questions. One such question will be whether the proposed benchmark adjustment is sufficient to encourage providers to care for low-income patients and members of other underserved groups and large enough to allow providers to meaningfully invest in the health of these populations. The value-based care movement has traditionally prioritized reducing spending, but advancing health equity demands spending more on underserved groups with unmet needs. If the benchmark adjustment isn't adequate to finance this increased spending, ACO REACH may not achieve its goals.

An audio interview with Dr. Wadhera is available at NEJM.org

Another consideration will be the types of investments that providers make in response to the benchmark adjustment. Facing incentives to care for disadvantaged patient populations, ACOs may respond in productive ways (for instance, improving care delivery for such populations) or in ways focused on profit generation (for instance, marketing more aggressively to them). In addition, the types of organizations that participate in ACO REACH will matter. Voluntary participation has limited the effects of other payment models, since providers who stand to benefit tend to join and those who perform poorly tend to drop out. Finally, it remains to be seen whether the health equity plan requirement will motivate real action. Although this idea is promising in theory, similar requirements — such as community-benefit and needs-assessment requirements for nonprofit hospitals — have proven weak in practice. Without proper oversight, this provision may become another administrative checkbox.

Value-based payment models implemented over the past decade have often been regressive, moving dollars away from patients, providers, and communities with fewer resources and toward those with more. ACO REACH reflects policymakers' efforts to mitigate this unintended consequence. It also lays a foundation for further steps to address the long history of underinvestment in the health of low-income and marginalized populations. Could this new approach to value-based payment be a tool for redistributing health care resources in a progressive way that meaningfully advances health equity? This may be the central question in the next decade of payment reform.

Disclosure forms provided by the authors are available at NEJM.org.

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Expanding Accountable Care's Reach among Medicare Beneficiaries

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Accountable care organizations (ACOs) are a critical component of the goals of the Centers for Medicare and Medicaid Services (CMS) to advance health equity; support high-quality, person-centered care; and promote affordability and sustainability in Medicare. ACOs bring together groups of doctors, hospitals, and other providers to deliver coordinated care to beneficiaries. They are also essential to achieving CMS's goal of having all beneficiaries in the traditional Medicare program cared for by providers who are accountable for costs and quality of care by 2030.

The CMS Medicare ACO portfolio consists of the Center for Medicare's Shared Savings Pro-

Performance on Selected Quality Measures among MIPS Group Practices and Medicare Shared Savings Program ACOs, Performance Year 2020.*

Domain, Measure, and Description	Mean Performance Rate of MIPS Group Practices	Mean Performance Rate of Shared Savings Program ACOs
	percent	
Care coordination and patient safety		
ACO-13. Falls: screening for future fall risk	82.42	84.97
Preventive health		
ACO-14. Preventive care and screening: influenza immunization	72.72	76.03
ACO-17. Preventive care and screening: tobacco use, screening and cessation intervention	78.98	81.67
ACO-18. Preventive care and screening: screening for depression and follow-up plan	67.95	71.46
ACO-19. Colorectal cancer screening	68.26	72.59†
ACO-20. Breast cancer screening	69.65	74.05†
ACO-42. Statin therapy for the prevention and treatment of cardiovascular disease	83.07	83.37
At-risk population		
ACO-40. Depression remission at 12 mo	9.61	13.99†
ACO-27. Diabetes mellitus: hemoglobin A1c poor control‡	15.28	14.70
ACO-28. Hypertension: controlling high blood pressure	69.12	72.87†

* Accountable care organizations (ACOs) are provided a sample of assigned beneficiaries to report on through the Centers for Medicare and Medicaid Services (CMS) Web Interface; performance rates represent performance reported by the ACO for this sample of beneficiaries. Data are shown for ACOs and Merit-Based Incentive Payment System (MIPS) groups that submitted complete reports in the CMS Web Interface.
† The value indicates a statistically significant difference between the performance rates of the MIPS group practices and the Shared Savings Program ACOs.
‡ A lower performance rate is desired for this measure.

gram and the Center for Medicare and Medicaid Innovation's ACO models. The Shared Savings Program, now 10 years old, includes 483 ACOs serving more than 11 million Medicare beneficiaries and more than 525,000 participating clinicians. Such ACOs have been found to perform better on certain patient-experience and performance measures than physician groups participating in the Merit-Based Incentive Payment System (see table).

The Innovation Center has tested several ACO models, of which the Pioneer ACO and ACO Investment Models have achieved net savings; others, including the Advance Payment ACO Model and the Next Generation ACO Model, have not. The Pioneer ACO program, which allowed providers with experience coordinating patients' care to move more rapidly from a shared-savings payment model to a population-based payment model, was associated with significant reductions in emergency department visits and inpatient admissions. The ACO Investment Model provided advance payments to participating organizations to make infrastructure investments aimed at improving care; such payments could be recouped by CMS by means of earned shared savings.

The ACO Investment Model resulted in more providers in rural and underserved communities signing on to participate in ACOs. These new ACOs invested in better care coordination, and savings have been attributed to fewer unnecessary acute hospitalizations, fewer emergency department visits, and fewer days in skilled nursing facilities among beneficiaries. The ACO Investment Model generated $381.5 million in net Medicare savings between 2016 and 2018.[1] The Innovation Center is currently testing the Global and Professional Direct Contracting Model, which has been redesigned as the ACO

Realizing Equity, Access, and Community Health (ACO REACH) Model. This model will examine the effects of new risk-sharing arrangements in traditional Medicare, additional flexibility for beneficiaries (such as the ability to receive in-home care management), provisions for advancing health equity, and reduced administrative burdens for providers on quality of care and Medicare's costs.

Although important lessons have been generated regarding payment and delivery-system reform, inadequate alignment among accountable care efforts, limitations of payment approaches, and a lack of focus on health equity have led to several challenges. For example, providers have been able to selectively participate in the programs that produce the most favorable financial outcomes, rather than those that provide the best opportunity to transform care. Participation in the Shared Savings Program has plateaued, and savings for ACOs and Medicare have been limited, partly owing to the benchmark methodologies used to calculate eligibility for savings. For example, "rebasing" — the process by which benchmarks are recalculated during contract renewals on the basis of observed spending during the previous agreement period — can create a "ratchet" effect, whereby ACOs that reduce their spending are subsequently subject to a lower benchmark, which undermines their chances of achieving savings going forward. Benchmark adjustments that take regional expenditures into account can make it difficult for providers caring for populations with high costs of care to be successful, thereby limiting their participation. Finally, Black, Latinx, Asian American and Pacific Islander, and American Indian and Alaska Native beneficiaries have had inequitable access to ACOs.

Ensuring high-quality, accountable care for all traditional Medicare beneficiaries by 2030 will require strategic alignment among CMS's ACO efforts. We are considering several changes to the Shared Savings Program and new models to expand participation in ACOs, increase savings for participants and for Medicare, and make access to ACOs more equitable.

First, we plan to use the Shared Savings Program as a chassis for growth and care transformation by synchronizing key ACO features. This approach will provide opportunities to transform care and avoid selection based on financial methods. The Innovation Center will align testing of new ACO models and features with the Shared Savings Program and will hold certain aspects, such as financial parameters, constant. Other program requirements could be waived to evaluate the effects of these changes on participation in ACOs, savings, and equity. This approach could include testing modifications to the Shared Savings Program's existing features and implementing standalone ACO-based payment and service-delivery models. Successful tests could inform decisions related to improving quality, reducing inequities, increasing savings, and expanding the Shared Savings Program — thereby giving innovations wider reach.

Second, CMS is committed to supporting organizations that are new to value-based care and increasing participation among small ACOs that lack experience with performance-based risk, have limited infrastructure and capital, and may need more time than larger organizations to move to two-sided risk. As part of efforts to expand access to the Shared Savings Program in underserved areas, CMS is considering adopting lessons from the ACO Investment Model to help provide the necessary upfront investments for organizations to successfully participate. We are also examining benchmarking approaches that could support increased participation, including among organizations serving patients with high costs of care. These efforts could include addressing the effects of rebasing and regional benchmark adjustments; for example, the Medicare Payment Advisory Commission has discussed the potential for using administratively set benchmarks.[2]

The Shared Savings Program has generated consistent cost savings for Medicare, including approximately $6 billion for the trust fund over the past 5 years,[3] and has been associated with improvements on some patient-experience measures[4] and with better performance than physician groups in the Merit-Based Incentive Payment System, as noted above. Boosting participation would increase opportunities for beneficiaries and providers to benefit from accountable care arrangements.

Third, we are focused on advancing health equity by expanding the reach of ACOs into underserved communities. ACOs can advance health equity by directing resources according to patients' needs,[5] which cannot be

done under the traditional Medicare fee-for-service payment system. CMS is examining the use of incentives to recruit providers that care for underserved populations to join ACOs, leveraging ACO peer-to-peer learning systems to disseminate best practices, implementing data-collection and quality-measurement requirements with the goal of closing gaps in outcomes, and asking providers to consider beneficiaries' social needs in care plans.

Starting in 2023, the ACO REACH Model will test equity-enhancing features, including a benchmark adjustment designed to mitigate disincentives for providers to care for underserved populations, requirements for participating ACOs to collect beneficiary-reported demographic and social-needs data and to submit health-equity plans, and a new benefit enhancement that aims to increase access to primary care by expanding nurse practitioners' privileges. Successful features could be evaluated for possible incorporation into the Shared Savings Program.

CMS has also promoted ACOs' efforts to address social needs. For instance, ACOs have reported using Medicare's annual wellness visit to screen for social needs, hiring community health and social workers as community navigators, and using technology to connect patients with community resources. Addressing social needs must be a central goal of ACOs going forward. Lessons from the Accountable Health Communities Model, which tested the effects of identifying and addressing beneficiaries' health-related social needs using screening, referral, and community-navigation services, will be examined for potential incorporation into the Shared Savings Program. We are also exploring whether new ACO quality measures related to identifying and addressing social needs could support these initiatives.

By better aligning CMS's ACO initiatives and policies, Medicare can create pathways for payers and providers to advance accountable care. This approach could bring improved quality and patient experience, as well as the ability to be part of a care relationship that meets medical and social needs, to more beneficiaries. For providers, alignment of initiatives and policies could increase participation rates and accelerate care transformation. We aim to send clear and consistent signals that the opportunities provided by the Shared Savings Program and Innovation Center models represent a coordinated pathway for supporting participation in value-based care arrangements.

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Russia's War in Ukraine — The Devastation of Health and Human Rights

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Since February 24, 2022, Russia has been waging a war of aggression in Ukraine and blatantly attacking civilians and civilian infrastructure. The recent shift in Russian strategy to a war of attrition carries ominous implications for civilian survival, the future of Ukraine as a nation-state, and the restraint that North Atlantic Treaty Organization (NATO) countries must practice to ward off Russia's threat of nuclear escalation. This conflict, initiated by an unprovoked Rus-