CMS Replaces GPDC Model with the ACO REACH Model and is Accepting Applications

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I. Background/Introduction:

On February 24, 2022, the Centers for Medicare & Medicaid Services ("CMS") announced the redesign and renaming of its Global and Professional Direct Contracting model ("GPDC"), which was paused in March of 2021. The model, now known as the Accountable Care Organization Realizing Equity, Access, and Community Health model ("ACO REACH"), was renamed in response to stakeholder feedback and to advance Administration priorities. CMS also announced its cancellation of the Geographic Direct Contracting model.

ACO REACH starts on January 1, 2023, and spans four performance years, ending December 31, 2026. All entities desiring to participate in the ACO REACH must submit their application through the application portal by 11:59 p.m. Eastern Time on April 22, 2022. Current GPDC participants need not reapply and are permitted to participate in ACO REACH provided they maintain a strong compliance record and agree to the requirements of ACO REACH (e.g., new governance requirements) by January 1, 2023. Alternatively, GPDC participants can elect to leave the model. With the application deadline fast approaching, this client update focuses on some of the key features of ACO REACH, requirements for participation, and notable changes relative to GDPC.

II. ACO Types:

The three types of ACOs under ACO REACH are as follows:

- Standard ACOs – Standard ACOs are composed of organizations with experience serving Medicare FFS beneficiaries. Standard ACOs must have at least 5,000 beneficiaries aligned prior to the start of each performance year, with a minimum of 3,000 beneficiaries that would have been aligned to the ACO during at least one base year (2017, 2018, or 2019).[1]
- New Entrant ACOs – New Entrant ACOs are comprised of organizations that have not traditionally provided services to a Medicare FFS population. New Entrant ACOs must have at least 2,000 beneficiaries aligned prior to the start of PY2023, 3,000 beneficiaries aligned prior to the start of PY2024, and 5,000 beneficiaries aligned prior to the start of PY2025 and PY2026.[2]
- High Needs Population ACOs – High Needs Population ACOs serve Medicare FFS beneficiaries with complex needs. These ACOs are expected to use a model of care designed to serve individuals with complex needs (similar to the model employed by PACE) to coordinate care for their aligned beneficiaries. High Needs Population ACOs must have 500 beneficiaries aligned prior to the start of PY2023, 750 beneficiaries prior to the start of PY2024, 1,200 beneficiaries prior to the start of PY2025, and 1,400

beneficiaries prior to the start of PY2026.[3]

III. Risk Sharing Options:

The two risk sharing options under ACO REACH are the following:

- Professional Option – This option offers partial risk sharing of 50% of savings/losses with risk corridors. Only capitation payments for primary care services are available with this option.

Risk Band: Gross Savings/Losses as a Percentage of PY Benchmark

ACO Shared Savings/Losses

Risk Band 1: Gross Savings/Losses

50% of savings/losses

Risk Band 2: Gross Savings/ Losses between 5% and 10%

35% of savings/losses

Risk Band 3: Gross Savings/Losses between 10% and 15%

15% of savings/losses

Risk Band 4: Grossing Savings/Losses > 15%

5% of savings/losses

Figure 1: Risk Corridors for Professional Option from ACO REACH Request for Application[4]

- Global Option – This option offers full risk sharing of 100% of savings/losses with broader risk corridors than the Professional Option.

Risk Band: Gross Savings/Losses as a Percentage of PY Benchmark

ACO Shared Savings/Losses

Risk Band 1: Gross Savings/Losses

100% of savings/losses

Risk Band 2: Gross Savings/ Losses between 25% and 35%

50% of savings/losses

Risk Band 3: Gross Savings/Losses between 35% and 50%

25% of savings/losses

Risk Band 4: Grossing Savings/Losses > 50%

10% of savings/losses

Figure 2: Risk Corridors for Global Option from ACO REACH Request for Application[5]

IV. Capitated Payments:

ACO REACH participants receive per-beneficiary-per-month ("PBPM") capitated payments. There are two Capitation Payment Mechanisms by which participants can be paid: (1) Total Care Capitation Payment ("TCCP") and (2) Primary Care Capitation Payment ("PCCP"). The TCCP is a PBPM capitated payment for **all services** provided to aligned beneficiaries by all Participant Providers and Preferred Providers who have opted to participate in TCCP. The TCCP is only available to ACOs participating in the Global Option for risk sharing. The PCCP is a PBPM capitated payment for **primary care services** provided to aligned beneficiaries by all Providers and Preferred Providers who have opted to participate in PCCP. The PCCP is available to ACOs participating in either the Global Option or Professional Option, and those participating in the Professional Option must select the PCCP.

V. Benchmarking:

ACO REACH relies on a benchmarking methodology for determining the PBPM capitated payment received by participants. For Standard ACOs, the Performance Year Benchmark is determined by "(1) calculation of the historical baseline expenditures, (2) trending the historical baseline expenditures forward, (3) blending the historical baseline expenditures with regional expenditures using the ACO/REACH KSS Rate Book, (4) risk adjustment [based on CMS HCC], and (5) applying necessary adjustments for quality performance and the discount (Global only)."[6]

Baseline Calculation: As mentioned above, benchmarking for Standard ACOs blends historical baseline expenditures and regional expenditures for all performance years.[7] High Needs ACOs with greater than 3,000 aligned beneficiaries follow this same blended methodology. For New Entrant ACOs and High Needs ACOs with less than 3,000 aligned beneficiaries, the benchmarking methodology does not incorporate historical baseline expenditures and relies exclusively on regional expenditures for PY2023 and PY2024. Starting in PY2025, blending of historical baseline expenditures and regional expenditures will be implemented for both New Entrant ACOs and High Needs ACOs.

Health Equity Adjustment: Newly added under ACO REACH, CMS will apply a health equity adjustment for benchmarking for all ACO types starting in PY2023. The health equity adjustment incorporates a combination of the Area Deprivation Index and Dual Medicaid Status for calculation. CMS may explore other variables to include for calculating this adjustment, and will notify applicants prior to the start of PY2023 if other variables are included.

Risk Adjustment: Standard and New Entrant ACO types follow the same risk adjustment methodology, which is based on the CMS Hierarchical Condition Categories ("HCC") prospective model. CMS expects to apply HCC Version 24 for risk adjustment, but the applicable risk adjustment model will be detailed in the Participation Agreement for the Model Performance Period. For High Needs Population ACOs, CMS will apply the CMMI-HCC concurrent risk adjustment model. CMS will apply the following risk score mitigation strategies to all ACOs in the ACO REACH:

- *Coding Intensity Factor* – For PY2023, CMS will continue to normalize risk scores and subject normalized scores to a retrospective Coding Intensity Factor which limits risk score growth across the entire model.
- *Symmetric Risk Score Cap* – Starting in PY2024, CMS will also apply to each ACO a symmetric 3% risk score cap relative to **demographic risk score growth** for a **static reference year population**. For example, if the demographic risk score growth from the static reference year to the performance year is +2%, then risk score growth will be constrained between -1% and 5%. Importantly, the reference year population remains the same throughout the entire model performance period. This risk score cap methodology significantly differs from the GPDC methodology which simply placed a symmetric 3% cap on risk score growth over a two-year period.

Discount: CMS applies a discount to the risk adjusted benchmark for all ACO types. The discount applies, however, only to ACOs that choose the Global Option for risk sharing. The same discount percentages apply to all ACO types in each performance year that are lower in ACO-REACH relative to what they were in GPDC. The discount for ACOs operating under the Global Option will be 3% in PY2023 and PY2024 and 3.5% for PY2024 and PY 2025.[8]

Quality Performance Adjustment: All ACO types rely on the same quality performance methodology for all performance years. ACO-REACH decreased the "withholding" percentage for quality performance relative to what it was under GPDC. Under ACO-REACH, for PY2023 and beyond, 2% of the risk-adjusted benchmark will be subject to a quality "withhold," which the ACO may earn back based on its performance on pre-determined quality measures and continuous improvement/sustained exception performance ("CI/SEP") criteria (compared to 5% under GPDC).[9]

VI. Governance Changes:

ACO-REACH includes the following two core changes to the governing board requirements for participating ACOs relative to the requirements under GPDC:

Participating Provider Control: ACO-REACH increased the required percentage of control held by Participant Providers relative to GPDC. Under ACO-REACH at least 75% of the control of the governing body must be held by Participant Providers or their designated representatives, compared to only 25% under GPDC.

Beneficiary Representative & Consumer Advocate: Under GPDC, the entity's governing board had to include a beneficiary representative and a consumer advocate, but a single person was permitted to fill both these roles and neither position was required to have voting rights. Under ACO-REACH, the governing board must still include a beneficiary representative and a consumer advocate, but a separate person must serve for each position and both must have voting rights.

VII. Health Equity Additions:

In addition to the Health Equity Adjustment described above, ACO-REACH implements additional health equity features not previously included in GPDC.

Health Equity Plan: Prior to each performance year (including PY2023), ACOs must submit to CMS in a form and manner and by a date specified by CMS a Health Equity Plan (and at such other times specified by CMS). CMS will supply ACOs with components that ACOs shall include in their Health Equity Plans, and ACOs must use template language provided by CMS to develop their plans. ACOs will also be required to report to CMS on implementation progress and goal achievement regarding their plans.

Demographic and Social Needs Data Collection: Beginning in PY2023, ACOs must collect and submit beneficiary-reported demographic data to CMS that includes all elements specified in the United States Core Data for Interoperability Version 2.

NP Services Benefit Enhancement: ACO-REACH will also offer a new benefit enhancement starting in PY2023 focused on providing more equitable access to care by allowing ACOs to extend to NPs certain activities to the extent permitted by state law that are otherwise impeded by current Medicare law.[10]

VIII. Screening & Monitoring Changes:

Screening: Each applicant will be subject to CMS Program Integrity ("PI") screening, and CMS may deny participation to an otherwise qualified candidate based on information uncovered during the PI review. Applicants will need to make various disclosures[11] in support of this PI review involving persons with ownership or control interest in the applicant, key executives, equity partners, and individuals or entities that the applicant expects to be Participant Providers or Preferred Providers.

Monitoring: CMS is expanding upon the monitoring framework already provided in GPDC for ACO-REACH. Some additional elements include: annual assessments as to whether beneficiaries are being moved in or out of Medicare Advantage, reviewing marketing materials to ensure accuracy and that beneficiaries understand their rights, monitoring ACO risk score growth, and auditing ACO provider contracts to evaluate downstream arrangements.

IX. Conclusion:

ACO-REACH changed several key components of GPDC to address stakeholder concerns, but still provides "new opportunities for a variety of different organizations to participate in value-based care arrangements in Medicare FFS."[12] Those considering applying should consider potential challenges and risks. New applicants are going to need to carefully consider the disclosure requirements under the application and make sure they do their due diligence with respect to choosing their expected Participant Providers and Preferred Providers. ACOs should plan for the ongoing monitoring by CMS and ensure that they have appropriate personnel to respond to requests or inquiries from CMS. Additionally, ACOs should scrutinize the changes made to the discount, quality performance withholding, and risk score cap to determine how these changes may affect their anticipated PBPM capitated payments and their selection of risk-sharing options.

Please contact a member of the Moore & Van Allen health care team if you have questions about the ACO REACH model.

[1] Ctrs. for Medicare & Medicaid Servs. , ACO Realizing Equity, Access, and Community Health (REACH) Model: Request for Applications 28 (2022) [hereinafter Request for Applications], https://innovation.cms.gov/media/document/aco-reach-rfa.

[2] *Id.*

[3] *Id.*

[4] *Id.* at 34-35.

[5] *Id.* at 35.

[6] *Id.* at 49-50.

[7] Benchmarking will incorporate only regional expenditures, however, for beneficiaries voluntarily aligned to Standard ACOs in PY2023 and PY2024.

[8] The discount percentages under GPDC were as follows: PY2023=3%, PY2024=4%, PY2025 and PY2026=5%.

[9] For ACOs that begin participation in PY2023 CI/SEP will begin to apply in PY2024.

[10] *See* Request for Applications, *supra* note 1 at 76-77.

[11] *See id.* at 11 (listing disclosure required as part of the application).

[12] *Id.* at 12.