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CMS Announces Updates to ACO REACH Model

On August 14, 2023, the Centers for Medicare and Medicaid Services (CMS) announced updates to their Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model.[1] In response to feedback from stakeholders, starting in performance year (PY) 2024, the agency expects to increase the predictability for the model and further advance health equity.[2] Only in its first PY, ACO REACH is a revision and replacement of the Global and Professional Direct Contracting (GPDC) model and the Geographic Direct Contracting (Geo Model) model, a subset of the GPDC model.[3] This Health Capital Topics article will discuss the updates to the ACO REACH model and its implications for existing accountable care organizations (ACOs).

As discussed more fully in a previous Topics article,[4] the GPDC model was widely considered a laissez-faire approach to the ACO concept, creating an "un-fair" environment for new entrants and incentivizing corporate profitability over quality of care.[5] CMS has a set of guidelines to follow when it develops a new ACO model. For example, a potential model must:

(1) Allow Medicare beneficiaries to retain all rights that are afforded to them, including freedom of choice of all Medicare-enrolled providers and suppliers;
(2) Work to promote greater equity in the delivery of high-quality services; and
(3) Extend their reach into underserved communities to improve access to services and quality outcomes.[6]

Because the GPDC model did not sufficiently meet these criteria, CMS attempted to fix these problems through the new ACO REACH model.[7] According to CMS, the ACO REACH model meets these three criteria and addresses other areas of concern that existed in the GPDC model by supporting value-based initiatives and changing the governance structures of ACOs; specifically, it requires a minimum of 75% of the ACO's governing body to be held by participating providers, up from the 25% minimum under the GPDC model.[8] Further, the ACO REACH model is more in line with CMS's ten-year strategic plan, as it better supports care innovation and focuses more on the social determinants of health.[9] For example, ACO REACH model does more than the GPDC model to advance health equity, increase access, and drive affordable accountable care.[10] Specifically, the ACO REACH model directly improves upon the GPDC model by promoting:

(1) A greater focus on health equity and closing disparities in care;
(2) An emphasis on provider-led organizations and strengthening beneficiary voices to guide the work of model participants;
(3) Stronger beneficiary protections through ensuring robust compliance with model requirements;
(4) Increased screening of model applicants and increased monitoring of model participants;
(5) Greater transparency and data sharing on care quality and financial performance of model participants; and
(6) Stronger protections against inappropriate coding and risk score growth.[11]

CMS's announced updates include a number of changes to the ACO REACH model that are spread out over the next couple of PYs. CMS will reduce the minimum required number of beneficiaries for new entrant ACOs from 5,000 to 4,000 for PY2025.[12] Minimums for high needs populations will also be reduced, from 1,200 to 1,000 for PY2025 and from 1,400 to 1,250 for PY2026.[13] As an additional flexibility, a 10% "alignment buffer" will be applied across all ACOs, allowing for ACOs to drop under the beneficiary minimum count temporarily; however, an ACO cannot remain below the beneficiary threshold for more than one of the remaining years for the model.[14]

CMS is also revising the composite measure that is utilized for the Health Equity Benchmark Assessment (HEBA).[15] The HEBA is a mechanism through which CMS "adjusts beneficiary-level premiums based on a composite measure of neighborhood and individual need" in an effort to "direct the right resources to the right people."[16] The revised measure incorporates a State-Based Area Deprivation Index and a Low-Income Subsidy Status to more easily identify underserved beneficiaries who live in high-cost areas.[17] Additionally, the HEBA benchmark amounts will be adjusted in order to increase the HEBA's impact. Starting in PY 2024, benchmarks will be:

(1) $30 per beneficiary per month (PBPM) for beneficiaries who have equity scores in the top decile;

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(2) $20 PBPM for beneficiaries who have equity scores in the second decile;
(3) $10 PBPM for beneficiaries who have equity scores in the third decile;
(4) $0 PBPM for beneficiaries in the following four deciles; and
(5) -$10 PBPM for the lowest three deciles.[18]

CMS's revised model will also allow for physician assistants (PAs) and nurse practitioners (NPs) participating in ACO REACH to certify and order pulmonary rehabilitation plans of care for beneficiaries who have chronic obstructive pulmonary disease (COPD).[19]

CMS asserts that these updates are "expected to improve the model test by 1) increasing predictability for model participants, 2) protecting against inappropriate risk score growth and maintaining consistency across CMS programs and Center for Medicare and Medicaid Innovation models, and 3) further advancing health equity."[20]

The National Association of ACOs (NAACOS) lauded CMS on their updates to the model.[21] Clif Gaus, President and CEO of NAACOS, stated:

> "[w]e appreciate that CMS continues to improve on the ACO REACH Model by addressing many concerns raised by NAACOS members.[22] These include financial protections from midyear changes to benchmarks, additions to the Health Equity Benchmark Adjustment to account for more patient characteristics, and updates to its risk adjustment policies.[23] We believe these changes will satisfy many concerns and stabilize future participation."[24]

Gaus added that NAACOS encourages "CMS to explore adding features of REACH into a permanent track within the Medicare Shared Savings Program."[25] The President and CEO of America's Physician Groups (APG), Susan Dentzer, shared the sentiment, applauding CMS for their updates. Dentzer stated that:

> "APG advocated for many of these changes based on the recommendations of our ACO REACH coalition members, and we appreciate the fact that the Innovation Center was so responsive to our members' perspectives and input.26 We look forward to working with CMS on additional refinements to the ACO REACH Model that will further improve the health care of Medicare patients and the model's financial and operational sustainability."[27]

ACO REACH model participants are required to identify disparities in care and implement a health equity plan.[28] The new model, which allows providers to take on more financial risk, and pushes providers to form ACOs for fee-for-service Medicare beneficiaries, currently has 132 participants.[29] The model is due to run for three more PYs, through PY 2026.[30]

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