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ACO REACH – a Good Opportunity?

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Another type of ACO has recently been unveiled – ACO REACH!

On February 24, CMS announced that effective January 1, 2023, the Direct Contracting, or DCE, Model would cease to exist. It is replacing DCE with a new form of ACO, the Realizing Equity, Access, and Community Health (REACH) Model. CMS will allow a DCE to transition into ACO REACH without even having to complete an application, provided that CMS is comfortable with the DCE's compliance record and the DCE agrees to meet all of the requirements imposed on ACO REACH. As for others the application process is very aggressive: the portal opened on March 7 and will close on April 22. ACO owners who first want to study the new model have likely decided to wait until next year to decide whether to file for 2024, but it's not too early to begin the analysis. Currently ACO REACH is a four-year model, running through 2026.

ACO REACH is designed to better reflect priorities of the Biden Administration, especially health equity as a central requirement to improving quality of care, and a focus on patients in underserved communities. CMS even redesigns the "triple aim," stating that the three principal purposes of ACO REACH are (a) reducing total healthcare expenditures; (b) preserving or enhancing quality of care for REACH Beneficiaries; and (c) promoting health equity to bring the benefits of accountable care to beneficiaries in underserved communities.

Risk prevails in ACO REACH, with two risk-sharing options. The Professional option is the lower risk alternative. It requires that provider primary care services (but no other services) be capitated and offers partial risk sharing of 50% of profits and losses. The Global option is the second alternative and is not for the faint at heart. It offers full risk sharing of up to 100% of profits and losses, with capitated payments for all services provided by providers who have agreed to participate in the ACO.

The benchmarking for the capitated payments is flexible and will be modified in a good way if the ACO's aligned beneficiaries includes a significant number of those considered underserved. In response to feedback received by CMS the quality incentive withholds required for DCEs has been markedly reduced. The rules on risk adjustment for DCEs have also been modified to improve the model.

Unlike ACOs, which require 75% Board membership to be held by participant providers or their

representatives, DCE only requires 25%. ACO REACH moves it back to 75%, and also requires that both a Medicare beneficiary and a consumer advocate (two different people) be included.

ACO REACH offers a new benefit enhancement, consistent with its concept of more equitable access to care, by allowing certain medical services not currently allowed under Medicare law to be performed by nurse practitioners and reimbursed (but only to the extent permitted by State law, which may be an issue in Florida).

There are, of course, a lot more details with the ACO REACH model, many of which will be discussed in the upcoming webinar. It should be clear, however, from this snapshot that even though DCE will be gone the new ACO REACH is a close relative but is heavily focused on risk and equity.

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