AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

Frequently Asked Questions About the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model

Overview

The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model is an alternative payment model being tested by the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare & Medicaid Services (CMS).

As with other alternative payment models, the government is testing whether paying health care providers in different ways will improve the quality of care they provide Medicare beneficiaries while delivering that care at the same, or lower, costs. In effect, the model puts physicians and other clinicians in the position of taking responsibility and accountability for the quality and total costs of care for their patients.

ACO REACH is also the first accountable care model to directly address health equity and access to care, with a specific directive to meet the needs of patients from marginalized and underserved communities.

Formerly called the Global and Professional Direct Contracting Model, this program was launched in April 2021 and then revamped by CMMI into ACO REACH in February 2022. The model will fully transition to ACO REACH in January 2023 and will run until December 2026.

As with other innovative value-based care models, ACO REACH departs from traditional, fee-for-service Medicare, which links payment to health care providers to the volume of services that they provide. Instead, under ACO REACH, providers can opt for fixed, per-patient payments provided in advance to cover care for a specific period of time, such as a year. The financial rewards for organizations participating in ACO REACH are thus linked to organizations' success at efficiently coordinating and delivering high-quality care for Medicare patients. These

payments are also adjusted for the health, socioeconomic status, and other factors specific to the patients served, so organizations can tailor their interventions to the specific needs of their patients.

Below is a list of frequently asked questions (FAQs) about the ACO REACH Model.

QUESTION: Is the ACO REACH Model a health insurance product?

ANSWER: No. ACO REACH is not an insurance product in which Medicare beneficiaries need to enroll – that is, sign up for on an annual basis. Beneficiaries in ACO REACH remain in the traditional Medicare program. The model is a way of compensating and incentivizing health care providers to encourage them to improve the quality and efficiency of health care. Beneficiaries in the ACO REACH Model still receive their insurance through the traditional Medicare program and have the freedom to see any provider who takes Medicare.

QUESTION: So, the ACO REACH Model is not the same as Medicare Advantage?

ANSWER: No. Again, it is part of the traditional Medicare program and is not administered by health plans, as is Medicare Advantage. You don't have to pick a plan and enroll annually, as you do with Medicare Advantage plans.

QUESTION: Is ACO REACH a way of "privatizing" Medicare?

ANSWER: No, it's just the opposite: Many of the same doctors, hospitals, and other providers that have long participated in the traditional Medicare program are now participating in ACO REACH. Those clinicians haven't changed; only the way they are paid for providing services has changed. ACO REACH is not an insurance product and is not administered by private health plans, as is Medicare Advantage.

QUESTION: As a Medicare beneficiary, do I have a choice of whether or not to enroll in an ACO REACH arrangement? Will I know if I am in one already?

ANSWER: There are two ways (#1 and #2 below) in which beneficiaries can become part of an ACO REACH Model. Both depend on whom you choose as your primary care doctor or other clinician, such as a nurse practitioner who practices primary care.

#1: If you regularly see a primary care doctor or clinician who is already part of an ACO REACH Model, you will be considered "aligned" with that organization, which simply means that any

medical care you receive, and the costs of that care, will be attributed to the ACO REACH organization. You will receive a letter informing you that your doctor or clinician is a part of the model. And importantly:

- You are still entitled to your normal Medicare benefits, plus some additional ones .
- Beyond this primary care clinician, you also can still see any provider of your choosing – for example, a specialist who provides heart, diabetes, cancer, or arthritis care.
- You can also pick a different primary care clinician if you don't want to be aligned with the ACO REACH Model.

#2: The second way you can become part of an ACO REACH Model is to choose "voluntary alignment," which means that the ACO REACH organization may contact you directly and ask you to participate in the model. The organization is likely to describe to you the additional benefits that you will receive for being part of the model. As described further below, you will still have broad access to specialists and other providers, but your primary care doctor will take pains to coordinate your care with them and help you find a specialist, a hospital, or other provider who will best suit your needs.

QUESTION: What are those extra benefits that I will receive for being in ACO REACH?

ANSWER: As described above, doctors caring for patients in ACO REACH coordinate their care across different providers, such as mental health specialists, hospitals, and nursing homes and rehab facilities. Health coaches are often available to help you understand how to eat right or take better care of your own health. Beneficiaries also have access to convenient telehealth services and can receive care in their own homes after being discharged from a hospital. Patients in ACO REACH also have expanded access to services provided by nurse practitioners and may get some financial assistance to pay their shares of Medicare health care bills. Many people in ACO REACH also receive help with transportation to and from medical appointments or with delivery of healthy meals to their homes.

QUESTION: What if I join an ACO REACH Model and I have a question or issue?

ANSWER: If your primary care clinician can't answer or resolve your question, you can call 1-800-MEDICARE and ask your question. The person who answers can connect you with the Medicare Beneficiary Ombudsman team, or with others who can help.

QUESTION: Does ACO REACH reward doctors or other providers financially for limiting the amount of care that I receive, or my access to specialists or hospitals of my choosing?

ANSWER: No. In fact, doctors and others participating in ACO REACH are motivated to make sure that you receive the best care for your health needs at all times, because this is the primary way that they will succeed financially in the model. They are paid more for keeping you healthy, not for suggesting more tests and services that don't help. What's more, you're not locked in — for each visit you can choose to see your ACO REACH doctor or any other specialist, hospital, or other provider that accepts Medicare.

There are a few services that you may need where Medicare requires "prior authorization" before you can receive the service. This is true in traditional Medicare and the ACO REACH model. The services include specific procedures in hospital outpatient departments, repetitive, scheduled non-emergent ambulance transport (RSNAT), and certain durable medical equipment (DME), prosthetics, orthotics, and supplies items. Your ACO REACH doctor can help ensure that Medicare's prior authorization requirements are met if you need any of these services.

QUESTION: What does the word "equity" mean in the ACO REACH name, and what does it mean for me as a beneficiary?

ANSWER: Health equity is when all people, regardless of race, sexual orientation, disability, socio-economic status, geographic location, or other aspects of their lives, have fair and equal access, opportunity, and resources to live their healthiest lives. This concept is at the heart of the ACO REACH Model. Not every provider group who wants to be a part of ACO REACH is automatically accepted into the program. Participants are chosen by the government specifically based on how they pledge to make health equity a reality.

Each organization must develop a specific plan of action that identifies any differences or disparities in the health status of the people they serve. The participating physicians, clinicians, and other members of a patient's care team must take tangible steps to reduce or eliminate any differences or disparities. These providers are paid to help care for people in communities that have historically lacked access to the types of services that keep them healthy in the first place, such as healthy food or affordable housing. The ACO REACH Model allows physicians and clinicians to take immediate action to fix what is adversely impacting the health of individuals living in these communities.

QUESTION: Is it true that ACO REACH organizations are often run by big private investment firms that are interested only in large profits and don't care patients' health?

ANSWER: ACO REACH is, like the rest of the traditional Medicare program or any other ACO, a partnership between the federal government and doctors, hospitals, and other entities that operate in the private sector. As part of this partnership, some ACO REACH participants have sought funding from private investors to build up their capacity to provide care.

For example, coordinating and managing the care of large numbers of sick patients requires sophisticated electronic health records and other health information technology information systems to keep track of patients' needs. These private investors will benefit the same way doctors and others involved in ACO REACH will benefit: If the model succeeds in improving the quality of care for patients without raising the costs, or by saving money for the Medicare program because care is being provided more efficiently, they will share in the savings to the government. This arrangement is precisely the "deal" struck by the federal government with the private sector: If you can improve the care for Medicare beneficiaries, and still save money for the taxpayers, we will share those savings with you.

QUESTION: Do organizations participating in ACO REACH Models have incentives to get paid more by exaggerating patients' diagnoses, and how sick they are?

ANSWER: No. When patients become part of an ACO REACH Model, their doctors or other clinicians give them a full medical exam to determine their health status – for example, what conditions they suffer from, and the severity of those conditions. They also consider other factors, including whether patients live in neighborhoods that have historically lacked access to health care. The amount of money that doctors and others receive to care for ACO REACH patients is then adjusted so that it is large enough to take care of their patients' needs. Year by year, ACO REACH organizations then have to demonstrate that they are improving outcomes for their patients while controlling costs. The government closely monitors this system to make sure that it's working well for patients and for taxpayers.

QUESTION: How will it be determined over time that the ACO REACH Model is a positive approach for both patients and American taxpayers?

ANSWER: The ACO REACH experiment will end in December of 2026. Between now and then, as well as afterward, the program will be evaluated by experts outside the government to measure its impact on the quality of care, the use of care by patients, their health outcomes, and overall costs. The results of these evaluations will be to be used to improve the model over time and also develop potentially even better ways to improve care for all Medicare beneficiaries while making the best use of taxpayer funding for the program.

QUESTION: How is the program saving money and improving care?

ANSWER: Results that CMS released about the Model indicate that this approach saves money and results in better quality of care. Medicare saved about $70 million in 2021 thanks to the Model, and all participating organizations attained quality scores of 100 percent in such areas as patient satisfaction and unplanned admissions for patients with chronic conditions.

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