COMPLEX CARE ALLIANCE

AT A GLANCE: Payment Models for Patients with Complex Illness and High Needs

Looking Beyond 2026 to Reduce Burden, Drive Savings and Promote Choice and Competition

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The High Needs Accountable Care Organization (ACO) Program, created as the Global & Professional Direct Contracting Model under the first Trump Administration and transitioned to the High Needs ACO Realizing Equity, Access, and Community Health (REACH) model, provides high quality care for the highest need patients.

The average aligned beneficiary has **12 chronic conditions** and **68% are dually eligible for Medicare and Medicaid**. This population also has very high costs, comprising 10 to 15% of the Medicare population but **accounting for 50 to 60% of Medicare Parts A and B spending**. Value-based payment is the best way to sustain care for these patients because interdisciplinary care coordination and management are resource-intensive and effectively impossible in a fee-for-service system that pays for procedures (vs outcomes). To adequately support high needs providers, payment models must retain flexibilities and special design elements that consider the unique needs of our beneficiaries.

Importantly, early results from the High Needs ACO Program show promising impacts on utilization and cost: **Financial results from 2023 show High Needs ACOs generating $143 million in gross savings and a 13.3% net savings rate**, and the second model evaluation report showed gross savings of 3.5% and reduced emergency department visits and hospitalizations. Continued growth in beneficiary alignment and recent policy adjustments are very likely to generate net savings in future evaluations.

However, ACO REACH, including the High Needs track, is scheduled to end after 2026. Given the progress made over the last four years and the vulnerability of the beneficiaries we serve, it is critical that CMS plan a next iteration of the High Needs model that builds on lessons learned from High Needs ACO REACH. **In our white paper, we identify key policies that CMS should add or maintain in any ACO model intended to include high needs beneficiaries.**

Future versions of a High Needs model must retain elements of High Needs ACO REACH that have allowed the model to work well for a specific subset of seriously ill beneficiaries. These elements include:

- **Lower alignment minimums;**
- **Multiple alignment options, including signed voluntary alignment;**
- **Concurrent risk adjustment;**
- **Multiple financial risk options;**
- **Differentiated, clinically appropriate quality and patient experience measures;**
- **Primary care capitation with advanced payment options; and**
- **Robust and timely data sharing.**

Additionally, we propose the following enhancements to improve care for patients and advance the goals of the ACO program:

- **Drive competition through patient and caregiver choice, engagement, and transparency** by giving beneficiaries more decision-making power and allowing ACOs to use innovative and easy-to-implement benefit enhancements and payment waivers.
- **Increase the number of high needs patients who can access proactive chronic care management** by providing the option for ACOs to participate at the organization level and treat all their beneficiaries as high needs if a minimum percentage of beneficiaries meet the eligibility criteria.
- **Improve benchmark stability and accuracy** by using a regional rate book similar to MA that is calibrated to the High Needs population.
- **Support rural communities** by helping ACOs reach and care for rural beneficiaries.
- **Deepen Medicare-Medicaid integration**, especially for long-term services and supports, through partnerships between ACOs and Medicaid risk-bearing entities.

There are several pathways that CMS could take to continue to support High Needs patients beyond 2026 and incorporate the policies outlined above. We offer considerations for the following options:

1. Extending the existing High Needs ACO REACH model;
2. Developing a new Innovation Center model specific to the high needs population; and/or
3. Creating a pathway to permanence for the High Needs model that incorporates the most critical elements of the model

CMS has the opportunity to reduce high-cost utilization, lower spending, and meaningfully improve the quality of life for the sickest and frailest beneficiaries in the Medicare and Medicaid programs. We look forward to working with CMS to implement the next generation of innovative payment and delivery models.

➜ The Complex Care Alliance is a group of 10 geographically diverse participants in the High Needs ACO REACH Model and several national partner organizations. We are committed to improving models of care for the sickest Medicare beneficiaries to meaningfully improve quality of life and reduce program spending.

Partner Organizations Contributing to this Publication

AAHCM AMERICAN ACADEMY OF HOME CARE MEDICINE

Accountable for HEALTH

AMERICA'S PHYSICIAN GROUPS

C+TAC COALITION TO TRANSFORM ADVANCED CARE

NAACOS Advancing Value in Health Care