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Within Reach

By Kevin McCune, MD

Advocate Aurora Health's entry into ACO REACH is ready for launch

The Centers for Medicare & Medicaid Services (CMS) took stock of Biden-Harris administration priorities and redesigned the previous administration's Global and Professional Direct Contracting (GDPC) Model. The resultant ACO Realizing Equity, Access, and Community Health Model, better known as ACO REACH, aligns its name with its purpose: "to improve the quality of care for people with Medicare through better care coordination, reaching and connecting healthcare providers and beneficiaries, including those beneficiaries who are underserved."[1] As part of its strategic plan, CMS has set a goal having all Medicare fee-for-service beneficiaries in a care relationship with accountability for quality and total cost of care by 2030. ACO REACH is one model that CMS is using to achieve that goal.

AMGA member Advocate Aurora Health was one of 110 health systems to be accepted into ACO REACH for its January 2023 launch. Last November, I had the privilege of sitting down with my colleagues at Advocate Aurora Health to discuss the decision to join this exciting new value-based initiative.

So, what does it take to be a part of ACO REACH?

A Strong Value Background

Don Calcagno, Advocate Aurora Health senior vice president and chief population health officer, explained that the genesis of their value journey predates the 2018 merger of Advocate Health Care in Illinois with Aurora Health Care in Wisconsin. "I'd say Advocate Health Care's approach to value-based care started with Advocate Physician Partners going all the way back to the 1990s, when capitation was significant in the Illinois market at the time," he said. "We took risk both on the physician side and the hospital side." In the early 2000s, Advocate formed one of the first significant clinically integrated networks (CINs) that became "foundational to value-based care work in pluralistic physician models."

So, when the advent of the Patient Protection and Affordable Care Act (ACA) suddenly introduced accountable care organizations (ACOs) in 2010, "it was not like we had to build a new construct," Calcagno said. "The CIN is really an ACO if you think about it, right? It's a group of physicians and hospitals working together to improve quality while lowering the total cost of care." At about the same time, Advocate sat down with the largest payer in Illinois and launched one of the first commercial ACOs in the country.

In the 1990s, the Wisconsin healthcare market looked similar to Illinois, but the Wisconsin market evolved differently. In the 2000s, capitation was limited, and many physicians were in an employed model. Aurora Health Care has had a high-performing employed medical group that works closely with the population health team. By utilizing an integrated medical record, deploying population health resources like care management and pharmacists, Aurora Health Care achieved top results in value-based care.

"When we came together as Advocate Aurora Health," Calcagno said, "we became one of the largest Medicare Shared Savings Programs

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(MSSPs) in the country. Taking advantage of capabilities in Illinois and Wisconsin has allowed Advocate Aurora Health to do incredibly well in value-based care. If you go back to the beginning of MSSP, we saved taxpayers just shy of half a billion dollars."

But is a background in value enough to warrant ACO REACH participation?

Prioritizing Health Equity

Megan Reyna, MSN, RN, system vice president of practice transformation & quality improvement, explained that Advocate Aurora had been evaluating different ACO models, determining which would perform well and help patients through high-quality participation.

As the promotion of health equity and addressing healthcare disparities for underserved communities are a central tenet of ACO REACH, Advocate Aurora Health found its match. "Health equity was already a focus of ours," said Reyna. "It's a platform for us to be able to redesign our work and participate in a value-based care program that we believe will prove beneficial for our patients."

The Health Equity Council at Advocate Aurora Health has already taken on two pilot projects aimed at reducing health disparities. The first looks to decrease the disparity between hypertension control in White patients versus Black and Latino patients.[2] "We've had some very big successes early on with a sample size of only about 400," Calcagno said. "We need to expand it and scale it faster." He went on to explain how the second project focuses on reducing the rate of unnecessary C-sections.

Calcagno summed it up in no uncertain terms: "Health equity needs to be a core pillar of your strategy. If it's not, then I wouldn't participate in ACO REACH."

But beyond this alignment of values and intent, an organization also needs strong data and analytics concerning patient populations to succeed in ACO REACH.

Robust Data

"We have the good fortune of having a decade's worth of experience in the Medicare Shared Savings Program," said Michael Barbati, vice president, government and value-based programs. "We have a history and robust data around these patient populations, and we have a good data infrastructure to be able to examine this without the help of an outside entity."

When programs like ACO REACH emerge, Barbati explained, "time can be a real barrier." Without the data and analytics in place, an organization can be doomed to playing catch up.

Calcagno elaborated: "Because of the way the model is constructed, you need to fully understand who these patients are. What's the cost burden they have today? What's the disease burden they have today? If you're going to be bearing risk"—which is an inexorable truth of value-based care—"you have to understand the population at a high enough level that you can make a meaningful impact on that patient and not be economically harmed—but maybe even economically rewarded."

Reyna went on to explain how Advocate Aurora Health's analytics even challenge some aspects of ACO REACH, particularly concerning the way in which the model treats the Area of Deprivation Index (ADI) at a national level. "Essentially, it fails to adjust for differences in cost of living between different geographic areas, especially high-cost urban neighborhoods," she said. "This leaves certain urban areas like New York City and the entire Bay Area with very few patients who actually qualify in that high ADI category for a program like ACO REACH. We saw it here on the south side of Chicago, as well."

Helping those high-need areas is "the intent of the entire program," Reyna said, "and we saw that people who would benefit from the program were not considered the most disadvantaged."

Barbati explained that in looking at the target patient population, Advocate Aurora Health was looking for patients who (1) seemed to be disadvantaged and living in disadvantaged areas, and (2) struggling to have their needs met through MSSP. "We looked at these patients and we said,

"I think some see CMMI programs as a one-and-done sort of thing. We need to think more broadly."
—Don Calcagno, Advocate Aurora Health Senior Vice President and Chief Population Health Officer

What Is ACO REACH?

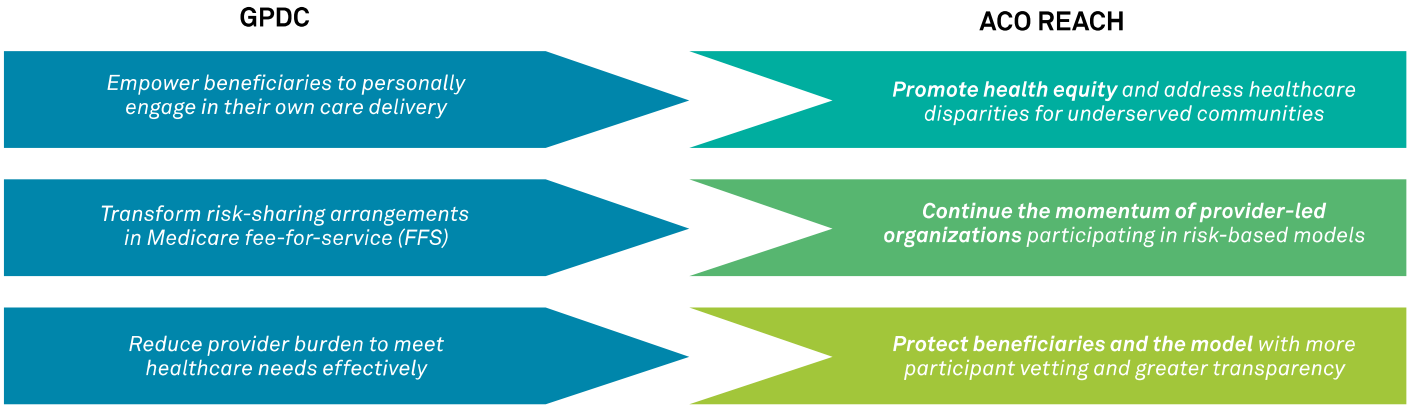
The ACO Realizing Equity, Access, and Community Health (ACO REACH) Model is an alternative payment model from CMS that encourages a shift away from fee-for-service compensation and into a value-based payment model.

This redesign of the Global and Professional Direct Contracting (GPDC) Model focuses on promoting health equity and addressing healthcare disparities, advancing the momentum of provider-led value-based models while protecting beneficiaries and the model with increased participant vetting and monitoring.

According to CMS, "The goal of ACO REACH is to provide beneficiaries with access to enhanced benefits and to increase the availability of high-quality, coordinated care, including for people in underserved populations."[3]

Figure 1

Reaching Beyond GPDC: ACO REACH Model Goals



Source: CMS.gov.[1]

'Our current model is not working for them. Let's put these patients in a new model. Let's see what enhanced capitation can do for them.'"

"That takes work and effort, and in some cases, infrastructure investment," Barbati continued. "If you were starting from scratch, that would be a huge deal-breaker."

But that's not the only potential deal-breaker for an organization looking to join ACO REACH.

Avoiding Overlap

Perhaps the most foundational barrier is the inability to participate in both MSSP and ACO REACH as the same entity.

"It would never make sense to take our 4,500 physicians and put them all in ACO REACH," Calcagno said. "If we didn't do something creative, the medical group could only be in MSSP or ACO REACH, so we spent a significant amount of time, political capital, and money—real dollars—to figure out how to set this up so that a subset of the medical group could participate in ACO REACH where it made sense."

"It didn't end up being a deal-breaker for us," Calcagno said, "but I would assume it prevented others in the country from participating."

Reyna agreed, saying, "We did a significant amount of work upfront, in a very short timeframe, to be able to participate in ACO REACH. It was important to us, because we wanted to be at the table for the first program that is looking at health disparities and how we can make a difference."

Keeping Value in Focus

As our conversation came to a close, Reyna said, "We really believe that we can help make a difference in our patients' lives. We believe thinking differently about providing care is how we make the health system better for our patients."

"We firmly believe value-based care is the future of health care," Calcagno added. "I think some see CMMI [Center for Medicare and Medicaid Innovation] programs as a one-and-done sort of thing. We need to think more broadly. How do we build the muscle memory and apply it in more areas outside of CMMI?"

As he concluded, "It's a lot harder to do than it sounds. That's what we spent and are spending our time on." GPJ

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