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The Next Evolution of ACO Models – Applications for the ACO REACH Model Are Due 22 April 2022

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On 24 February 2022, the Centers for Medicare and Medicaid Services (CMS), through the Centers for Medicare and Medicaid Innovation (CMMI), unveiled the new "ACO REACH" Model (Accountable Care Organization Realizing Equity, Access, and Community Health), its redesigned successor to the Next Gen ACO model.

ACO REACH serves as the replacement to the Global and Professional Direct Contracting Model (GPDC). Announced in December 2020, GPDC was originally intended to serve as a replacement to the Next Gen ACO model. However, in March 2021, CMS paused the GPDC model, announcing that it would not accept any further applications. CMS then undertook an evaluation of the GPDC model in light of stakeholder feedback and the Biden administration's priorities, with a new focus on health equity and participant experience.[1] This launch of ACO REACH is the culmination of CMS' GPDC evaluation and revision.

The ACO REACH program differs from prior programs in a number of ways, for example:

- Model goals emphasize improving health equity and disparities for underserved populations.
- Particularly, the program contains a variety of provisions aimed at addressing health equity through new data collection requirements, a requirement for an ACO Health Equity Plan (Health Equity Plan), new benchmarking adjustments, and new payment benefit enhancements.
- There is an increased focus on provider and beneficiary control over ACO governance.
- CMS is introducing a variety of enhanced ACO monitoring and compliance efforts.

APPLICANT TYPES AND TRACKS

While the model is perhaps geared most directly to prior Next Gen or current GPDC participants, it is available to a variety of provider-based organizations. Three types of organizations can apply to join:

- Standard ACOs – which are organizations that have experience servicing Medicare patients aligned to an accountable care organization ("ACO") and have previously participated in another CMMI shared savings model or in the Medicare Shared Savings Program (MSSP).

- New Entrant ACOs – which are organizations that do not have the same degree of ACO experience.

- High Needs Population ACOs – which are organizations that primarily service Medicare patients with specific complex needs.

There are two voluntary, risk-sharing participation tracks available for interested ACOs. The first is the *Professional* option, which is the lower risk-share option and includes a 50% shared savings/losses component, as well as a primary care capitation payment. The second track is the *Global* option, which is a 100% shared savings/losses option and includes either a primary care capitation payment or a total capitation payment that includes all covered services, including specialty care, provided by the ACO Participating Providers.

Provider participation in ACO REACH is defined at the tax-identification number/national provider identifier (TIN/NPI) level.[2] Accordingly, organizations participating in another Medicare shared savings model that captures participation at the TIN/NPI level can also patriciate in ACO REACH. However, this requires that the specific TIN/NPI combinations do not overlap between two or more models—i.e., certain providers within an organization can participate in one model, and other providers can participate in the second model. For organizations participating in MSSP, since MSSP defines participation across the organization's entire TIN, organizations will not be able to participate in both MSSP and ACO REACH.

SUMMARY OF KEY CHANGES TO GPDC[3]

ACO REACH incorporates a variety of changes to the GPDC model that are largely designed to: (i) address stakeholder concerns about benefit protection, program monitoring, and transparency; and (ii) incorporate a new focus on health equity, consistent with the CMMI's overarching goals announced as part of the Innovation Center Strategy Refresh.[4] Below, we have briefly summarized some of the key changes incorporated into the ACO Reach Model.

Health Equity

CMS's renewed focus in addressing disparities in health equity can be seen in a series of equity-focused initiatives that are introduced in ACO REACH.

First, starting in Performance Year (PY) 2023, each REACH ACO will need to develop a Health Equity Plan. This Health Equity Plan will identify health disparities in the ACO's market and discuss specific actions the ACO will take that are intended to mitigate the identified health disparities. The contents of the Health Equity Plan will be largely based on the CMS Disparities Impact Statement pilot initiative.[5] The Health Equity Plan will need to be updated each year, and ACOs will need to report on their progress in implementing the Plan and achieving their health equity goals. In the coming months, CMS plans to provide a template Health Equity Plan for ACOs to complete.[6]

Second, ACO REACH introduces a new adjustment to the ACO's benchmark to address health equity and support delivery and care coordination in underserved communities. In developing this

equity adjustment, CMS will create a blended per-beneficiary score that incorporates: (i) an Area Deprivation Index percentile score, and (ii) the prevalence of dual eligible Medicare status. Beneficiaries with a score in the top decile will be attributed an upward per beneficiary per month (PBPM) adjustment (US$30 PBPM), and beneficiaries in the lower five deciles will be attributed a smaller downward PBPM adjustment (US$6 PBPM). An ACO's total benchmarking adjustment is then based on the composite adjustment of its attributed beneficiaries. CMS estimates a total benchmark adjustment for ACOs to range from +1% to -0.5%.[7]

Third, ACOs will be required to collect and report on a variety of beneficiary-reported demographic and social needs data. Specifically, ACOs must submit demographic data consisting of each of the elements specified in the United States Core Data for Interoperability Version 2. These data elements include race, ethnicity, language, gender identity, and sexual orientation. This data can be reported to CMS either through a CMS-provided questionnaire, which will utilize the Fast Healthcare Interoperability Resources data standard, or through using a CMS-provided Excel template. In PY2023, CMS will offer an upward-only quality score adjustment to ACOs for successfully reporting data, although in future years, CMS may institute a downward adjustment for an ACO's failure to report.[8]

Fourth, ACO REACH provides for a new benefit enchantment to increase the range of services that may be offered by nurse practitioners (NPs) to improve access and care coordination in underserved communities. Under this benefit enhancement, starting in PY2023, NPs that are Participant Providers or Preferred Providers in the ACO will have additional flexibilities to operate independently of a supervising physician, specifically through waivers allowing the NPs to:

- Provide an initial certification that a patient is terminally ill and in need of hospice care.
- Document and certify a beneficiary's need for diabetic shoes, without that certification needing to be "incident to" the care of a supervising physician.
- Establish, review, and sign a written care plan for an ACO REACH beneficiary's cardiac rehabilitation.
- Establish, review, sign, and date an ACO REACH beneficiary's home infusion therapy care plan, without requiring periodic review by a physician.
- Refer ACO REACH beneficiaries with diabetes or renal disease to dietitians or nutrition professions for medical nutrition therapy.[9]

ACO Governance

The ACO REACH model significantly alters the governing body requirements that applied to GPDC. Under ACO REACH, Participating Providers will be required to have controlling voting rights over the ACO governing board. Specifically, participating providers must hold at least 75% of the governing board voting rights, as compared to GPDC's requirement that participating providers hold only 25% of governing board voting rights.

In addition, each REACH ACO governing board will be required to include both a beneficiary representative and a consumer advocate, who must be different people and both of whom must have voting rights.[10] GPDC also required a governing board to have both a beneficiary representative and

consumer advocate; however, under GPDC, these could be the same person and that person was not required to have voting rights.

As a result of these changes, non-provider entities affiliated with the ACO—such as payors, private equity partners, or supporting organizations—will be limited to only a minority of voting control of the ACO. Indeed, such entities will be entitled to less than 25% of governing board voting rights when factoring in the voting requirements of ACO participants, the beneficiary representative, and the consumer advocate.

Monitoring and Compliance

While the development of ACO compliance plans and routine CMS monitoring of ACO operations has existed throughout the beginning of CMMI models, there is a notable step up in focus by CMS in the ACO REACH model. The ACO REACH monitoring and compliance efforts reflect a move closer to the level of oversight that might be seen in a Medicare Advantage setting. For example, CMMI discusses that enhanced compliance efforts will focus on examining an ACO's risk score to check against inappropriate coding practices, monitoring use, and potential misuse of beneficiary data and anti-competitive behavior, requiring review of REACH ACO marketing materials, among other compliance efforts.

Specifically, as discussed in the ACO REACH Request for Applications (RFA), CMS intends to take the following steps, at its discretion:

- Record audits and claims analyses intended to identify fraudulent behavior or other program integrity risks, such as "inappropriate reductions in care, efforts to manipulate risk scores for aligned populations, overutilization, and cost-shifting to other payers or populations."
- Review of demographic data to identify potential discriminatory behavior in marketing activities.
- Monitoring ACO implementation of its Health Equity Plan.
- Interviews of ACO leadership and management, Participant Providers, Preferred Providers, and other individuals and entities participating in ACO activities.
- Site visits to ACO Participant Providers and Preferred Providers.
- Documentation requests, such as surveys and questionnaires.
- Comprehensive annual audits.[11]

ACO and Participant/Preferred Provider cooperation with these CMS monitoring efforts will be a required element of the ACO Participation Agreement with CMS.

Reduction in Global Discount Rates and Quality Withholds

To incentivize greater participation in full risk-based fee-for-service initiatives, CMS has reduced the discount rate for Global ACOs that is applied to the ACO benchmark before gross savings and losses are calculated. Under GPDC, CMS applied a global discount of 2% starting in PY2021, which

increased on a sliding scale up to 5% in PY2026. Under ACO REACH, based on further CMS analysis and stakeholder feedback, this discount now tops out at 3.5% in PY 2026, rather than 5%. There is also a significant reduction in the quality withhold that is applied to benchmarks for both Global and Professional ACOs. Under GPDC, this quality withhold was 5%, whereas under ACO REACH, this withhold has been reduced to 2%. In making this change, CMS indicated it recognized: (i) that this adjusted withhold would be commiserate to the size of withholds in prior ACO initiatives, and (ii) that since ACO REACH quality scores are focused on a relatively small set of outcomes measures, versus process measures, a 2% withhold would be sufficiently rigorous.[12]

APPLICATION PROCESS

ACOs, ACO participants, and other provider organizations interested in applying to ACO REACH will need to quickly get up to speed on program changes and requirements, including new application processes, in order to meet the application deadline of 22 April 2022. While this deadline subject to change, at this time CMMI has no plans to offer any additional application cycles in future years.

The RFA provides the comprehensive application template that should be completed for prospective applicants. Approval into the program is not guaranteed. Applicants will be scored on a variety of categories, including organizational readiness, financial plans, risk-sharing experience, clinical care models, and data and health information technology capabilities. CMMI has also stated that it may, at its discretion, limit the number of applications approved for participation in the program.[13] The breadth and depth of information requested by CMS within the application process will take considerable efforts to address. Therefore, interested provider organizations would be well served by starting this application process as early as possible.

FOOTNOTES

[1] *See* https://innovation.cms.gov/innovation-models/gpdc-model.

[2] CTRS. FOR MEDICARE & MEDICAID SERVS., ACO REALIZING EQUITY, ACCESS, AND COMMUNITY HEALTH (REACH) MODEL REQUEST FOR APPLICATIONS 17 (Feb. 24, 2022), https://innovation.cms.gov/media/document/aco-reach-rfa [hereinafter RFA].

[3] Note that this alert does not provide a comprehensive list of all changes or new additions to the ACO REACH model—for complete details, interested organizations should consult the ACO REACH Request for Applications (RFA), available at: https://innovation.cms.gov/media/document/aco-reach-rfa.

[4] The Innovation Center Strategy Refresh is available at: https://innovation.cms.gov/strategic-direction-whitepaper.

[5] *See* https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.

[6] *RFA, supra* note 2, at 77.

[7] *Id.* at 67–68.

[8] *Id.* at 79–80.

[9] *Id.* at 75–77.

[10] *Id.* at 13–14.

[11] *Id.* at 81.

[12] CTRS. FOR MEDICARE & MEDICAID SERVS., March 1, 2022 CMS Webinar on the ACO REACH Model (Mar. 1, 2022), https://innovation.cms.gov/media/audio-file/aco-reach-ovw-webinar-recording.

[13] *Id.*

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