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How ACO REACH Model Participants Can Meet 2023 CMS Health Equity Requirements

Introduction

In January 2023, the Centers for Medicare & Medicaid (CMS) will be replacing the current Accountable Care Organization (ACO) contracting model with a new, person-centric model that places an emphasis on social determinants of health (SDoH) and the goal of achieving health equity in communities.

The Realizing Equity, Access, and Community Health (REACH) model will enable ACOs to better meet the needs of historically underserved communities and reduce health disparities across the country. This policy shift highlights the fact that addressing people's social needs—not only clinical ones—will drive down healthcare costs and lead to better health outcomes.

To participate, ACOs must meet new health equity requirements, including the establishment of a transparent health equity plan and prioritization of health equity data collection.

With these criteria in mind, how can ACOs meet the new requirements at every step of the care journey in 2023?

A Closer Look at the New Health Equity Plan Requirement

To support organizations in meeting these requirements, CMS provides the following Disparities Impact Statement template "to be used by health care stakeholders to achieve health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations" to:

1. **Identify health disparities and priority populations.**
2. **Define your goals.**
3. **Establish your organization's health equity strategy.**
4. **Determine what your organization needs to implement its strategy.**
5. **Monitor and evaluate your progress.**

The primary goal of this template is to guide ACOs in using comprehensive data to understand—at both the community and individual level—where gaps in social services and programs exist so they can better serve their patients and communities.

Sending social care referrals to community-based organizations, such as food pantries and rental assistance programs, can be a valuable way for ACOs to establish a health equity strategy. Identifying mission-aligned thought partners at the beginning of this process is critical in ensuring the delivery of whole-person care. This helps ensure high-risk individuals are promptly connected to the care they need and avoids a costly emergency department (ED) visit or inpatient admission down the road.

Beyond sending social care referrals, tracking referral outcomes data is also a critical step in monitoring and evaluating progress on a health equity strategy. For instance, using a technology tool that provides robust data visualizations on how the network serving your members is performing can help ACOs better understand the impact of their work and identify gaps while meeting the needs of their beneficiaries. Important data points to track may include:

- How individuals are being served (e.g. names and locations of organizations in the community who are helping the individual)
- What services they are receiving (e.g. medically tailored meals, boxes of food from a food pantry, etc.)
- What the outcome was (e.g. did they receive the care they needed, or not? If not, why?)

It's helpful when data visualizations include a way to compare measures, such as organizations, programs, client demographics, and cases. For example, an ACO might use measure comparison to see how certain organizations compare to other options in the community, or how the needs of individuals served in a certain ZIP code compare to individuals served in other areas.

In these ways, continuing to monitor and evaluate both individual and population progress over time is a key component of establishing a strong health equity strategy.

How Can ACOs Identify High-Need Populations?

Identifying high-need populations is another critical component of establishing a strong health equity strategy. CMS provides the Area Deprivation Index (ADI), a "multidimensional evaluation of a region's socioeconomic conditions," as "a simple-to-use tool to provide an efficient mechanism to alert health care providers to screen and refer patients for problems related to social determinants of health." Tools such as the ADI can be beneficial for ACOs who are looking to identify health disparities and priority populations.

In addition, using technology tools that help identify areas and individuals likely to have unmet needs can also help ACOs identify which specific disparities are priorities in a given community. For instance, a Social Needs System (SNS) tool has the ability to show a breakdown of Social Needs Factors in a given geographic area, leveraging an integrated health and social care database to systematically predict and measure social, environmental, and economic marginalization. In the 2023 Medicare Advantage Announcement, CMS included the Unite Us Social Needs System among other key SDoH data assets to consider in Medicare Advantage Star Ratings and risk adjustment.

With this information in hand, ACOs can align their health equity plans with their beneficiary pool to better address priority populations.

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Unite Us' End-to-End Solution

As part of the new health equity data collection requirement, ACOs must submit beneficiary-reported demographic data and SDoH data on an annual basis.

For ACOs who do not already have mechanisms in place for regular SDoH data collecting and reporting, utilizing a technology platform can be instrumental in meeting data collection requirements. Unite Us supports ACOs with monitoring, evaluating, and reporting on SDoH metrics and measuring impact on underserved beneficiaries.

ACO REACH includes a two-percent quality measure withhold that participants have the opportunity to earn back by hitting their quality targets. There is up to a 10-percent opportunity to get a bonus or to earn back that two-percent withhold by collecting SDoH-related demographic data.

The ACO REACH financial incentives around health equity are a noteworthy development and an indicator that CMS programs should expect the agency to ask them to collect demographic and SDoH data in the future.

With Unite Us' end-to-end solution, providers across sectors identify social care needs, send and receive secure, electronic referrals, report on tangible outcomes, and transform payment models within a secure and collaborative ecosystem. Using Unite Us, ACOs can go far beyond resource searches and electronic referrals by confirming the specific outcome of every service episode.

The Unite Us Platform gives ACOs the ability to track important social care information, such as:

- Services provided, Units, and Amounts (dollars, time)
- Interactions
- Messages to clients (text/email)
- Assessment and care plan updates
- Resolved and unresolved outcomes

Outcomes may include:

- Received Clothing and Household Goods
- Received Furniture
- Applied for Housing/Voucher Program
- Submitted Recertification for Housing/Voucher Program and more

As ACOs prepare to meet new health equity requirements in 2023, establishing a transparent health equity plan and prioritizing data-driven strategies to support health equity will be critical components on the road to success.

To learn more about how Unite Us can help ACOs meet the new CMS health equity requirements in 2023, visit **uniteus.com/demo/**.