ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

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CMMI Announces Revisions, Rebranding, and Relaunch of GPDC:

Analysis of the new ACO REACH Model

On February 24, 2022, the CMS Innovation Center announced a redesign of the controversial Global and Professional Direct Contracting Model and the launch of a replacement initiative, termed the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. This brief will help you understand the key changes, new provisions, and potential implications of this revised model for your next step in value.

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On February 24th, 2022 the Centers for Medicare & Medicaid Services (CMS) revealed the highly-anticipated fate of the CMS Innovation Center's (CMMI) Direct Contracting model options, announcing a redesign of the Global Professional Direct Contracting (GPDC) Model and the permanent cancellation of the Geographic Direct Contracting ("Geo") Model. The revamped and rebranded GPDC model—now called Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH)— aims to better reflect the agency's vision and Administration's priorities for system transformation, incorporate stakeholder feedback, and alleviate the concerns of GPDC's critics while maintaining the key features of the model and building on the momentum of the accountable care movement.

In the weeks leading up to the announcement of the transition of GPDC to ACO REACH, provider groups and value-based payment (VBP) proponents were fearful of the model's imminent cancelation, with hundreds of providers rallying to save it. The announcement of the ACO REACH Model represents an important practical opportunity for organizations to engage in an attractive advanced alternative payment model (APM), it also represents a powerful momentum builder for the broader value movement. While the framework of the model will largely remain the same, the updated provisions under ACO REACH represent tangible steps toward including health equity meaningfully into APM design.

This brief **offers a short background** on the model's history and recent controversies leading up to the announcement, **summarizes the major provisions** of the new ACO REACH Model, outlining the key changes from the GPDC design, and **considers potential implications** for the 99 Direct Contracting Entities (DCEs) currently participating in the model as well as the broader value movement.

Model Overview and Objectives

Background

The Direct Contracting models—including GPDC and the permanently canceled Geo model—represented CMMI's most advanced ACO pilots to date. The models were designed by applying lessons from previous Medicare ACO models, including the Medicare Shared Savings Program (MSSP), the Pioneer ACO Model, and the Next Generation ACO (NGACO) Model. The Direct Contracting model options were also unique as they borrowed elements from Medicare Advantage (MA) and the private sector, like the ability to negotiate downstream contracts with providers and the inclusion of engagement incentives and benefit enhancements. These models were met by the industry with great excitement, representing the bridge from fee-for-service (FFS) -based shared savings models to more sophisticated APMs.

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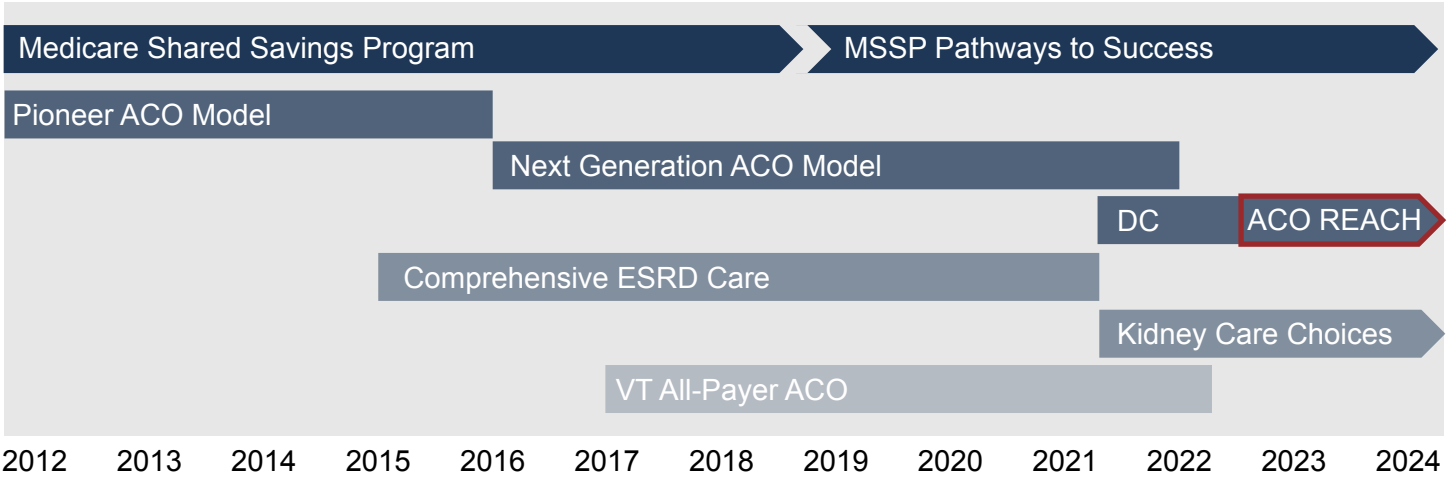
▶ Figure 1: Timeline of CMS and CMMI ACO Models



However, while many are excited about the prospect of this next chapter in the value movement, several features of Direct Contracting have caused concern and confusion —with some valid criticisms and others based on misunderstanding or politics. For example, while GPDC was always technically an ACO model, given its name and the label identifying participants as Direct Contacting Entities or "DCEs" (rather than ACOs), as well as the inclusion of new entity types, some were unsure how to classify the model. Additionally, DC Geo, while it shared the same name, represented an entirely different (and much more controversial) model. While CMMI is making substantive changes to GPDC in response to many of the criticisms—like restoring provider representation on boards back to the levels under NGACO, increasing monitoring and beneficiary protection efforts, and making changes to risk adjustment—the rebranding may be the most critical. With this redesign and rebranding, CMS is aiming to refocus the model on its "ACO roots."

Unlike many other aspects of health policy, the movement to value has bipartisan support. ACO models—which represent the largest vehicle for payment and delivery transformation to date—have spanned three presidential administrations, and garnered significant levels of industry support by demonstrating savings and real potential for moving the needle on cost and quality.

> *Under the ACO REACH Model, health care providers can receive more predictable revenue and use those dollars more flexibly to meet their patients' needs—and to be more resilient in the face of health challenges like the current public health pandemic,"*
>
> *– Liz Fowler, Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation*

Refocused Objectives

With the revisions and rebranding, CMS aims to address the concerns of stakeholders and the priorities of the Biden-Harris Administration in three areas:

1. Advancing Health Equity

In line with CMMI's strategy refresh, health equity is taking a central role in ACO REACH. Applicants will now be asked to include detail on their experience providing quality care to underserved beneficiaries and participants will be required to maintain a Health Equity Plan. ACOs serving the neediest beneficiaries will receive upward adjustments to their benchmark and will be incentivized to collect patient demographic and social determinants of health (SDOH) data. Finally, a scope-of-practice expansion for Nurse Practitioners (NPs) will enable additional care flexibilities in underserved areas.

2. Promoting Provider Leadership and Engagement

Several stakeholders expressed concern that GPDC was squeezing provider-led ACOs out in favor of New Entrants and non-provider led organizations. Although CMS still intends the ACO REACH model to be available to non-traditional participants, a series of changes make REACH more provider focused than GPDC. Applications for REACH will request information on participants' experience providing direct patient care, highlighting a shift toward a more provider-focused strategy. Provider-led ACOs selected for participation will now benefit from an increase in provider representation on ACO boards, reductions in the Global Discount and quality withhold, and more favorable risk adjustment methodologies. Those that are currently accepted under GPDC and wish to continue under

ACO REACH in 2023 will have to demonstrate compliance with the new program requirements.

3. Enhancing Beneficiary Protections
Another point of contention came from the perception that beneficiaries were being taken advantage of, being forced into MA-like plans without their consent, and subjected to inadequate treatment. While much of this perception arose from a lack of understanding, CMS still made additional efforts to ensure that beneficiaries were protected. ACO boards must now have stronger representation for consumer and beneficiary advocates and CMS has promised more frequent and transparent monitoring of ACOs, including addressing specific concerns by specifying monitoring activities aimed at ensuring adequate care and that beneficiaries are not being funneled into private plans through the ACO.

> *"Overall, the ACO REACH modifications are positive and advance the program in ways that will benefit providers and the populations they serve. Notably, CMS has improved several existing features to encourage participation in the program and has gone further to address health equity beyond any Medicare program to date."*
>
> *– Joe Satorius, Senior Vice President, Lumeris*

Model Design

While CMS made several changes to GPDC's administrative requirements and financial methodologies under the rebranded ACO REACH Model, many of the foundational elements of the model design are the same. This section will provide an overview of the design of the ACO REACH model, highlighting which components differ from GPDC. Beginning in January 2023, all model participants— including both ACOs starting in the model for the first time and legacy DCEs continuing into ACO REACH from GPDC—will be required to adhere to the model requirements outlined in the ACO REACH Request for Applications (RFA).

Model Participants

Eligibility

According to CMS, ACO REACH aims to attract more provider-led organizations to join the model, including former NGACO participants or MSSP ACOs who are interested in deepening their participation in Medicare risk arrangements, as well as provider entities who are new to these initiatives. CMS will continue to allow some entities who are new to CMMI initiatives to participate in ACO REACH, but model applicants and participants will be subject to more scrutiny and oversight than participants in GPDC. This includes enhanced screening of applicants to gain better insight into financial interests and affiliations, as well as information on relevant direct patient care experience, particularly experience with underserved communities.

Specifically, during the application process, applicants will be asked to describe their experience furnishing care to underserved populations and list the specific populations they have experience caring for. Additionally, potential participants will need to describe the metrics they use to identify inequities in their population and processes for improving identified disparities. Strong performance in these areas will not ensure that an ACO's application is accepted just as poor performance will not preclude inclusion. However, by adding these application questions CMS is hoping to select ACOs that can best meet the needs of the historically underserved.

The ACO REACH model requires that applicants serve a heterogenous group of patients, rather than specific sub-populations. Beginning in PY2023, no more than 50 percent of each REACH ACO's population may have a given medical condition or belong to a specialized sub-population for which a targeted total cost of care model exists. For example, because CMMI already offers a total cost of care model focused on renal disease, called Kidney Care Choices (KCC), organizations or participant providers who primarily serve beneficiaries with chronic kidney disease (CKD) or end stage renal disease (ESRD) should apply for KCC, not ACO REACH. This requirement could have implications for organizations like DaVita, which serves primarily patients with CKD and ESRD and is currently operating a DCE under the name Vively Health.

Governance

Perhaps the starkest change from the GPDC model to ACO REACH is the explicit way in which the model attempts to address disparities in health outcomes. The new requirements are a manifestation of the recent commitment to health equity made by CMS in the Innovation Center's Strategy Refresh. Nowhere is this more evident than in the requirement that all participating ACOs develop and implement a Health Equity Plan, based on CMS' Disparities Impact Statement, with the intention of:

- Identifying health disparities
- Defining health equity goals
- Establishing a health equity strategy

- ▶ Developing a plan to implement the strategy
- ▶ Monitoring progress in providing care to underserved communities

CMS plans to provide more details on the components of, and a template for, these plans and how they will be used to all interested applicants. Additionally, CMS has stated that Health Equity Plans will be iterative throughout the life of the model and that ACOs will be required to submit a new plan prior to each performance year. ACOs will also be required to submit reports regarding their progress towards plan implementation and realization of health equity goals, which will be assessed regularly by CMS.

Further, in an effort to amplify the voices of beneficiaries and providers in the oversight of ACOs, the ACO REACH model has increased the minimum requirement for provider and beneficiary participation in governance. Under GPDC, Participant Providers or their representatives were required to hold at least 25 percent control of the governing board. Under ACO REACH, this percentage has been increased to 75 percent, which is where this requirement stood under NGACO. While GPDC required a consumer representative and Medicare beneficiary to be involved in the governing body and allowed that role to be held by the same individual, ACO REACH requires that these be two separate individuals and grants these representatives voting rights.

Participant Types

The new ACO REACH model will retain the same three participant types introduced in the GPDC model—**Standard, New Entrant,** and **High Needs Population** (described in more detail in Table 1). However, the label given to the entities who contract with CMS to receive and distribute the capitated payments and bear risk for the services provided by their network of Participants and Preferred Providers has changed. While under GPDC these entities were known as DCEs, they will now be called "REACH ACOs." Like in GPDC, REACH ACOs will be defined by both the TIN and NPI, allowing participants to be specific about which providers to include in their network.

As with NGACO and GPDC, ACO REACH will continue to distinguish between Participant Providers and Preferred Providers. CMS will not be requiring ACO applicants to submit official lists of Participant Providers or Preferred Providers for PY2023, although applicants who are selected for the model must submit proposed lists of providers for closer review.

- ▶ **Participant Providers** are the core providers and suppliers used to align beneficiaries to the ACO and who are responsible for reporting quality.
- ▶ **Preferred Providers** are intended to extend the ACO's network and enhance care delivery by leveraging model waivers and benefit enhancements. While preferred providers are aligned with the goals of the ACO, they are not used to align beneficiaries.

Payment Model and Risk Sharing

Risk Tracks

The ACO REACH model will retain the same participation options as the GPDC model, with two tracks: Professional and Global.

- ▶ The **Professional Track** includes a lower risk-sharing option, with ACOs held accountable for 50 percent of losses or eligible for 50 percent of savings. ACOs in this track only have one option for payment, Primary Care Capitation.
- ▶ The **Global Track** requires global risk-sharing, with ACOs responsible for 100 percent of losses and eligible for 100 percent of savings. ACOs in this track can choose between either Primary Care Capitation or Total Care Capitation.

▶ Table 1: ACO REACH Participant Types

ACO Type	Description	Minimum Lives Threshold	# Current Participants
Standard	Traditional ACOs with experience bearing risk for Medicare FFS lives	5k beneficiaries in PY1	78
New Entrant	Designed for entities new to serving Traditional Medicare beneficiaries (<50% of participating providers experienced in Medicare FFS APMs)	1k beneficiaries in PY1 (5k by PY5)	13
High Needs Population	Tailored to ACOs serving beneficiaries with impaired mobility and/or complex high needs; expected to use a model of care similar to PACE	250 beneficiaries in PY1 (1,400 by PY5)	8

Capitation Options

The three payment options outlined in GPDC have also been carried over to the REACH model, Total Care Capitation (TCC), Primary Care Capitation (PCC), and the PCC + Advanced Payment Option (APO). Capitated payments will flow from CMS to the ACO, but payment structure from the ACO to Participating and Preferred Providers allows more flexibility in distribution mechanisms. The risk-sharing arrangements and capitated payment options available to each participant are detailed below and in Table 2.

Total Care Capitation

TCC is only available to participants in the Global Track. Under TCC, 100 percent of Medicare Part A and Part B services furnished to aligned beneficiaries are reimbursed through Per Beneficiary Per Month (PBPM) payments. Providers must still submit claims to CMS but will receive payments from the ACO based on the terms of their negotiated downstream contracts. Participant Providers are required to take a 100 percent reduction to claims under TCC, while Preferred Providers can choose to have their claims reduced by 1-100 percent. Monthly payments received by ACOs represent 1/12th of the ACO's benchmark in a given performance year, minus a discount, explained in greater detail in Benchmarking. (Among the 99 current DCEs, 27 have elected the TCC payment option.)

Primary Care Capitation

ACOs in both the Global and Professional tracks may elect to receive payments through PCC. Participant Providers within ACOs electing PCC are required to reduce a portion of their primary care claims (starting at a minimum of 10 percent in PY2023 and increasing to 100 percent in PY2026) and instead receive a payment as defined by their contract with the ACO to furnish a defined set of primary care services to beneficiaries. Participation in PCC is optional for Preferred Providers. (Among the 99 current DCEs, 30 have elected the PCC-only payment option.)

Advanced Payment Option

Participating and Preferred Providers receiving PCC may also choose to channel a portion of their non-primary care claims through the Advanced Payment Option (APO). This option would reduce claims-based reimbursement from CMS anywhere from 1 to 100 percent (as determined by provider) for non-primary care services provided. CMS would make estimated PBPM payments to the ACO, which will be reconciled against actual spending at the end of the performance year. This option allows providers to engage further in risk-based payment, without committing to global capitation. (Among the 99 current DCEs, 42 have elected the PCC plus APO payment option.)

Stop-Loss Arrangement

Participating and Preferred Providers receiving PCC may also choose to channel a portion of their non-primary care claims through the Advanced Payment Option (APO). This option would reduce claims-based reimbursement from CMS anywhere from 1 to 100 percent (as determined by provider) for non-primary care services provided. CMS would make estimated PBPM payments to the ACO, which will be reconciled against actual spending at the end of the performance year. This option allows providers to engage further in risk-based payment, without committing to global capitation. (Among the 99 current DCEs, 42 have elected the PCC plus APO payment option.)

▶ Table 2: Payment Options by Model Track

		Capitated Payment Options			
Track	**Risk Sharing**	**Total Care Capitation**	**Primary Care Capitation**	**Advanced Payment Option**	**2022 Participant Composition**
Professional	50% losses/ savings	Not Available	▶ Participating Providers: Mandatory, floor of 5% in PY2022 to 100% in PY2025 ▶ Preferred Providers: Optional, 1-100%	Optional, 1-100%	27 Participants (~27%)
Global	100% losses/ savings	ACO must choose TCC or PCC ▶ Participating Providers: Mandatory, 100% ▶ Preferred Providers: Optional, 1-100%	ACO must choose TCC or PCC ▶ Participating Providers: Mandatory, floor of 5% in PY2022 to 100% in PY2025 ▶ Preferred Providers: Optional, 1-100%	Optional with PCC, 1-100%	72 Participants (~73%)

Attribution Methodology

Beneficiary Eligibility

To be aligned to an ACO, a beneficiary must first meet certain eligibility criteria, followed by ACO alignment criteria (which varies by ACO type). Consistent with GPDC, to be considered alignment-eligible in a given month, a beneficiary must:

- Be enrolled in both Medicare Parts A & B and have Medicare as their primary payer
- Not already be enrolled in an MA plan, Medicare Cost Plan, or PACE organization
- Be a resident of the US and residing in a county included in the ACOs service area
- Have a condition that impairs mobility and/or meets the high needs special conditions for eligibility (this only applies to ACOs eligible for alignment to a High Needs Population ACO, and includes dually eligible beneficiaries)

When a beneficiary no longer meets the eligibility criteria, they will be excluded from expenditure calculations for that month and all subsequent months.

Attribution Mechanisms

Also consistent with GPDC, CMS will prospectively align beneficiaries to REACH ACOs for each performance year – utilizing beneficiary alignment to identify the population for which an ACO will be held accountable and to determine the organization's historical baseline expenditures for the purposes of calculating the PY benchmark. Patients are aligned to REACH ACO participants through two alignment mechanisms:

1. **Claims-based Alignment** based on plurality of primary care services received from a Participant Provider, leveraging claims utilization data to identify qualifying services; and

2. **Voluntary Alignment** based on beneficiary designation of a Participant Provider as their primary clinician or main source of care, leveraging paper-based form or electronic submission via Medicare.gov.

The methodology for beneficiary alignment has not undergone any major changes in transitioning from GPDC to the ACO REACH model and includes the same attribution mechanisms and "Prospective Plus" option. Notably, CMS did not include Medicaid Managed Care Organization-based alignment (an attribution mechanism included in the original DC design then quickly rolled back) in the ACO REACH Model.

For claims-based alignment, precedence is given to services furnished by primary care providers (PCPs), however patients can become aligned to a non-primary care specialist if less than 10 percent of relevant charges were billed to a PCP during the 2-year lookback period. For Federally Qualified Health Centers and Rural Health Clinics, all services are treated as services provided by PCPs for the purposes of the ACO REACH alignment algorithm.

As with the GPDC model, ACO REACH will continue to place a strong emphasis on voluntary alignment, relative to other CMS initiatives. Despite some misrepresentation by model critics, ACO REACH does not limit patient choice—still granting beneficiaries the option to receive care from any Medicare provider—but aims to empower beneficiaries to choose the health care providers with whom they want to have a care relationship. If a beneficiary who voluntarily aligns to an ACO would be aligned to a different ACO on the basis of claims-based alignment, voluntary alignment will take precedence. Additionally, if an ACO fails to provide any services to voluntarily aligned beneficiaries during a PY, but another non-ACO provider in the same service area does furnish services, the ACO could lose the patients based upon voluntary alignment.

Minimum Beneficiary Thresholds

In order to make it easier for non-traditional entities to participate, ACO REACH (like GPDC) sets minimum beneficiary thresholds lower for New Entrant and High Needs Population ACOs. These thresholds gradually increase over the span of the model, requiring participants to attract a greater number of beneficiaries.

- Table 3: ACO REACH Minimum Beneficiary Thresholds

Preformance Year	Standard	New Entrant	High Needs
2021 (GPDC)	5,000 with a minimum of 3,000 beneficiaries who were aligned during at least one base year (CYs 2017, 2018, 2019)	1,000	250
2022 (GPDC)			
2023 (ACO REACH)		2,000	500
2024 (ACO REACH)		3,000	750
2025 (ACO REACH)		5,000	1,200
2026 (ACO REACH)			1,400

Benchmarking

The process for setting the benchmark — which helps to determine the size of capitated payments as well as the magnitude of potential shared savings or losses earned by ACOs — has not changed significantly from GPDC. However, CMS has made some methodological changes and added a new payment adjustment to support ACOs that provide care for a larger share of underserved populations. The basic steps for determining the benchmark are as follows:

1. **Baseline benchmark determination**
    a. Calculating baseline expenditures via historical expenditure analysis
    b. Trending baseline expenditures forward and adjusting for geography via the rate book
    c. Blending baseline expenditures with the regional rates
2. **Risk adjustment**
3. **Post-baseline adjustments**
    a. Global discount
    b. Quality performance
    c. Health equity adjustment

Baseline Benchmark Determination

The process for calculating baseline expenditures for an ACO's performance year has not changed from GPDC to ACO REACH. Calculation is based on a three-year period of claims history with more recent expenditures weighted more heavily. The three-year baseline period will remain static, though the calculated expenditures can change as the mix of attributed beneficiaries changes. Once baseline expenditures are established, the benchmark is adjusted for geographic trends. The ACO REACH model, like GPDC before it, will use a prospective trend based on the projected US Per Capita Cost (USPCC) growth trend, adjusted for differences in geography, using regional Geographic Adjustment Factors (GAFs) which account for variations in the cost of doing business across the country.

Regional expenditures will be incorporated into benchmarks based on a modified version of the MA Rate Book, tailored specifically to ACO REACH. The impact of regional expenditures will grow over the course of the ACO REACH performance period. By PY2025, regional expenditures will hold equal weight to claims data in benchmarking calculations. This timeline, outlined in Table 4 is slightly accelerated in ACO REACH as compared to GPDC. An acceleration of the regional expenditures component of the blend benefits higher-performing providers since the rate book is based on average expenditures for the county rather than historical activity for the provider, and thus a positive development in the transition to ACO REACH.

► Table 4: Blend of Claims-Based and Regional Spending Used to Set Benchmarks in GPDC Compared to ACO REACH

PY	Claims Data/Regional Expenditures Blend			
	Standard Claims-based / High Needs > 3,000 beneficiaries		New Entrant / High Needs ≤ 3,000 beneficiaries / Voluntarily aligned	
	GPDC	REACH	GPDC	REACH
2021	65% / 35%	65% / 35%	0% / 100%	0% / 100%
2022				
2023		60% / 40%		
2024	60% / 40%	55% / 45%		
2025	55% / 45%	50% / 50%	55% / 45%	50% / 50%
2026	50% / 50%		50% / 50%	

Risk Adjustment

While much of the risk adjustment methodology will be carried over from GPDC, in response to stakeholder concerns of risk score gaming, two additional protections against inappropriate risk score increases have been added to REACH beginning in PY2024:

1. Static reference year population
2. Demographic adjustments

The first methodology change under ACO REACH will aim to slow down risk score growth by using a static reference year population for the entire performance period. GPDC used a rolling reference year population with a two-year lookback (e.g., PY2021 used 2019 as a reference year, PY2022 used 2020, and so on). Using a rolling reference population presented the possibility of risk score gaming, allowing participants to increase risk score growth year after year. Stakeholders expressed concern that some of the new non-provider led organizations with extensive experience in risk coding would be able to "outcompete" traditional provider-led organizations. Using a static reference

year population will limit that opportunity by limiting risk growth relative to a single year. However, this change runs the risk of re-creating the issue that the rolling reference year population was meant to address: if a beneficiary received poor care management in the past and had not been properly diagnosed, a thorough risk assessment could lead to risk score growth exceeding the 3 percent cap. This was a concern particularly for voluntarily aligned beneficiaries. However, an unintended consequence on ACO REACH participants would be, due to the lack of prior diagnosis, the true acuity may not ever be realized and reflected in the benchmark due to the cap. Thus, limiting an ACO's best and appropriate intentions to manage the total cost of care reflected to an accurate risk adjusted benchmark.

The second change may help offset the change to the reference population, allowing for a more accurate assessment of risk and, if necessitated, risk score growth higher than the statutory 3 percent. Under ACO REACH, the risk score cap will become more flexible, with adjustments made based on the demographic makeup of aligned beneficiaries in a given performance year. If the demographic risk score in a performance year increases relative to the reference year population, the risk score cap will move in the same direction with the same magnitude. For example, if the demographic risk score increases by 1 percent, the risk score cap would slide from +/-3 percent to -2 percent to +4 percent. Allowing this adjustment should help to address adverse selection issues that may arise from the imposition of the static reference year population.

Additional Benchmark Adjustments

After creating a benchmark which has been prospectively trended, regionally blended, and risk adjusted, there are three additional adjustments which will impact an ACO's financial performance – the global discount, the quality withhold, and the new health equity benchmark adjustment – all explained in more detail below.

Global Discount

As in the NGACO and GPDC models, for ACOs participating in the Global Track of ACO REACH, where the organization can earn up to 100 percent of savings, CMS has instituted a discount on the benchmark to ensure a portion of savings are retained by CMS to lock in expected actuarial government savings by instituting and managing the model . However, in response to stakeholder concerns about the size of the discount applied to the Global track under GPDC, CMS will reduce the discount under the ACO REACH model moving forward, dropping from a maximum of 5 percent in PYs 2025 and 2026 to 3.5 percent in the same years. The model designers felt a 3.5 percent discount would allow participants room to be successful in the model, while still ensuring the model garnered savings for the Medicare Trust Fund.

Quality Withhold

The quality incentive under REACH remains much the same as it did under GPDC, structured as a quality withhold, where a portion of the benchmark is held at risk by CMS and then earned back by the ACO depending on quality performance. The major change under REACH is that the quality withhold has been reduced from 5 percent of the benchmark to 2 percent. The trimming down of the withhold comes in response to stakeholders who expressed concern that some smaller, provider-led ACOs with less capital than larger ACOs, may struggle to meet the thresholds for quality performance early on in their participation, leading to the potential for non-trivial losses. The 2 percent withhold will be instituted as a pay-for-performance set of quality measures through the conclusion of the program in 2026.

An additional quality incentive, the High Performers Pool (HPP), will also be carried over from GPDC to be made available to ACOs in their second or subsequent performance years. The HPP will be funded by the withhold amounts not returned to or retained by CMS. These funds will be distributed to the highest performing ACOs, proportional to the number of aligned beneficiaries. Performance will be assessed along criteria yet to be released by CMS, but which may include an evaluation of ACO performance relative to previous years, performance relative to a set benchmark, or a combination of both.

Health Equity Benchmark Adjustment

Data suggest that participation in value-based care models by providers who treat underserved communities and the subsequent outcomes for those populations tend to be unsatisfactory. Contributing to this problem is the fact that some populations are more apt to forgo care relative to their needs, leading to spending that is lower than is actually necessary to properly care for these populations. This historical spending is used to calculate artificially low benchmarks which makes it

more difficult for providers caring for these patients to earn savings in shared risk models.

Many stakeholders have voiced the need for consideration of health equity and SDOH when setting benchmarks. Reflecting these considerations, the ACO REACH model will add a Health Equity Benchmark Adjustment beginning in PY2023 that will increase the benchmark for ACOs serving higher proportions of underserved beneficiaries. The hope is that by addressing this historical miscalculation, organizations will see the opportunity to realize savings in communities they had previously been reluctant to enter. This adjustment can help underserved communities benefit from the enhanced, high quality, and coordinated care provided by a REACH ACO.

The adjustment will be calculated based on the Area Deprivation Index, which reflects disadvantage at the community level, and dual eligibility status to reflect beneficiary-level disadvantage. ACOs will see their benchmark adjusted upward by $30 PBPM for each aligned beneficiary that falls into the top ten percent of scores based on these two measures. This upward adjustment will be financed by small reductions ($6 PBPM) for more well-off beneficiaries falling into the bottom half of the distribution. CMS estimates that most ACOs will see a change of only +/- 0.2 percent to their overall benchmark, but ACOs with the highest proportions of underserved beneficiaries could see an increase of up to 1 percent, while those serving the most well-off beneficiaries could see a decline of up to 0.5 percent.

> *The ACO Reach Model provides the tools and methodologies necessary to succeed in bringing much needed value-based strategies to historically underserved beneficiaries. Providers already engaged in or looking to expand population health and care delivery models to historically underserved communities now have a supportive value-based model and the potential to improve brand loyalty across these communities through better care delivery and improved access, particularly on a first to market competitive advantage."*
>
> *– Rick Goddard, VP, Strategy & Commercialization, Lumeris*

Data Collection and Reporting

As part of the Innovation Center's refresh, all new models, including ACO REACH, will require participants to collect and report demographic data for their beneficiaries and will encourage collection and reporting of SDOH data. To incentivize the collection of demographic data, ACOs will have the opportunity to receive up to a 10-percentage point increase to its Total Quality Score (TQS) for their reporting. While no downward adjustment to the TQS will be assessed in PY2023 for ACOs that fail to collect demographic data, CMS leaves open the possibility for such a change in the future. Additionally, while the current model design uses incentives to encourage the collection of demographic data, CMS anticipates that future iterations will also require the collection of SDOH data as a component of quality performance. CMS plans to provide questionnaires that can be used by providers when collecting these data. These questionnaires will include all required demographic data points as well as an optional section which includes SDOH information. Since the reporting of these data will be at the discretion of the beneficiary, ACOs cannot require that these data be collected. However, ACOs may document that the beneficiary chose not to disclose, for which the ACO will receive credit for having collected the data.

► Table 5: Summary of Post-Baseline Benchmark Adjustments

	PY	Discount (Global Track only)	Quality Withhold	Health Equity Adjustment
GPDC	2021	2%	5% (2.5% Quality Measures, 2.5% CI/SEP)	N/A
	2022			
REACH	2023	3%	2% (1% Quality Measures, 1% CI/SEP)	Top 10%: + $30 PMPM Bottom 50%: - $6 PMPM
	2024			
	2025	3.5%		
	2026			

Aside from these updates, the provisions regarding quality monitoring in the ACO REACH model mirror those in GPDC. All metrics used for reporting in PY2022 under GPDC remain in PY2023 under ACO REACH (see Appendix).

Beneficiary Enhancements, Incentives, and Protections

It is the responsibility of CMMI to test new payment and delivery models which may enable organizations to provide higher quality, more efficient, and more coordinated care through service enhancements and patient incentives. While piloting these models, it is also the responsibility of CMMI to ensure beneficiaries are protected from any negative impact related to the experimental nature of the models, a factor that several stakeholders expressed concerns with related to GPDC. The following sections describe the beneficiary enhancements and incentives built into the ACO REACH model which intend to improve care for patients, as well as the patient protections built into the model by CMS, which have been augmented under ACO REACH.

Enhancements

Enhancements are optional waivers of certain Medicare requirements that give ACOs additional flexibilities in providing services. The enhancements available under ACO REACH are the same as those under GPDC, with the exception of the new Nurse Practitioner Services Benefits Enhancement, an enhancement that had been considered for future performance years under GPDC as well. All enhancements apply to both the Professional and Global Tracks, except for the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement, which is limited to Global Track ACOs. There are seven enhancements available for ACOs to select from and we have also compiled, via analysis of the 2022 Direct Contracting Entity Participant List, the 2022 utilization of each Enhancement:

1. **3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement:** beneficiaries meeting CMS criteria do not need a three-day inpatient stay prior to admission to an SNF. The SNF Enhancement is utilized by 81 percent of 2022 DCE participants, the highest utilized Enhancement.

2. **Telehealth Benefit Enhancements:** allows dermatology and ophthalmology services which would normally only be covered with synchronous telehealth to be done asynchronously; waives the rural geographic component of originating site requirements so a beneficiary's home can be the originating site (the latter benefit is already a given due to the Bipartisan Budget Act of 2018). The Telehealth Enhancement is utilized by 57 percent of 2022 DCE participants.

3. **Post-Discharge Home Visits Benefit Enhancement:** allows auxiliary staff to perform home visits post-discharge under general supervision, rather than direct supervision. This Enhancement is utilized by 70 percent of 2022 DCE participants.

4. **Care Management Home Visits Benefit Enhancement:** waives the requirement for direct supervision to allow for payment for certain home visits furnished to eligible beneficiaries proactively in advance of a potential hospitalization. This Enhancement is utilized by 67 percent of 2022 DCE participants.

5. **Home Health Homebound Waiver Benefit Enhancement:** allows home visits for patients with multiple chronic conditions; current rules only allow home visits for beneficiaries with functional limitations. This Enhancement is utilized by 70 percent of 2022 DCE participants.

6. **Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit Enhancement:** allows beneficiaries who have opted for hospice care to still receive curative/conventional care; only available to Global Track ACOs. This Enhancement is utilized by 40 percent of current DCE participants, the least participation amount among all the Enhancements. However, this is expected to grow in participation as palliative and hospice programs are adopted within REACH ACOs to support end-of-life care.

7. **[NEW] Nurse Practitioner (NP) Services Benefit Enhancement:** allows for five services to be delivered by NPs, increasing the flexibility of care delivery:

   a. Hospice Care Certification
   b. Certification of Need for Diabetic Shoes
   c. Certification of Cardiac Rehabilitation Care Plan
   d. Certification of Plan of Care for Home Infusion Therapy
   e. Referrals for Medical Nutrition Therapy

While the addition of the new Nurse Practitioner (NP) Services Benefit Enhancement may be useful to all beneficiaries, CMS anticipates that it will disproportionately aid underserved populations in seeking care. Recent research suggests that areas with high demand for primary care clinicians, such as low-income and rural areas, are seeing an increase in the number of NPs being used to fill those needs. By allowing increased latitude in the scope of care NPs are allowed to provide, these areas will experience greater levels of access and, ideally, improved outcomes.

Incentives

Carried over from GPDC, the goal of patient incentives is to get beneficiaries more involved in managing their own health. There are three types of incentives that REACH ACOs can offer to aligned beneficiaries and we have likewise examined the current utilization of these Incentives from the 2022 DCE participants:

1. **In-kind Incentives**, or non-monetary incentives (e.g., vouchers for over-the-counter

medications, wellness program memberships, meal programs, etc.).

2. **Cost Sharing Support for Part B Services**, where ACOs reimburse Participant and Preferred Providers for co-pays or co-insurance not collected from a beneficiary; this service is intended to reduce the financial barriers to patients for obtaining needed treatment. This Incentive is utilized by 58 percent of 2022 DCE participants.

3. **Chronic Disease Management Reward Program**, where ACOs may provide gift cards of up to $75 to beneficiaries who participate in a chronic disease management program. This Incentive is utilized by 62 percent of 2022 DCE participants.

Protections

GPDC faced intense criticism from some stakeholders who feared that beneficiaries were being shepherded into a new privatized program that would lead to worse health outcomes without their knowledge. Contrary to accusations, GPDC (and now ACO REACH) have a host of beneficiary protections, with even greater protections added to ACO REACH based on stakeholder feedback.

As with any CMMI model, aligned beneficiaries retain full Traditional Medicare benefits and can seek services from any Medicare-enrolled physician, even physicians that are not Participating or Preferred Providers. ACOs must notify beneficiaries annually of their alignment to the ACO, their ability to opt out of data sharing, and that all benefits of Traditional Medicare are retained, including channels for reporting complaints. Primary care settings must also prominently display information alerting patients of a provider's alignment to an ACO.

Enhanced monitoring by CMS will be added to REACH in response to stakeholder concerns. In addition to activities undertaken with GPDC, CMS will now also be:

- Assessing annually whether beneficiaries are being shifted into or out of MA, addressing concerns that DCEs/ACOs were a tool being used to funnel beneficiaries to MA plans
- Monitoring for anti-competitive behaviors and misuse of beneficiary data
- Increasing use of data analytics to ensure appropriate care is being provided, addressing concerns reminiscent of the HMO-era where care skimping was a prominent avenue to cut costs
- Requiring submission of marketing materials and annual review of websites to ensure accurate information is being conveyed to beneficiaries
- Auditing provider contracts to identify any concerns regarding financial arrangements

Model Overlap

ACOs are not permitted to participate in more than one REACH risk sharing option (Global or Professional) during a performance year. An ACO can move between Global and Professional tracks prior to signing the Model Performance Period (MPP) participation agreement, but after signing, can only move from Professional to Global. Should a Professional-track ACO elect to upgrade to Global, they must indicate that intention prior to the start of a performance year.

Once in a performance year, ACOs and Participant Providers will be prohibited from participation in models that involve shared savings (e.g., MSSP, KCC, Vermont All-Payer ACO Model), as well as Primary Care First, Independence at Home, and the Maryland Primary Care Program, even though these three models do not involve shared savings. CMS will determine whether there is overlap during a performance year at the TIN level. Provider organizations may split their TIN in order to have different clinicians participate in separate models simultaneously, but providers participating under a new TIN will not have historical claims to contribute to model attribution or benchmarking.

Preferred Providers are not limited by these overlap rules and can continue participation in various capacities in other models. CMS may issue further guidance to help ACOs and Participant Providers understand the options for concurrent participation in other models and how to account for beneficiaries who are aligned to more than one initiative.

Timeline

The application period for the ACO REACH model is open as of March 7, 2022 and will continue through April 22, 2022. Applicants will be notified of acceptance in June 2022 and must sign and return the participation agreement by late December 2022 (exact date forthcoming). For participants beginning in PY2023, CMS will not require a Letter of Intent (LOI) or a final/official list of Participant and Preferred Providers for the purposes of the PY2023 application, though final provider lists must be submitted before the start of the performance

year. The first performance year will begin January 1, 2023, with an optional Implementation Period (IP3) running from August 1 through December 31, 2022. ACO REACH will last four performance years, ending on December 31, 2026. (See Figure 2)

Remaining Uncertainties

While CMS released many materials describing the new ACO REACH model soon after its announcement—including a press release, fact sheet, graphic, GPDC comparison table, more information on current participants, an RFA, and model overview webinar—some model details are still forthcoming. Remaining materials are expected to be released by Summer 2022 and include:

- The Model Performance Period Participation Agreement, which will include details on the required content for Health Equity Plans, additional safeguards and protections deterring the abuse of Beneficiary Engagement Incentives, and other details.
- Quality Measurement Methodology, which will provide information on the Continuous Improvement/Sustained Exceptional Performance Criteria and the distribution of funds from the High Performers Pool.
- ACO REACH/KCC Rate Book, which will detail regional expenditure rates and other technical details on aspects of risk adjustment.

Implications

Because the new ACO REACH provisions detailed above will apply to all participants in January 2023 regardless of when they joined the model, the updates to GPDC's administrative requirements and financial methodologies will impact both the current DCEs who are interested in remaining in the model as well as the prospective participants who hope to join the ACO REACH Model for what CMS says will be its final round of applications. The sections below consider the potential implications for current and future model participants, as well as the broader value movement.

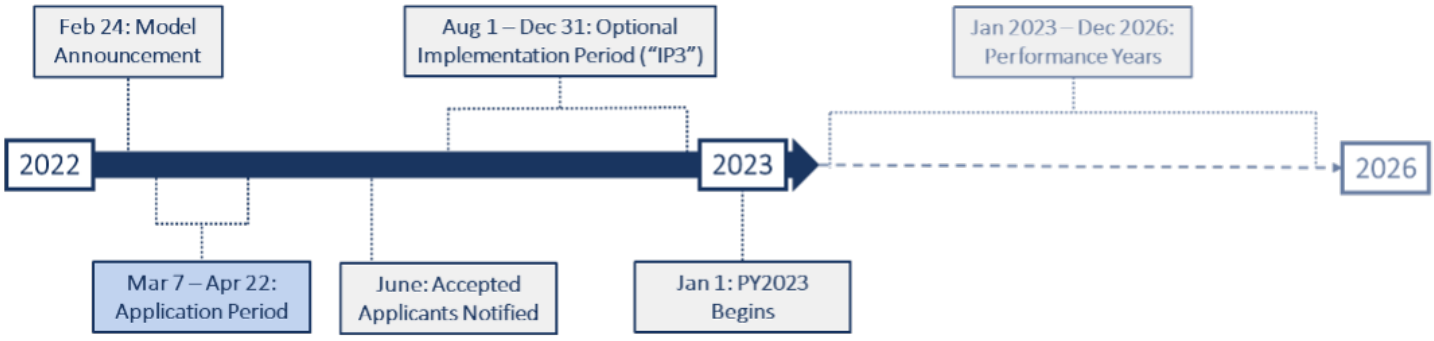
Implications for Current DCEs

Along with the announcement of the new ACO REACH Model, CMS also released more information on the 99 DCEs that are currently participating in GPDC, as part of the agency's renewed commitment to greater transparency. With this additional information on the current GPDC participants—including DCE type, track, capitation payment mechanisms, state footprint, and selection of benefit enhancements and beneficiary engagement incentives—researchers can now analyze the types of entities who are engaged in the model and better speculate about the implications of the new ACO REACH provisions on the PY2021 and PY2022 cohorts. (ACLC members can access previous intelligence briefs analyzing the GPDC participants here and here.)

Although CMS will not require reapplication, the 99 active DCEs who are interested in continuing their participation in the model after GPDC officially transitions to ACO REACH must become compliant with the new model requirements by January 2023 to stay in the model. Figure 3 below outlines some of the key considerations for current DCEs to ensure compliance. While every DCE will have to make adjustments to meet the new requirements of the ACO REACH model, these efforts should not represent too big a lift for organizations to implement over the next eight months.

DCEs will likely be even more motivated to remain in the model, given the updates to the financial methodology that make ACO REACH even more compelling than the GPDC design. Specifically, the reduced Global discount and quality withhold will make it easier for organizations to generate and keep savings, while the updated risk adjustment and stop loss provisions will add more precise protections (to both model participants and CMS) than the prior policies. While the final details of the financial methodology will not be released until Summer 2022, the ACO REACH Model is shaping

▶ Figure 2: ACO REACH Timeline



up to be a promising opportunity for provider-, payer-, and enabler-led entities to advance their value-based payment and delivery transformation efforts to serve Traditional Medicare beneficiaries with similar flexibilities and predictability afforded by MA. For additional analysis, access the recent Race to Value podcast on ACO REACH, featuring Rick Goddard and Joseph Satorius of Lumeris.

Figure 3: Key Considerations for Current DCEs to Ensure Compliance

Current DCEs must comply with new model requirements by January 2023 to remain in the ACO REACH Model (but need not re-apply)

- **Restructure governing body** to include 75% Participant Providers and two distinct beneficiary and consumer advocate voting members.
- **Ensure population aligned to DCE Participants reflects heterogenous population** (relevant to organizations serving large population of beneficiaries with CKD and ESRD).
- **Resolve potential market overlap issues** as a High Needs Population ACO cannot co-exist in the same geographical market as a Standard or New Entrant ACO owned by the same parent company.
- **Begin assessing opportunities to address health disparities**, define health equity goals, establish a health equity strategy and a plan for implementing, monitoring, and evaluating progress.

Assuming all 99 active DCEs can comply with the new governance and health equity requirements under ACO REACH—and will likely want to remain in the model under its updated design—it is still unclear whether CMS will decide to force out any existing DCEs with convoluted ownership or evidence of misaligned financial interests.
DC has represented an exciting opportunity for MA plans and PE-backed disruptors since the model's announcement. While not explicit about intentions to leverage GPDC to funnel beneficiaries into MA products, many participating entities reference their engagement in the model during investor presentations—one recent example being the 2022 JP Morgan Health Care Conference presentations from Clover, Bright Health, Alignment Healthcare, agilon, Cano, and One Medical/Iora. While these entities may couch their engagement in GPDC as an opportunity to expand their reach and apply their scalable technologies and proven clinical care models in the service of Traditional Medicare beneficiaries, the context of these strategies can, in some cases, make consumer advocates wary.

To address this going forward, CMS will significantly enhance its oversight of REACH ACOs (described under "Beneficiary Enhancements, Incentives, and Protections" above), including monitoring for anticompetitive behavior and efforts to move beneficiaries into, or out of, MA plans. While enhanced oversight is critical to ensuring the integrity of the model, it is important to note that CMS is allowing non-provider participants to engage in the model because the agency believes the benefits outweigh the risks. By design, the DC model options and the rebranded ACO REACH Model aim to include new entities who have not previously participated in Medicare APMs, allowing payers and enablement companies to apply their ample resources and expertise towards testing a sophisticated ACO model that few provider organizations are equipped to administer themselves.

While participants in GPDC/ACO REACH should be thoughtful about how the CMMI model fits into their broader VBP portfolio and Medicare strategy, organizations must be extremely diligent in drawing clear, appropriate boundaries between their ACO REACH and MA marketing strategies (if applicable) and ensuring beneficiaries have access to high-quality care and the freedom of choice regardless of their program alignment.

Implications for Prospective REACH ACOs

The opportunity to join the GPDC/ACO REACH model is something many organizations have been anxiously awaiting since CMS announced the postponement of the second application cycle in April 2021. According to CMMI, this application period (March 7 – April 22) will likely be the final opportunity to become a REACH ACO in its current form. As with its predecessor ACO models, CMMI will likely introduce the next iteration of its sophisticated population-based model after applying lessons from ACO REACH as it nears its conclusion in 2026, unless the pilot is certified for expansion.

Anticipating significant interest in the model, CMS indicated in the RFA that it may cap the number of accepted applicants but did not indicate how many entities will be chosen for the PY2023 cohort. Both prior cohorts of GPDC have roughly 50 DCEs each (50 active PY2021 starters and 49 active PY2022 starters), so that may be a fair assumption for the final round of applicants.

Regardless of the number of applicants accepted to join, CMS has clearly indicated a strong preference for provider-led entities – particularly those with

experience providing direct patient care and with a successful track record (i.e., high quality outcomes) serving patients in underserved communities. The ACO REACH RFA spells out screening criteria to guide prospective participants in developing a strong application.

Notably, the GPDC model was intended to be a landing place for NGACOs after the model sunset at the end of 2021. NGACOs who applied for GPDC were given the option to defer their start under the new model until 2022, though many former NGACOs opted to wait to apply – some believing that GPDC would have a second round of applications and others speculating that CMMI would extend the NGACO model. At least 18 former NGACOs are already participating in GPDC, leaving roughly 40 additional former NGACOs who may be interested in applying. While BASIC Level E or the Enhanced Track of the MSSP may offer a "safer" Advanced APM option, former NGACOs may appreciate the payment mechanism flexibilities included in ACO REACH. Moving away from FFS-based shared risk models toward prospective payments is a critical evolution for the value movement and necessary for sustainable transformation.

Implications for the Broader Value Movement

With the precarious timing of DC's announcement and launch—coinciding with the COVID-19 pandemic, Presidential election and Administration change, and postponement of GPDC's second application cycle—VBP proponents were concerned about the implications of the delays for the momentum of the value movement. When then-HHS Secretary Alex Azar revealed the agency's ambitious goals for moving Medicare, MA, Medicaid, and Commercial payments into risk-based APMs at the Fall 2019 Health Care Payment Learning & Action Network (LAN) Summit, he spoke of DC with great promise, saying, "Direct Contracting is the next major step. Having providers take responsibility for the total cost of care is the ultimate goal."

While the Biden-Harris Administration has remained committed to advancing value-based payment and delivery transformation—outlining a 10-year vision for the Innovation Center and establishing clear priorities for advancing equitable, accountable care across the health system—industry observers were unsure about the fate of the GPDC model.

With the timing of the ACO REACH Model's announcement, current GPDC participants will have plenty of time to comply with the new requirements to continue their participation in ACO REACH and, perhaps more importantly, give additional prospective participants the window of opportunity to apply.

While changes made to GPDC in its evolution to ACO REACH will not fully satisfy all concerns of stakeholders, industry reaction to the changes has been overwhelmingly positive. CMS' commitment to fixing, not cancelling, GPDC is heartening to VBP proponents – building on the momentum of the value movement and renewing faith in CMMI as a reliable vehicle for advancing value transformation through thoughtful APM pilots that participants can invest in.

About Lumeris

Lumeris enables a new model for healthcare. As the trusted partner for next-generation health systems, Lumeris helps providers deliver extraordinary clinical and financial outcomes. With partners across the country, we align providers and payers with a proven model that coordinates operational processes, resources and technology to achieve high-quality, cost-effective care with satisfied consumers and engaged physicians. To learn more, visit lumeris.com.

About the ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the ACLC serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the ACLC, visit accountablecareLC.org.

Appendix: Quality Measurement

Domain	Measure Title	Method of Data Submission	Pay-for-Performance (P) or Pay for Reporting (R)
Care Coordination / Patient Safety	Risk-Standardized, All Condition Readmission	Claims	P
Care Coordination / Patient Safety	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	P
Care Coordination / Patient Safety	Timely Follow-up after Acute Exacerbations of Chronic Conditions	Claims	P
Care Coordination / Patient Safety	Days at Home for Patients with Chronic, Complex Conditions High Needs Population ACOs	Claims	P
Patient / Caregiver Experience	Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	Survey	P (for Standard/New Entrant) R (for High Needs)