



ACO REACH Program

Ivy Dong, FSA, MAAA
914.359.4881 • ivy.dong@wakely.com

Dani Cronick, FSA, MAAA
720.531.6133 • dani.cronick@wakely.com

ACO REACH - Direct Contracting Redesigned with Enhanced Focus on Health Equity

The Innovation Center at the Center for Medicare and Medicaid Services (CMS) has announced that it will be sun-setting the Global and Professional Direct Contracting Model (GPDC) effective January 1st, 2023, and replacing it with a revised program called the Accountable Care Organization Realizing Equity, Access, and Community Health Model, or ACO REACH. The ACO REACH program is intended to target similar participants as the previous Direct Contracting model, along with existing Accountable Care Organizations (ACOs) participating in other risk sharing arrangements, such as the Medicare Shared Savings Program (MSSP). It also intends to attract those who have not previously participated in Medicare FFS or Innovation center models, like provider organizations who have historically taken risk in Medicare Advantage or Managed Medicaid. The goal behind ACO REACH is to improve the quality of care for Medicare beneficiaries, with an enhanced focus on those beneficiaries who are underserved.

While much of the new ACO REACH model resembles the prior Direct Contracting model, participating entities and potential participants should be aware of the new financial program parameters and other model requirements prior to applying for a 2023 start date. The remainder of this whitepaper will discuss the goals and key changes of this new program, as well as the application timeline.

Wakely Consulting Group, along with HMA and its family companies, will release further analyses of the program components when more detail becomes available. A more thorough comparison of the MSSP performance tracks and the ACO REACH model options will also be available in the coming weeks.

Goals of the new ACO REACH program

Along with the rebranding of the program, CMS has announced a new set of goals and objectives for the ACO REACH model to target.

1. **Advance Health Equity** – As the title of the new program suggests, improving health equity within the Medicare space is at the forefront of CMS's goals for this redesigned model. CMS is especially focused on addressing the needs of currently underserved communities and reducing health disparities within their beneficiary populations. Current plans to target this goal include:
 - a. Requiring participating ACOs to submit a Health Equity Plan including details for how they intend to address current health disparities within their aligned population.

- b. Adjusting the financial benchmark to adjust for historical inequities related to geographic and socioeconomic variations in care provided (i.e. benchmark will be increased for ACOs serving higher proportions of underserved beneficiaries).
 - c. Enhancing the data collection requirements for ACOs to include more demographic and social needs data.
 - d. Expanding the services that Nurse Practitioners can provide, to improve access to care in specific underserved communities.
2. **Promote Provider Leadership and Governance** – To enhance CMS’s commitment to the value of provider led patient care, CMS is requiring that 75% of the governing body of an ACO participating in the REACH model must be made of participating providers or their designated representatives. This is an increase from the prior 25% requirement in the previous program.
 3. **Improve Transparency and Protect Beneficiaries** – In order to ensure protection of Medicare beneficiaries, and to ensure program participants are aligned with the CMS vision, CMS will enhance the screening of program applicants. CMS is also altering the risk adjustment provisions within the program to further protect against inappropriate coding practices.



<https://innovation.cms.gov/innovation-models/aco-reach>

Differences between ACO REACH and GPDC

In the following sections we outline the key changes in the ACO REACH model from the GPDC model, based on our interpretation of the CMS released information. The changes are summarized in the following categories:

- Benchmark Determination
- Risk Adjustment
- Stop Loss
- Additional Administrative and Operational Changes

Benchmark Determination

The main structure of the benchmark methodology will be staying the same, including using historical expenditures and regional rates for claims aligned beneficiaries, and using regional expenditures only for voluntarily aligned beneficiaries in their first few years. However, four key changes are introduced in the ACO REACH model with respect to benchmark determination.

First, a health equity adjustment will be applied starting for PY2023. This adjustment will be based on a combination of Area Deprivation Index (ADI) and Dual Medicaid Status. The ADI was developed by the University of Wisconsin and captures the local socioeconomic factors correlated with medical disparities and underservice. At the beneficiary level, the beneficiary’s census block group of residence will be used for the ADI determination (percentile score from 1-100). An additional 25-point increase will be applied if the beneficiary is dully eligible, for a total not to exceed 100. CMS will then stratify all aligned beneficiaries based on this score. The top decile will receive an upward adjustment of \$30 PBPM and the bottom five deciles a downward adjustment of \$6 PBPM.

Secondly, the ACO REACH model reduced the discount rate for Global ACOs to 3% ~ 3.5% in PY2024 through PY2026, from the previous 4% ~ 5% under the GPDC model. For PY2023, the discount rate stays at 3%, as previously determined.

Thirdly, the quality withhold has been reduced from 5% to 2% for PY2023 through PY2026. The entire 2% will be performance-based. The quality measures stay the same.

Lastly, for claims aligned beneficiaries, the weights used for blending historical expenditures and regional expenditures have been changed for PY2023 through PY2025. Both models reach a 50% / 50% blending in PY2026, while the ACO REACH moves faster in decreasing the weight for historical expenditures. The table below shows the weights under the GPDC model and ACO REACH¹.

Table 1 - Composition of the Performance Year Blended Benchmark

Performance Year	GPDC	ACO REACH
2023	65% historical / 35% regional	60% historical / 40% regional
2024	60% / 40%	55% / 45%
2025	55% / 45%	50% / 50%
2026	50% / 50%	50% / 50%

¹ The source of the GPDC weights is the PY2022 Financial Operating Guide. These weights are slightly different for PY2023~PY2025 from those specified in the GPDC RFA released on Nov. 25, 2019. We relied on the PY2022 Financial Operating Guide as more recent information.

Risk Adjustment

The ACO REACH model continues to use the prospective CMS-HCC model for risk adjustment for standard and new entrant ACOs, and a concurrent CMMI-HCC model for high-need ACOs. CMS states the 2020 CMS-HCC model (Version 24) will be used as the prospective model for PY2023, same as PY2021 and PY2022. There are two key changes for risk adjustment, both related to the risk score cap.

The GPDC model uses a DCE-specific +/-3% symmetric cap to limit risk score growth for claims-aligned beneficiaries and continuously voluntarily-aligned members. The average normalized risk score for the DCE in the PY will be constrained to be no more than 3% above or below the DCE's normalized risk score for the DCE-specific reference population. Under GPDC the reference year changes on a rolling basis for each performance year. For example, for PY2022, the reference year is 2020. For PY2023, the reference year is 2021².

The first key change within the ACO REACH model is related to the reference year. Under the ACO REACH, starting in PY2024, a static reference year population will be adopted. CMS states that this change will serve to further restrain risk score growth across performance years for those ACOs exhibiting progressively higher levels of risk score growth over time. CMS has not released any information on which year will be used as the static reference year.

The second key change is the introduction of *demographic risk score growth* in determining the ACO-specific cap. The ACO's demographic risk score growth from the reference year to the performance year will be factored into upper and lower bounds for cap determination. For example, if an ACO's demographic risk score growth is 1%, then the +/- 3% boundaries will be adjusted to -2% and +4%. CMS states that linking the cap to demographic risk score growth, which does not include diagnoses and thus is not subject to inflated reporting of diagnosis information, will more appropriately constrain risk score growth based on the true health status of the beneficiary.

CMS has not specified how the static reference year population or the ACO-specific demographic risk score growth will be determined in the information released so far.

Stop Loss

Starting with PY2023, the ACO REACH Model will make an adjustment to the optional stop-loss arrangement. Rather than using a fixed attachment point across all ACOs and populations, the attachment points will be risk-adjusted to reflect beneficiary risk scores and benchmarks. The optional stop-loss arrangement will instead protect against exposure for high-cost beneficiaries whose healthcare spending exceeds their predicted spending by a certain amount.

² CMS is continuing to monitor the potential impact of COVID-19 on reference year 2021 for applying the symmetric cap.

Similar to the optional GPDC stop loss design, model-wide attachment points will be calculated prospectively using historical data from a national reference population. Instead of using these attachment points directly, they will be adjusted to the beneficiary level using beneficiaries risk scores and the ACO's regionally based benchmarks to form an attachment point for each beneficiary. CMS will continue to require ACOs to retain a portion of the expenditures above the attachment point, as an incentive for ACOs to continue to manage beneficiary expenditures.

Further details regarding the beneficiary-specific attachment point determination has not been released.

Additional Administrative and Operational Changes

Benefit Enhancement

In addition to the Medicare payment waivers allowed under the GPDC model, ACO REACH has added nurse practitioner services as a new benefit enhancement. It allows ACOs to increase flexibility in care delivery and improve care coordination, particularly in areas with limited access to physicians, by allowing NPs to undertake certain responsibilities that they were not able to undertake previously.

Health Equity Plan

Starting in PY2023, CMMI is requiring all ACOs participating in the ACO REACH Model to develop and implement a Health Equity Plan based on the CMS Disparities Impact Statement. Monitoring and evaluating progress of the plan will also be required, to achieve health equity for underserved communities.

Quality and Performance

Beginning in PY2023, ACOs will be required to collect beneficiary-reported demographic data on an annual basis to submit to CMS for purposes of monitoring and evaluating the ACO REACH Model.

In PY2023, CMS is proposing to reward ACOs for successful reporting of beneficiary demographic data by providing a bonus to the ACO's Total Quality Score of up to 10 percentage points. There will be no downward adjustment for non-submission and ACO Total Quality Scores will not be permitted to exceed 100%.

ACO Governing Body

At least 75% control of the ACO's governing body shall be held by Participant Providers or their designated representatives. This is an increase from the 25% control requirement for PY2021 and PY2022 under the GPDC model. The ACO may seek an exception from this requirement, subject to review and approval by CMS.

Applying for ACO REACH

All entities that want to participate in the ACO REACH model in PY2023 are required to submit an application. The application portal will be open beginning on March 7, 2022 and will close on April 22, 2022.

CMS has defined a voluntary implementation period leading up to PY2023 (referred to as 'IP3'). IP3 will begin August 1, 2022 and run through December 31, 2022. All applicants accepted for PY2023 can choose to participate in IP3 to conduct voluntary alignment activities in preparation for meeting the applicable beneficiary alignment minimum at the start of PY2023. While the participant providers will be established for IP3 for conducting voluntary alignment activities, no beneficiaries will be aligned to the ACO for IP3, either through voluntary or claims-based alignment. ACOs participating in IP3 do not take financial risk or receive any beneficiary-identifiable data during IP3.

For current GPDC participants, they need to maintain a strong compliance record in 2022 and agree to meet all the ACO REACH requirements beginning January 1, 2023 in order to participate in the ACO REACH Model.

Conclusion

The ACO REACH Model builds upon prior CMS/CMMI value-based arrangements and aims at advancing health equity, a pillar in the CMS strategic vision. The imminent opening of the PY2023 application window provides an opportunity for ACOs and other organizations currently not in the GPDC program to apply, with the goals of improving quality of care and care coordination for patients in Traditional Medicare, especially for patients in underserved communities. Existing GPDC participants should carefully assess and ensure compliance with changed requirements to continue participating in PY2023. Similar to any other model, organizations intending to apply to ACO REACH need to carefully assess the opportunity, risks, and organizational readiness before participating.

Wakely Consulting Group, along with HMA and its family companies, will be releasing further whitepapers and briefs as more detailed information around this new program is released. The organization will also be hosting an upcoming webinar on ACO REACH. Please stay tuned for further information.

Please contact Ivy Dong at ivy.dong@wakely.com or Dani Cronick at dani.cronick@wakely.com with any questions or to follow up on any of the concepts presented here

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

We go beyond the numbers

Learn more about Wakely Consulting Group at www.wakely.com