Overall

NAACOS strongly supports the ACO REACH (Realizing Equity, Access, and Community Health) Model. Through our dialogue with members who participate in ACO REACH, we've shared the below recommendations to improve the model with the CMS Innovation Center in recent months.

Improve Transparency About Participants

- Make information available in public use files for REACH comparable to that of the Medicare Shared Savings Program (MSSP).
- We thank the Innovation Center for making additional ACO REACH data available to researchers via the Virtual Research Data Center.

Create More Opportunities for ACOs to Address Patients with High Needs

- Allow ACOs to operate a High Needs REACH ACO and Standard ACO in the same market.
- Extend flexibilities and benchmarks given to High Needs ACOs to beneficiaries that meet the qualifications for high needs that are aligned to Standard ACOs, allowing Standard ACOs and participant practices to better serve their high-needs patients.

Participation Lists

- We appreciate aligning deadlines between REACH and MSSP.
- CMS needs a better process to reconcile participation lists between REACH and MSSP.
- More time would be appreciated before participation lists are due. This would allow time for more practices and to join these important models.

FINANCIALS

Retrospective Trend Adjustment (RTA)

REACH uses a prospective trend to adjust benchmarks between the historic spending and performance year. However, in recent years, CMMI overestimated spending and had to retrospectively adjust the trend, lowering benchmarks for REACH ACOs in the process.

- Put bands around the size of the RTA such as +/-5 percent.
- Use a regional RTA when replacing with the prospective trend.
- Allow ACOs to sign an optional amendment that changes program parameters. CMMI did something similar for Next Gens in 2020.

Risk Adjustment

- Provide more information on how CMS will employ the static reference year population in 2024.
- Limit the negative impact on ACOs in the move to version 28 of the HCC risk adjustment model.
- Make the 3 percent ACO-level cap on risk adjustment greater.
- Apply the Coding Intensity Factor before the cap on risk scores.

Rate Book

ACO REACH employs its own adjusted rate book, similar to but different from the one used by Medicare Advantage, to set historic benchmarks.

- Expand the number of years from the current three, such as the five employed by Medicare Advantage, or only include one COVID year.
    - The current ACO REACH rate book will create arbitrary winners and losers based on vast regional variation in Medicare spending that was exacerbated by the pandemic.
- Limit losses for ACOs with negative rate book impacts if COVID years are present.
- Introduce a rate book corridor, so trends could only increase or decrease by a limited percentage.
- Release rate book in advance and allow for stakeholder feedback via a comment period prior to finalizing as is also done in Medicare Advantage.

Historical Benchmark

Many of the current financial rules make it harder for historically successful ACOs to participate and succeed in ACO REACH. The below changes could mitigate that.

- CMS should consider the following approaches to account for the ratchet effect:
    - Flipping the weighting of the benchmark years used in historical expenditures to give greater weight to the year farthest away. This makes it comparable to new ACOs in MSSP.
    - Adding shared savings back into baseline spending for benchmarking purposes.
    - Removing historic spending altogether by relying solely on the REACH Rate Book.

Other Financial Changes

- Allow current Professional ACOs to increase their shared savings rate to 75 percent.
- Make necessary changes to the financial guarantee to make it less burdensome.

HEALTH EQUITY

ACO REACH adds several health equity requirements, including requiring ACOs develop a health equity plan to identify disparities in their communities and describe how they intend to address them, collecting demographic and social needs data to identify and monitor progress in reducing disparities, and applying a health equity benchmark adjustment to incentivize serving certain populations.

Health Equity Benchmark Adjustment

- REACH needs a better index than the area deprivation index (ADI) alone for the benchmark adjustment.
    - Use a combination of ADI with life expectancy.
    - Adjust ADI for variations in cost of living.
    - Use a recalibrated ADI at the local level rather than using national ADI benchmarks.
- REACH needs a better way to apply the health equity benchmark adjustment.
    - Consider removing the budget neutrality aspect.
    - Apply the adjustment to more than just the top 10 percent of the scale.
    - Use a sliding scale with more gradients than the current three (+$30 PBPM, no adjustment, and -$6 PBPM) to give more opportunities to ACOs serving more diverse patient populations.

Demographic and Social Determinants of Health Data Reporting Requirements

ACO REACH requires all ACOs to collect and report beneficiary-reported demographic and social needs data.

- The data collection and reporting aspects of these new requirements are proving to be particularly challenging.
    - ACOs are collecting demographic data that is targeted to their communities; however, this information does not easily map to the US census data.
    - Using the CMS reporting template will require ACOs to manually map EMR data to the template for each EMR. An ACO's practices are often on multiple EMRs, meaning multiple efforts to map.
- ACOs seek clarification they can use any one of the three templates for each practice, meaning they may use one template for one practice and a different template for another practice.
    - The templates vary from each other, making it challenging for ACOs.
    - Broadly, ACOs need easier ways to collect and submit SDOH data and would like to better understand how CMS intends to use the data.

Provide More Guidance on the Drafting of Health Equity Plans

- Certain ACOs feel that they are struggling to identify appropriate populations to help.
- Small ACOs have difficulty identifying discrete populations that are statistically underserved as compared to the rest of the aligned population.
- Similarly, ACOs that operate in an area where there are disproportionately few underserved patients have difficulty identifying populations. These ACOs feel that they would have to expand into new geographic areas in an effort to identify for underserved patients.

Quality

ACOs are unsure of where they stand on the three claims-based measures. NAACOS has asked that CMS provide ACOs the following additional data:

- Quarterly reports on the claims measures data.
    - This was done in MSSP, and ACOs found them useful and were upset when CMS took it away.
- Beneficiary-level details on performance and risk adjustment coefficients on those measures that are risk adjusted so the CMS methodology can be externally validated.
    - The lack of these data is problematic both in terms of being able to track performance during the PY as well as validating the data CMS provides. Both are important to managing quality.
- Numerator count, denominator count, raw unadjusted rate, expected rate (based off their risk adjustment), confidence intervals, and all percentile thresholds.

Data

- Provide more detailed information on claims data reports to help ACOs make capitation payments.
    - ACOs have reported having too little information via claims data on which to pay their downstream providers such as not knowing specific services provided by which provider to which patient and when.
- Implement Use of the HIPAA Eligibility Transaction System (HETS) for Event Notification.
    - This would allow providers to better support care coordination by viewing eligibility checks in real-time using a secure connection.
- Provide ADI and dual-eligible status at the beneficiary level on the monthly alignment report.
    - This would help ACOs better understand their health equity benchmark adjustments.