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ALERT • Health Care

March 3, 2022

REACH-ing for Something New: CMMI DCE Model to Be Replaced by new ACO Model – Understanding the Key Differences

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On February 24, 2022, the Center for Medicare & Medicaid Innovation ("CMMI") at the Centers for Medicare & Medicaid Services ("CMS") announced a redesigned accountable care innovation model focused on achieving health equity through the use of accountable care organizations ("ACOs"). The revised model, which will take effect January 1, 2023, will be called the Accountable Care Organization Realizing Equity, Access, and Community Health Model (the "ACO REACH Model"). CMMI has released a Request for Applications.

The ACO REACH Model will replace the politically polarizing Global and Professional Direct Contracting Model (the "GPDC"). The current time frame to apply to participate in the ACO REACH Model is from March 7, 2022 to April 22, 2022; however, existing Direct Contracting Entities ("DCEs") may participate in the ACO REACH Model without reapplication, and will become "ACOs" under the new program if they have a strong compliance record in the GPDC and agree to meet the requirements of the ACO REACH Model before January 1, 2023 through execution of an Amended and Restated Participation Agreement with CMS.

This Alert outlines the fundamental differences between the models, including administrative burdens, legal risks and practical considerations key to understanding the new model.

Key Features of the ACO REACH Model

The new model builds upon predecessor ACO models and includes several aspects of the GPDC, including Standard, New Entrant, and High Needs tracks. It will also continue for the term originally contemplated for the GPDC, concluding at the end of calendar year 2026. Several other policies, recently thought to be at risk, remain unchanged, including (i) no caps on the number of participating providers or aligned beneficiaries, and no geographic constraints; (ii) no limitation on who can own or fund an ACO (which would allow private equity sponsors, insurers, health care providers and others to participate), although it will continue to be important to demonstrate a proven experience/track record related to managing patients (see below discussion on "Application"); and (iii) the opportunity for an ACO to participate in full capitation without any minimum savings rate ("MSR) or minimum loss rate ("MLR").

In addition to the changes noted below, CMMI has provided a detailed comparison table of the ACO REACH Model and GPDC, available here, and hosted a webinar on March 1, 2022 to discuss the changes presented by the transition to the ACO REACH Model. Presentation slides from the CMS webinar are available for download here.

Five key features of the ACO REACH Model, distinct from the GPDC, include the following:

1. **Governance.**

   i. The ACO REACH Model requires that participating providers or their appointees control 75% of the ACO's governing body, an increase over the 25% requirement under the GPDC but consistent with CMS requirements for the Medicare Shared Savings Program ("MSSP") and other shared savings initiatives, such as the Kidney Care Choices Program. The ACO Reach Model will also require the ACO's governing body to include two separate individuals to serve as Medicare beneficiary representative and consumer advocate, and that each of these representatives has voting rights. Importantly and as noted above, CMMI has not foreclosed ACO ownership by strategic investors or insurance companies, but, with these changes, CMMI has signaled an expectation that entity governance should rest with providers and patient stakeholders.

2. **Health Equity.**

   i. The ACO REACH Model introduces a health equity benchmark adjustment to support care delivery for underserved communities that will impact the ability of a participating ACO to achieve shared savings.

   ii. ACOs must develop a health equity plan that identifies underserved communities and implements initiatives to "measurably reduce" health disparities within beneficiary populations. A template health equity plan will be provided to current DCEs based on the form CMS Disparities Impact Statement. This is the second CMMI program to require the implementation of a health equity plan (the first being the Accountable Health Communities Model). CMMI indicated that it will issue additional guidance on meeting the health equity plan requirements.

   iii. ACOs will also be required to collect beneficiary-reported demographic and social needs data, and CMMI has indicated it will utilize health equity questions in applications and scoring criteria as part of the review process.

3. **Increased Screening and Monitoring.**

   i. The ACO REACH Model introduces stronger beneficiary protections with increased screening and monitoring of applicants and participants. For example, CMMI is focused on collecting more information on an applicant's leadership, ownership, and governing board members, with the focus on ownership and financial interests and affiliations reviewed as a means for CMS to ensure alignment with its vision.

   ii. ACOs will be subjected to additional monitoring and compliance efforts focusing on ACO risk score growth, changes in beneficiaries' access to care, audits of provider contractors to monitor downstream arrangements, review of marketing and online materials, and noncompliance with prohibitions against anti-competitive practices and misuse of beneficiary data. Practically, this means there will be additional audits and documentation requirements, leading to additional administrative requirements, in order to comply with the new model as opposed to the GPDC. ACOs that enter the program will need to ensure they have the qualified personnel and/or contractors to assist with the new requirements.

4. **Risk Score Growth Cap.**

   i. The ACO REACH Model implements two changes to the risk score growth cap to mitigate potentially inappropriate risk score gains: (i) adoption of a static reference year population; and (ii) capping ACO risk score growth relative to ACO demographic risk score growth in determining the ACO-specific 3% risk score cap thresholds. For example, if an ACO's demographic risk score growth from the reference year to the performance year is +1%, then the symmetric 3% risk score cap will constrain growth between -2% to +4%. By keeping the reference population the same for the duration of the model for purposes of risk score growth, CMMI is significantly limiting an ACO's ability to increase risk scores year over year, which may harm ACOs with high-risk beneficiaries who may experience significant health changes over the term of the model. ACOs may need to make changes to their Participant Provider lists to prevent a negative impact to their benchmarks.

5. **Additional Financial Changes.**

   i. CMMI is modifying the discount applied to Global ACOs, capping it at 3.5% rather than the 5% cap that applies to Global DCEs. The discount will be applied to the ACO's benchmark before gross savings (or losses) are calculated. CMMI hopes the lower cap will further its goal of increasing participation in full-risk fee-for-service initiatives.

ii. CMMI is also reducing the quality withhold for both Professional and Global ACOs from the GPDC 5% withhold to 2%. This is a positive change (from the DCE program) as it effectively means more upfront funding for ACO activities.

Considerations for Existing Participants

The ACO REACH Model shifts the GPDC towards the operational principles underlying the MSSP and Next Generation ACO Model. DCEs have a short window to determine whether the ACO REACH Model is the right fit for their provider network and whether they will continue to participate. For instance, should a DCE wish to convert to the MSSP, rather than proceed with the ACO REACH Model, the DCE will likely need to apply for the MSSP by June 2022, although CMS has not yet announced an application deadline for ACOs wishing to have a January 1, 2023 start date. These and other key considerations should be carefully evaluated with Ropes & Gray or other outside counsel.

1. Operational. DCEs must consider whether they can achieve appropriate oversight over their business and care model while shifting control of their governing body. DCEs must also consider whether they are able to re-design their existing processes to capture and achieve on the health equity benchmark adjustments and new risk adjustment constraints contemplated by the ACO REACH Model while managing financial benchmarks of the current GPDC performance year. Under the ACO REACH Model, ACOs should expect CMMI to be more aggressive in its auditing and monitoring of participating ACOs to ensure that the agency achieves the model goals. DCEs will be served well to further invest in existing compliance resources, compliance training, and compliance personnel to ensure strict adherence to all ACO REACH Model requirements.

2. Financial. CMMI is not expected to publish detailed financial methodology papers for the ACO REACH Model until Summer 2022. However, there are three key changes to the financial methodology that have been announced, two of which alleviate some of the financial risk presented by the GPDC. First, the discount applied to the benchmark of Global ACOs will be reduced for performance years 2024 through 2026, down to 3% (-1%) for 2024 and 3.5% (-1.5%) for 2025 and 2026. The discount will remain at 3% for 2023. Second, the quality withhold applied to the quality score benchmark for shared savings is being decreased from 5% to 2% for PY2023 through 2026. Third, the re-designed cap on risk score growth, which is intended to ensure that risk scores within the ACO REACH Model do not grow faster than the risk scores in all of traditional Medicare, may impact current DCEs that have particularly high-cost populations. The extent of that impact warrants further financial assessment and review of health equity adjustment opportunities.

The changes offered by the ACO REACH Model present unique opportunities for well-positioned DCEs that want to proceed with participation in the model. The revamped model may also prove more accessible to experienced ACOs currently participating in MSSP or otherwise sitting on the sideline. Whether those opportunities are the right fit for a given DCE, however, is organization-specific; this is not a one-size-fits-all model.

If you have any questions, are considering application to the ACO REACH Model, or transitioning a DCE to the ACO REACH Model, please do not hesitate to contact the authors or your usual Ropes & Gray advisor.