July 6, 2021

Shalanda Young
Acting Director
U.S. Office of Management and Budget
725 17th Street, N.W.
Washington, DC 20500

RE: Methods and Leading Practices for Advancing Equity and Support for Underserved Communities through Government

Dear Acting Director Young:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for information (RFI), *Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government* [Federal Register Number 2021-09109]. 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. 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.

NAACOS is the largest association of ACOs, representing more than 12 million beneficiary lives through more than 370 Medicare Shared Savings Program (MSSP), the Next Generation ACO Model, and commercial ACOs. NAACOS is an ACO member-led and member-owned nonprofit that works on behalf of ACOs 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 ACO members want to see an effective, coordinated, patient-centric care process that focuses on keeping patients healthy.

Social factors and systematic discrimination have led to wide and longstanding gaps in health equity for underserved communities.[1] 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.[2] These social factors cannot be addressed if they are not adequately measured, tracked, and reported on.[3] 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. 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

information technology (IT) and infrastructure to provide coordinated care make them uniquely poised to address health inequities.[4]

We strongly support the administration's goal to equitably serve all eligible individuals and communities. In order to support these activities and reduce inequities in our health system, we recommend the changes detailed in this letter. We are submitting feedback to the specific question: "How can agencies address known burdens or barriers to accessing benefits programs in their assessments of benefits delivery?"

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. Specific recommendations, which are further detailed below, include that Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) should:

1. **Create new opportunities and funding for ACOs to address health equity,**
2. **Ensure quality reporting is thoughtfully designed and implemented to avoid penalizing ACOs treating patient populations struggling with health inequities,**
3. **Leverage the ACO model to test expansions in telehealth for the ability to improve access and quality while controlling costs, and**
4. **Improve ACOs' access to data needed for care coordination.**

ACOs and Health Equity

The COVID-19 pandemic highlighted the deeply embedded inequities in our health care 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.[5]

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 is critical to delivering high quality care in a cost-effective manner and focusing on the broader concept of an individual's overall health. 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.[6] 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 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.

Recommendation 1: Create new opportunities and funding for ACOs to address health equity by:

a. Providing additional flexibilities with Medicare rules for providers to deliver supplemental benefits to patients to help improve 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. NAACOS was pleased to see guidance from the HHS Office of Inspector General, providing additional flexibility from the federal healthcare program anti-kickback statue for providing transportation to patients.[7] We recommend HHS and CMS offer additional flexibilities to allow ACOs to deliver other benefits such as those related to housing or food insecurity.

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.[8] Some examples of supplemental benefits that may be offered include food, pest control, indoor air quality equipment, structural home modifications, and others. As population-focused organizations, ACOs are incentivized to address health equity in order to improve the total quality of care for their populations. 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 the types of services they provide to meet the needs of identified populations.

b. Providing funding to ACOs to support expanding social services to improve health equity.

As reflected in the examples above, many ACOs already have initiatives to address health equity and other ACOs are in the process of planning to introduce similar initiatives. However, financial barriers and resource constraints remain a major hurdle to this work. Without additional funding and incentives to do this important work, true progress will not be realized.

CMS could provide grant funding to ACOs to expand and develop their connections with CBOs and to enhance ACOs' internal capacity to target underserved populations and meet social needs.

The Center for Medicare and 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 upfront funding to address health equity gaps within their patient populations. 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.[9]

Recommendation 2: Ensuring quality reporting is thoughtfully designed and implemented to avoid penalizing ACOs treating patient populations struggling with health inequities

Recent changes to the way ACOs are required to measure and report on quality, finalized in the 2021 Medicare Physician Fee Schedule Rule (CMS-1734-P), may have inadvertent negative impacts on health equity. Lack of standardization across electronic health records (EHRs) will cause significant administrative burden and high costs, which will direct resources away from patient care and equity interventions. Requiring ACOs to report 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.

ACOs have been left with many unanswered questions about how to implement these changes, and they are grappling with this at a time when they are still challenged by the COVID-19 pandemic and its related impacts. In order to avoid these potentially negative impacts to patient care and health equity, NAACOS makes the following recommendations:

- Delay the mandatory reporting of electronic Clinical Quality Measures (eCQMs) and Merit-based Incentive Payment System (MIPS) CQMs for at least three years
- Limit ACO reporting to ACO assigned beneficiaries only, rather than all patients across payers
- Reassess the appropriateness of the measures included in the Alternative Payment Model (APM) Performance Pathway (APP) measure set and solicit additional input through the

Measures Application Partnership (MAP) prior to finalizing a complete set of patient-centered measures for MSSP reporting

NAACOS has highlighted these recommendations and others with additional detail on unanswered questions and concerns in a letter[10] to HHS Secretary Becerra in May. We encourage these changes be made quickly to ensure that ACOs can equitably and effectively serve their assigned populations.

Recommendation 3: Leverage 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. 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. To ensure that telehealth is expanded in a cost-effective manner that ensures 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.

Recommendation 4: Improve ACOs' access to data needed for care coordination

While substance use disorder (SUD) affects all racial and ethnic groups, Black and Latinx Americans are less likely to complete treatment for SUD.[11] By equipping providers with the necessary information for coordinated, whole-person care, these disparities can begin to be addressed. Section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act helped to align Part 2 with the Health Insurance Portability and Accountability Act (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 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. NAACOS asserts[12] that current regulations allow CMS to deliver unredacted claims data to ACOs. We urge[13] 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.

Conclusion:

Thank you for the opportunity to provide our response to OMB's RFI: *Methods and Leading Practices for Advancing Equity and Support for Underserved Communities through Government*. Should you have any questions about our comments, please contact Allison Brennan, SVP, Government Affairs at abrennan@naacos.com.

Sincerely,

Clif Gaus
President & CEO
NAACOS

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[1] https://www.ncbi.nlm.nih.gov/books/NBK367640/pdf/Bookshelf_NBK367640.pdf
[2] https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext
[3] https://www.nap.edu/read/12875/chapter/1#xiii
[4] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0979
[5] https://www.healthaffairs.org/do/10.1377/hblog20210609.824799/full/
[6] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0727
[7] https://www.govinfo.gov/content/pkg/FR-2016-12-07/pdf/2016-28297.pdf
[8] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
[9] http://medpac.gov/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf?sfvrsn=0
[10] https://www.naacos.com/aco-coalition-letter-on-mssp-quality-overhaul
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3570982/
[12] https://www.naacos.com/naacos-letter-calls-on-cms-and-samhsa-to-provide-acos-access-to-substance-use-disorder-claims-data
[13] https://www.naacos.com/brooks-lasure-letter