The Role of ACOs in Addressing Health Equity

Introduction:

Social factors and systematic discrimination have led to wide and longstanding gaps in health equity for underserved communities.[i] Improving health equity is critical to delivering high quality care in a cost-effective manner, as some research shows that social drivers of health contribute more significantly to health outcomes than medical care.[ii] These social factors cannot be addressed if they are not adequately measured, tracked, and reported.[iii] Innovative payment and care delivery models that rely on data provide an opportunity to better understand and highlight existing disparities and also to provide the opportunities to tailor interventions based on individual needs. Total cost of care models such as accountable care organizations (ACOs) are incentivized to improve quality while controlling costs, and the upfront investments that ACOs make in health information technology (HIT) and infrastructure to provide coordinated care make them uniquely poised to address health inequities.

The National Association of ACOs (NAACOS) is the largest association of ACOs and Direct Contracting Entities (DCEs) representing more than 12 million beneficiary lives through hundreds of Medicare Shared Savings Program (MSSP), Next Generation ACO Model, Global and Professional Direct Contracting Model (GPDC), and commercial ACOs. NAACOS is a member-led and member-owned nonprofit organization that works on behalf of ACOs and DCEs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency. NAACOS is committed to advancing the value-based care movement and our members want to see an effective, coordinated, patient-centric healthcare system that focuses on keeping all individuals healthy. Strengthening the ACO model and other total cost of care models provides an important opportunity to reduce health inequities and transition our health system to a culture of value.

Our recommendations to address health inequities in federal healthcare programs hinge on increasing patient and provider participation in proven ACO models, which can be leveraged to advance health equity while also working to improve patient outcomes and lower healthcare costs.

Background:

The COVID-19 pandemic highlighted the deeply embedded inequities in our healthcare system, revealing significant disparities in disease burden, access to testing and treatment, quality of care, and health outcomes. During the pandemic, population-focused organizations like ACOs have been uniquely poised to adapt workflows to continue to support care coordination due to their financial flexibilities and existing infrastructure that support the patients and communities they serve.[iv] Even prior to the pandemic, ACOs have been doing important work to address social needs and reduce inequities among their patient populations. Improving health equity and addressing patients' social needs is critical to delivering high quality care in a cost-effective manner and focusing on the broader concept of an individual's overall health. The ACO model aims to keep patients healthy and improve the value of

services delivered whereas the traditional fee-for-service (FFS) model heavily ties reimbursement to caring for sick patients with less emphasis on whole-person, preventive care.[v]

Studies have shown that ACOs are increasingly working to address patients' nonmedical needs to improve their health, such as partnering with other organizations in the community to meet housing and transportation needs and address food insecurity.[vi] Other examples of initiatives being implemented by ACOs to improve health equity include:

- Leveraging information technology and analytics for targeted outreach to identify patients with unmet needs;
- Identifying discrepancies in patient populations and providing additional interventions to address identified gaps;
- Mapping to identify communities with poor internet access to address the digital divide;
- Focusing on end-stage renal disease (ESRD) and chronic kidney disease (CKD), which disproportionately affect Black patients to shift care to a better, less expensive setting that meets patient needs and preferences;
- Stratifying ambulatory-sensitive admission rates and primary care-sensitive emergency room visits by race/ethnicity to identify inequities; and
- Developing tools to identify and reach out to high-risk patients with trained staff to check for food and housing insecurity and verify that they have access to needed medications.

To continue and build upon these activities, ACOs need appropriate tools, data, financial incentives, and resources to address health equity and develop partnerships with community-based organizations (CBOs). Due to their accountability for the total cost and quality of care for a patient population, ACOs are uniquely positioned to develop and test health equity-focused interventions.

Recommendations:

1. **Providing funding to support an expansion of social services to address health equity**
   Many ACOs already have or are developing initiatives to address social determinants of health (SDOH), improve health equity, and meet the social needs of their patients. However, financial barriers and resource constraints remain a major hurdle to this work, especially for smaller, physician-led ACOs. Without additional funding and incentives to do this important work, true progress will not be realized. There are multiple avenues through which this could be achieved. CMS could provide grant funding to ACOs to expand and develop their connections with community-based organizations (CBOs) and to enhance ACOs' internal capacity to target underserved populations and meet social needs.

   Additionally, the Center for Medicare & Medicaid Innovation (CMMI) could establish a voluntary model within the MSSP for ACOs focused on health equity. These ACOs could apply to the model and detail to CMMI how they would use the upfront funding to address health equity gaps in their patient populations. If the ACO generates shared savings, the initial investment could be recouped by CMS; and if it does not generate savings, the funds would be forgiven by CMS as long as the ACO remains in the program. This model would be similar in design to the Community Health and Rural Transformation (CHART) Model, which builds off the ACO Investment Model (AIM) that was one of the most successful CMMI models to date. This also aligns with recent recommendations from the Medicare Payment Advisory Commission (MedPAC) to test innovations within a population-focused model to control for cost and quality.[vii]

2. **Increasing benchmarks to benefit ACOs treating vulnerable populations**
   Achieving favorable outcomes for patient populations with greater social risk may be more difficult or require different or additional resources than achieving the same level of outcomes in a more socially advantaged population.[viii] However, providers are often not compensated for addressing these social risk factors in order to improve health outcomes. Due to the lack of investment in this area, providers are not able to address these concerns with their patients and are often discouraged from even screening for unmet social needs without being able to connect patients with adequate, appropriate resources.[ix]

   A study examining health systems that were investing in social determinants found that only 9.1 percent of health systems invest in social determinant and/or community health programs and of those investing health systems, 86 percent participate in an ACO, compared to only 52 percent of non-investing health systems.[x] This shows that ACOs are more likely than non-ACOs to invest in social determinants work and this work could be supported and expanded by providing additional compensation for this work to be done. One way to achieve this is to update the MSSP benchmarking methodology to reflect the work that is being done. Benchmarks should be adjusted to fairly and appropriately compensate providers for providing care to vulnerable or underserved populations to reflect the differences in providing care.

3. **Providing ACOs with both grant money and adjusted benchmarks to support this work**
   As noted previously, developing and implementing health equity initiatives requires data, infrastructure, relationships with CBOs, and other resources. In order to support the initiation and operation of such initiatives, ACOs should be provided with the opportunity to apply for upfront funding for innovations that aim to improve health equity. In addition to this, to promote sustainability of models that address health equity, financial benchmarks should be adjusted to account for the social complexity of certain populations. Providers serving large proportions of vulnerable or underserved patients should be fairly and appropriately compensated for the additional time and resources these patients require to achieve equitable health outcomes.

4. **Adapting CMMI's CHART Model to cover urban areas that meet the definition of a distressed community and focusing on this model as a way to support ACO work in this area**
   The CHART Model aims to address disparities faced by rural populations by providing a way for rural communities to transform their healthcare delivery systems through innovative financial arrangements.[xi] The ACO Transformation Track of the model builds on the success of AIM, which has been one of the Innovation Center's most successful models to date. There is an opportunity to leverage this success to address health inequities among distressed communities in urban areas, in addition to rural areas as the model currently focuses on. We encourage CMS to begin an initial expansion of the model for ACOs that serve a high proportion of patients with negative SDOH, such as lack of education, housing instability, food insecurity, poverty, unemployment, etc. Then, the agency should expand the model further to make financial support to address SDOH needs available beyond "distressed" communities and within all value-based models.

5. **Developing a supplemental Medicare benefit/service to allow ACOs to bill Medicare for things like beneficiary transportation—as part of a "chronic social determinant management" service (akin to chronic care management codes)**
   CMS recognizes the importance of Chronic Care Management (CCM) as a critical component of primary care that contributes to better health outcomes. The agency began paying separately for CCM services delivered to Medicare patients with multiple chronic conditions in 2015.[xii] However, to treat the whole patient and the conditions that contribute to chronic disease, social determinants of

health such as environments, cultures, and behaviors need to be considered and addressed.[xiii] This could be accomplished through chronic social determinants management services, modeled after CCM, to allow ACOs to bill Medicare for services that address social determinants, improve health equity, and meet social needs.

6. **Providing additional flexibility with Medicare rules for ACOs to deliver supplemental benefits to patients to help address health equity**
   As ACOs continue to develop and test innovative approaches to improving health equity, they require additional flexibility with Medicare rules for providers to deliver supplemental benefits. To support ACOs' work, NAACOS recommends that Health and Human Services (HHS) and CMS offer additional flexibilities to allow ACOs to deliver benefits related to transportation, housing, food insecurity, as well as supports for other social needs. There is precedent in Medicare for allowing such flexibilities, recently illustrated by new policies in Medicare Advantage (MA) that allow premium dollars to go towards addressing social needs. The Bipartisan Budget Act of 2018 expanded the types of benefits that may be offered by MA plans for chronically ill patients.[xiv] Some examples of supplemental benefits that may be offered include food, pest control, indoor air quality equipment, structural home modifications, and others.

   As population health-focused organizations, ACOs are incentivized to address health equity in order to improve the total quality of care for the populations they serve. Many ACOs are already leveraging their data and health IT infrastructure to identify target populations for improving health equity. Since ACOs are held accountable for the total health outcomes of the populations they serve and the total cost of care, they should be allowed similar flexibilities in how they allocate resources to meet the needs of a certain population. Caring for patients with greater social risk requires more time and resources, and providers will not be able to meet the needs of these patients without appropriate flexibilities and funding.

7. **Ensuring quality requirements are thoughtfully designed and implemented to incentivize ACOs to further target quality improvement efforts for populations struggling with health inequities**
   ACOs have made great strides in improving quality in the MSSP. Quality improvement is a cornerstone of the ACO model. Improving health equity is critical to delivering high quality care in a cost-effective manner. While performance on the MSSP quality measures appears very high across most ACOs in the program today, if this performance is stratified by race, ethnicity and other factors, we suspect there is more room for targeted improvement for populations that may have access issues and increased unmet social needs. In combination with providing additional funding to do more targeted work with this population, stratifying quality measure performance by race and ethnicity as a starting point could provide ACOs with additional opportunities to improve the health of the population they serve. However, before this can be done, there must be broader efforts to incentivize necessary data collection and standardization. This can first be done by implementing incentives for ACOs to report such data, using a step-wise approach that could be utilized to improve data collection and eventually adjust quality requirements to allow ACOs to advance quality improvement for the underserved.

   Additionally, requiring ACOs to report and be evaluated on all patients across all payers rather than just ACO-assigned Medicare beneficiaries may adversely affect ACO practices treating vulnerable populations, such as those with high rates of Medicaid and uninsured patients. For example, many ACOs have relationships with Federally Qualified Health Centers (FQHCs) to provide care to their assigned beneficiaries. Differences in the medical complexity, social needs, or other factors in these populations will skew performance on quality measures and penalize ACOs and ACO practices

treating more vulnerable populations at a time when they need the resources the most. For this reason, a more thoughtful approach is required when looking at applying electronic clinical quality measures (eCQMs) to ACOs and, therefore, requiring quality reporting and assessment on each measure for all patients meeting the measure criteria, regardless of payer or whether the patient is an assigned-ACO patient.

8. **Leveraging the ACO model to test expansions in telehealth for the ability to improve access and quality while controlling costs**

   In the wake of the COVID-19 pandemic, ACOs were able to quickly pivot to telehealth and remote patient monitoring to meet the needs of their patients in a safe and accessible manner. Virtual care has provided unprecedented access for patients, but it has become clear that uncertainty as to the future of telehealth under Medicare will halt or reverse further adoption and utilization—to the detriment of both patients and providers. While the digital divide remains an issue for patients without access to reliable broadband services, telehealth has greatly expanded access to primary and specialty care for patients in rural areas with limited access to services.

   NAACOS supports broader telehealth coverage and wants to see many of the flexibilities granted during the COVID-19 pandemic be made permanent; however, there are concerns about potential adverse effects on spending and ACO attribution. To ensure that telehealth is expanded in a cost-effective manner that supports the continued delivery of high-quality care and does not disrupt ongoing patient-provider relationships, we recommend ACOs and other APMs be used to test broader reforms. To prevent a disruption in care continuity, incentives should be provided to have care delivered in virtually integrated practices as part of an ongoing comprehensive care strategy. Deference should be given to Medicare providers such as ACOs, who are accountable for patients' spending, quality, and health outcomes.

9. **Improving ACOs' access to data needed for care coordination**

   NAACOS continues to call for the alignment of 42 CFR Part 2 (Part 2), which governs patient substance abuse treatment records, with the Health Insurance Portability and Accountability Act (HIPAA). This alignment will improve care coordination and quality improvement and allow ACOs and other providers to deliver the kind of patient-centered, well-coordinated care necessary to improve health outcomes and reduce inequities. Section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act helped to align Part 2 with HIPAA by allowing the sharing of this important data after initial patient consent; however, implementation has been challenging. Currently, ACOs lack access to the full suite of necessary information to allow them to achieve the goals of well-coordinated patient care, improved quality, and preventive care required to limit opioid overdose deaths and other adverse events associated with substance use disorder (SUD). While ACOs are provided claims data through Claim and Claim Line Feed (CCLF) files, these data lack SUD-related information, thus limiting ACOs' ability to treat the whole person and potentially harming patient care and outcomes.

   While SUD affects all racial and ethnic groups, Black and Latinx Americans are less likely to complete treatment for SUD. By equipping providers with the necessary information for coordinated, whole-person care, these disparities can begin to be addressed. NAACOS asserts[xv] that current regulations allow CMS to deliver unredacted claims data to ACOs. We urge[xvi] HHS and CMS to work together to send SUD-related claims data to providers practicing in APMs to help support their work in population health management and SUD-focused initiatives. As mentioned, many ACOs are implementing new initiatives to address health inequities, but these programs cannot effectively

reach the right patients if ACOs do not have the appropriate data to target outreach to vulnerable populations.

Closing:
ACOs are already beginning to do the work of addressing negative SDOH to improve quality and control costs for the patients they serve. However, they cannot be broadly effective or achieve desired outcomes without proper funding and support. There are many flexibilities, tools, and resources needed to implement and deploy interventions to reduce these inequities and to improve patient care for underserved populations. The above outlined policy recommendations will poise ACOs to integrate health equity initiatives into their programs. The implementation of these recommendations will help to ensure that ACOs are equipped to effectively measure, track, and address health equity in their work.

[i] https://www.ncbi.nlm.nih.gov/books/NBK367640/pdf/Bookshelf_NBK367640.pdf
[ii] https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext
[iii] https://www.nap.edu/read/12875/chapter/1#xiii
[iv] https://www.healthaffairs.org/do/10.1377/hblog20210609.824799/full/
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[vi] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0727
[vii] http://medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf?sfvrsn=0
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[xvi] https://www.naacos.com/brooks-lasure-letter