MILLIMAN WHITE PAPER

ACO REACH: Leveraging data to reach the underserved and address disparities

CMS requires new REACH ACOs to study and address health equity

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CMS requires newly formed REACH ACOs to submit a Health Equity Plan, which provides an opportunity to study and address health inequities.[1]

The Centers for Medicare and Medicaid Services (CMS) has created a new accountable care organization (ACO) program, ACO Realizing Equity, Access, and Community Health (REACH). REACH represents an effort to better reflect CMS's goals of achieving equitable outcomes through improving quality of care and focusing on patients in underserved communities.

Addressing health inequities is one of the key new elements in what was previously the Global and Professional Direct Contracting (GPDC) model,[2] and a place where providers may have a large learning curve with regards to data analysis.

In this paper, we provide some background on health equity, its role within REACH, and focus on guidance on the Health Equity Plan that REACH ACOs will need to develop under the new program. We then present two examples of simple health equity data analyses using claims and other information, with results presented by race and area deprivation index.

Health equity and ACO REACH

BACKGROUND ON HEALTH EQUITY

While health equity has long been a subject of publication, interest has accelerated in the last 20 years.[3] More recently, Executive Order 13985, signed by President Biden on January 20, 2021, tasked federal programs with assessing and mitigating racial inequities produced by their policies.[4]

CMS requires REACH ACOs to assess health equity in their aligned populations and "promote greater equity in the delivery of high-quality services."[5] Participants' financial benchmarks will be impacted by the extent to which their aligned population is composed of underserved beneficiaries (described below).

The ACO REACH model defines the term "equity"[6] as defined in Executive Order 13985[7]: "the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American individuals, Asian Americans and Pacific Islanders and other individuals of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals; individuals with disabilities; individuals who live in rural areas; and individuals otherwise adversely affected by persistent poverty or inequality."

Health inequity is closely linked to social determinants of health (SDOH), which Healthy People 2030 defines as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." One domain is healthcare access and quality. Examples of SDOH are safe housing, access to transportation, educational attachment, income, food security, language, and literacy.[8]

NEW ACO REACH HEALTH EQUITY PROGRAM REQUIREMENTS

REACH builds on the principles and methodology set forth in the previous GPDC model[9] to reflect the current administration's priorities, incorporate stakeholder feedback, and improve participant experience.

REACH's stated goals include "improving the quality of care for people with Medicare through better care coordination, reaching and connecting healthcare providers and beneficiaries, including those beneficiaries who are underserved."[10]

To achieve these goals, CMS has released five new Health Equity policies[11] (each of which are briefly described further below):

1. Health Equity Plan Requirement
2. Health Equity Benchmark Adjustment
3. Health Equity Data Collection Requirement
4. Nurse Practitioner Services Benefit Enhancement
5. Health Equity Questions in Application and Scoring for Health Equity Experience

The Health Equity Plan policy (the primary focus of this paper) will require ACOs to be proactive in addressing health equity in REACH. The purpose of the plan is for each ACO to identify underserved communities within its aligned beneficiary population and implement initiatives to measure and reduce health disparities for those populations over the course of the model performance period. Each REACH ACO must identify health disparities, define health equity goals, establish a health equity strategy, and plan for implementing the health equity strategy to achieve health equity for underserved communities.[12.]

The second policy adjusts the benchmarks based on the health equity needs of the aligned population. ACOs with a higher or lower proportion of underserved beneficiaries, as measured by Area Deprivation Index and Dual Medicaid Status, will have an upward or downward adjustment to their benchmarks, respectively*.

The third policy specifies data to be collected to monitor and evaluate the REACH model, including beneficiary demographics and SDOH data.[13]

The fourth policy creates waivers for nurse practitioners to take on certain responsibilities and provider services without physician supervision[14]

The fifth policy updates CMS's program application development and scoring to encourage application of entities with experience providing care to underserved communities.[15]

ACO REACH Program Health Equity Plans

GENERAL DESCRIPTION

CMS is requiring REACH ACOs to submit a Health Equity Plan in early 2023. CMS will release a template for completing plans that is based on the CMS Disparities Impact Statement, created by the CMS Office of Minority Health (OMH).[16]

The Disparities Impact Statement lays out in a step-by- step worksheet format the requested information about REACH ACOs' underserved populations, goals, strategies, and action steps. Figure 1 summarizes these steps.

FIGURE 1: ACO REACH PROGRAM DISPARITIES IMPACT STATEMENT STEPS[17]

* CMS estimates the impact of health equity to be +/-0.2% of performance year benchmark for most ACOs

In developing and carrying-out these Health Equity Plans, REACH ACOs may consider forming a health equity committee. This committee could consist of representation from executive leadership, clinical staff, quality experts, case management, data analysts, and people with lived experience in underserved communities served by the ACO. Together, the committee members could bring their individual experiences and expertise to identify health inequities and underserved populations and implement strategies to address and reduce these health disparities.

ACTION PLAN

As a part of the Disparities Impact Statement, REACH ACOs are also asked to fill out an action plan for each improvement goal. Figure 2 shows the action plan worksheet provided by CMS.

The action plan organizes and summarizes the information gathered from the disparities impact statement. For each improvement goal, the REACH ACO is asked to identify the health disparity to be addressed and the priority population. It is then asked to list both short-term and long-term goals and identify action steps, resources and key stakeholders, metrics to monitor progress, and measurable outcomes for each goal.

FIGURE 2: ACO REACH PROGRAM ACTION PLAN

ACTION PLAN Fill out one for each improvement goal. Health Equity Technical Assistance is available for stakeholders completing the Disparities Impact Statement. Contact HealthEquityTA@cms.hhs.gov.

Health Equity Champion: | Executive Sponsor: | Date:

Improvement Goal
What health disparity are you addressing and who is (are) your priority population(s)?

Health Disparity:

Priority Populations(s):

Goals	Action Steps	Resources & Key Stakeholders	Metrics	Measurable Outcomes/Impact
List out your short-term and long-term goals from Step 2. Add rows as needed.	List the action steps needed to achieve your goals.	List the resources needed to accomplish action steps, including key staff or stakeholders from the Stakeholder Engagement Plan.	What will you monitor? What data will you use to track progress and how often?	Consider the longer term outcomes: how will you evaluate the impact and sustainability of your actions?
Short-Term Goal				
Long-Term Goal				

Source: CMS Disparities Impact Statement at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf

Identifying health disparities and priority populations: Case study

INTRODUCTION

The first step for ACOs is to identify disparities among their aligned beneficiaries. This will involve carefully developing an understanding of the ACO's beneficiaries, including any with disadvantaged status and/or disparities in health access or outcomes.

Disadvantaged or under-resourced communities can include people of color, low-income households, women, people with negative encounters with police or the justice system, LGBTQIA+ people, people with disabilities, people of minority religions or who speak non-English languages, the elderly, people who live in less healthy or less safe neighborhoods, and many more groups. Some of these characteristics are more easily identified than others from standard data sources, but challenges with identifying certain populations do not mean that these populations should not receive consideration when developing health equity improvement plans.

We have completed a sample analysis looking for health disparities and priority populations along two dimensions, similar to an analysis a REACH ACO might perform, using the nationwide 2017-2019 Medicare Limited Data Set – 5% Sample (5% Sample), published by CMS.[18] For this illustrative analysis, we have focused out of convenience on disparities by race/ethnicity and Area Deprivation Index (a measure of community-level economic conditions). In an analysis that a REACH ACO might perform, many additional layers of analysis should be considered, based on the data available and input from the community it serves.

For race/ethnicity, we relied on the Beneficiary Race Code in the Medicare 5% Sample. We acknowledge that this field has important limitations in the way that it represents race.** For the sake of clarity, we have used the language used by CMS when referring to different races throughout this paper. Sample sizes by race ranged from roughly 8,300 beneficiaries for the North American Native cohort to roughly 1.2 million beneficiaries for the white cohort, while roughly 26,000 and 22,000 were included in the unknown and other cohorts respectively.

** Limitations may include: only allowing a small range of responses, using verbiage that those of different races may not choose to use to describe themselves, categories changing over time, and providing limited representation for multiracial or multiethnic individuals.

For community-level economic conditions, we have used the Area Deprivation Index (ADI) by Census Block Group,[19] published by the Center for Health Disparities Research at the University of Wisconsin. A higher ADI score corresponds to a more disadvantaged area. Sample sizes for the ADI decile group ranged from roughly 15,200 to 249,000 beneficiaries.

RESULTS

The case study considers two healthcare utilization measures: the proportion of individuals with annual wellness visits (AWVs) and the proportion of individuals with at least one emergency room (ER) visit (either involving mental health or non-mental health). For AWVs, as the CMS name for this benefit suggests, each beneficiary should receive a wellness visit yearly[20]. For ER visits, because visits to the ER are frequently preventable through better use of primary care and better control of chronic illness[21], the optimal result would be a lower proportion of individuals with at least one emergency encounter, suggesting that beneficiaries are able to manage their health without their needs becoming emergent and that they have access to adequate resources for non-emergent needs outside of the ER.

We observed significant disparities between beneficiaries identifying as different races and based on ADI. We found Black, Hispanic, and North American Native beneficiaries to have substantially worse results for both AWVs (lower proportion) and ER visits (higher proportion) both for mental health and non-mental health visits than white and Asian beneficiaries. Figures 3 and 4 present these comparisons.

FIGURE 3: PERCENTAGE OF BENEFICIARIES WITH AN ANNUAL WELLNESS VISIT BY RACE

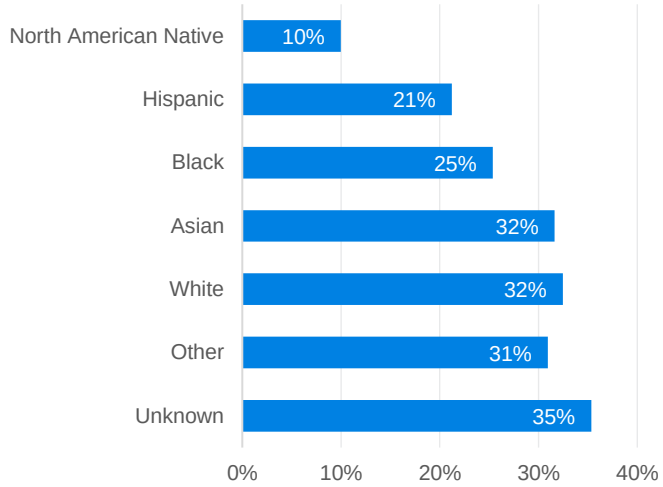
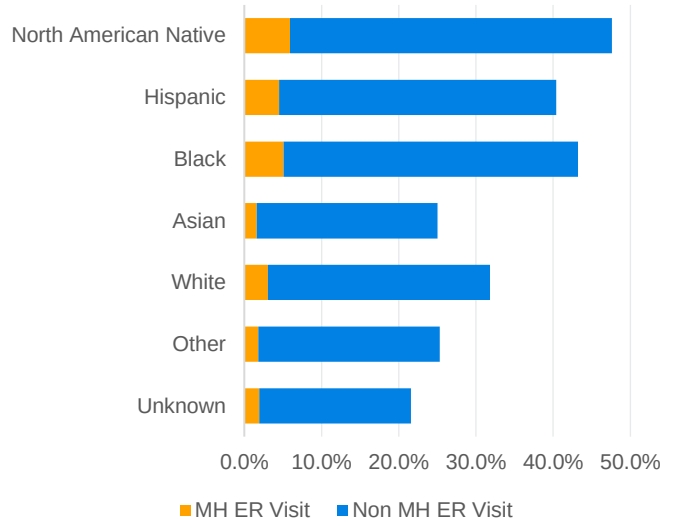


FIGURE 4: PERCENTAGE OF BENEFICIARIES WITH AN ER VISIT BY RACE



Similarly, results for AWVs and ER visits showed substantially worse results for beneficiaries from high ADI areas (the most deprived).

Interestingly, especially low ADI areas (the least deprived) also had relatively low frequencies for AWVs, which may be explained by relatively better health outcomes, access to other means of healthcare, or other factors. Figures 5 and 6 present these comparisons.

FIGURE 5: PERCENTAGE OF BENEFICIARIES WITH AN ANNUAL WELLNESS VISIT BY COUNTY ADI DECILE

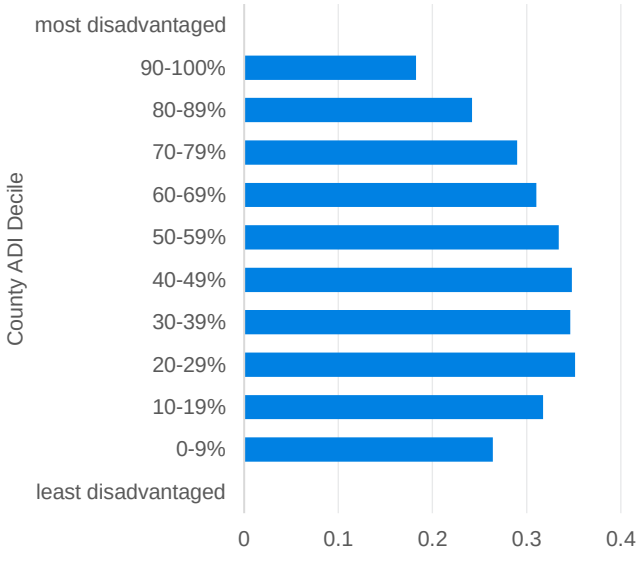
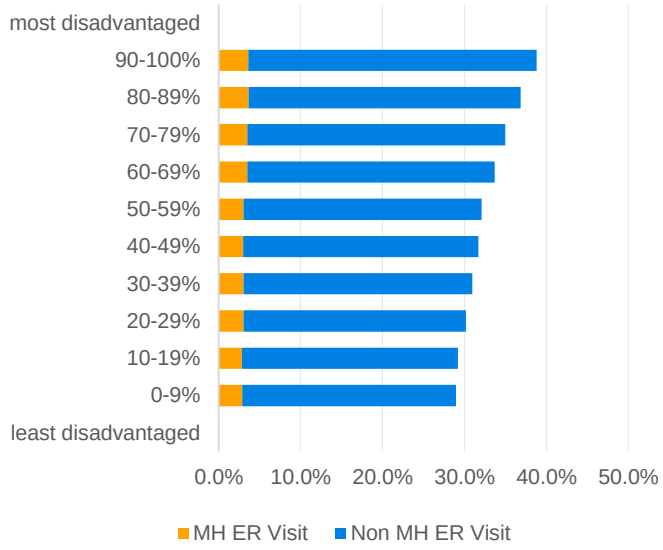


FIGURE 6: PERCENTAGE OF BENEFICIARIES WITH AN ER VISIT BY COUNTY ADI DECILE



It is notable that percent of beneficiaries with ER visits for mental health needs varied much more by race (1.6% -5.9%) than by ADI decile (2.8 - 3.6%).

If this or a similar analysis was conducted as part of the Health Equity Plan for a REACH ACO, the health equity committee could choose to investigate and address the causes of disparities in AWV frequency and ER usage among North American Natives, Hispanic Americans, and Black Americans. For example, are Native Americans receiving relevant services via Indian Health Service (IHS) facilities that are not coordinated with Medicare? The committee may also want to explore the frequency of ER visits and investigate further those groups that are outliers with extremely high ER utilization.

A REACH ACO could work with health equity experts to move through Steps 2 to 5 shown in Figure 1 above to define goals for addressing disparities, develop an action plan, identify resources, and monitor and evaluate progress. The approaches needed to resolve observed disparities would likely vary by community, and may include efforts to solve resource problems, such as lack of transportation or dependent care challenges, access problems such as provider availability or cultural competence, or others.

DATA AND METHODS

For this analysis, the authors relied on data from the 5% Sample data. As the name implies, it is claims data from a sample rather than the entire Medicare fee-for-service (FFS) population. Future results for individual REACH ACOs will vary from those presented herein.

The 5% Sample is published by CMS and contains a persistent cohort of the Medicare FFS population. We evaluated the national population of the 5% Sample, using all members with at least 10 months of data in the years studied.

The 5% Sample also provides a race field that we used in our analysis. For the Area Deprivation Index, we averaged the ADI for each census block within a county, and paired county averages with the county for each beneficiary available in the 5% Sample data. We then organized the county outputs by deciles: 0% to 9%, 10% to 19%, etc. For the utilization measurements, we used Healthcare Common Procedure Coding System (HCPCS) and diagnosis code values to assign indicators for the types of service.***

*** For annual wellness visits, we used information provided by CMS (see https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf). Specifically, HCPCS G0438, G0439, G0468. For ER visits, we used categorizations as provided by the Milliman Health Cost Guidelines™. We also separately identified mental health ER visits using diagnosis codes beginning with F.

Summary

As the role of equity and eliminating disparities expands in healthcare, understanding opportunities to strategically measure and address health equity are increasingly important for ACOs. For REACH ACOs, CMS has established this as a requirement. While the case study in this paper provides an illustration of key metrics and approaches ACOs could use in developing their health equity plans, we recommend that ACOs consider their own individual populations and available data. Additionally, other sources such as the CMS 100% data paired with publicly available data pertinent to social determinants of health[22] may be helpful for both developing and monitoring their plans on an ongoing basis. Sophisticated data analysis and a deep understanding of social determinants of health considerations may be important for ACOs as they develop their health equity plans.

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ENDNOTES

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