July 5, 2021

**VIA ELECTRONIC MAIL**

Amira Boland
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Re: Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government

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Dear Ms. Boland:

The Health Care Transformation Task Force (HCTTF or Task Force) appreciates the opportunity to comment on the Office of Management and Budget, Executive Office of the President's Request for Information on methods and practices for advancing equity and support for underserved communities (86 FR 24029).

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the health care delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the health care industry – including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver better health and better care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by the Centers for Medicare and Medicaid Services and other public and private stakeholders, can increase the momentum of delivery system transformation.

The Task Force's detailed comments and recommendations are captured below. These recommendations – while organized according to the categories defined in the RFI – reflect the following cross-cutting themes:

## Coordination Within and Across Agencies is Critical Now More than Ever

- Now is the time to put a laser focus on coordination and collaboration within and across federal agencies, particularly in light of the new opportunities afforded by the American Rescue Plan Act.

- It is critical that the administration seek to reduce regulations that create barriers to leveraging federal funds and create new avenues for coordination across agency-level funding streams.

**Value-Based Payment for Health Care Can Improve Outcomes and Address Health Disparities but Investments are Needed to Realize the Promise for ALL Individuals**

- Investing in providers working in underserved communities to ensure they have the infrastructure to support interoperable data exchange that allows for improved care coordination within institutions and between institutions and community organizations.

**Assessing the Impact of Federal Policies and Programs on Underserved Populations Needs to Reflect the Universe of Factors that Affect Equitable Access**

- Assessing whether programs or policies are achieving equitable results requires accurate race and ethnicity data, but also needs to be more broadly conceptualized to look at other factors that impact equitable access to supports.
- Focused cross-agency coordination would better address opportunities to improve social determinants of health for communities in need as a step toward seeking to achieve health equity.

**The Federal Government Should Leverage Lessons from Past and Present Programs to Inform the Design and Implementation of New Efforts.**

- Existing models, such as Accountable Health Communities, can provide important lessons on what is, and is not, successful when it comes to engaging with underserved communities, identifying needs, and coordinating connections to resources.

We appreciate the opportunity to provide input to the administration on these important topics.

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## I. Equity Assessments and Strategies

The Task Force appreciates the administration's movement toward addressing health equity in current and future government policies, budgets, regulations, grants or programs. For federal agencies to develop strategies and interventions that address inequities in how underserved individuals and communities engage with and/or access federal programs, they need to assess the current environment. The Task Force submits for consideration the following tools, all of which have been used and tested in various environments and for varying purposes, to achieve the goals described in the RFI.

- North Carolina Child, in partnership with the Division of Public Health Women's Health Branch and the Office of Minority Health and Health Disparities, developed a Health Equity Impact Assessment and Implementation Guide that enables decision makers to intentionally focus and align strategies to reduce health disparities. The tool comes with

an implementation guide and instructions for facilitators, as well as pre-work activities to help users identify the correct policy, evaluation team, and data profile used to evaluate the policy.
- While originally developed for Oral Health Policy, Community Catalyst's Oral Health Policy Equity Tool can serve to evaluate the impact of policy proposals on the intervention population. The tool offers six questions to inform policy agenda setting, as well as accompanying questions focused on how various populations will be impacted by the policy and relevant resources in the field. This tool centers legislative agenda-setting around the principles of equity and community engagement.
- Applicable to both policy and program design, the Choosing Health Equity: Understanding Decision Points in Policy and Practice tool – developed by The National Partnership for Women & Families – identifies the decision points that make up the design process. For each point, it provides a set of concrete questions to consider related to health equity, and provides recommendations and resources for stakeholders to apply to address develop solutions to dismantle inequities.

Evaluating the equity of programs requires a high volume of accurate race, ethnicity, and other demographics data. To collect accurate demographics data on race, ethnicity, gender identity, sexual orientation, and other social determinants of health (SDOH), the Task Force strongly encourages HHS and other agencies to invest in data collection efforts in parallel with efforts to expand and significantly improve interoperability infrastructure with appropriate privacy protections. This will allow for exchange and use of demographic and SDOH data already collected via EHRs to be shared between health care organizations.

- Working with Press Ganey, Mount Sinai in New York re-vamped their data collection system to better collect race and ethnicity data.
- The American Hospital Association Institute for Diversity and Health Equity released a Disparities Toolkit which provides hospitals, health systems, clinics and health plans with information and resources for systematically collecting race, ethnicity, and primary language data from patients.
- The UCLA Williams Institute and the Fenway Institute offer best practices for accurately collecting Gender Orientation and Sexual Identity information from patients. The Fenway Institute also offers a briefer on Eights Tips for Building Coalition Support and Moving SOGI Data Collection Forward in an Organization to help organizations move towards collecting all data necessarily to evaluate the equity of a program.

### Assessing Value Payment Models' Effects on Equity

The Task Force is an organization dedicated to advancing the transformation to value-based payment as a driver toward improved care delivery. Thus, the Task Force understands the unique opportunity value-based payment offers to address disparities in health care delivery. Alternative payment models (APMs) that establish incentives to providers to move beyond fee-for-service delivery to deliver coordinated, high-value care for all patients that results in improved outcomes at lower costs can also be a vehicle toward providing more equitable care, if so incentivized. The Families USA guide, National Priority Agenda to Advance Health Equity Through System Transformation, provides 19 recommendations that highlight a path towards an equitable, transformed care system.

Furthermore, a resource from the Center for Health Care Strategies, Leveraging Medicaid Accountable Care Organizations to Address Health Equity: Examples from States, highlights how accountable care organizations (ACOs) can be a powerful tool to address health equity. States with successful ACO programs describe formulating payment around data collection, paying for equity using value-based payment, adjusting for social risk factors, increasing member engagement, supporting non-traditional providers, increasing ACO internal capacity to advance a culture of equity, partnering with community-based organizations, and integrating the social determinants of health into care.

As the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI) moves into its second decade, the Task Force encourages it to continuously assess APMs and their effects on health equity. For example, CMMI should evaluate episode payment models to identify potential unintended consequences (on both patients and providers) resulting from bundled payment rates not accounting for the needs of underserved patients who may be receiving care at a later stage of their condition/disease Another example is the lack of a requirement that participants in the Bundled Payments for Care Improvement Advanced (BPCI-A) model to collect race and ethnicity data. Without accurate demographic data, payers and providers are unable to stratify data in a way that allows for targeted interventions. To this end, CMMI should evaluate the effects of APMs on patients, stratifying outcomes by race, ethnicity, and other demographics. This will require that CMMI mandate model participants to collect demographic data, and to include the use of metrics that are relevant to assessing disparities in care across different demographic groups within a certain condition's population. The Task Force encourages the mandated collection of race, ethnicity, and other demographics data in all future alternative payment models, as well as the use of a standardized set of evaluation metrics (based on outcome measures that are applicable to both primary care providers and specialists participating in a model) that can be stratified by these factors to compare different population segments and identify any existing health disparities.

Finally, we use federal agencies, including HHS and others, to broaden risk assessment criteria to accurately encompass all factors that impact equities in health care. Risk assessments are often focused on income and education as defining characteristics for health disparities; however, these variables do not adequately reflect the challenges inherent in addressing maternal morbidity and mortality for BIPOC birthing people, as the mortality and morbidity rates do not correlate to income or education.

## II. Barrier and Burden Reduction

The Task Force appreciates the urgency of addressing and eliminating the external (*i.e.,* specific to an individual's circumstances) and internal (*i.e.,* program administration requirements) factors that create barriers to accessing benefits from a given policy or program. There needs to be attention paid, and efforts made, to address and understand how various programs' disparate eligibility rules, appeals processes, and other programmatic elements truly affect people's financial, mental, physical, and emotional well-being. Policies such as asset tests and annual redeterminations for disability and income create significant burden and program churn, without a concurrent positive outcome. More research needs to be done to understand why this occurs.

Notably, some programs have created inadvertent barriers. The Federal Communications Commission (FCC) launched a telehealth program, the Connected Care Pilot Program, to support selected applicants with the provision of connected care services. The program included funding to cover 85 percent of eligible costs of broadband connectivity, network equipment, and information services necessary for the intended patient population. While the overall intent of this program was positive, the final rule restricted eligibility to non-profit organizations, which limited the impact for the populations who could benefit from the program. Another example is the Coronavirus Response and Consolidated Appropriations Act of 2021, which contains a provision requiring Medicare beneficiaries using behavioral telehealth services to attend an in-person office visit both before and after the telehealth visit, thus imposing a burden on beneficiaries who may not have the means to access an in-person visit due to health status, transportation, or other factors. The same legislation also requires the elimination of audio-only telehealth services following the end of the public health emergency, which will disproportionately impact those in rural and other communities that are underserved by broadband and cannot access video telehealth visits. To better measure and understand the delivery of audio-only telehealth services, we encourage the development of a specific billing modifier to allow payers to track and measure the use of audio-only services.

### Reducing Barriers Through Government Coordination

The lack of equitable access to care should be addressed at the earliest stages, long before a person presents at a hospital with an emergency. Too often, the burden of the social determinants of health (SDOH) are shifted onto patients, community-based organizations, hospitals, and other health care organizations, leaving them with a monumental task to address. Addressing SDOH upstream requires coordination and collaboration within and across agencies, particularly in light of new opportunities afforded by the American Rescue Plan. The government should act by reducing regulations that create barriers to leveraging federal funds and should create avenues for coordination across agency-level funding streams.

There are several examples of state agencies that are working in concert to remove barriers and align efforts, which in turn, reduces barriers for individual's receiving support from various programs.  For example, the National Academy for State Health Policy's (NASHP) Health and Housing Institute supported five states - Illinois, Louisiana, New York, Oregon, and Texas – in their efforts to break down silos within government agencies to support low-income and vulnerable populations in finding and remaining in stable housing. Similar agency alignment efforts are present in Georgia. Georgia recently passed HB 163 which directs the Department of Community Health to seek federal approval to establish express lane eligibility for Medicaid, and directs the Department of Human Services to automatically enroll and renew eligible children in Medicaid based on application data received for the Supplemental Nutrition Assistance Program (SNAP).

At a federal level, the Special Supplemental Nutrition Assistance Program (SNAP) for Women, Infants, and Children (WIC) offers a positive example of coordination across federal programs. Through adjunctive eligibility, individuals can establish their income eligibility by showing proof they participate in Temporary Assistance for Needy Families (TANF), SNAP, or Medicaid. This streamlines the burden for administration as well as for individuals participating in the programs. Lessons learned from the coordination between WIC, Medicaid, SNAP and TANF should be applied a greater level to streamline application processes for government safety-net programs. For example, Medicaid and SNAP often have conflicting renewal processes for re-determining eligibility after the end of a predefined cycle. CMS and the USDA Food and Nutrition Service should work together to encourage states to coordinate Medicaid and SNAP enrollment and renewal – like Georgia's HB 163 Bill mentioned previously - by using SNAP income data for Medicaid renewals, aligning SNAP and Medicaid renewal due dates, and utilizing Express Lane Eligibility.

Aligning agencies at the federal level requires a huge shift from how programs are financed today. The Task Force encourages the government to create one "bucket" of spending across government agencies to create additional flexibilities in program financing. Furthermore, the Task Force recommends federal agencies work closely with their respective Office of the Actuary's (OACT) to address cost-neutrality over a longer-term horizon instead of expecting cost savings in the short-term.

State-specific approaches can be a key to addressing health equity; however, states (particularly in the aftermath of the COVID-19 pandemic) do not have the resources to design or implement new models.  Thus, the Task Force encourages CMMI to invest in creating a new program – perhaps modeled after the former State Innovation Models (SIM) - that provides states with resources to invest in innovation and infrastructure that support APM implementation.  These investments can be used at the local level to adopt the use of community health workers, patient navigators or other care management models to reduce patient barriers to accessing care. For example, Colorado – under a three-and-a-half-year State Innovation Models (SIM) grant to support behavioral health integration – implemented a regional health connector program. Although no longer running, the program saw great success in finding unique ways to address behavioral health among communities served. Similar mechanisms should be applied at a hospital or health care level to enter a community, learn about barriers for community members, and help patients navigate those barriers.

Value-Based Payment's Role in Removing Barriers

The Task Force continually emphasizes the role that value-based payment can play in developing funding streams, including providing resources to health care providers in underserved communities to enable the implementation of data and technology infrastructure that supports care coordination and high performing care delivery. The Accountable Health Communities (AHC) model, a CMS Innovation Center model, addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization. The AHC model drove community partnerships and clinical-community collaboration screening of community beneficiaries to identify unmet health-related social needs, referral of beneficiaries to increase awareness of community services, provision of navigation services to assist high-risk beneficiaries with accessing community services and encouraging alignment between clinical and community services to ensure that community services are available and responsive to the needs of beneficiaries.

Recently CMS released a new guide for the AHC Health-Related Social Needs Screening Tool to identify health-related social needs, such as food insecurity, housing instability, and lack of access to transportation, among community-dwelling Medicare and Medicaid beneficiaries. The tool enables staff to take the next step of connecting beneficiaries with community resources that can address their unmet needs and provides key insights for implementing universal screening for health-related social needs based on the experiences of organizations participating in the AHC model. While early results of the AHC model have proven its effectiveness in identifying higher cost utilization beneficiaries, we encourage critical analysis of the lessons learned from the AHC model to identify ways to distribute resources more effectively to further achieve the desired outcome. HCTTF urges agencies refer to aspects of this model to identify means to provide financial assistance and support procurement of services by industries that benefit underserved communities and individuals.

## III. Financial Assistance

The Task Force is pleased OMB is looking for feedback on strategies to more efficiently channel grant opportunities to underserved communities. We urge the administration to create a comprehensive strategy to reimagine the way federal resources are directed toward supporting historically underserved communities, so as to address structural racism and the infrastructure developed around it. The following practices comprise this strategy:

- Build capacity among community-based organizations. Improving federal program supports ability to reach the intended recipients requires community-based organizations to serve as partners. For too long, the expectation of community-based organizations to serve as points of contact for various federal programs has been built on an expectation not grounded in the reality of underfunded organizations. Establishing funding streams that go directly to community partners for capacity building to help individuals connect with agencies and community-based organizations is a key component to addressing underserved individuals' unmet needs.

- Allow flexibilities in how federal health care dollars can be spent. Providers – particularly those in health systems – are eager to offer patients with ways to address social risk factors that can be detrimental to the clinical care being delivered. For example, patients with cardiac or respiratory conditions may receive the finest clinical care within the walls of the health system, but if they go home to an environment that lacks food, clean air, or climate control, the clinical treatment will not have its intended effect.
- CMS should eliminate geographic restrictions that inhibit beneficiaries' access to clinical and mental health coverage to ensure beneficiaries can receive necessary health care to improve health inequities and individual wellbeing. Prior to the COVID-19 pandemic, Medicare limited telehealth reimbursement to those living in rural areas. In response to COVID-19, CMS implemented telehealth waivers to grant additional flexibility in traditional Medicare to utilize telehealth. The waivers allowed any Medicare beneficiary to receive telehealth benefits, not only those living in rural areas and permitted Medicare to reimburse for in-home telehealth visits, to name a few. This policy change is critical to retain, and emphasizes that clinical conditions and mental health needs do not choose the individual they burden based on geographic location.
- Community health workers (CHWs) have proven to improve the health outcomes of vulnerable populations; however, there is not a sustainable financing mechanism to pay CHWs for their work, with some state and local agencies relying solely on grant funds. Several states are exploring opportunities to use Medicaid to fund CHWs and we urge CMS reduce barriers so Medicaid can more easily pay CHWs to address inequities. The Association of State and Territorial Health Officials (ASTHO) has outlined bills introduced by states that would reimburse CHWs through Medicaid.
- Refer to lessons learned and best practices from Community Health Centers and Federally Qualified Health Centers regarding successful financial assistance provision.
- Identify and address disparities in access to and funding for public health resources. These disparities, which have always existed, were further exacerbated, and made visible by the COVID-19 pandemic. The Task Force applauds aspects of the American Rescue Plan Act of 2021 that are aimed at helping community partners build capacity, including increased funding for community health centers and community care, block grants for community mental health services, and the state option to provide qualifying community-based mobile crisis intervention services. Providing local public health programs with resources and connections in the community to address the fragmented national health system will help address unmet social needs of individuals and reduce health inequities.

## IV. Stakeholder and Community Engagement

The Task Force appreciates the administration's desire to improve stakeholder and community engagement. Meaningful stakeholder and community engagement requires paying people and organizations for their time and expertise, implementing efficient models of engaging stakeholders and incorporating their input into the process, and creating effective feedback loops to ensure that outcomes are shared with those who are engaged. It is critical that community stakeholders' voices are valued and heard, which can be accomplished via robust representation on organization governing boards, patient-and-family advisory councils, and other engagement vehicles, not solely as advisors, but in meaningful roles with input into decision-making, governance, and strategy. The Task Force urges OMB to adopt strategies from the below initiatives to improve stakeholder and community engagement.

- HCTTF and Community Catalyst's *Center for Consumer Engagement in Health Innovation* (CCEHI) executed a project which explored the engagement structures of three health care systems (Children's Mercy Kansas City, Hudson River Health Care, and Trinity Health) all of which made the commitment to engaging patients and families at the organizational and system levels. The project examined these structures and what it takes for organizations to operate them, and the impact of them on both the organizations and on the people and communities they serve. The resulting case studies informed a Change Package to guide leaders and staff across the health care spectrum to aid in developing meaningful, person-centered engagement structures at the organizational level.
- Raising the Bar: Health Care's Transforming Role, a project funded by the Robert Wood Johnson Foundation, is developing principles and providing practical guidance for the health care sector to achieve optimal well-being for those who face the greatest barriers to health. The project is focused on defining health care's role in addressing social factors and systemic inequities inside and outside of clinical walls that affect health. While the final project product has not yet been released, we encourage OMB to commit to these principles and refer to the lessons learned once available to the public.
- Refer to lessons learned and best practices from Community Health Centers and Federally Qualified Health Centers regarding including patients in governing bodies and how to effectively engage them in decision-making.

The Task Force also encourages OMB to implement strategies for the health care system to employ and/or partner with Black, Indigenous, and People of Color (BIPOC) providers to create options for patients to see a more diverse health care workforce that is representative of the community's race, ethnicity, cultural background, and language. Agencies should also evaluate the National Health Service Corporation to gain a better understanding of which students are receiving funding, to better track what is transpiring in the workforce pipeline. As federal agencies work to implement successful strategies to improve community engagement, the Task Force urges OMB refer to the above best practices and encourage agencies to take accountability for ensuring that programs are servicing those whose lives they were designed to support.

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The Task Force appreciates the opportunity to advise OMB and by extension, executive agencies, regarding strategies to improve equity. Please contact HCTTF Executive Director Jeff Micklos (jeff.micklos@hcttf.org) with questions related to this statement.

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