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So What is the ACO REACH Model?

What is required and how real-time data and actionable interoperability can help

May 19, 2022

Pings™

A BAMBOO HEALTH SOLUTION

Housekeeping

- Speakers will present for approximately 45 minutes
- Q&A will take the remainder of time
  - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
  - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question
- Webinar is being recorded
  - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available

Molly Kane

Manager, Government Affairs & Strategy

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Bamboo Health: Cultivating care collaboration, everywhere.

Our Vision

To revolutionize healthcare in the U.S. by connecting every payer, provider and care team to address whole person care.

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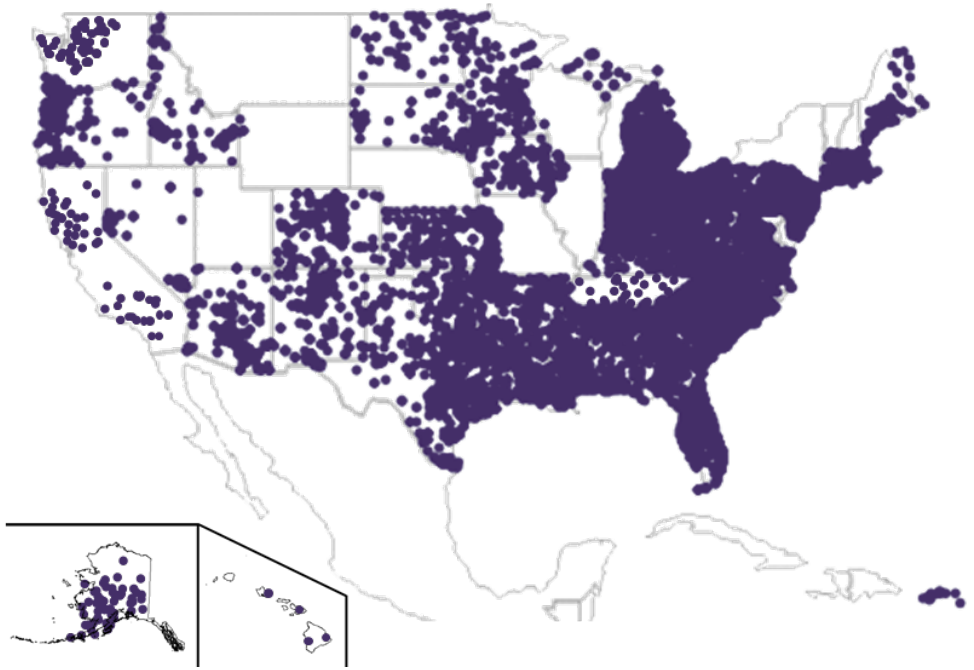
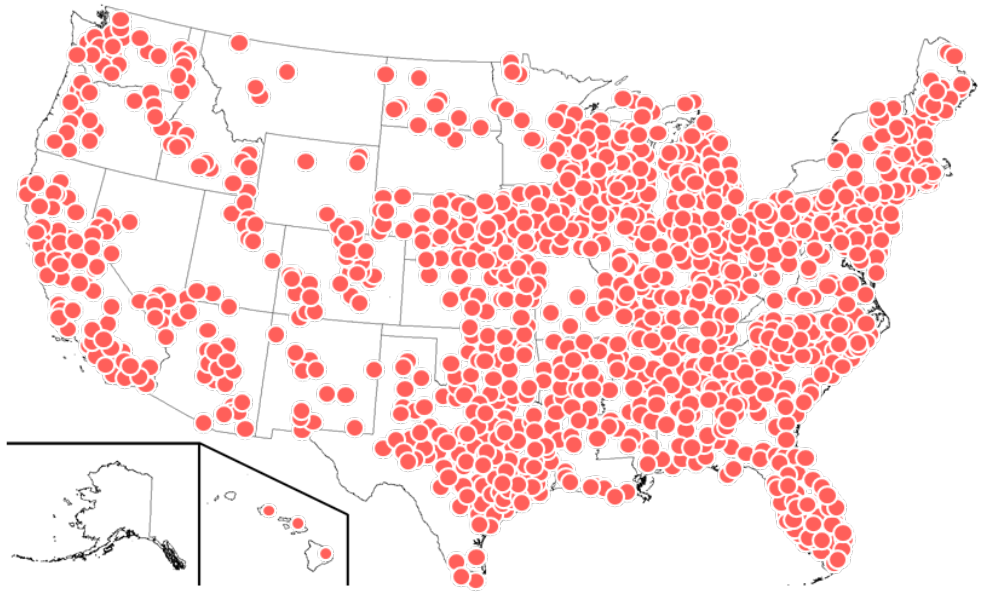
Bamboo Health was created when industry leaders Appriss Health and PatientPing came together in 2022

APPRISS® HEALTH



PATIENTPING



1B+	PATIENT ENCOUNTERS PER YEAR
~8K	POST ACUTE FACILITIES
~3k	HOSPITALS
25K+	PHARMACIES
~1.2M	CLINICIAN USERS
50	STATES

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Objectives

- ACO REACH model incentives and requirements – what's new and important
- Actionable interoperability – what it means and why it matters
- Effective care coordination – what it looks like today and what must be done to improve it

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What's new for VBC in 2022?

*On February 24, 2022, CMS & CMMI announced the overhaul of the **Global & Provider Direct Contracting (GPDC)** model, revamping it to the **ACO Realizing Equity, Access, and Community Health (REACH)** model.*

Direct Contracting → ACO REACH

Key Dates

Application Period: March 7 – April 22

Model Requirements Met: January 1, 2023

Performance Period: Begins January 1, 2023

Performance Years Covered: PY2023-PY2026

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Why ACO REACH?

CMS & CMMI designed ACO REACH with the goals of creating a model that has a greater focus on:

- Health equity
- Health care provider leadership
- Beneficiary voice in model participant decisions
- Robust screening, monitoring, and transparency

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Who can participate in ACO REACH?

The ACO REACH model offers three types of participants:

Standard

Substantial experience serving Medicare members, including with dual-eligible members

May have gained experience through a shared savings model

New Entrant

Have not traditionally served Medicare members

Membership gained through voluntary alignment with limited claims-based attribution

High-needs Population

Experience serving Medicare members with complex needs

Care models expected to be tailored to complex-needs members, such as PACE

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The move from Direct Contracting to ACO REACH

Key Model Updates

Health Equity

- Equity Benchmark Adjustment of $30 PBPM increase for top decile and $6 decrease for bottom 50%
- Health Equity Plan requirement
- Intentionally incentivizing proactive outreach and engagement with historically underserved populations

Risk Adjustment

- Static Risk Score Cap linked to Demographics

Governance

- 75% of ACO governing board made up of Providers

Discounts and Quality Withhold

- Reductions in:
  - Performance Year Discount Rate (3.5% vs. 5%)
  - Quality Withhold (2% vs. 5%)

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Considerations for organizations looking to succeed in the ACO REACH model

Organizations should look to ensure success in an ever-changing world of value-based care by focusing on core strategies applicable across models

Maximize revenue

- ✓ Beneficiary engagement tactics that support retention
- ✓ Processes to support maximizing quality scores

Maximize shared savings

- ✓ Care management resources and processes to minimize avoidable utilization
- ✓ Beneficiary engagement tactics that support proactive preventative care

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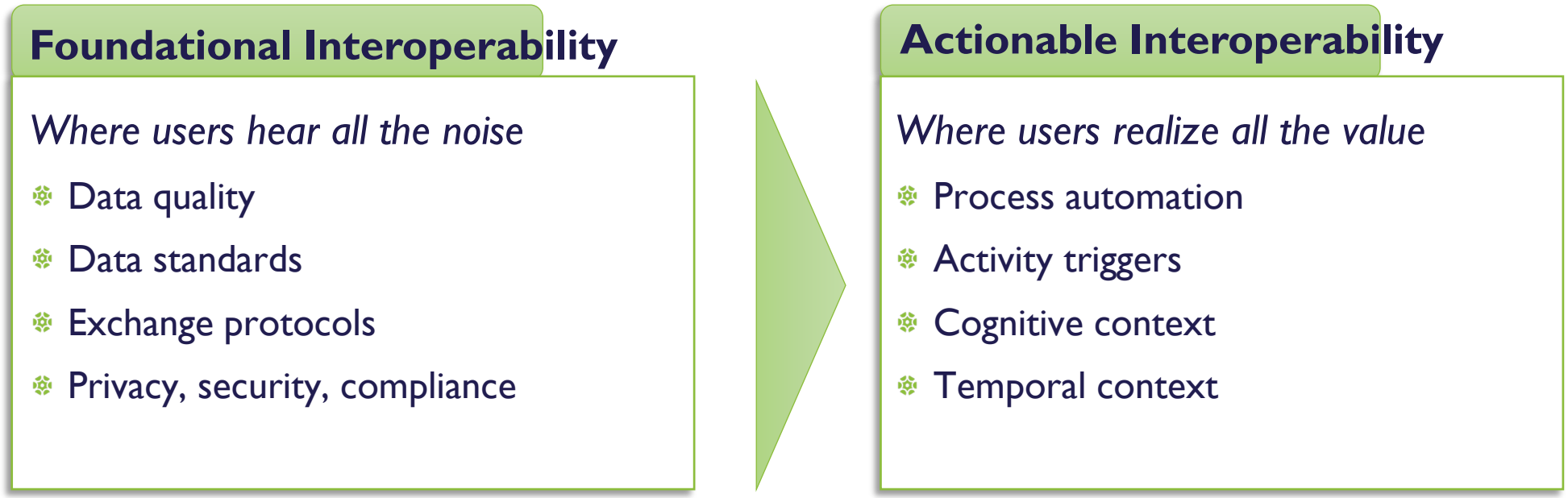
The shift from foundational to actionable interoperability supports success in VBC models



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Actionable interoperability improves patient outcomes and the provider experience

- Process automation
- Activity triggers
- Cognitive context
- Temporal context

- ✓ Build upon foundational interoperability
- ✓ Leverage real-time data to surface clinical and contextual information
- ✓ Deliver decision-ready analytics within a provider's workflows
- ✓ Account for patient preferences

Gaps in care are closed more easily and frequently, improving patient health and reducing the total cost of care

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Care Coordination

Emergency Department Patient Use Case

Data
Patient

Where we were

Emergency Department

- Demographics
- Clinical Chart

Primary Care

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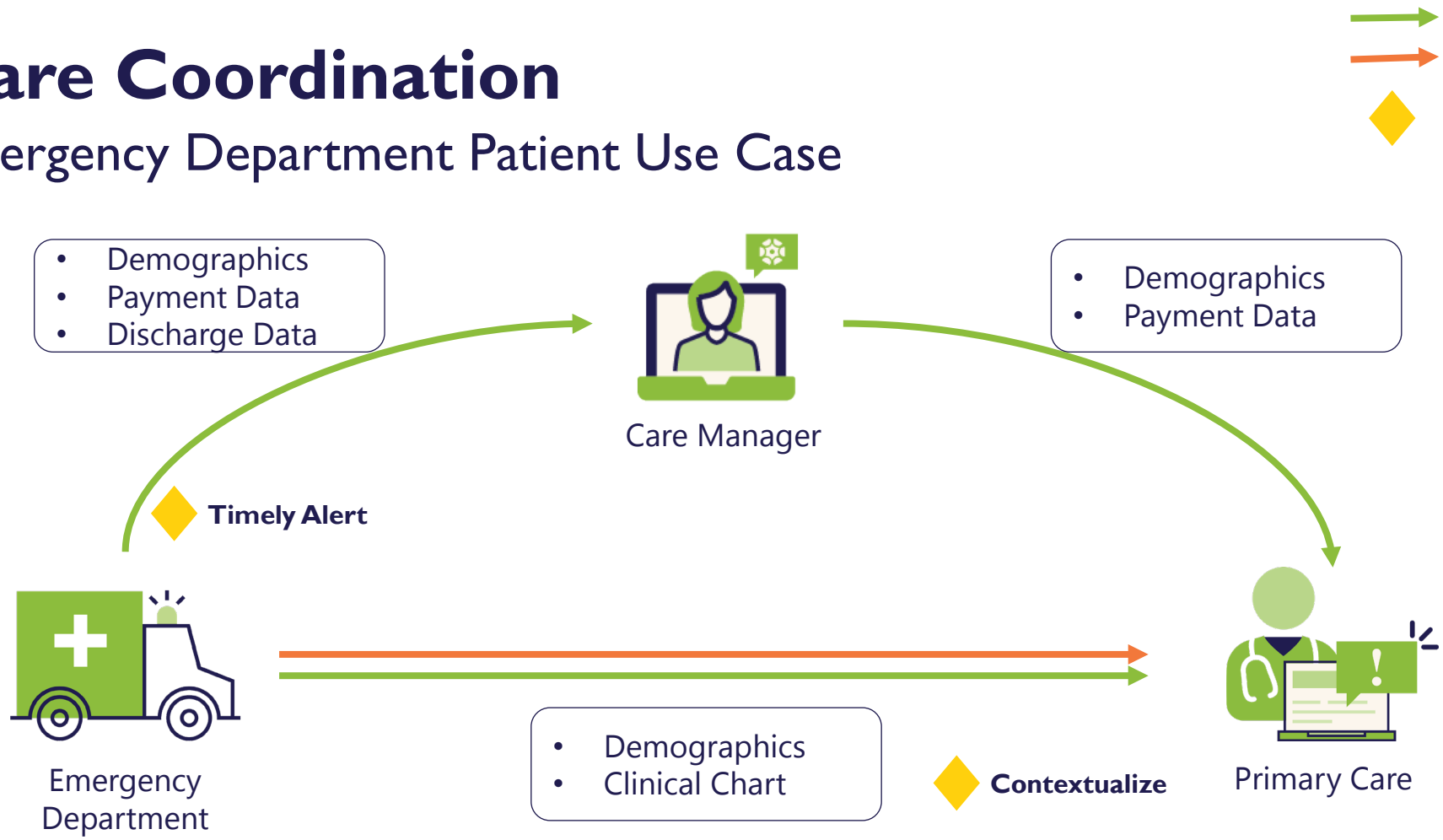
Care Coordination

Emergency Department Patient Use Case



Where we are (sort of)

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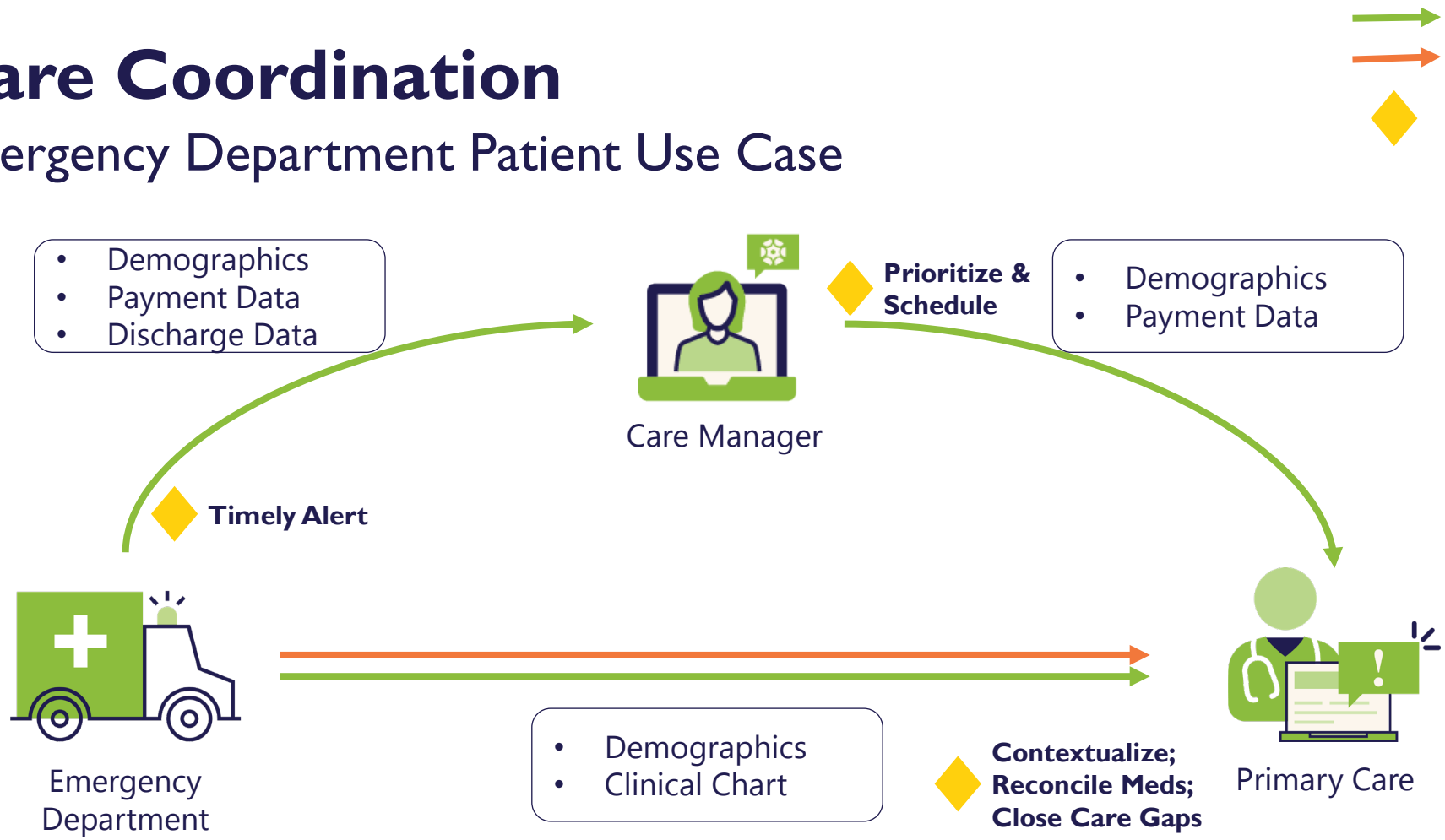
Care Coordination

Emergency Department Patient Use Case



Where we should be

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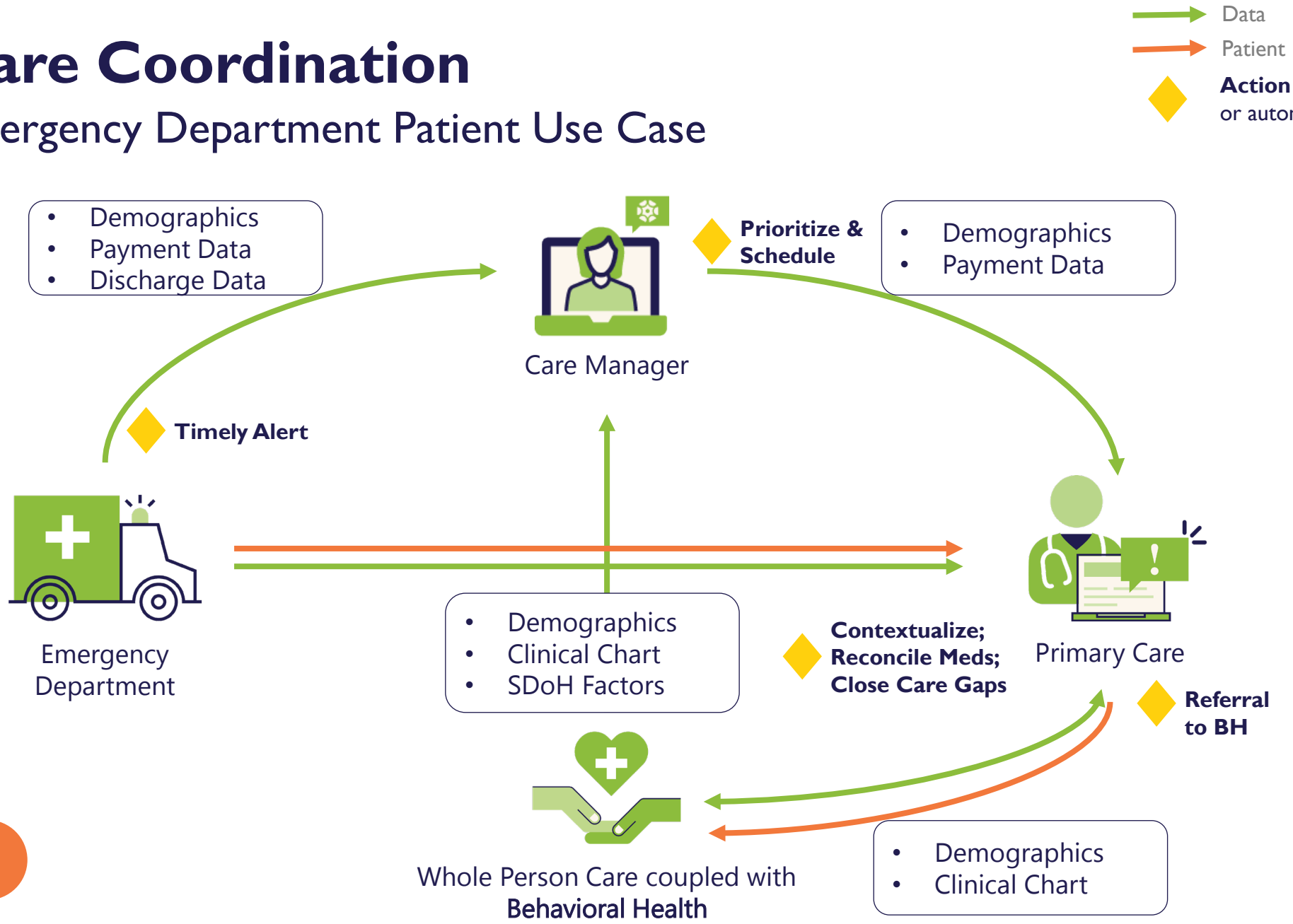
Care Coordination

Emergency Department Patient Use Case



Where we really should be

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Actionable Interoperability in Practice

1

Nationwide Provider Organization

Challenge

- Delayed visibility of patient care events (8-10 day avg) leading to gaps in discharge follow-up

Solution

- Pings platform with real-time event notifications & workflow integration

Results

- 250% increase in post-discharge visit completion rate in one quarter

2

50/50 Hospital/Physician led ACO

Challenge

- Managing ACO patients at affiliated SNF facilities without integrated communication

Solution

- Pings platform integrated with preferred SNF facilities

Results

- 25% reduction in 30-day readmission rates
- 28% reduction in SNF LOS

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How is interoperability likely to evolve over time?

	Next 1-2 Years	Next 3-5 Years
Foundational Interoperability	• Federal gov't drives acceptance of more and broader use cases.	• Industry agrees on higher level of data quality; market & gov't drive adoption.
Actionable Interoperability	• Continued innovation + early end-user adoption.	• Broad end-user adoption, especially to drive care coordination and quality.
Whole Person Care	• State gov'ts drive adoption of BH & SDoH networks. • Industry agreement on (some) SDoH standards.	• End-users drive adoption of BH & SDoH networks. • Early adoption of (some) SDoH standards.

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What do I need to do to get there?

Key questions you should ask…

Provider

- What parts of your stack and workflow are vendors enabling for you?
- What do you need to enable yourself, or through other solutions?

Payer

- How are you assembling the pieces to achieve the outcomes you need?
- How limited are those pieces? Can they trigger or automate the action?

Patient

- What are you trying to achieve?
- Coordinating your own care? How can get your caregivers share your data?
- Taking care of a loved one? What tools give you access vs. recs vs. do the job?

HIT Vendor

- What are you really looking to do?
- What is your secret sauce vs. what the user needs to accomplish?
- How much do you need to build vs. leverage what is out there?

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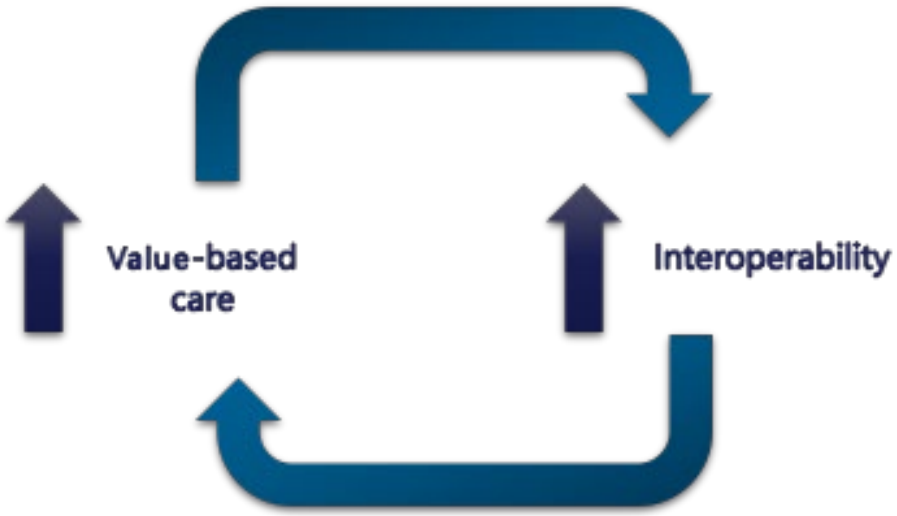
The future of value-based care and interoperability



What's Next?

The industry is continuing to trend toward an **increase in value-based care models** and an **increase in interoperability**, with each of the two further driving the other

While much may change in the coming years, **care coordination** remains at the heart of both sides of this equation

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Thank you!

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