October 18, 2021

Physician-Focused Payment Model
Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Social Determinants of Health (SDOH) Request for Input

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC):

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for input (RFI) on how Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs) can help to incentivize health care providers to collect data related to social determinants of health (SDOH) and equity; use this data to ensure that patients' physical, behavioral health, and social needs are being met; measure the impact of these activities; and address related payment issues. Accountable care organizations (ACOs) are groups of doctors, hospitals, and/or other health care providers that work together to improve the quality of patient care while lowering costs. 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 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, more than many other health care organizations, want to see an effective, coordinated, patient-centric health care 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.

Improving health equity is critical to delivering high quality care in a cost-effective manner and focusing on the broader concept of an individual's overall health, as SDOH contribute significantly to health outcomes. These social factors cannot be addressed if they are not adequately identified, measured, tracked, and reported. Many ACOs have been doing important work to address social needs and health inequities among their patient populations. Improving and expanding ACOs and other total cost of care models provides an important opportunity to reduce health disparities often caused by negative SDOH and to transition our health system to a culture of value.

NAACOS responses to RFI questions on APMs and health equity and SDOH:

Question 1: *What types of SDOH-related social needs data (e.g., food insecurity, housing or transportation needs) could be collected within the context of optimizing value-based care in APMs and PFPMs, by whom, and how? What kinds of SDOH-related data may be particularly relevant for addressing the needs of specific populations, such as Medicare beneficiaries?*

Standardized collection of SDOH-related social needs data and demographic data is integral to improving care quality and reducing health inequities. Improving health equity and addressing SDOH are critical to delivering high quality care in a cost-effective manner, as research shows that social drivers of health contribute more significantly to health outcomes than medical care.[1] These social factors cannot be addressed if they are not adequately measured, tracked, and reported.[2] While some ACOs have begun implementing SDOH-screening tools to collect this data, many of these tools are unstandardized or untested, and may not be compatible with electronic medical records (EMRs), making the data less actionable. For ACOs that have begun to address patients' nonmedical needs, the most common needs they have identified are for housing, transportation, and food.[3] Having access to accurate data on SDOH affecting their patients would allow ACOs to develop targeted interventions for high-risk populations to eliminate health disparities. Ideally, providers should collect data on patients' SDOH-related social needs within the five domains of SDOH as defined by the Healthy People Initiative, which are economic stability, health care access and quality, social and community context, education access and quality, and neighborhood and built environment.[4]

Question 3: *How can health care providers effectively share SDOH- and equity-related data with payers, community-based organizations, and other partners across the continuum of care? How can providers be incentivized to form partnerships through data platforms and referral systems that link the health care and social services sectors to facilitate efforts to address SDOH and equity? What data interoperability or other data sharing challenges need to be addressed to facilitate information sharing between health care providers, community-based organizations (CBOs), and other partners? What specific capabilities and incentives are needed for smaller safety net providers or rural providers?*

In order for health care providers to be able to effectively share SDOH and equity-related data with partners, industry standards need to be updated. Currently, there is no standardized way to make referrals to CBOs, and the CBO referral platforms that do exist often have limited or no interoperability with electronic health records (EHRs). ACOs need actionable data in order to develop and target effective SDOH interventions to the populations that need them most. NAACOS urges policymakers to work together with health systems and providers, EHR vendors, and community partners to develop standards for data collection and interoperability that will ensure data is uniform and actionable. It is also important to consider the additional financial challenges faced by smaller safety net providers and rural providers, as the upfront costs to implement EHR upgrades for data collection and referral platforms can be prohibitive. Upfront funding or other financial incentives should be provided to ensure that those serving vulnerable populations are not left out of this transition.

NAACOS has also recently authored a white paper with several recommendations on how to improve health equity.[5] One recommendation to incentivize providers in ACOs to form partnerships with

community organizations and address their patients' SDOH is to develop a supplemental Medicare benefit to allow ACOs to bill Medicare for the management of negative SDOH through a "chronic social determinant management" service modeled after Chronic Care Management (CCM).

Question 4: *What are some of the identified barriers, challenges, and other concerns for providers, their partners, and patients, related to collecting, using, and/or sharing SDOH- and equity-related data? Are there any additional barriers related to collecting, using, and/or sharing data related to patients' behavioral health needs?*

It has been reported that many ACOs lack data on both their patients' social needs and the capabilities of their potential community partners.[6] There is an overwhelming lack of standardization in data collection and sharing, which has significantly affected organizations' abilities to address SDOH. A 2019 HHS report provides key recommendations for improving the exchange of SDOH data, including defining and standardizing SDOH data, creating a sustainable infrastructure for SDOH data by improving financial alignment, strengthening the capacity of community organizations, and supporting local and state-based decision-makers.[7]

Another key challenge is that providers lack the time to review SDOH data and address unmet needs with their patients. A 2018 survey by the American Academy of Family Physicians (AAFP) found that 80 percent of providers felt they did not have enough time to properly discuss SDOH with patients during a standard visit.[8] Adequate reimbursement for the time it takes to collect and assess SDOH data and to discuss individual needs with patients would allow providers the time and resources to effectively address SDOH.

The structure of Health Insurance Portability and Accountability Act (HIPAA) laws also creates challenges for collecting, tracking, and reporting SDOH data. For example, health information exchange (HIE) data requirements create data-sharing barriers for ACOs because they are not considered Medicare suppliers or providers. Even when a patient has given consent for data sharing, ACOs may not be able to share data shared across the ACO and its care plan partners, leading to impediments in communication within ACOs and with CBOs. CMS does not consider care coordination and accountability to fall under payment, treatment, and operations, and therefore ACOs are limited in sharing data for these purposes. However, care coordination is necessary for addressing SDOH and providing integrated, whole-person care.

Additionally, there are concerns about using SDOH and equity-related data inappropriately. For example, in the proposed 2022 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) requests feedback on potentially adjusting quality measure benchmarks for ACOs serving vulnerable populations. In NAACOS' comments, we stress that CMS must avoid adjusting quality benchmarks for race and ethnicity.[9] Doing so is endorsing and accepting that for an underserved population, it is acceptable to have lower quality or poor outcomes. Instead, NAACOS offers several recommended policy changes that could help to advance the efforts of quality improvement in relation to improving equity in health outcomes across ACOs. These recommendations include collecting race and ethnicity data in a more standardized way, with incentives for ACOs who are early adopters, updating patient survey data to incorporate health equity, providing incentives to ACOs who attest to using a SDOH screening tool, stratifying a subset of quality measures by race and ethnicity, providing

incentives to ACOs for improving quality scores for subpopulations identified as having lower performance, and developing new quality measures to address health equity.

NAACOS continues to call for the alignment of 42 CFR Part 2 (Part 2), which governs patient substance abuse treatment records, with 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. While substance use disorder (SUD) affects all racial and ethnic groups, Black and Latinx Americans are less likely to complete treatment for SUD.[10] By equipping providers with the necessary information for coordinated, whole-person care, these disparities can begin to be addressed. 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 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. We thank Congress for the work done through the Coronavirus Aid, Relief, and Economic Security (CARES) Act to allow the sharing of this important SUD data after initial patient consent. However, while Section 3221 of the CARES Act helped to align Part 2 with HIPAA, implementation has been challenging. For example, Section 3221 did not provide specifics on what is required to obtain the initial patient consent. Additionally, because care coordination is not considered by CMS to fall under treatment, payment, and health care operations, ACOs still lack access to vital SUD-related data on their patients.

Question 7: *What types of investments are needed to support services aimed at addressing the social needs of patients and advancing health equity, and by whom? What are the necessary funding streams and payer mechanisms for supporting activities and infrastructure related to addressing SDOH and equity for health care providers?*

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.[11] 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.[12] In order to support services aimed at addressing social needs of patients and advancing health equity, providers need both upfront funding to implement programs and reimbursement for services provided. NAACOS recommends providing ACOs with both grant money and adjusted financial benchmarks to support this work.

Under current policy, CMS uses Hierarchical Condition Category (HCC) prospective risk adjustment models to calculate beneficiary risk scores and adjust ACOs' financial benchmarks to reflect the increased cost for treating patients with high clinical risk factors that are beyond an ACO's control. Each HCC has a corresponding risk adjustment factor (RAF) score that is used by CMS to determine the medical complexity of a patient and to calculate the amount CMS will anticipate allocating for that beneficiary in the upcoming performance year. The intention behind this risk adjustment methodology

is to adequately cover the costs of providing covered benefits to beneficiaries. However, RAFs do not include social risk factors that can have a significant impact on health and health outcomes. In order to fully capture the risk level of a beneficiary and the costs associated with caring for that patient, changes need to be made to current risk adjustment calculations. Current MSSP benchmarking methodology should be updated to fairly and appropriately compensate providers caring for vulnerable or underserved populations with greater social risk factors to reflect the differential costs associated with achieving positive health outcomes for these populations.

Additionally, ACOs should be given additional flexibilities with Medicare rules to deliver supplemental benefits that address SDOH or health equity. 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. NAACOS recommends that ACOs be offered additional flexibilities 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.[13] Some examples of supplemental benefits that may be offered include food, pest control, indoor air quality equipment, structural home modifications, and others. 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.

Question 10: *What other types of process measures, outcome measures, and/or other performance metrics could be used in the context of APMs and PFPMs to encourage provider accountability and meaningfully reflect the impact of efforts to address SDOH and advance equity?*

There are several opportunities to address health equity via quality measurement for ACOs. There are many quality measures that CMS currently considers to be "topped out," meaning performance is high among most reporting the measures; however, these measures may show additional room for improvement when stratified by social risk factors such as income level, as an example. Stratifying quality measures by social risk factors may allow ACOs to target tailored interventions designed to have the most meaningful impact on underserved populations. Other metrics that could be used include standardized collection of race/ethnicity data, patient feedback data on equity, and standard use of a SDOH screening tool. NAACOS also recommends the development of new measures that address health equity at the population health level. We recommend that CMS collaborate with ACOs to help identify the most appropriate, population-health focused measures on equity.

Question 12: *Are there any other important questions that remain unanswered relating to the incorporation of efforts to address SDOH and equity into APMs and PFPMs?*

There are many challenges faced by ACOs and other APMs to address SDOH and health equity. For example, Stark Law and Anti-Kickback Statute (AKS), as they are currently written, create challenges for ACOs to be able to effectively address SDOH and coordinate care. Under existing waivers, there is

significant uncertainty concerning whether, as well as the extent to which, an incentive program offered to a physician with respect to assigned MSSP patients may, without creating potential Stark Law issues, also be offered to the same physician for non-MSSP patients. This makes it difficult for ACOs to establish SDOH initiatives, as there are concerns about which patients qualify for these programs, and it limits the potential for these programs to have a meaningful impact on SDOH, as enrollment and benefits change regularly. This also creates confusion for providers, limiting uptake.

Additionally, capacity and workforce training issues are an impediment to addressing SDOH. Addressing SDOH requires significant change management and workforce development for which most organizations do not have the funding or bandwidth. Policymakers need to work to ensure that medical education includes training on addressing social determinants. Existing clinicians should be provided with the necessary training and technical assistance on how to implement policies and initiatives to measure and address the negative SDOH of their patients.

Importantly, it must be emphasized that relying on good data to address health equity is critically important to the success of these efforts. It is critical to note that we cannot embark on these changes without also giving clinicians and ACOs the tools and resources they need to implement and deploy interventions to reduce these inequities and to improve patient care for underserved populations. There must also be a recognition that health equity solutions will be localized and, therefore, will need to look different in different locations, markets, and populations. Finally, as these policy options are considered, it is important to recognize the additional burden that may be placed on clinicians, and, therefore, it will be critical to find ways to minimize this burden. NAACOS encourages any efforts to address SDOH and health equity to be collaborative and include the voices of diverse patients, community partners, providers, and other key stakeholders.

Conclusion:

Thank you for the opportunity to provide comments on the PTAC RFI on addressing social determinants and health equity in APMs and PFPMs. Should you have any questions about our comments, please contact Allison Brennan, SVP, Government Affairs, at abrennan@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO

[1] https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext
[2] https://www.nap.edu/read/12875/chapter/1#xiii
[3] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0727

[4] https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[5] https://www.naacos.com/acos-and-health-equity-white-paper
[6] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01266
[7] http://reports.opendataenterprise.org/Leveraging-Data-on-SDOH-Summary-Report-FINAL.pdf
[8] https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf
[9] https://www.naacos.com/naacos-proposed-2022-mpfs-comments
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3570982/
[11] https://www.healthaffairs.org/do/10.1377/hblog20210414.379479/full/
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