SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Changes in the ACO REACH Model

OVERVIEW

On February 24th, the Center for Medicare and Medicaid Innovation (CMMI) announced the redesign of the Direct Contracting program under the new title of "ACO Realizing Equity, Access, and Community Health" (ACO REACH).

For those who are familiar with the GPDC model, the below document summarizes notable changes from the GPDC model to the ACO REACH model. SPG has also prepared a full summary of the ACO REACH RFA, which is available here.

APPLICATION AND ORGANIZATION

Application Process and Timeline

The REACH ACO model will continue through 2026, as GPDC policies will not vary based on the cohort in which the ACO started (2021, 2022, or 2023), so new REACH ACOs will need to begin further along the "glide path" for certain provisions, such as minimum claims reductions under PCC.

New organizations interested in becoming a REACH ACO may apply from March 7th to April 22nd. This is currently the only application window CMMI intends to conduct. Existing DCEs will not need to reapply, but they will need to comply with new ACO REACH requirements. Depending on the volume of applications received, CMMI may choose to limit the total number of selected REACH ACOs.

CMMI seeks to identify applicants with demonstrated success (1) providing direct patient care and/or (2) furnishing high-quality care to underserved communities. It has expanded, updated, and restructured the application questions and scoring to emphasize these qualities.

An approximate crosswalk of the application scoring is below.

GPDC RFA	ACO REACH RFA
Organizational Capacity: 10 points **Leadership and Management**: 20 points	**Organizational Readiness**: 15 points 1. Incorporation, License, and Structure 2. Leadership Team 3. Governing Body 4. Oversight and Representation 5. Information on Expected Participant/Preferred Providers 6. Disclosures 7. Information on Partners/Vendors
Financial Plan and Risk-Sharing Experience: 20 points	**Financial Plan and Risk-Sharing Experience**: 35 points 8. Revenue Sources (clinical and non-clinical) 9. Risk-Sharing Experience 10. Implementation Plan (including health equity)
Patient Centeredness & Beneficiary Engagement: 25 points **Clinical Care**: 25 points	**Clinical Care Model**: 35 points 13. Care Coordination 14. Population Health

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11. Clinical Process Improvement (10 points) 12. Care Coordination (10 points)	15. Care Management 16. Beneficiary Engagement 17. Patient Centeredness 18. Community Engagement
19. Data Capacity (5 points)	**Data and HIT Capability**: 15 points 20. Technical Capability 21. Data and HIT to Inform Clinical Care (including collection of data to address health disparities)

Third Implementation Period

All selected REACH ACOs will be able to participate in an optional third Implementation Period (IP3) from August 1, 2022 through December 31, 2022. Unlike in previous IPs, ACOs will not be able to receive beneficiary-identifiable data during IP3. Instead, ACOs in IP3 will be focused only on conducting voluntary alignment outreach activities to meet their enrollment thresholds. Voluntary alignments received during IP3 will be effective as of January 1, 2023.

Prohibition on Serving Subpopulations Covered by Other Models

REACH ACOs are intended to serve either a "general, heterogeneous population" or a subpopulation that is **not** otherwise covered by a CMMI total cost of care model (whether current or announced). CMMI will not accept ACOs whose participants would be primarily composed of providers who serve such a subpopulation, or whose aligned population is more than 50% composed of individuals in such a population. Currently, the only such model is the KCC model. As such, CMMI will not accept applications from ACOs whose participants would "primarily" be renal disease providers, and an ACO whose aligned population becomes more than 50% composed of individuals with chronic kidney disease (CKD) and/or end-stage renal disease (ESRD) would be subject to remedial action.

Program Integrity and Review

Under ACO REACH, CMMI intends to conduct a more rigorous Program Integrity (PI) screening process. Most requirements remain the same, but some new ones include:

- A requirement for more detailed disclosures of the financial and compliance history of all persons who are owners or controllers, key executives (defined the same way as in GPDC), equity partners, or expected Participant or Preferred Providers in the proposed ACO;
- A requirement to disclose whether any individuals or entities in the applicant's governing body have an ownership interest in the ACO; and
- Potential review of demographic data for program integrity activities. For example, CMS may seek to identify discriminatory behavior in marketing activities.

CMS also outlined a number of additional remedial actions it could take in response to various violations, such as retroactively reversing voluntary alignments that are found to be inappropriate.

Other governance requirements that have been enhanced under ACO REACH include:

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- Each ACO governing body must have a Medicare beneficiary and a separate consumer advocate, each of whom must have voting rights. Beyond this, CMMI "strongly encourages" additional beneficiary participation in advising the ACO.
- At least 75 percent control of the ACO's governing body must be held by Participant Providers or their designated representatives. This is a return to the level of participant governance required for MSSP ACOs and Next Generation ACOs. Like previous models, REACH ACOs may seek an exception from CMS if they demonstrate that they will involve providers in governance.

Under GPDC, CMS provided Stark and Anti-Kickback Law waivers to cover certain activities of participants, and the Anti-Kickback safe harbor for CMS initiatives was also available. However, CMS has not yet determined what fraud and abuse waivers it may issue for REACH ACOs.

MODEL DESIGN

Health Equity Plan

CMMI has established a new requirement that, in PY 2023, all REACH ACOs must develop and implement a Health Equity Plan. CMMI will provide a template for the Plan, which must be used by ACOs. An ACO's plan will:

- Identify health disparities within the ACO's aligned population;
- Define health equity goals; and
- Establish a plan to implement the ACO's health equity strategy, which must include metrics by which to monitor and evaluate progress.

ACOs will then be required to periodically report to CMS on progress implementing their Health Equity Plans.

If the ACO's plan involves actions that involve protected classes of beneficiaries, they will be required to show that the action is necessary, including by submitting substantiating data, and cannot be performed in a protected class-neutral way.

Quarterly Updates

The REACH ACO RFA now incorporates provisions in the GPDC Participation Agreement concerning the ability of CMS to make quarterly updates to monthly capitation amounts (PCC, TCC, or APO).

It also notes that the ACO's defined Service Area may be expanded on a quarterly basis, if new office locations are added, for the purposes of marketing and Prospective Plus voluntary alignment.

Marketing

ACOs may provide marketing materials and hold outreach events to the extent permitted by law, but must submit all such materials and activities to CMS for review. ACOs may not conduct marketing activities to their aligned population to recruit them into MA or other Medicare managed care products. Similarly, they may not target marketing efforts to individuals already enrolled in Medicare managed care.

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Nurse Practitioner (NP) Services Benefit Enhancement

CMS is making a new benefit enhancement available for PY 2023, which allows NPs who are network providers in an ACO to receive a waiver to expand their scope of practice as follows:

- *Hospice*: NPs may provide the initial 90-day certification that a beneficiary is terminally ill and in need of hospice care (the medical director of the hospice would continue to provide periodic ongoing certifications).
- *Diabetic Shoes*: NPs may document and certify that a beneficiary needs diabetic shoes without involvement of a physician.
- *Cardiac Rehabilitation*: NPs may establish, review, and sign written care plans for cardiac rehabilitation.
- *Home Infusion*: NPs may establish, review, and sign a plan of care for home infusion (including the type, amount, and duration).
- *Medical Nutrition*: NPs may refer patients for medical nutrition therapy.

Voluntary Alignment

In recognition of the increasing use of telehealth, ACOs may accept Voluntary Alignment Forms submitted through a patient portal, subject to audit.

If a beneficiary seeks voluntary alignment via both electronic and paper-based, the most recent valid attestation will take precedence. To be "valid," the attestation must have been made within two years of the start of the PY, or the designated Participant Provider must have furnished a PQEM service to the beneficiary in that time period.

During an ACO's Final Financial Settlement, CMMI will retroactively remove any voluntarily-aligned beneficiaries who:

- Did not receive any service from a Participant or Preferred Provider in the ACO; **and**
- Did receive a PQEM service from a provider who is located in the ACO's service area but is not in the ACO.

Clinical Populations for High Needs Population ACOs

The GPDC RFA indicated that High Needs Population DCEs could be further limited to a specific, clinically defined subpopulation, but this text has been removed in the ACO REACH RFA.

Demographic Data Collection

To help CMS monitor health disparities, beginning in PY2023, REACH ACOs will be required to collect and submit beneficiary-reported demographic data on an annual basis. ACOs must seek to collect all elements in the current version of the Core Data for Interoperability standard (USCDI v2), such as:

- Race;
- Ethnicity;
- Language;
- Gender identity; and

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- Sexual orientation.

This data will be used by CMS to monitor health disparities and to compare ACO performance on cost and quality across specific subpopulations of beneficiaries. Beneficiary submission of information is voluntary. ACOs may document a beneficiary's choice not to disclose information (e.g., "Prefer not to say") and receive credit for reporting.

In PY2023, ACOs will be rewarded for successfully reporting this data with a bonus to their Total Quality Score of up to 10 percentage points (which will correspond to as much as 0.2% of the PY Benchmark). The bonus will be determined based on the percentage of beneficiaries with at least 6 months of alignment for whom the ACO successfully reports all required data. The bonus may not cause the Total Quality Score to exceed 100%. There will currently be no penalty for non-submission.

ACOs are also encouraged, but not required, to collect beneficiary-level data on social determinants of health (SDOH), using the CMS-provided questionnaire. CMS expects to include submission of such data as a component of quality performance in future years.

FINANCIAL METHODOLOGY

Quality Withhold

The amount of the quality withhold has been decreased from 5% to 2% of the PY Benchmark, reducing risk related to quality outcomes. For example, for an ACO that scores 90% on its Total Quality Score, this corresponds to regaining 0.3% of the PY Benchmark.

The proposed High Performers Pool (HPP) and continuous improvement/sustained exceptional performance (CI/SEP) quality criteria will be introduced in PY2023 for existing ACOs and PY2024 for new ones. If an ACO is subject to and does not pass CI/SEP criteria, the amount of the quality withhold that it re-earns will be reduced by half.

Global Discount Factor

The phase-in of the discount factor for Global ACOs has been reduced from a maximum of 5% to a maximum of 3.5%. The discount is now:

- **PY 2021-22**: 2% of the Total Benchmark Expenditure
- **PY 2023-24**: 3% of the Total Benchmark Expenditure
- **PY 2025**-26: 3.5% of the Total Benchmark Expenditure

Symmetric 3% Cap on Growth of Risk Scores

For Standard and New Entrant ACOs, CMS will apply a symmetric ±3% cap on changes in risk scores. Under GPDC, the cap applied on a rolling two-year lag. For example, in PY2023, an ACO's average normalized risk score will not increase or decrease by more than 3% compared to that ACO's average normalized risk score in PY2021. Starting in PY 2024, the cap will no longer be applied on a rolling basis. Instead, the ACO's average risk score in that PY will be compared to its risk score in a single static reference year (not yet specified) for the rest of the demonstration. Growth will then be capped to

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±3% compared to that ACO's changes in demographic risk scores (i.e., the component of HCC based on age, sex, Medicaid status, and Medicare eligibility category).

For example, if an ACO's demographic risk score growth is 1% between the reference year and performance year, that ACO's average risk score may not be higher than the reference year's by more than 4% or lower by more than 2%. Since demographic risk scores are unlikely to grow significantly, this would likely limit total risk score growth from PY2024 to PY2026 to be close to 3%.

Under GPDC, High Needs Population entities were not subject to this cap. This is not specified in the ACO REACH RFA. More information will be released in the Risk Adjustment methodology paper.

Other Risk Adjustment Changes

The ACO REACH RFA states that the model-level Coding Intensity Factor (CIF) will continue in PY2023, but does not specify beyond that.

Under ACO REACH, CMS intends to continue monitoring risk scores and may implement additional measures "if an unacceptable level of coding intensity is identified."

Health Equity Adjustment

Starting in PY2023, CMS will apply a flat adjustment to increase the benchmarks of ACOs that serve higher proportions of underserved beneficiaries. Underserved beneficiaries will be measured by a combination of geography and dual eligibility:

- The percentile of the Area Deprivation Index associated with the Census block in which the beneficiary's residence is located (a score between 0 and 99 points); and
- The beneficiary's Medicaid status (25 points).

Scores may thus range from 0 points to 124 points. CMS will stratify all beneficiaries based on this score and assign them to deciles. The adjustment will then be applied as follows:

- For each aligned beneficiary in the top-scoring 10%, an ACO's benchmark will be increased by a flat $30 PBPM. This decile will likely be composed almost exclusively of dual eligibles.
- For any beneficiary in the bottom 50%, an ACO's benchmark will be reduced by $6 PBPM.

In general, almost all Census blocks in New York City outside of the Bronx are ranked below 50 in the Area Deprivation Index. Conversely, most Census blocks upstate are ranked above 50.

Stop-Loss Arrangements

Starting in 2023, the optional stop-loss offered by CMS will consist of residual-based reinsurance. Attachment points will be determined on a beneficiary-specific basis, based on predicted spending for that beneficiary, rather than a fixed point for all high-cost beneficiaries. ACOs will continue to retain liability for a portion of expenditures above each beneficiary's attachment point.

The calculation of the PBPM stop-loss "charge" to the ACO's Performance Year Benchmark will be changed correspondingly, to be based upon the amount of stop-loss that would have been incurred in the ACO's baseline period (i.e., the percent of expenditures in excess of predicted spend above the applicable attachment point for each beneficiary during the baseline period).