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ACO REACH: Is It for You?

What You Need to Know to Make ACO REACH a Success

Executive Summary

The Centers for Medicare and Medicaid Services (CMS) recently announced a new model for accountable care organizations (ACO). The new model, called ACO REACH for Realizing Equity, Access, and Community Health, replaces the current Global and Professional Direct Contracting (GPDC) model. CMS stopped accepting new applications for GPDC and plans to end that program at the end of 2022.

ACO REACH includes several new policies to increase health equity in the United States. They include:

- Requiring ACOs to develop health equity plans to increase support for underserved Medicare beneficiaries
- Collecting demographic and social needs data on beneficiaries
- Expanding healthcare access by using nurse practitioners and other healthcare professionals
- Giving physicians and providers more control over ACOs by requiring they make up at least 75% of the voting membership of each organization's governing body
- Protecting beneficiaries and the ACO REACH model itself by increasing provider vetting to help ensure that participants are aligned with CMS' vision for the model and closely monitoring participant performance
- Including stronger protections against inappropriate coding and risk score growth

This paper outlines the goals of the ACO REACH model, how it differs from the current GPDC model, what you need to get ready for ACO REACH, and what you can do to make it a success for your practice, your patients, and your community.

What is ACO REACH?

ACO REACH is a new model for accountable care organizations developed by the Center for Medicare and Medicaid Innovation (CMMI). The REACH model—Realizing Equity, Access, and Community Health—is scheduled to replace the current Global and Professional Direct Contracting (GPDC) model on January 1, 2023.

The new model is part of *"a renewed vision and strategy for how the Innovation Center will drive health system transformation to achieve equitable outcomes through high quality, affordable, person-centered care for all beneficiaries,"* Liz Fowler, Ph.D., JD, deputy administrator & director of CMS, said in a March 2022 CMS webinar.

"Under the ACO REACH Model, healthcare providers can receive more predictable revenue and use those dollars more flexibly to meet their patients' needs and to be more resilient in the face of health challenges like the current public health pandemic. The bottom line is that ACOs can improve healthcare quality and make people healthier, leading to lower total costs of care," Fowler said.

ACO REACH focuses on three types of provider-based organizations introduced in GPDC: standard ACOs, high needs population ACOs, and new entrant ACOs. Beneficiaries in all three types of ACOs may be voluntarily aligned or claims-based aligned.

Three Types of REACH ACOs

Standard ACOs	Serves original Medicare patients
High-Needs Population ACOs	Serves Medicare patients who have complex needs
New Entrant ACOs	No prior service provided to original Medicare patients

Standard ACOs are organizations experienced in serving original Medicare patients, including Medicare-only and dually eligible beneficiaries. These organizations have previously participated in other CMS Innovation Center shared savings models, such as the Next Generation ACO Model. Similar programs include CMS' Medicare Shared Savings Program (MSSP). Or they may be new organizations made up of original Medicare providers and suppliers who have formed a standard ACO. Clinicians participating in these organizations usually have significant experience caring for original Medicare beneficiaries.

High-Needs Population ACOs serve original Medicare patients who have complex needs. This type of ACO typically uses care models designed explicitly for high-needs patients, including Programs of All-Inclusive Care for the Elderly (PACE), to coordinate care for their patients.

New Entrant ACOs are organizations that have not traditionally provided healthcare services to original Medicare patients. Beneficiaries served by these organizations are typically aligned voluntarily, for at least in the first few performance years, though claims-based alignment may also be used.

What is a REACH ACO?

REACH ACOs are similar to other accountable care organizations but must meet specific model requirements. Participating organizations must meet all the requirements outlined in the ACO REACH Model Request for Applications (RFA), including the structure of the governing body, their history with Medicare, a policy governing conflicts of interest, and more. ACOs must be legal entities structured as described in the RFA and identified by a tax identification number (TIN) contracted with CMS for participation in the ACO REACH.

Organizations applying to be a REACH ACO should have direct patient care experience and a strong track record serving underserved communities. Standard REACH ACOs should have a minimum of 5,000 traditional Medicare beneficiaries, while New Entrant and High Needs REACH ACOs will have a glide path to reach that number of patients. All ACO participants must use an Electronic Health Record (EHR) system.

REACH ACOs are responsible for receiving any shared savings and paying any shared losses to CMS. They must be capable of administering payments to Participant Providers and, if applicable, Preferred Providers.

Beneficiaries aligned to an ACO retain full access to receive care from any Medicare-enrolled providers and suppliers. They keep all traditional Medicare benefits, and there are no provider networks, prior authorizations, or other constraints on their access to traditional Medicare coverage and benefits.

How ACO REACH and GPDC Differ

The ACO REACH and GPDC models share many components, but there are some important differences between the two programs. Here are some of the ways ACO REACH differs from GPDC:

Primary Goals of ACO REACH

Promote health equity and address historical healthcare disparities for underserved communities

Continue the momentum of provider-led organizations participating in risk-based models

Protect beneficiaries and the model with:

More participant vetting

Monitoring

Greater transparency.

A New Focus on Health Inequities

One of the most significant differences between ACO REACH and GPDC is the new focus on health inequity. ACO REACH includes several components to identify beneficiaries who need extra assistance or aren't getting the necessary care to help close those healthcare gaps.

Health Equity Plans

Participating ACOs will have to develop and submit a health equity plan. Each plan should identify health disparities present in the community and describe how the organization intends to address them. ACOs will be required to report their progress in implementing the plan and the outcomes they are achieving. CMS has not yet released detailed specifications for the health equity plans and reporting requirements.

A New Focus on Health Inequities cont'd

Benchmark Adjustments

ACOs that serve beneficiaries in their region's neediest tenth of the population, determined by the beneficiary's Area Deprivation Index (ADI), will receive an upward adjustment to their benchmark of $30 per beneficiary per month (PBPM). ACOs who serve beneficiaries in the bottom five deciles for their region will have a $6 PBPM downward adjustment to their benchmark.

Beneficiary Engagement Incentives and Beneficiary Enhancements

The ACO REACH model permits ACOs to provide beneficiaries with incentives and in-kind benefits to help build engagement and encourage better management of chronic conditions. For example, ACOs can help beneficiaries manage their blood pressure better by providing an at-home blood pressure cuff. Or they could give patients travel vouchers to help them travel to and from appointments.

Expanded Roles for Nurse Practitioners

ACO REACH expands the role of nurse practitioners to help underserved beneficiaries—particularly those in areas with a limited number of physicians—get the healthcare they need. Under the new model, nurse practitioners will "help reduce barriers to care access, particularly for beneficiaries in areas with limited access to physicians," explained Dora Hughes, MD, MPH, chief medical officer of the CMS Innovation Center. "Under this benefit enhancement, nurse practitioners will be able to assume certain responsibilities or furnish certain services without physician supervision."

According to the U.S. Department of Health Resources & Services Administration, nearly 91.5 million Americans live in "Health Professional Shortage Areas." That includes more than 65% of rural areas and almost 30% of non-rural regions. When allowed by state law, nurse practitioners will be able to certify a REACH beneficiary's need for hospice care, certify a REACH beneficiary's need for diabetic shoes, and order and supervise cardiac rehabilitation for REACH beneficiaries. They will also be able to establish, review and sign a REACH beneficiary's home infusion therapy plan of care, and refer REACH beneficiaries for medical nutrition therapy.

What is the Benchmark?

CMS developed benchmarks to measure shared shavings or shared costs for a performance year by comparing an ACOs performance to what Medicare FFS would have been for aligned beneficiaries. CMS's benchmark is expressed as a dollar amount per beneficiary per month (PBPM).

The benchmarks include the total cost of care for Medicare Parts A & B services. Part D services are not included. There are separate benchmarks for the Aged & Disabled (A&D) and end-stage renal disease (ESRD) beneficiary entitlement categories.

CMS uses different methods for calculating the benchmark, depending on the type of REACH ACO and if beneficiaries are aligned to the ACO through either claims-based or voluntary alignment. Benchmarks for Standard REACH ACOs with claims-based alignment will be calculated using historical expenditures for the years 2017 through 2019.

Standard REACH ACOS with voluntary alignment, New Entrant ACOs, and High-Needs ACOs use two methods to calculate benchmarks. The Regional Benchmarking Approach does not use historical data but instead uses regional expenditure data from the ACO REACH/ KCC Rate Book. The Modified Standard Benchmarking Approach uses recent historical expenditure data, beginning with performance year 2021.

Other Differences Between ACO REACH and GPDC

Demographic Data Collection Requirements

ACO REACH requires that participating organizations capture and report beneficiary demographic data, including race, ethnicity, language, gender identity, and sexual orientation. REACH ACOs must provide demographic data about their patients to CMS as part of the program,however they may not require patients to answer demographic questions. Because of that, CMS will credit ACOs for beneficiaries who choose not to provide demographic information.

CMS will provide an app that uses the Fast Healthcare Interoperability Resources (FHIR) data format, or ACOs can supply data in an approved spreadsheet format.

In addition to the demographic data, ACOs can collect Social Determinants of Health (SDoH) data from beneficiaries, however, ACOs are not required to submit SDoH data to CMS.

Composition of Governing Bodies

One concern about GPDC was that it gave investors too much control over senior healthcare. ACO REACH addresses that problem by requiring that at least 75% of each organization's governing body consists of physicians. That is an increase from the 25% required under GPDC and is intended to give providers more control. In addition, ACO REACH requires that every board have at least one beneficiary member and at least one consumer advocate. Both of those members must have full voting rights.

Reducing the Potential for Risk Coding Abuse

GPDC included provisions designed to protect against inappropriate risk coding growth. ACO REACH expands those provisions by changing the cap on risk score growth from 3% year over year to a 3% cap from a static base year. That means that risk scores can never grow more than 3% during the entire model performance period—from January 1, 2023 to December 31, 2026—as long as the underlying demographics of the ACO do not change.

One goal of ACO REACH is to increase access to underserved Medicare patients. Bringing those patients into an ACO may cause that organization's risk score to grow more than 3%. As a result, the ACO REACH model allows for additional risk score growth if the underlying demographics—including sex, age, disability, and dual eligibility status—shift from the base year.

Risk-Sharing Options

ACO REACH has the same two risk-sharing options as the GPDC model. The professional option gives ACOs a lower risk-sharing arrangement of 50% of savings and losses. The only payment option for participants is a Primary Care Capitation Payment. That is a risk-adjusted monthly payment that covers primary care services.

ACOs assume 100% of the risk for savings and losses in the global option and have two payment choices. They can receive the same Primary Care Capitation Payment as ACOs in the professional plan or receive a Total Care Capitation Payment. That option is a risk-adjusted monthly payment that covers all services, including specialty care, provided by the ACO.

The ACO REACH Timeline

ACO REACH will begin with Performance Year (PY) 2023. Any organization not already part of the Global and Professional Direct Contract model must submit a non-binding application. The application period runs from March 7, 2022 to April 22, 2022. The ACO REACH application includes a new section for potential ACOs to describe previous experiences in serving underserved populations.

ACO REACH Timeline

April 22, 2022	August 1, 2022 - December 31, 2022	December 31, 2022	January 1, 2023	December 31, 2026
New ACOs must apply for ACO REACH. Current GPDC ACOs do not need to apply.	ACO REACH voluntary implementation period	GPDC program ends and GPDC ACOs must agree to ACO REACH terms to continue.	ACO REACH begins	ACO REACH ends

CMS has scheduled a voluntary implementation period from August 1, 2022 through December 31, 2022. All applicants accepted for PY2023 can participate in that voluntary alignment period to prepare to meet applicable beneficiary alignment minimums at the start of PY2023. Participating ACOs can only conduct voluntary alignment activities during that period as no beneficiaries will be aligned to the voluntary or claims-based alignment. ACOs that participate in the voluntary implementation period will not cause any financial risk, nor will they receive any beneficiary-identifiable data.

Current GPDC participants that want to participate in ACO REACH must maintain a strong compliance record throughout 2022 and agree to meet all the ACO REACH requirements beginning January 1, 2023. They do not need to apply by April 22, 2022.

ACO REACH is scheduled to operate through PY2026 and end on December 31, 2026. The Secretary of Health and Human Services may extend the program and broaden its scope if it achieves one of three results: quality of care remains the same while the cost of care is reduced, quality of care improves while the cost of care remains the same, or in the best result, the quality of care improves, and the cost of care drops.

How ACO REACH Helps Medicare Beneficiaries

The ACO REACH model includes several provisions intended to improve access to high-quality healthcare for all Medicare beneficiaries, particularly underserved populations, and improve care for patients with chronic conditions. Among those provisions are an increased role for nurse practitioners, better follow-up care through telehealth and other technology, home follow-up visits after a beneficiary's discharge from a hospital, and cost-sharing support to help patients with copays.

Medicare beneficiaries included in ACO REACH retain all the rights, benefits, and coverage of traditional Medicare, including the freedom to see any Medicare-enrolled provider they want. Beneficiaries may not be restricted to seeing only providers who are part of the ACO. In addition, beneficiaries can use FFS Medicare channels to raise concerns or report complaints.

How to Make ACO REACH Work for You

Supporting innovation is a strategic objective of the ACO REACH program. In fact, during a March webinar, representatives from CMS described that objective:

"Leverage a range of supports that enable integrated, person-centered care such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities."

When CMS' emphasis on data, technology, and innovation is combined with its focus on increasing health equity, accurate coding, and demographic information, it is clear that high-quality datasets are important. ACOs need a data infrastructure—such as the Innovaccer® Health Cloud's Data Activation Platform—to aggregate data from disparate sources and bring it together into a unified patient record that providers can use to help improve the quality of care they provide and reduce the cost of care.

Innovaccer Can Help You Prepare for ACO REACH

Innovaccer, recognized as 2022 Best in KLAS in the new data and analytics platform category, has developed an ACO REACH Accelerator Program. It was designed to help providers apply technology-enabled services to integrate population health management, SDoH services, and financial management services to successfully participate in ACO REACH.

The Innovaccer ACO REACH Accelerator Program

Innovaccer's ACO REACH Accelerator Program is a collection of solutions and services focused on improving health equity, providing beneficiaries with better quality care, and lowering healthcare costs.

Succeeding in ACO REACH may involve processes—claims adjudications, claims processing, and downstream contracting with specialist providers—that are new to you. Innovaccer has a strong network of partners with extensive industry experience who can develop customizations to help with your implementation processes to manage incentive-based contracts, downstream specialists, and claims processing.

Improve Population Health and Reduce Risk With Better Data

With Innovaccer's population health and SDoH management tools, you will have a better understanding and more holistic view of your patients' needs. The Social Vulnerability Index (SVI) tool lets you drill down to the individual level. With that information, you'll be able to develop targeted social interventions, streamline care coordination, and build patient engagement. Your dashboard provides point-of-care insights to measure risk adjustment and ensures you are within the ACO REACH risk score growth guidelines.

Our integration with Aunt Bertha, community-based organizations, and other third-party resources make it easy for you to connect your patients to the best community resources to meet their needs. You'll realize seamless communication between care managers, community resource workers, and your patients.

For financial management, the ACO REACH Accelerator Program includes claims adjudication and financial analytics that help manage business processes, including claims processing, downstream contracting, performance forecasts and benchmarks, and other activities.

In addition, ACOs that want to maximize the benefit of risk-sharing agreements can access, analyze and act on data from multiple sources to track patients through every step of their healthcare journey. Data sources may include clinical and financial data and SDoH data, and information about underserved patients in their region. Patient data comes from several disparate sources, including EHRs, claims, specialists, hospitals, skilled nursing facilities, labs, pharmacies, primary care facilities, and providers outside the ACO network.

The Innovaccer Data Activation Platform (DAP) aggregates all data, and activates it to create a unified patient record that provides a 360-degree picture of your patients at every stage of the care continuum. The DAP has more than 200 connectors to widely used healthcare data systems and applications that enable the aggregation of information from multiple facilities, locations, and clinicians, making comprehensive patient data easily accessible at the point of care. DAP provides a platform for successful population health management that provides patients with higher quality care at a lower cost. It was designed to help organizations meet the ACO REACH objective of increasing health equity among your beneficiary population.

Activated, integrated data can be used to identify and address many of the socioeconomic causes of health inequity, including food insecurity, lack of transportation, language and literacy, whether or not your patients work and the type of work they do, their health history, family support, culture, and access to technology. With that data, you can work with beneficiaries to provide needed services. For example, you can provide travel vouchers or ride-sharing services if transportation is an issue. You can provide guidance on at-home monitoring equipment to track blood glucose levels or monitor compliance. Or, you can use telehealth to meet with beneficiaries who cannot come to your office.

Conclusion

ACO REACH is the latest iteration of CMS's drive to move healthcare providers away from a fee-for-service payment model to a reimbursement model based on value-based care. Unlike its predecessors that focused on care quality and the cost of care, ACO REACH adds the goal of reducing health inequity among Medicare beneficiaries.

Data aggregation and activation are key to any organization that embraces ACO REACH. By establishing a single source of easily accessible data that includes unified patient records, SDoH information, and other relevant information, ACO REACH providers can gain insights to provide quality, efficient care and help build health equity.

High-quality data can also put ACOs in the best position to meet the model's goals of increasing health equity, reducing the cost of care, and improving quality. At the same time, they have easy access to the data they need to manage their financial performance, measure themselves against CMS benchmarks, and track their progress toward implementing their health equity plan.

Innovaccer Inc., the Health Cloud company, is a leading San Francisco-based healthcare technology company committed to accelerating innovation in healthcare. The Innovaccer® Health Cloud unifies patient data across systems and settings, and empowers healthcare organizations to rapidly develop scalable, modern applications that improve clinical, operational, and financial outcomes. Innovaccer's solutions have been deployed across more than 1,000 care settings in the U.S., enabling more than 37,000 providers to transform care delivery and work collaboratively with payers and life sciences companies. Innovaccer has helped organizations unify health records for more than 24 million people and generate more than $600 million in savings. Innovaccer is the #1 rated Data and Analytics Platform by KLAS, and the #1 rated population health technology platform by Black Book.

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