ACO REACH tweaks help smaller group practices, promote health equity

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Value-based care

Experts unlimited are getting a closer look at the ACO REACH model CMS suddenly unveiled in February, and it's looking good for ACOs who don't have financial resources, as well as for the advancement of CMS' health equity cause.

After months of controversy over the CMS Global and Professional Direct Contracting (GPDC) model from the Center for Medicare and Medicaid Innovation (CMMI), CMS announced Feb. 24 that, starting in 2023, the program would be transformed into the Accountable Care Organization (ACO) Realizing Equity, Access and Community Health (REACH) model, or ACO REACH. Its participants would be called ACOs instead of Direct Contracting Entities (DCE) (*PBN 2/28/22*, *3/7/22*).

Since the announcement, CMMI has issued a request for applications, which are due by April 22, 2022, and must be submitted by portal (*see resources, below*). Applicants may include current GPDC entrants who want to remain in the program when it turns into ACO REACH, as well as new groups interested in value-based design.

Take a look at ACO Reach details

Experts have parsed the technical details announced by CMMI. The lowering of the quality withhold from 5% to 2%, for example, is a break for ACOs, especially those who can't afford to invest too much up front, explains Lauren Patrick, president and CEO of qualified registry Healthmonix in Malvern, Pa. This is meaningful because critics, such as Sen. Elizabeth Warren (D-Mass.), had complained about well-funded private equity interests' potential domination of the program.

"CMS holds back a percent of the savings to be adjusted based on the quality scores on quality measures that CMMI/CMS have included in the program," Patrick explains. "For example, the current Global DCE would get 95% of their savings regardless of their performance on the quality metrics. Then the remaining 5% would be based on how well quality metrics are achieved."

By lowering the withhold, CMMI may reduce some entrants' anxiety over quality measures. "Providers find it difficult to gather quality metrics and even harder to perform well," she says. "So any reduction in the dependence on quality measures is considered a 'win' by the providers."
The "benchmark discount" adjustment — for Global DCEs, it went from 2% to 5% over six years, whereas it now goes from 2% to 3.5% for Global ACOs — is another break for less-well-funded entrants, because it lowers the benchmark that the provider group is being measured against.

And the addition of a "static year summary" to the risk adjustment plan for the program, which only allows risk scores to go up or down 3%, is meant to "prevent additional 'gaming'" of risk adjustment, which was a concern of GPDC critics because it "allows the total risk score to rise or fall additionally if the population in the group changes — that is, if a group added some older patients or patients with significant diseases," Patrick says. Thus, an ACO can't lock in a high-risk factor and then dump sicker patients to take advantage.

Ashley Ridlon, vice president of health policy at Evolent Health in Arlington, Va., notes that some of the program features are similar to other models from CMS and CMMI. The "coding intensity factor," for example, "looks at how risk coding is going in your population versus the broader Medicare population to see if it's excessive," Ridlon says, "and that's something we're familiar with for Medicare Advantage."

But the changes in ACO REACH tilt the field more toward the smaller provider. "Entities become the payers for those providers per whatever agreement they have," Ridlon says. "That takes a lot of infrastructure as well as more outreach to get beneficiaries into your population. I think the concern was this attracts new entrants with a lot more capital while provider groups would face a little bit more of a challenge."

The equity angle

"Health equity," an area of focus that CMS has emphasized in recent rulemaking, is prominent in the ACO REACH literature (*PBN 8/2/21*). But details on how the program will actually improve equity remain forthcoming.

"CMMI solicited a ton of input from the stakeholder community on health equity with a number of RFIs [requests for information] across multiple agencies," Ridlon says. "This is the first glimpse we're seeing into where they want to take that."

Among the features to watch will be an upcoming health equity benchmark. "They want to see more ACO entities in areas that are currently being underserved," Ridlon says. "They're looking at the demographics of the model population, to see if they're reflective of the communities that they're in. They want to make sure there are incentives to motivate those entities to serve parts of the country not currently being served and serve beneficiary populations that are more reflective of their communities. This could draw in new provider types with experience serving underserved populations."

In addition to requiring 75% provider representation on each REACH ACO's governing board — up from 25% under GPDC — CMS is requiring that boards have at least two "beneficiary advocates." The ACO also must have a health equity plan and collect health equity data for CMS.

"There are gaps in what people can obtain as far as access to health care services goes, so the concept of this is good," says Christopher J. Kutner, a partner in the health services practice group at Rivkin Radler LLP in Uniondale, N.Y. "The challenge is engaging individuals to advocate for their own health care. Unfortunately, in underserved communities, where people may have two jobs or one-parent families, maybe they don't know the questions to ask."

John Dickey, COO at Acclivity Health in Jacksonville, Fla., expects that "over time CMS will increase the relative importance of health equity in determining model performance. In early years they will take a 'carrot' approach and move to a 'stick' in later years as organizations will have had time to prepare and make any necessary changes for compliance."

"For example, in 2023 ACOs participating in the ACO REACH model will be eligible to receive positive quality performance adjustments for collecting and submitting data on health equity," Dickey says, "but there is no penalty for failing to report. In later program years there will be."

Resources

CMMI, ACO REACH request for applications: *https://innovation.cms.gov/media/document/aco-reach-rfa*
CMMI, ACO REACH application portal: *https://innovation.cms.gov/innovation-models/aco-reach*