

Draft Pending Adoption

Draft: 4/19/22

Health Innovations (B) Working Group
Kansas City, Missouri
April 4, 2022

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Kansas City, MO, April 4, 2022. The following Working Group members participated: Andrew R. Stolfi, Chair (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs (WI); Sarah Bailey (AK); Anthony L. Williams (AL); Doug Ommen and Andria Seip (IA); Julie Holmes (KS); Chad Arnold (MI); Cynthia Amman (MO); John Arnold (ND); Maureen Belanger (NH); Nancy Clark and Chris Herrick (TX); Tanji J. Northrup (UT); Molly Nollette (WA); and Erin K. Hunter (WV). Also participating were: Weston Trexler (ID); and Katie Merritt (PA).

1. Adopted its 2021 Fall National Meeting Minutes

Mr. Houdek made a motion, seconded by Ms. Nollette, to adopt the Working Group' Dec. 11, 2021, minutes (*see NAIC Proceedings – Fall 2021, Health Insurance and Managed Care (B) Committee. Attachment Five*). The motion passed unanimously.

2. Heard Presentations on Coverage Changes Associated with the End of the COVID-19 PHE

Commissioner Stolfi said state Medicaid programs have been limiting redeterminations during the pandemic, but this pause will end after the COVID-19 public health emergency (PHE) ends. He said maintaining coverage for individuals who leave Medicaid will take coordination between federal officials, states, and health plans, as well as public education. He said a recent report from State Health and Value Strategies outlines steps state insurance regulators can take to aid in this transition.

Anne Marie Costello (federal Centers for Medicaid & Medicare Services [CMS] Center for Medicaid & CHIP Services [CMCS]) presented on planning the CMS has performed to prepare for the resumption of redeterminations and resources available for states. She said the CMS is committed to ensuring that individuals remain covered as the PHE ends. She said states received enhanced federal match for Medicaid if they paused redeterminations. She said states will have 12 months to renew eligibility for all enrollees once the PHE ends. She said 15 million individuals will be at risk for Medicaid coverage terminations, about half of which are for procedural reasons. She said it may have been two to three years since state Medicaid agencies were in contact with some enrollees. She said states prepared communications strategies, but they are waiting for the PHE to end before launching public communications. She said the CMS gathered toolkits for states and other guidance at the website [Medicaid.gov/unwinding](https://www.medicaid.gov/unwinding). She said preparing for the end of the PHE is the highest priority for the CMS.

Jeff Grant (federal Center for Consumer Information and Insurance Oversight—CCIIO) presented on strategies for making Marketplace coverage accessible for individuals who leave Medicaid. He said the CMS is working to smooth transitions when appropriate, including implementing policy and operational flexibilities. He said the CCIIO paused certain data matching issues and Special Enrollment Period (SEP) verifications to prevent unnecessarily blocking people from getting coverage. He said the administration as a whole supports extending subsidies currently in place under the American Rescue Plan. He said the CCIIO is examining its data capabilities to keep track of coverage transitions and perform targeted outreach. He said the CMS Office of Communications is pursuing a chase campaign to encourage individuals to enroll. He said state-regulated plans are important partners, particularly those that offer Medicaid managed care plans, as well as Marketplace plans. He said the

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CMS is asking such plans to coordinate across their lines of business and make a commitment to year-round enrollment. He said issuers should be aware of all the guidance the CMS is putting out.

Commissioner Stolfi asked if the CMS has identified what states can do beyond a communications and outreach campaign and how much flexibility would be available under a waiver. Ms. Costello said states are doing a lot in addition to communications, such as planning systems changes, making process improvements, working to improve renewal rates, and enhancing staff capacity. She said fair hearing processes are also being improved and streamlined. She said there are several suggestions for steps states can take besides waiver authorities outlined in a recent State Health Official letter. Mr. Grant said time is of the essence, so states should approach the CMS early if they want to do something different. He said some states with state-based exchanges are exploring streamlined applications and enrollment, which may be called auto-enrollment in some states. He said states would receive a 60-day warning before the PHE ends, so the current assumption is that the current deadline of April 16 will be extended, likely until July.

Jeremy Vandehey (Oregon Health Authority—OHA) presented on the OHA's preparations for the end of the PHE. He said every state is facing this issue. He said Oregon has 300,000 more Medicaid enrollees since before the PHE, and it is likely to lose a similar number once eligibility determinations resume. He said state survey data show Oregon has the lowest uninsured rate ever, largely due to the policy of pausing redeterminations, with disproportionate improvement among Black residents. He said Oregon saw gains in what had been called the "churn population," those who transition off and on Medicaid, sometimes moving to Marketplace eligibility. He said the Oregon legislature passed a bill to provide flexibility and direct the OHA to develop a new program to provide more continuous coverage to the churn population with income just over Medicaid eligibility. He said the legislature's goal is to maintain coverage as much as possible, rather than the prior practice of frequent coverage changes. He said Oregon will perform redeterminations first on those who are likely to remain eligible and only later address those at higher risk for coverage loss. He said the legislation also calls for a bridge plan that would be developed in a waiver application; i.e., either a basic health plan under the ACA or a state innovation waiver. He said most individuals go between Medicaid and no insurance, not Medicaid and Marketplace coverage. He said the bridge plan would allow them to continue to have coverage through their Medicaid managed care plan by allowing them to continue coverage even when an individual's income rises to 200% of the federal poverty level. He said this approach could be a pathway for other states in the future. He said the end of the PHE is an opportunity for Medicaid and other coverage sources to work together in ways they have not in the past. Commissioner Stolfi said Oregon's plan would address not only the end of the PHE, but the problem of churning coverage that pre-dated it.

Marissa Woltmann (Massachusetts Health Connector) gave a presentation on how the Massachusetts state-based marketplace is working to maintain coverage for individuals who leave Medicaid after the end of the PHE. She said both federal and state subsidies are available through the Connector. She said Connector enrollment has dropped as individuals who move to Medicaid have stayed there over the last two years. She said the Connector expects about 100,000 people to enroll after leaving Medicaid. She said the expiration of enhanced federal subsidies would complicate the transition to the individual market for many enrollees. She said the Connector worked to reduce the administrative burden, establish automatic SEPs for those losing Medicaid, and support individuals who need to use paper documents. She said the Connector is adding an option for automatic enrollment for those with \$0 premiums and looking to maintain continuity of care for those who transition. She said clear messaging will be critical in reaching individuals who need to transition coverage. She said the transition is a high stakes project that requires collaboration across many entities. Commissioner Stolfi asked about how health insurance premium rates might be affected by the influx of enrollees from Medicaid. Ms. Woltmann said projections have not yet been developed, but because several Medicaid managed care plans also participate in the state's individual

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market, they likely have good data on the expected cost of these enrollees. Commissioner Stolfi said Oregon expects that more enrollees from Medicaid could lead to a better risk pool in the individual market.

Wayne Turner (National Health Law Program—NHLP) and Karen Siegel (Health Equity Solutions) presented on suggestions for state insurance regulators to address the end of the PHE. Mr. Turner said consumer representatives met over the last two months to develop recommendations for state insurance regulators. He said large coverage losses are possible. He said some individuals will transition coverage, but others will be unlawfully terminated from Medicaid, and maintaining coverage for them as they go through the process is important. He said some consumers may not know they have lost coverage until they need a service and are denied coverage, and these may be the ones who come to state insurance regulators. Ms. Siegel said people of color have less access to employer-sponsored coverage, while people with disabilities may have less access to receiving and understanding important information sent to them about their coverage. She said working with community-based organizations can help assist individuals who experience these challenges. She said frequently asked questions (FAQ) and other messaging should be clear, and community organizations can help workshop messaging. She said consumers will need assistance both in enrolling in plans and in using their coverage. Mr. Turner said transitions are often not smooth, so there will be disruptions to care. He referenced the NAIC's *Health Benefit Plan Network Access and Adequacy Model Act* (#74) and its provisions on continuity of care provisions, which have been adopted in some state laws. He said departments of insurance (DOIs) should link consumers to other resources, including Medicaid, the Marketplace, state prescription drug assistance programs, and others. He encouraged state insurance regulators to examine health insurers' payment of commissions for Marketplace products and network adequacy.

Jackson Williams (Dialysis Patient Citizens—DPC) urged state insurance regulators to consider the ongoing care needs of individuals with chronic diseases, not just continuity of care for patients who are in the middle of an acute care episode.

3. Received an Update on Research into Health Disparities

Kelly Edmiston (NAIC) presented an update on research he conducted with Center for Insurance Policy and Research (CIPR) colleagues on the health disparities effects of the rise in telehealth services and the move to alternative payment models. She said the end of the PHE has some implications for telehealth policy, as some restrictions on telehealth use were relaxed during the PHE.

Mr. Edmiston said CIPR's overall assessment on telehealth is that it provides a significant opportunity to increase access to care and reduce disparities, but at the same time, it creates the possibility for a new disparity among vulnerable populations who lack access to the digital tools or culturally competent care.

Mr. Edmiston said alternative payment models can be vulnerable to opportunistic behavior from providers, so the models should be adjusted to account for this challenge. He said different alternative payment models all have features that may create incentives to treat vulnerable populations differently and inequitably. He said value-based payments have pros and cons regarding health disparities. He said the highest cost patients have the greatest opportunity to reduce costs, and there are incentives for care coordination in value-based payments. He said risk adjustment mechanisms in value-based care are not sophisticated enough to remove incentives to avoid high-risk patients.

Mr. Edmiston said the CIPR could help in developing ideas for how the Working Group could present evaluation findings in response to its charges from the Special (EX) Committee on Race and Insurance. Commissioner Stolfi

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said the Working Group would solicit feedback from members and interested parties, then he would work with the CIPR and the Working Group vice chairs and support staff to write an evaluation or recommendations for the Special Committee.

Having no further business, the Health Innovations (B) Working Group adjourned.

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DRAFT

Month xx, 2022

To: Members of the Special (EX) Committee on Race and Insurance
From: Health Innovations (B) Working Group
RE: Mechanisms to resolve disparities through improved access to care

With this memo, NAIC's Health Innovations (B) Working Group conveys a summary of its findings on certain mechanisms to resolve disparities by improving access to care. In 2021, the Special (EX) Committee on Race and Insurance assigned charges to the Working Group requesting an evaluation of these mechanisms. The charges are as follows:

*The **Health Innovations (B) Working Group** will evaluate mechanisms to resolve disparities through improving access to care, including the efficacy of telehealth as a mechanism for addressing access issues; the use of alternative payment models and value-based payments and their impact on exacerbating or ameliorating disparities and social determinants of health; and programs to improve access to historically underserved communities.*

This memo focuses on the first two mechanisms referenced in the charges, telehealth services and alternative payment models. The Working Group has met several times since 2021 and heard numerous presentations on these topics. In March 2021, the Working Group heard from a telehealth expert with the Center for Connected Health Policy, a provider viewpoint from the American Psychiatric Association, and about health plan experiences from Regence and Asuris Health Plans. In December 2021, it gathered further input from health plans from Blue Cross Blue Shield-North Carolina and Anthem. NAIC's Center for Insurance Policy and Research (CIPR) also presented to the Working Group in December 2021 on its detailed research on telehealth and updated its findings with additional information on alternative payment models in April 2022. To supplement these presentations, CIPR further developed written reports for the Working Group on the impact on health disparities of telehealth services and alternative payment models.

- [Trends in Telehealth and Its Implications for Health Disparities](#)
- APM Report [link to be added]

This memo provides a summary of the overall evaluations of telehealth services' and alternative payment models' impacts on health disparities based on the assessments in the CIPR reports and presentations to the Working Group. The Working Group does not provide explicit recommendations to the Special Committee. Rather, it seeks to inform the Special Committee and allow the committee to determine next steps. The evaluations contained here could be used in a report of the committee, recommendations for NAIC action, to charge another NAIC group with further investigation, or for other purposes as the Special Committee finds appropriate.

Key findings include:

Telehealth

- While there are many barriers to health equity, we find physical access to care to be the most substantial and pervasive obstacle that could be alleviated with the increased use of telehealth.

- Telehealth has great potential to bridge the gap in access to care by connecting isolated people with culturally competent health practitioners and reducing the need for transportation to receive such care.
- Insurance regulators may choose to support increased access to telehealth services with regulations that require it to be covered or offered with favorable cost sharing.
- To help assure that greater use of telehealth does not exacerbate disparities, regulators should be aware of the limitations and consider steps to increase digital literacy and access to the technology needed by the patient to support the delivery of telehealth services, such as hardware, software, and broadband access. Regulators should also recognize the patient's need for privacy for such a visit.

Alternative Payment Methods/Value Based Payments

- Alternative payment models and VBPs have incentives that could either ameliorate or exacerbate health disparities.
- While designed to create value rather than to eliminate or mitigate disparities, APMs and VBPs have *potential* to reduce disparities because these same patients present the greatest opportunities to realize savings.
- A provider could seek to better manage high-cost conditions and capture a share of the savings, which can reduce health disparities. Or it could seek to avoid treating such populations, leading to continued disparities.
- Populations with a high cost to treat and a low likelihood of producing savings or improving quality can challenge provider finances under APMs or VBPs. Risk adjustment programs seek to ameliorate these concerns, but to date have done so incompletely.
- As they seek to reduce the racial and ethnic disparities that stem from health insurance, state regulators may choose to:
 - more closely monitor health insurers' use of APMs and VBPs;
 - seek to better understand how their regulatory tools can be used to encourage models that promote greater provider engagement with disadvantaged populations and reform models that can lead to providers avoiding high-need populations; and
 - seek ways to promote the testing and implementation of more effective risk adjustment mechanisms for alternative payment models.

This memo does not address the final portion of the charge, "programs to improve access to historically underserved communities." Many programs result in improved access for historically underserved communities, from government-supported health care financing efforts like Medicare, Medicaid, and premium tax credits under the Affordable Care Act to local efforts like community health workers and mobile clinics. The Working Group continues to work to define the scope of the charge and gather information from stakeholders. The Working Group plans to follow up with additional assessments once this work advances.

Health Disparities

Health disparities are *avoidable* differences among demographic and socioeconomic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality. Health disparities in the United States are well-documented. Health disparities have narrowed over time, but significant disparities remain. For example, the most recently available data show life expectancy at birth is 3.5 years shorter for Black individuals than for Whites, and Native Americans have a lower life expectancy than Black individuals. Disparities evident during the COVID-19 pandemic have served to amplify the issue in the last two years. Recent research projects that the decline in life expectancy at birth due to COVID-19 would be 0.68 years for the White population but 2.10 years for the Black population and 3.05 years for the Latino population.

There are also disparities in *health care*. While these have declined over time, they persist across numerous domains within the health care system. For about 40 percent of 250 health care quality measures tracked by the U.S. Agency for Healthcare Research and Quality (AHRQ), Black patients receive “worse care” than White patients. Latinos receive worse care than Whites for more than one-third of quality measures and Asians for nearly 30 percent. The quality differential in health care across race and ethnicity is pervasive. A voluminous research literature shows that hospitalized Black patients and other racial and ethnic minorities receive less intensive care across numerous procedures and have been reported to receive less aggressive treatment, for example, for cancer and HIV. There are also marked disparities in health care *utilization* by racial and ethnic minorities, which leads to worse health outcomes.

Telehealth and Health Disparities

In general terms, “telehealth” refers to “the use of medical information exchanged via electronic communications to support and provide health care.” Broadly defined, examples include direct provider-to-patient interactions via videoconferencing (virtual visits), chat-based interactions, remote patient monitoring, physician-to-physician consultations, patient education, data transmission and interpretation, and digital diagnostics (algorithm-based support), whether alone or in combination with conventional modalities.

The pace of expansion in telehealth accelerated rapidly with the onset of the COVID-19 pandemic. While utilization of telehealth has since moderated, it remains exceptionally high compared with pre-pandemic levels (about 17 percent of physician visits, much of which is for mental or behavioral health). We find that telehealth has great *potential* as a mechanism for ameliorating disparities and the social determinants of health, but the benefits telehealth could bring are limited by disproportionately inadequate broadband access at home for disadvantaged and marginalized populations and insufficient levels of digital literacy.

Prospects for Reducing Disparities. The accelerated development and substantial increase in the utilization of telehealth during the COVID-19 pandemic has sparked considerable interest in telehealth, and along with that interest, questions about the implications of increased telehealth utilization for socioeconomic and demographic health disparities.

While there are many barriers to health equity, we find physical access to care to be the most substantial and pervasive obstacle that could be alleviated with the increased use of telehealth. A critical problem facing rural areas is an insufficient supply of physicians and other healthcare professionals. Large areas with sparse populations lack the capacity to support many health care services. In particular, the overall distribution of physicians in the United States is exceedingly uneven. We also find substantially lower concentrations of physicians in areas with high Black and Hispanic populations.

The problem of a dearth of physicians and other health care professionals in rural and high-minority-concentrated areas is exacerbated by transportation deficits in these same areas, particularly *access* (not ownership) to private vehicles. Lack of vehicle access corresponds closely with race and ethnicity. Arguably, telehealth has great potential to bridge the gap in access to care by connecting isolated people with health practitioners and reducing the need for transportation to receive care. Existing research shows that

lessening the necessity of physical transportation to access medical care improves access and mitigates disparate health outcomes.

While access to any kind of care often is problematic for vulnerable populations, for some, what is lacking is not access to health care *per se*, but rather, access to *culturally competent* health care; that is, "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs." Telehealth has great potential to bridge the gap in access to care by connecting isolated people with culturally competent health practitioners and reducing the need for transportation to receive such care.

Limitations. One of the most pressing concerns in the evolution of the digital economy, which has persisted throughout the internet's history, is that of a digital divide, or a gap in internet access and digital literacy, across economic, demographic, and social lines. More advantaged individuals historically have been the first to adopt and benefit the most from the introduction of new technologies. Lack of broadband access, particularly at home—and privacy is a significant concern with telehealth—is considerably more pronounced among vulnerable populations, including racial and ethnic minorities, lower-income individuals, and seniors. The communities likely to benefit the most from telehealth—these groups as well as those in rural areas—also are the least likely to have access to broadband internet.

A lack of digital literacy for vulnerable populations also stands in the way of more universal access to care through telehealth. To have successful telehealth appointments, patients need to understand digital technology generally and how telehealth platforms work. Research finds disproportionately low digital literacy in the health context among the less educated and those who are members of racial or ethnic minority groups. Research also suggests those with lower levels of digital literacy are less engaged and receive fewer psychological benefits from telehealth interactions even when they participate.

Insurance regulators may choose to support increased access to telehealth services with regulations that require it to be covered or offered with favorable cost sharing. To help assure that greater use of telehealth does not exacerbate disparities, regulators should be aware of the limitations noted above and consider steps to increase digital literacy and expand broadband access.

Alternative Payment Models, Value-Based Payments, and Health Disparities

Payment Models and Value Based Payments Described. A payment model is the process in which physicians, hospitals, and other health care providers are compensated for the care they provide. We define an alternative payment model (APM) as any model that deviates from the fee-for-service (FFS) model. Although FFS is the prevailing payment model outside of Medicare, a consensus has developed among patients and third-party payers, as well as many health care practitioners, that a transition away from the FFS model to APMs is necessary to "bend the cost curve" and improve treatment outcomes.

Incentives for Quality Improvement and Cost-Efficiency. Our focus in this memo and the associated report is the implications of APMs and value-based payments (VBPs) for ameliorating or exacerbating racial and ethnic health disparities. First, we briefly describe basic payment models.

From a broad perspective, there are three types of payment models: fee-for-service (FFS), case-based, and capitation. All of these payment models are *volume-based*. That is, there are financial rewards for increasing the *quantity* of care provided. Each payment model also has implicit (dis)incentives for reducing costs or improving quality of care.

Under FFS systems, provider compensation is determined by the quantity of specific services they provide. Outside of Medicare, the FFS model is the standard payment model in the United States. Most fees per service are pre-negotiated through networks such as preferred provider organizations (PPOs). FFS models

incentivize providers to deliver more services, which increases the cost of health care. There is little, if any, incentive to control costs.

With case-based models, providers are compensated for the quantity of care *episodes* encountered and their diagnoses. An episode of care includes all health care related to a single health care "event." The provider receives a standardized "bundled payment" that compensates them for usual cost of care. If actual costs are lower than the bundled payment, the provider profits. Likewise, if costs exceed the bundled payment, the provider takes a loss on the case. Case-based models incentivize providers to undertreat, a phenomenon that is supported by empirical research.

Capitation models compensate providers for the quantity of individuals under the provider's care, regardless of the amount of care the individuals require. The most common capitation system is the HMO. Providers reimbursed on a capitation basis are incentivized to increase the number of individuals in their organization, not only to increase the volume of capitation payments, but also to spread risk across a larger pool. The model incentivizes providers to minimize the provision of services to participants. Further, capitation models may incentivize providers to keep costs below a fixed capitation level through favorable risk selection rather than through cost-efficient provision of services. That is, they may be encouraged to attract people who are least likely to use medical care while devising ways to avoid enrolling people most in need of services.

Provider compensation can also be salary-based. Over 60 percent of physicians receive salaries, but most physicians report being paid by multiple methods. Strictly salaried providers do not have incentives to increase the volume of patients or services, but they also have little incentive to create value through cost reduction or enhanced quality of care. Research suggests some salaried physicians use resources other than their own time and effort to meet their customers' needs, such as excess referrals to specialists. These alternatives likely would increase costs.

Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs) are additional innovations designed to promote improved quality of care and cost-efficiency, although compensation typically follows one of the payment models described above. An ACO is a group of physicians, hospitals, and other providers who voluntarily join as a legal entity and contract with insurers to coordinate care for a defined patient population. An ACO that keeps spending below a financial benchmark while meeting quality standards shares the savings with a payer. But they also bear the risk of sharing losses with the payer. Although the ACO resembles capitation, most make volume-based payments (such as FFS) to providers. A PCMH is similar in many ways to an ACO in that both are characterized by multidisciplinary, coordinated care and a focus on primary care. But rather than sharing gains or losses, financial incentives in the PCMH generally come in the form of "enhanced" payments.

Value-Based Payments (VBPs) reward providers financially for achieving quality goals and delivering more cost-efficient care, and providers can be penalized for failing to do so. A VBP can be an adjunct to any payment model, including FFS. Because APMs and VBPs are conceptually similar, we do not differentiate them in our discussion of implications for racial and ethnic health disparities, as the issues are the same.

Potential for Ameliorating or Exacerbating Health Disparities. Each of the payment models and VBPs have incentives that could either ameliorate or exacerbate health disparities. We organize the discussion around the mechanisms for affecting disparities rather than type of model. Often multiple models have the same incentives with similar consequences. We have little reason to suspect differential treatment of disadvantaged or marginalized patients in salary-based models (notwithstanding individual prejudices).

APMs and VBPs were designed to create value rather than to eliminate or mitigate disparities. In some sense, the focus on value is a drawback of these programs when considering health disparities. This is because the incentives to surpass quality metrics or cut costs lead some providers to avoid delivering health care services to disadvantaged and marginalized populations, who are more likely to have poor treatment outcomes and

socioeconomic circumstances that make them more expensive to treat. Still, APMs and VBPs have *potential* to reduce disparities because these same patients present the greatest opportunities to realize savings.

Consider the cases of chronic diabetes and hypertension. Members of racial and ethnic minority groups are disproportionately affected by these conditions compared with non-Hispanic Whites. The incidence of diabetes is 11.8% in the Hispanic population, 12.1% in the non-Hispanic Black population, and 14.5% in the American Indian population, compared with 7.4% for non-Hispanic Whites. The Black population in the United States has the highest rate of hypertension worldwide, approaching 60% of adults.

Both emergency department visits and hospitalizations are more common with among individuals with diabetes. Non-Hispanic Blacks and Hispanics also have the highest rates of hospitalization for diabetes. Moreover, both diabetes and hypertension often complicate other illnesses and injuries, therefore raising the cost of treatment for those cases. But lower-cost treatments are available for these conditions. Diabetes and hypertension usually can be controlled well with comparatively much lower-cost pharmaceutical and lifestyle regimens. Providers offering more intense monitoring and aggressive management of these chronic conditions could reduce emergency department visits and hospitalizations, which would reduce the costs associated with these conditions dramatically and generate savings. One study suggests that an increase of 10% in the medication possession ratio (total usage over a year/requirement for a year with strict adherence) for diabetics could halve the cost.

Providers operating under APMs or VBPs can respond to populations with higher costs in different ways depending on how the payment model is structured and the provider's strategy. A provider could seek to better manage high-cost conditions and capture a share of the savings, which can reduce health disparities. Or it could seek to avoid treating such populations, leading to continued disparities.

Moving away from FFS to APMs/VBPs can reduce a provider incentive to provide the services that are most valuable to the provider rather than the patient. The FFS model rewards the provision of high-margin services and large turnover. The margin is a measure of the efficiency with which a provider can turn services into profits. For FFS providers, there may be a financial disincentive to treat disadvantaged and marginalized populations because these populations often need low-margin services such as primary care, monitoring of chronic diseases like hypertension and diabetes, and behavioral health care.

However, APMs and VBPs can introduce their own disincentives that discourage providers from serving disadvantaged and marginalized populations. Populations with a high cost to treat and a low likelihood of producing savings or improving quality can challenge provider finances under APMs or VBPs. Risk adjustment programs seek to ameliorate these concerns, but to date have done so incompletely.

The proximate cause of health disparities is, in large part, disparities in socioeconomic conditions, although disparities also appear within socioeconomic groups. The incidence of specific diseases varies significantly across races and research suggests that traditionally disadvantaged and marginalized groups tend to have worse health outcomes even with the same treatment.

Because of disparities in health status and the socioeconomic environment in which they often live, traditionally disadvantaged and marginalized groups have higher-than-average medical needs and incur disproportionately high health costs. Research shows, for example, that health care for people who are dually enrolled in Medicare and Medicaid costs more than those who are beneficiaries of Medicare only, even after accounting for coexisting conditions.

APMs and VBP systems make adjustments for patient risk in an effort to account for socioeconomic determinants of health that are outside the provider's control. Risk adjustment systems assign patients a risk score based on demographic factors and health status. But current risk-adjustment methods are not sufficiently sophisticated to reliably distinguish poor-quality care or cost inefficiencies from high medical and/or social risk. The American Medical Association reports that most risk adjustment systems only predict about 20% to 30% of the variation in services and spending across patients. Moreover, AMA argues that

these risk-adjustment methods are designed to predict spending on a large insured patient population, not to adjust for differences in patient needs. Reports to Congress in 2016 and 2020 both emphasized a "consistent finding that social risk adjustment in current programs would be unlikely to substantially improve financial circumstances for safety-net providers."

As a consequence of inadequate risk controls, health care providers with high proportions of disadvantaged patients are likely to *lose* money under APMs and VBP systems without improved risk adjustment. Indeed, VBPs have been shown to disproportionately penalize providers that serve the poor. Consider Medicare's Physician VBP Modifier. One in four physicians who care for the most dual-eligible enrollees would be penalized under the VBP system, compared with 1 in 12 for all other physicians. As APM and VBP design currently stand, health care providers have incentives to avoid treating disadvantaged and marginalized populations, including racial and ethnic minorities.

Providers can avoid disadvantaged populations both in their choice of where to participate in APMs (provider selection) and who to serve under such models (patient selection). Research evidence seems to validate both types of avoidance. For example, ACOs are less likely to form in high poverty areas than in more affluent areas. This evidence is consistent with provider selection. ACO-attributed patients are less likely than other patients to be Black, disabled, or socioeconomically vulnerable, and patients with higher clinical risk scores are more likely to exit an ACO than those with lower clinical risk scores, which is suggestive of patient selection. Evidence abounds of the effects of the unintended incentive of APMs and VBPs to avoid treating vulnerable populations. Thus, APMs and VBPs will be more likely to avoid exacerbating existing health inequities if their risk adjustment practices are reformed.

As they seek to reduce the racial and ethnic disparities that stem from health insurance, state regulators may choose to more closely monitor health insurers' use of APMs and VBPs. They could seek to better understand how their regulatory tools can be used to encourage models that promote greater provider engagement with disadvantaged populations and reform models that can lead to providers avoiding high-need populations. In particular, state insurance regulators may wish to seek ways to promote the testing and implementation of more effective risk adjustment mechanisms for alternative payment models.