



## Addressing Equity in Quality Measurement for ACOs

### Introduction

The World Health Organization (WHO) defines health equity as, “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.”<sup>1</sup> Social factors and systemic discrimination have led to wide and longstanding gaps in health equity for underserved communities.<sup>2</sup> The social determinants of health (SDOH), non-clinical factors that influence health outcomes, have an important influence on health inequities.<sup>3</sup> SDOH are defined as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.”<sup>3</sup> Social needs, the immediate necessities deemed by the individual’s preferences and priorities, are also important factors in health equity and while they are related to and affected by SDOH, they are distinct.<sup>4</sup> For example, living in a food desert without access to fresh and nutritious food options is a social determinant, whereas having healthy meals to help manage diabetes is a social need. In this instance, the social need may be met immediately by connecting this patient to a local food pantry or produce delivery service, but addressing the SDOH would require significant time and resources to build a grocery store and eliminate the food desert.

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 (IT) 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 lever by which health inequities can be reduced.

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.<sup>5</sup> Social risks and social needs cannot be addressed if they are not adequately measured, tracked, and reported.<sup>6</sup> Innovative payment and care delivery models that rely on data provide an opportunity to better understand and highlight existing disparities and the tools to tailor interventions based on individual need. For example, ACOs assume accountability for a population’s cost and quality of

care, and many are beginning to address patients' social needs such as housing, transportation, and food insecurity as a way to improve health outcomes.<sup>7</sup>

One important way to support ACOs in addressing health equity is through quality measurement at the population health or ACO level. There are many quality measures which the Centers for Medicare & Medicaid Services (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. In this way, ACOs can address health inequities existing within their patient populations. These efforts to address health inequities through quality measurement must be coupled with other efforts to support ACOs in addressing health equity. Equity initiatives require significant upfront investment to be effective, and, therefore, ACOs require additional flexibility and resources to be able to address these concerns with their patient populations.

This paper discusses seven policy changes that CMS could consider, which could help to advance the efforts of quality improvement in relation to improving equity in health outcomes across ACOs. These policy changes must be implemented in a step-wise manner, and each recommendation is designed to build off of the learnings of each change. Importantly, it must be emphasized that relying on good data to address health equity is critically important to the success of these efforts. Finally, 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 that could come in the form of additional data collection requirements and potential costs to alter electronic health records (EHRs) to collect and report data. 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. Implementing these policy changes can provide an important opportunity to reduce health inequities and transition our health system to a culture of value.

### *Recommended Policy Changes to Improve Equity in Health Outcomes Across ACOs*

#### **Collection of Race/Ethnicity Data**

It is critical to begin collecting race and ethnicity data in a standardized way in order to be able to begin to deploy more targeted care coordination and improvement strategies to close equity gaps. The U.S. Census Bureau or other national standard could be used, and CMS could look to electronic clinical quality measures (eCQMs) to report data to CMS to begin measuring this critical information. This could be accomplished by using existing eCQM data fields that are currently optional. Caution should be used when considering mandating requirements that would necessitate costly EHR upgrades and adjustments. As such, incentives could be put in place to allow ACOs time to incorporate this data collection and provide financial incentives to those who are ready to move forward with adoption. As an example, quality bonus points could be awarded to those ACOs who are ready to begin reporting this data.

#### **Updating Patient Survey Data to Incorporate Equity**

Communication and feedback from patients/those being marginalized is incredibly important for confronting and understanding systemic and structural inequities. ACOs are currently required to field a Consumer Assessment of Healthcare Providers (CAHPS) Survey annually. The CAHPS Survey could be

adjusted to begin incorporating equity questions, such as adding a domain focused on receiving timely access and culturally appropriate care. However, there are longstanding concerns with the CAHPS Survey in that it is often collected months after a patient received care and needs to be more real time in order to incite change/action. The survey also needs to be offered in both electronic and paper form and in the patients preferred language in order to not marginalize populations from even taking the survey. Questions may include patient perceptions of how their race/ethnicity affects the care they receive, whether their provider asked about their social needs in context of their health, and whether their provider assisted with accessing and receiving needed care that may have been affected by their social needs, such as transportation. The addition of questions to existing patient surveys can help in the collection of data without added reporting burden on ACOs and provide information that may not be available through other sources.

### **Incorporating SDOH Screening Tools**

Today, many ACOs utilize SDOH screening tools to identify social needs for the patients they serve. However, to date, there is no one standardized screening tool, and many clinicians are hesitant to screen for social needs if they have no way to connect the patient with services to fill those needs. As a first step, CMS should look to incorporate an ACO program requirement in the form of an attestation to use a SDOH screening tool of the ACO's choosing. This would allow ACOs to use the screening tool that is most appropriate for their organization and to conduct the screening in the manner that is most appropriate and feasible for the ACO. As ACOs continue to use these tools, best practices can be identified, and this requirement can be expanded to further encourage use of SDOH screening tools with the eventual goal of identifying standardized screening and reporting practices.

### **Stratify a Subset of Quality Measures by Race/Ethnicity**

The National Committee for Quality Assurance (NCQA) has begun to stratify a subset of quality measures by race and ethnicity to identify areas of improvement. CMS should begin to identify a subset of ACO quality measures that could be stratified by race and ethnicity. In order to do this successfully, however, there first must be accurate and complete data on race and ethnicity available to ACOs. CMS could also look to the Health Resources and Services Administration (HRSA) efforts in this space, as Federally Qualified Health Centers (FQHCs) are currently required to report data in this manner as part of the Uniform Data System (UDS) Resources Requirements. Specifically, hypertension data in the UDS are reported by race and ethnicity which allows HRSA to identify potential health disparities and develop innovative solutions to address them. From 2016 to 2018, the UDS shows that among the adult HRSA Health Centers (HCs) population, Asians, Hispanic and non-Hispanic Whites, and individuals who reported multiple races had the highest percentages of controlled hypertension. Conversely, non-Hispanic Blacks and Native Hawaiians had the lowest percentages of controlled hypertension.<sup>8</sup> Reporting data in this way would allow ACOs to identify possible disparities and improve equity through targeted care coordination and improvement strategies.

### **Providing Incentives to ACOs for Improvement**

CMS should consider providing incentives for improving quality scores for subpopulations identified as having lower performance based on race and ethnicity categorizations. This could be done through bonus or improvement points added to an ACO's final quality score. This will necessitate relying on complete and accurate baseline data and is therefore a more advanced stage policy recommendation. Therefore, initially bonus points could be awarded to an ACO for reporting race and ethnicity data accompanied with quality data. As accurate baselines develop, improvement points could be awarded for improvement within specific subcategories. As an example, HRSA currently provides performance-based supplementary funding through its Quality Improvement Awards to HCs that made at least a 10 percent improvement toward stated targets from prior years in at least one or more racial/ethnic groups.<sup>9</sup> In

addition, currently measures and benchmark may unfairly affect performance of ACOs with a larger portion of patients with social need. Stratifying subpopulations and incentivizing improvement could help ACOs invest in resources to make improvements.

### **Develop New Quality Measures to Address Equity**

As CMS identifies best practices from the previously mentioned policy changes, it should also look to develop and incorporate into ACO programs quality measures that address health equity at the population health level. This is currently a gap in the quality measure portfolio. NAACOS encourages CMS to work collaboratively with ACOs who could help in identifying the most appropriate, population-health focused measures on equity based on the learnings from implementing the policy changes identified in this paper.

### **Avoid Adjustments to Quality Benchmarks for Race/Ethnicity**

CMS must avoid making adjustment to quality benchmarks for race and ethnicity. Doing so is endorsing and accepting that for an underserved population it is acceptable to have lower quality or poor outcomes. Instead, the policy adjustments discussed in this paper should be used to advance equity efforts in the quality space.

### ***Closing***

Social factors and systematic discrimination have led to wide and longstanding gaps in health equity for underserved communities. 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.<sup>10</sup> These social factors cannot be addressed if they are not adequately measured, tracked, and reported. Policy solutions that rely on data provide an opportunity to better understand and highlight existing disparities and provide the opportunities to tailor interventions based on individual needs. Total cost of care models such as ACOs are incentivized to improve quality while controlling costs, and the upfront investments that ACOs make in health IT and infrastructure to provide coordinated care make them uniquely poised to address health inequities. The above policy recommendations will allow ACOs to advance quality improvement for the underserved. However, ACOs cannot begin to do this work without also providing the tools and resources needed to implement and deploy interventions to reduce these inequities and to improve patient care for underserved populations. NAACOS has also provided CMS with additional [policy recommendations](#) for program design modifications to achieve these goals.

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<sup>1</sup> [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_3](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3)

<sup>2</sup> [https://www.ncbi.nlm.nih.gov/books/NBK367640/pdf/Bookshelf\\_NBK367640.pdf](https://www.ncbi.nlm.nih.gov/books/NBK367640/pdf/Bookshelf_NBK367640.pdf)

<sup>3</sup> [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1)

<sup>4</sup> <https://www.milbank.org/wp-content/uploads/mq/Volume-97/Issue-02/Meanings-and-Misunderstandings-A-Social-Determinants-of-Health-Lexicon-for-Population-Health.pdf>

<sup>5</sup> [https://www.ajpmonline.org/article/S0749-3797\(15\)00514-0/fulltext](https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext)

<sup>6</sup> <https://www.nap.edu/read/12875/chapter/1#xiii>

<sup>7</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0727>

<sup>8</sup> <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd/dr/dataspotlight-hypertension.pdf>

<sup>9</sup> <https://bphc.hrsa.gov/program-opportunities/quality>

<sup>10</sup> [https://www.ajpmonline.org/article/S0749-3797\(15\)00514-0/fulltext](https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext)