (census)?
 - If yes, recommend using real-world data to get clinical trial recruitment goals.

- If no, does the literature support a decreased risk due to a factor other than access to care?
 - If no or unclear, census data is recommended to get clinical trial recruitment goals.
 - If yes, ask a final question: does the literature of real-world data suggest an increased disease severity?
 - If yes, census data is recommended to get clinical trial recruitment goals.
 - If no, real-world data is recommended to get clinical trial recruitment goals.
- The current iteration of the framework is endorsed as methodologically sound and ethical but is only a solid foundation to build and enhance upon. Challenges include varying depth and reliability in capturing disease rates/ high amounts of missing values for race and ethnicity in real-world data. and potential bias in medical literature.
- To improve representation, data providence and standardization for race and ethnicity variables are required. Recruitment and retention of historically underserved groups and enrollment levels that facilitate sub-group analysis are also needed.
- Pfizer does aspire to transfer this approach and framework outside of the United States.

The Role of Value-Based Payment in Advancing Health Equity

Kate de Lisle, Associate Principal, Payment & Delivery Transformation

Leavitt Partners, an HMA Company

Leavitt Partners is a health care consulting and research firm founded by former HHS Secretary, Mike Leavitt, with a focus on studying and advancing the movement to value-based payment and the delivery reforms associated with these changes. Kate de Lisle has led their value-based payment (VBP) research team for close to 9 years. She frequently conducts interviews with the provider leaders responsible for implementing these changes and payers who are seeking to design programs.

- Understanding that some audience members may not be familiar with key VBP terms and concepts, Kate began by offering a brief level-set.
 - VBP is a broad term that refers to innovative payment strategies that retool or replace traditional fee-for-service (FFS) with alternative methods of payment or reimbursement tied to cost and quality outcomes. Importantly, VBP is not a short-term solution for savings. These reforms are designed to use payment as a lever for driving changes in the delivery of care. When done well, VBP fundamentally reorients care delivery in ways that will result in higher value: improving quality and holding cost steady, reducing costs while holding quality steady, or ideally both.
 - There are many types of alternative payment models (APMs) with varying levels of financial risk, from small performance-based bonuses, to shared savings/risk arrangements in which providers are still paid on a fee-for-service basis but have the opportunity to share in their generated savings or potentially owe financial penalties at the end of the performance year (these FFS-based shared savings arrangements are currently the most common type of VBP model). On the furthest end of the risk spectrum, under the most advanced types of VBP models, providers aren't paid on a fee-for-service basis at all but are paid prospectively on a per-person basis. While most provider organizations are not yet equipped to operate under these sophisticated capitated arrangements, adoption is growing, particularly in the MA market.

- In addition to understanding the varying types of payment models used by public and private payers in value-based arrangements, it can be helpful to categorize VBP models by the scope of services covered – from episode-based payment models in which providers assume accountability for a limited set of services (e.g., bundles), to population-level, total-cost-of-care payment models in which providers come together to assume responsibility for the overall cost and quality outcomes of a defined population of patients (e.g., ACOs). These total cost of care models are the most common vehicle for public and private sector VBP adoption to date, with Leavitt Partners tracking over 1,200 ACOs covering more than 34 million lives. These accountable care models include stronger incentives for provider participants to understand the needs of the population, making the business case for collecting race and ethnicity data more apparent.
- Kate reviewed VBP adoption data from [Leavitt Partners and the Health Care Learning and Action Network](#) showing that the ACO movement is maturing. Though the number of new ACOs has plateaued in recent years, existing ACOs are growing their participation in accountable care. As organizations become more comfortable and committed to new models of care—investing in the infrastructure and capabilities needed to manage populations—they seek to move more of their patients under value-based contracts to reap the returns of those investments.
- As with many other payment reforms, the Centers for Medicare & Medicaid Services (CMS) has been a big driver of the value movement, but VBP is not a Medicare-only initiative. Commercial payers represent the bulk of ACO contracts, often following the lead of the CMS Innovation Center (CMMI). This trend is expected to continue as the Biden Administration continues to reaffirm its priorities of driving greater adoption of VBP and using these models as a vehicle for advancing health equity. Central to [CMMI's strategy](#) is the ambitious goal of moving all Medicare beneficiaries and the majority of Medicaid enrollees into ACOs by 2030. CMS is committed to embedding health equity into every VBP model – from model development, application requirements, benchmarking and financial incentives, data collection, quality measures, to model evaluation. Kate highlighted examples of health equity-related provisions in notable CMMI APMs including the ACO REACH Model, Medicare Shared Savings Program and Enhancing Oncology Model (*shown below*). CMMI also plans to release 3-4 new APMs in 2023.

CMMI Strategy Refresh Signals Future Market Direction



Expect more rapid growth of ACOs moving forward:

- CMMI's bold goal to move all Medicare beneficiaries & majority of Medicaid enrollees into ACOs by 2030.
- ACO REACH, KCC, and EOM will represent millions of additional ACO-covered lives and catalyze adoption of other contracts.
- Updates to the MSSP will attract new participants.
- Expect 3-4 new CMMI APMs in 2023.
- States are increasingly adopting & advancing Medicaid ACO models.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

Sources: Innovation Center Strategy Refresh, LP analysis of model updates

CMS has committed to embedding health equity in every model

Examples include:

ACO REACH Model

- Health equity questions in application and scoring for health equity experience
- Health Equity Plan requirement
- Health equity benchmark adjustment
- Health equity data collection requirement
- NP services benefit enhancement

Medicare Shared Savings Program

- Equity-adjusted advanced payments
- Reduced caps on negative regional adjustments
- Account for demographic changes on risk score methodology
- Health equity adjustment to ACOs' quality performance scores

Enhancing Oncology Model

- Health Equity Plan requirement
- Screenings for health-related social needs
- Requirements to report patient demographic data (e.g., race, ethnicity, language, gender identity)
- Offering an additional payment for Enhanced Services to duals

- Traditional FFS payment systems fail to recognize health equity as a priority. They do not reimburse providers for collecting race and ethnicity data or systematically measuring and addressing health equity related gaps. There's no business case for it.
- VBP, on the other hand, represents a promising vehicle for advancing health equity by using a needs-based approach. When providers are accountable for the cost and quality outcomes of a defined population of patients. Understanding the needs of that population becomes a business initiative.
- *Resources to learn more:*
 - [CMS Framework for Health Equity 2022-2032 \(CMS\)](#)
 - [Building the Business Case for Health Equity Investment: Strategies to Secure Sustainable Support \(Health Care Transformation Task Force\)](#)
 - [The Role of ACOs in Advancing Health Equity: A Comparison of ACO REACH and the MSSP \(Leavitt Partners\)](#)
 - [Advancing Health Equity through APMs \(HCP-LAN Health Equity Advisory Team\)](#)
 - [Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models \(AAFP\)](#)
 - [Aligning Value-Based Payments with Health Equity \(JAMA Viewpoint\)](#)
 - [Health Equity and Value-Based Payment Systems: Moving Beyond Social Risk Adjustment \(Health Affairs\)](#)
 - [Strategies to Reduce Bias in Electronic Health Records \(Center for Health Care Strategies\)](#)

Moderated Discussion

Moderator: Amy Abernethy, MD, PhD

Discussants:

Citizen Voice: Yasmeeen Long

Lt Col Rob Flemming, Leo Russo, Kate de Lisle

The moderated discussion took questions from the question-and-answer chat as well as those posed by our moderator to further expand on the workshop's presentations, and to discuss the importance of setting up a framework to ensure the capture and curation of race and ethnicity data needed to advance health equity. The moderated discussion reinforced that health equity, and thus the capture, curation and transfer of race and ethnicity data, is a good business decision. Hot takes from the discussion:

- There is lots of room to improve structural metrics regarding health equity, patient safety, provider and system performance and payment overall.
- Focusing on health equity isn't just the right thing to do, it also makes good business sense as investments in improving care for populations most in need offer institutional and competitive advantages, especially as they relate to value-based purchasing arrangements with meaningful two-sided risk shared by the delivery system.
- Developing value-based purchasing measures and associated VBP models can be improved by engaging populations early on that have the greatest need to experience improvements in health equity and quality. Beginning with patient-centered care in the model design is a good start, but we also need to consider how patient reported outcomes differ across cultures and different types of people to better understand how health equity can be achieved.
- We can take better care of people by embedding health equity into business systems and data collection processes for the long term i.e., how data is collected and disaggregated into meaningful categories. There needs to be a focus on the humanistic factor.
- Always be conscious of the limitations of the data source being used, be diligent on what the variables are and bring in people who can assess any gaps.
- Starting to invest in an infrastructure for population health management requires retooling systems and culture. A solution to fill in some data gaps is to tie health equity and the collection of race and ethnicity data to existing initiatives (that have funding and leadership buy-in).
- The risks of an organization not addressing health equity are greater than the risks of investing additional funds. Incentives work if the goal is to create sustainable systems that drive health equity across clearly defined health outcomes. Mandates may be able to drive things faster.
- We need to develop a multi-stakeholder consensus approach to set up a framework that ensures the capture and curation of race and ethnicity data needed to advance health equity.
- A great heuristic is "business case plus the evidence base plus the human face just captures our work."

Please join us for future RAISE Workshops:



Community Workshop Series

**1st & 3rd
Thursday
of the
month at
2 pm ET**

#	Date / Time (ET)	Key Theme
1	Jan 26 / 2-4 pm	Opportunities to Improve Race & Ethnicity Data in Health Care
2	Feb 2 / 2-3 pm	Collecting Better Data I: Incentives, Framework, Mission
3	Feb 16 / 2-3 pm	Collecting Better Data II: System Infrastructure
4	Mar 2 / 2-3 pm	Creating Safe Space I: Reporting Race 101
5	Mar 16 / 2-3 pm	Creating Safe Space II: Capturing Race and Ethnicity Data
6	Apr 6 / 2-3 pm	Technical challenges in the transfer of information
7	Apr 20 / 2-3 pm	Factors & Impact of Missingness, Misclassification, and Measurement Bias
8	May 4 / 2-3 pm	Advanced Analytics – Novel Ways to Apply Existing Race & Ethnicity Data
9	May 18 / 2-3 pm	Advanced Analytics - Interim Solutions When Race & Ethnicity are Missing
10	Jun 1 / 2-3 pm	Reactions to Barriers, Opportunities & Proposed Solutions
11	Jun 15 / 2-4 pm	Summary - Visioning & Next Steps