Health Care Transformation Task Force

Patients, Payers, Providers and Purchasers Partnering to Promote Value

HEALTH CARE

TRANSFORMATION TASK FORCE

The ACO REACH Model

The ACO Realizing Equity, Access, and Community Health (ACO REACH) Model

- The ACO REACH is a voluntary CMMI model scheduled to operate for 4 years from 1/1/2023 until 12/31/2026

- It is redesign of the Global and Professional Direct Contracting Model (GPDC) Model in response to stakeholder feedback and Administration priorities and is intended to better reflect CMMIs focus on advancing health equity and improving beneficiary care.

- The REACH model retains design elements of the GPCD global and professional tracks and adds new requirements to advance equity, promote provider governance, and protect beneficiaries.

- All existing GPDC participants will need to meet the new ACO-REACH model requirements by 1/1/23 to remain in the model

Key Changes in REACH Model

Governance:

- CMS increased provider participation requirements on the governing board from 25 percent (GPDC) to 75 percent
- CMS requires each governing board to include a separate beneficiary and consumer advocate representative with voting rights (*under GPDC this role could be fulfilled by a single individual without voting rights*)

Beneficiary Protections:

- CMS increased monitoring and compliance requirements allowing it to track and respond to issues including beneficiary movement from REACH to Medicare Advantage, ACO risk score and coding changes, compliance with anti-competitive behavior prohibitions, and changes in service utilization that could indicate stinting of care.

Key Changes in ACO REACH Model

Heath Equity Requirements:

- CMS requires all ACOs to develop a health equity plan, and collect beneficiary-reported demographic and social needs data
- CMS implements an enhanced health equity benchmark to incentivize care delivery to underserved populations (used Area Deprivation Index and Dual Eligible Status as variables)
- CMS increased the range of services that can be provided by Nurse Practitioners under the model to promote access to care in provider shortage areas

Discount/Withhold Reductions:

- CMS reduced the benchmark discount from a maximum of 5 percent (GPDC) to 3.5 percent
- CMS reduced the quality withhold from 5 percent (GPDC) to 2 percent

Myth #1
The ACO REACH model is an untested takeover of Original Medicare.

Fact

ACO Reach is a temporary model run by the CMS Innovation Center (CMMI) and is designed to end after four years (1/1/23-12/31/26).

All CMMI models undergo rigorous ongoing evaluations to monitor impacts and may only be expanded at the discretion of the Secretary of HHS if they are shown to:

1. Improve quality without increasing costs,
2. Reduce costs without negatively impacting quality, or
3. Improve quality and reduce costs.

Myth #2
The ACO REACH model will switch patients from Medicare to a private insurance plan.

Fact

ACO REACH model beneficiaries are still covered by Original Medicare (not Medicare Advantage). They have the freedom to receive care from any Medicare provider they choose and may switch providers at any time. Additionally, the model includes reporting requirements to allow CMS to monitor for efforts to transition beneficiaries to Medicare Advantage plans.

Myth #3
ACO Reach incentivizes providers to cut costs at the expense of patients' health and quality of care.

Fact

Unlike Original Medicare fee-for-service, ACO REACH directly ties a provider's financial success to performance on quality measures which incentivize the delivery of high-quality care and care coordination with a beneficiaries' other providers. The model also includes health equity requirements to encourage providers to address disparities in care and the non-clinical social needs that impact overall health and wellbeing.

Myth #4
ACO REACH will auto-enroll patients in secret and allows providers to dictate their patients' participation.

Fact
Beneficiaries are only included in the program if:

1. They voluntarily tell CMS they want to be assigned to an ACO REACH participating provider.
2. They already receive a plurality of their primary care services from an ACO REACH participating physician.

This is similar to other ACO models including the Medicare Shared Savings Program.

ACOs must alert beneficiaries who have been aligned to the ACO and inform them of their right to opt-out of CMS sharing certain data about them with the ACO

Myth #5
ACO REACH lacks mechanisms for CMS to protect beneficiaries and address bad actors

Fact

Under the ACO REACH Model, CMS will implement a monitoring plan designed to protect beneficiaries and address potential program integrity risks. This includes:

- Audits of charts, medical records, Implementation Plans, and other data from the ACO;
- Review of demographic data to identify program integrity risks, such as discriminatory behavior in marketing activities;
- Site visits and Interviews with any individual or entity participating in ACO activities, including members of the ACO leadership/management and providers;
- Feedback from beneficiaries and their caregivers; and
- Documentation requests sent to the ACO, its Participant Providers, and/or Preferred Providers, including surveys and questionnaires

CMS may take a range of actions with ACOs that violate the model agreement including terminating them from the model

Myth #6
Ending ACO REACH will strengthen and protect Original Medicare and help patients.

Fact

Ending ACO REACH will eliminate flexibilities and resources for providers interested in health care reform efforts and set back the value movement. Beneficiaries in these models stand to benefit from enhanced care coordination, improved affordability, and increased incentives for providers to invest in improving health through social supports. ACOs remain a critical part of transforming Original Medicare and have proven their ability to improve care and control costs. ACO REACH is critical to CMS efforts to engage providers and achieve its goal of having all Medicare beneficiaries in accountable care relationships by 2030.