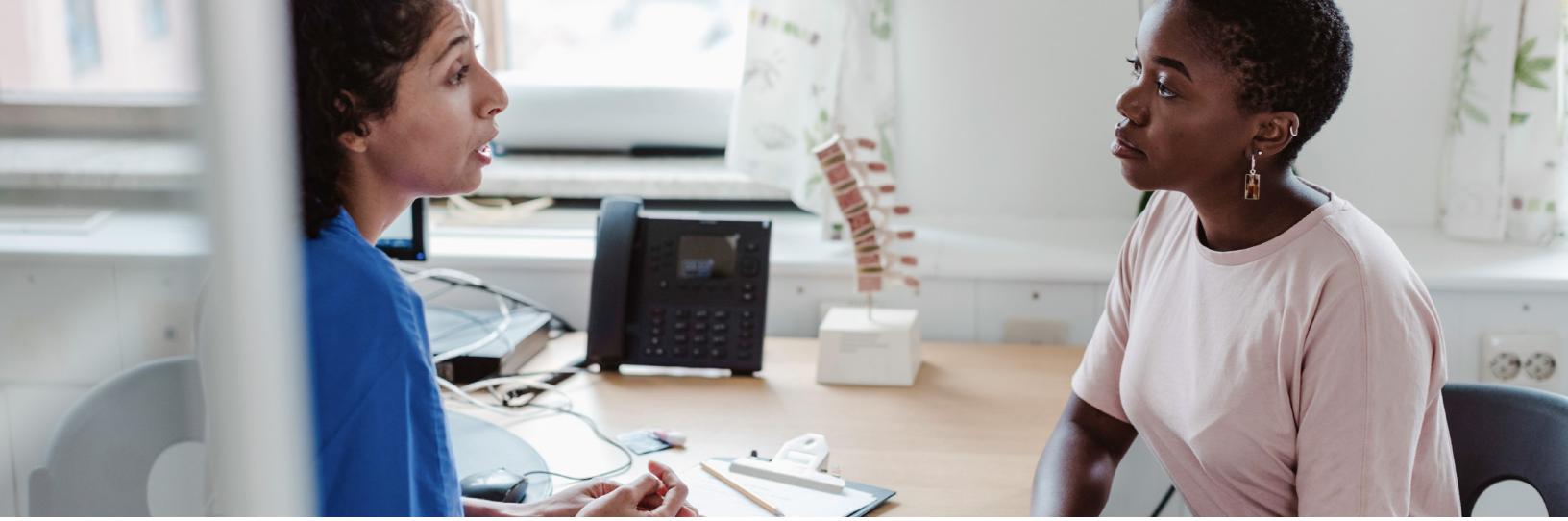

April 2022

Your challenge. Our mission.

Who Should Consider Applying for the ACO REACH (Realizing Equity, Access, and Community Health) Model; the CMS redesign of the Global and Professional Direct Contracting (GPDC) Model?

The article will discuss:
- Opportunities for new applicants as CMS rebrands GPDC to "ACO REACH" model
- **Key changes participants should know about before ACO REACH model goes live Jan. 2023**
- Administration's new program goals and adjustments to incentivize health equity
- Who should consider applying and how to evaluate likelihood of successful performance?
- Timelines for new applications and continuing existing GPDC participation

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Introduction

From March 7th to April 22, 2022, the Centers for Medicare & Medicaid Services (CMS) will briefly re-open a Request for Applications (RFAs) offering new organizations the opportunity to participate in the Direct Contracting program's new "Accountable Care Organization Realizing Equity, Access, and Community Health" (ACO REACH) model. Existing Global & Professional Direct Contracting (GPDC) entities can continue their program participation in the ACO REACH model without submitting RFAs, but will have to meet the new model's requirements before the GPDC sunsets on January 1st, 2023. Continue reading this article for details regarding the ACO REACH model's RFA criteria, participation requirements, health equity incentives,key timelines and considerations for new applicants.

Background

In 2020 CMS launched a new Alternative Payment Model (APM) called the Direct Contracting (DC) program. The program mirrored previous APM goals of incentivizing providers to improve quality outcomes and reduce unnecessary healthcare costs for traditional Medicare fee-for-service (FFS) beneficiaries. Similar to the Next Generation Accountable Care Organization (NGACO) model, the DC program utilizes a PCP-centered group called a "Direct Contracting Entity" (DCE). DCEs are composed of "Participating" and "Preferred" providers who operate as strategic partners under a DCE's common legal structure to manage the health care and claim costs of its aligned beneficiaries throughout the program. For the DC program's GPDC model, DCEs can select to participate in either the lower-risk "Professional" track with Primary Care Capitation (PCC) payments, or the higher- risk "Global" track with a choice of either PCC or Total Care Capitation (TCC) payments. Based on these selections, CMS will then calculate a "Performance Year (PY) Benchmark" for each GPDC entity. The PY Benchmark serves as a financial target budget to measure if a GPDC achieves annual healthcare savings or losses, by comparing the GPDC entity's actual financial performance and against their benchmark.

When designing the GPDC program, CMS leveraged lessons learned from other APMs to offer more varieties of GPDC model selections. This empowered participants to build customizable arrangements with CMS that encourage innovation, expand provider participation, and drive implementation of new benefit enhancements. Each GPDC entity chooses a specific population model with corresponding beneficiary alignment thresholds, a Global or Professional path for accepting higher/lower levels of risk, and either a TCC or PCC payment structure for monthly payments. To reduce administrative reporting burdens, GDPC entities utilize a smaller set of core claims-based quality measures and qualify as an Advanced APM to offer eligible participants the opportunity to receive a 5% incentive payment and be excluded from MIPS.

After the initial GPDC cohorts completed their first PYs in 2020 and 2021, CMS responded to program stakeholder and participant feedback with an announcement on February 24th, 2022, advising the current GPDC model would sunset on January 1st, 2023. CMS will then seamlessly implement a redesigned and rebranded GPDC program called the ACO REACH model. The new program will focus on similar strategies to improve and expand upon the GPDC's existing initiatives while also advancing health equity goals, supporting provider governance, and strengthening protections for beneficiaries.

New model highlights: GPDC vs. ACO REACH

While still maintaining many original program structures and features, the ACO REACH model's new initiatives demonstrate key focus areas that CMS seeks to further advance and expand upon progress achieved during the current GPDC model's first performance years. The following requirements and incentives will become effective for both new and existing program participants on January 1st, 2023.

Health equity: One of the most significant new model revisions that CMS will implement is a strategy to address the GPDC's lack of explicit health equity initiatives. The first item on the ACO REACH model's agenda for PY 2023 is a requirement for all participating entities to develop an annual Health Equity Plan for addressing their Medicare population's unique health disparities and gaps in care. Each ACO's Health Equity Plan must:

1. Identify health disparities within their aligned beneficiary populations;
2. Define health equity goals & metrics to periodically report progress;
3. Develop health equity strategy & identify resources needed to implement the Plan; and
4. Report entity's Health Equity Plan progress to CMS

In addition to the action plans, CMS will implement two (2) new financial incentives to further boost ACO's momentum for improving health equity and data documentation.

1) **Health equity reporting bonus** - Quality score bonus points will be awarded to ACOs that meet new requirements to collect and submit beneficiary-reported demographic and social needs data. ACOs will be eligible to increase their total quality score by up to 10 percentage points, which can impact up to 0.2% of their PY Benchmark. ACOs will report data to CMS using current Core Data for Interoperability standard. Collecting this data will allow CMS to measure and compare ACO health disparities across regionally similar populations and/or specific beneficiary subpopulations. CMS hasn't announced a penalty for non-submissions.

2) **Health Equity Benchmark** - CMS will introduce a "Health Equity Benchmark Adjustment" to provide additional funding to ACOs that serve a higher proportion of underserved Medicare beneficiaries for a more even playing field and better care delivery/ coordination. The adjustment factor will consider the Area Deprivation Index Percentile[1] and Medicaid eligibility of beneficiaries to either increase or reduce their aligned ACO's PY benchmark. For each aligned beneficiary within the top-scoring 10th percentile, the aligned DCE's benchmark will increase by a flat $30 PBPM. For each beneficiary in the bottom-scoring 50th percentile the aligned ACO's benchmark will reduce by $6 PBPM.

New Benefit Enhancement: To further serve beneficiaries, CMS will also implement a new waiver to expand the scope of practice for Nurse Practitioners (NPs) participating in ACO REACH networks. The waiver will empower eligible[2] NPs to perform specific services without physician assistance. The expanded scope of services include:

- referrals for nutrition therapy
- certifications for initial 90-day hospice
- certifications for diabetic shoes; and
- establish care plans for home infusion and cardiac rehabilitation.

This approach will promote increased flexibility in care delivery and improvement in REACH ACO's care coordination.

Stop-loss options

ACO REACH participants will be offered additional stop-loss options known as 'residual based reinsurance'. This methodology will utilize cost points to help protect ACOs against excessive exposure from high-cost beneficiaries whose actual healthcare claims expenditures surpass the ACO's budgeted benchmark projections.

Other provider incentives

To promote taking on higher levels of risk, CMS will reduce the original Global Discount and Quality Withhold rates for all participating REACH ACOs. These changes incentivize participants to accept higher amounts of downside risk in exchange for increased amounts of upfront capitated funding and eligible shared savings that can be earned.

- Global Discount Rates will be reduced from 4% to 3% for PY 2024, and from 5% to 3.5% for PYs 2025 to 2026.
- Quality Withholds will be reduced from 5% to 2%.

In addition to these reductions, the ACO REACH model will also set limits to reduce the proportion of beneficiary subpopulations covered by other CMS Innovation programs, like the End Stage Renal Disease (ESRD) model, that can be aligned to participating Global and Professional ACO REACH entities.

Timelines for new applicants & existing participants

CMS is offering a brief window for new applicants to submit RFAs for an opportunity to participate in the rebranded ACO REACH program. Unlike the GPDC program, CMS will not require Letters of Intent (LOIs) as a prerequisite to submit applications. The most significant impacts to the GPDC vs. ACO REACH models' application scoring criteria were weight adjustments to the following three (3) application sections:

	GPDC	ACO REACH
Application scoring sections	**Max. score points**	**Max. score points**
Financial plan & risk-sharing experience	20 pts	35 pts
Organizational readiness	30 pts	15 pts
Data and HIT capability	5 pts	15 pts

In addition to meeting RFA scoring criteria, CMS will prioritize selecting new ACO REACH applicants that demonstrate prior experience providing high-quality care to underserved patient populations and communities.

1 Area Deprivation Index Percentile allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest at the state or national level. It includes factors for the theoretical domains of income, education, employment, and housing quality. https://www.neighborhoodatlas.medicine.wisc.edu/

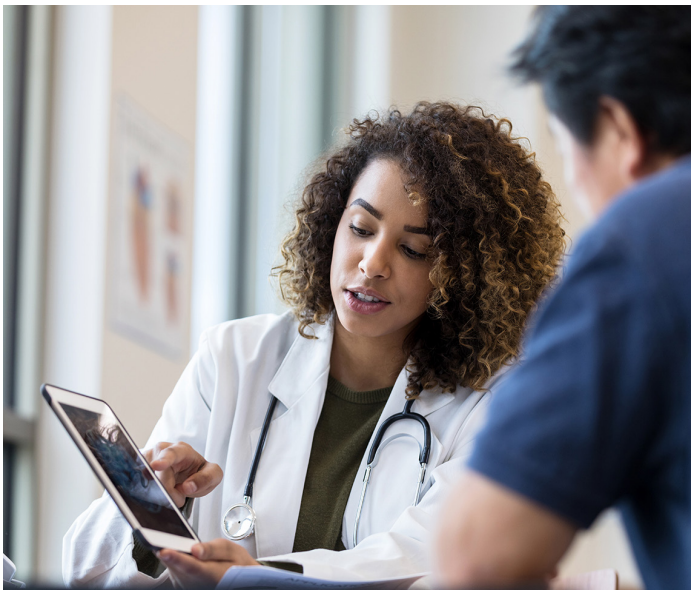
2 NPs are still required to practice within the confines of state law

Key timelines

- March 7th - April 22nd, 2022: Period for new entities to submit RFAs for ACO REACH model.
- August 1st – December 31st, 2022: Implementation Period (IP) for newly selected ACO REACH participants to prepare for their first PY.
- January 1st, 2023: First performance year (PY1) for ACO REACH participants. CMS will expect new participants to comply with existing GPDC requirements set for PY 2023, such as glide path thresholds for beneficiary alignment and minimum PCC claim reductions.
- January 1st, 2023 - December 31st, 2026: Duration of three (3) full PYs that both new and existing participants will perform in ACO REACH model.

Existing GPDC entities are not required to submit new RFAs for continuing their participation in the ACO REACH model but will need to comply with the rebranded model's Health Equity plan, demographic data reporting, increased physician led governance structure, and other compliance requirements.

At this time, CMS hasn't announced additional RFA periods for the ACO REACH model.



Conclusion & applicant considerations

CMS designed the GDPC and ACO REACH model options to encourage a broader range of providers and organizations to enter different levels of risk with CMS. Before applying, interested applicants should first evaluate which payment mechanism, Medicare FFS population, and level of financial risk will best position their unique ACO REACH entity for successful outcomes and performance.

In addition to considering attribution, strategic partnerships, and quality performance capabilities, applicants are strongly recommended to conduct a preliminary financial analysis for modeling their unique projected "PY Benchmark Rate". Even the most skilled participants will only earn savings if they can successfully reduce aligned beneficiaries' healthcare costs below the ACO's unique PY Benchmark Rate set by CMS. The PY Benchmark Rate is calculated using a combination of weighted averages from the participating entity's historic claims cost experience and CMS' regional rates. This methodology results in an ongoing challenge for participants to compete against a PY Benchmark that will reduce as historic claims and weight adjustments begin to catch-up with their entity's YOY cost savings.

In addition, providers that are currently taking on risk with Payers for Medicare Advantage populations should also consider applying to the program if they have not already. This inventive model offers a unique opportunity for providers to participate in a program designed to reward providers who can demonstrate the ability to improve healthcare delivery and quality of care. Many provider groups/IPAs are already familiar with value-based care delivery and could create a new revenue stream by participating in this unique program.

References

1) The CMS Innovation Center. (2022, February 24). ACO Realizing Equity, Access, and Community Health (REACH) Model Request for Applications (RFA). Retrieved from Innovation Models: https://innovation.cms.gov/media/document/aco-reach-rfa

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