ROPES & GRAY

ALERT

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What ACO Leaders Need to Know: Implications of the Differences in the 2023 Reach Participation Agreement

In December of 2022, CMS released the 2023 Accountable Care Organization Realizing Equity, Access and Community Health ("ACO REACH") Participation Agreement (the "2023 Agreement.") The summary below highlights key differences in the Agreement compared to its predecessor, the 2022 Global and Professional Direct Contracting Model ("GPDC Model") Agreement (the "2022 Agreement").

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I. Overview

The 2023 Agreement imposes certain new requirements that operationalize the transition from the GPDC Model to the ACO REACH Model, including more detailed governance requirements and an explicit focus on health equity. In addition, CMS has made changes to the ACO REACH financial methodology (*e.g.*, changes to the risk adjustment process) and has expanded its enforcement powers, particularly as it relates to the Beneficiary alignment process. Capitalized terms used but not defined shall have the meaning given to them in the 2023 Agreement.

The table below enumerates key differences[1] between the 2022 Agreement and 2023 Agreement, each of which is addressed in the summary that follows.

Table 1. Key Changes in 2023 Agreement

Section(s)	Description	Page Numbers in 2023 Agreement
Key Organizational and Governance Changes		
3.02(A-B)	Governing Body Composition and Control Requirements.	16–17
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II. Summary of Key Changes

a. Key Governance and Organizational Changes

1. **Governing Body Composition and Control Requirements [Sections 3.02(A-B)]:** The 2023 Agreement updates the requirements for the composition and control of the ACO Governing Body. The Governing Body must now include two separate individuals to serve as Consumer Advocate and Beneficiary Representative (in prior years, a single individual could serve both roles) and must afford both individuals voting rights.[2] Additionally, individual Participant Providers (or their designated representatives) must hold at least seventy-five percent (75%) control of the ACO governing body, increased from twenty-five percent (25%) in prior years.[3] The 2023 Agreement also includes new limitations on who may serve as the designated representative of an individual Participant Provider: only "entity" Participant Providers may appoint a designated representative, and the representative must be "an individual employed by or under contract with, the Participant Provider entity."[4] CMS has made clear that Participant Providers may not designate external third parties (including external legal consultants or investor groups) as their representatives.

   Additionally, CMS revised the methodology for calculating percent control to include the Beneficiary Representative and Consumer Advocate in both the numerator and the denominator.[5] Previously, the calculation excluded both individuals from the calculation altogether; depending on the size of a particular ACO's Governing Body, this change could have a significant impact on the control calculation.[6] Finally, CMS has added a new requirement that the ACO's Governing Body must "implement a process for documenting governing body composition, meetings, and decisions," which are subject to the existing document retention requirements set forth in Section 16.02 of the 2023 Agreement.[7]

2. **Ownership Restrictions [Sections 3.03(C-E)]:** The 2023 Agreement imposes new restrictions on who may own ACO entities operating in the same ACO Service Area (which CMS defines to include (i) the counties in which the ACO's Participant Providers have physical offices (the "Core Service Area"), and (ii) all adjacent counties as identified by CMS (the "Extended Service Area").[8] Specifically, no individual or entity that holds an ownership interest in a Standard ACO or New Entrant ACO may hold an ownership interest in a High Needs Population ACO that is participating in the ACO REACH Program and operates in the same ACO Service Area and vice versa.[9] The 2023 Agreement also provides an explicit definition of ownership interest, which includes (1) direct or indirect ownership interests (or a combination thereof) equal to at least 5 percent (5%) or more in the ACO REACH entity, or (2) an ownership interest of at least five percent (5%) in any obligation (*e.g.*, a mortgage) secured by an ACO REACH entity if that interest equals at least five percent (5%) of the value of the property or assets of the ACO REACH entity.[10]

b. Key Programmatic Changes

1. **Individuals/Entities Ineligible to be added as Participant Providers during a Performance Year [Section 4.03(A)]:** The 2023 Agreement enumerates four categories of individuals/entities that CMS will not accept as mid-Performance Year additions to the Participant Provider or Preferred Provider lists: (1) individuals/entities that bill under a TIN participating in the Medicare Shared Savings Program or any other Medicare initiative that involves shared savings and identifies participants by an entire TIN, (2) individuals/entities identified by a TIN/NPI combination participating in the Kidney Care Choices Model, the Vermont Medicare ACO Initiative, another REACH ACO, or any other Medicare initiative that involves shared savings and identifies participants by a TIN/NPI combination, except as otherwise specified by CMS, (3) individuals/entities identified by a TIN/NPI combination participating in the Maryland Total Cost of Care Model, and (4) individuals/entities identified by a TIN/NPI combination participating in the Primary Care First Model or the Independence at Home Demonstration.[11]

2. **Health Equity Plan [Section 5.10]:** Beginning in Performance Year 2023, each ACO must submit to CMS a Health Equity Plan. The plan must identify one or more "Target Health Disparities" (disparities experienced by underserved communities among the ACO's population) and identify specific initiatives to reduce these disparities. The Health Equity Plan must also include a gap analysis to identify resources the ACO will need to implement the interventions, establish a project timeline, identify quantitative performance measures, and identify annual performance year goals.[12] CMS must approve the initial plan and any subsequent amendments thereto.[13] Beginning in Performance Year 2024, each ACO must submit a progress update that includes updated outcomes data based on the specified performance measures, updates to the gap analysis, and updates to the project plan. CMS may take any of the remedial actions authorized by Section 17.01 of the 2023 Agreement in the event that the update to the Health Equity Project Plan does not satisfy the requirements of the 2023 Agreement or other CMS Guidance, does not demonstrate that the Health Equity Plan is likely to accomplish the ACO's stated Health Equity Goals or otherwise jeopardizes program integrity or Beneficiary access to care.[14]

3. **Demographic and Social Determinants of Health Reporting [Sections 9.04(H), 13.01(D)]:** Consistent with the ACO REACH program's focus on health equity, the 2023 Agreement introduces a requirement that each ACO "collect and report to CMS demographic and social determinants of health data." The ACO "shall make a reasonable effort to collect [such data] from all REACH Beneficiaries." Should a Beneficiary decline to provide the requested data, the ACO must indicate this response in its report to CMS. Per the 2023 Agreement, CMS separately will specify requirements for the substance of the reports and the time/manner of their submission. CMS will also implement a Health Equity Data Reporting Adjustment, which will adjust an ACO's total quality score for each Performance Year. In 2023, CMS will make an upward adjustment for complete reporting but will not make any downward adjustments to the total quality score.

4. **Nurse Practitioner and Physician Assistant Services Benefit Enhancement [Section 10.12, Appendix T]:** Starting in Performance Year 2023, an ACO may elect to offer a new benefit enhancement, which permits nurse practitioners and physician assistants that meet CMS eligibility requirements to provide certain services to ACO REACH Beneficiaries that ordinarily would need to be provided by a physician, including: (1) certifying a Beneficiary as terminally ill for hospice care; (2) certifying a Beneficiary's need for diabetic shoes; (3) establishing, reviewing, and signing an individualized cardiac rehabilitation care plan; (4) establishing a plan of care for home infusion therapy; and (5) referring a Beneficiary for medical nutrition therapy services.[15] In order to obtain reimbursement for such services, the Beneficiary must be aligned to the ACO (or have been aligned within the last 90 days).[16] As with all Benefit Enhancements, the ACO must elect to participate at the time specified by CMS, must submit an implementation plan to CMS, and timely submit a list of the Participant and Preferred Providers that have agreed to participate in the benefit enhancement.[17] CMS must approve the list of providers, and upon notification from CMS that a particular provider is ineligible to participate, the ACO must remove the

provider from the list within 30 days.[18] CMS also has extended AKS safe harbor protection to cover certain refunds that an ACO may be required to issue to a beneficiary pursuant to the benefit enhancement.[19]

5. **Additional Primary Care Services for Beneficiary Alignment [Appendix A]:** The 2023 Agreement includes additional procedural codes ("CPT Codes") to the list of Primary Care Services considered during the Beneficiary Alignment process.[20] In particular, the 2023 Agreement adds new codes for Principal Care Management to its list of Telephone Visit (Online Digital or Audio Only) services,[21] and adds (or, in some instances, clarifies) the proper CPT codes for certain Chronic Care Management services.[22] Notably, this addition of CPT Codes may increase the amount of Primary Care Capitation received by ACOs participating in that payment arrangement.

c. Key Compliance and Oversight Changes

1. **Beneficiary Marketing Restrictions and Retroactive Reversal of Beneficiary Alignment [Sections 5.04(F); 5.04(J)]:** The 2023 Agreement includes a new prohibition against ACOs (and Participant/Preferred Providers or other individuals/entities engaged in ACO Activities or Marketing Activities) targeting communications related to Medicare Advantage or other Medicare Managed Care Plans towards ACO REACH Beneficiaries.[23] Significantly, in the event that an ACO falsely certifies compliance with program marketing requirements, CMS may retroactively reverse alignment of Beneficiaries that occurred solely due to Voluntary Alignment; while this authority existed in the 2022 Agreement, the 2023 Agreement expands this authority to permit CMS to retroactively reverse the alignment of Beneficiaries aligned during the Performance Year via Prospective Plus Alignment.[24] Unlike the 2022 Agreement, however, the 2023 Agreement also permits CMS to retroactively reverse the alignment of Beneficiaries that were aligned through claims-based alignment but does not provide an example of when this authority would be exercised.[25]

2. **Restrictions on the use of Beneficiary-Identifiable Data [Section 6.02(E)]:** CMS affords ACOs a mechanism to request Beneficiary-identifiable data (*i.e.*, data subject to HIPAA), such as Beneficiary alignment data, risk adjustment data, and claims data. While the 2022 Agreement restricts the use of such data to care management, care coordination, quality improvement activities, and similar population-based health activities, the 2023 Agreement makes the prohibition more explicit and expressly prohibits ACOs from using such data to conduct "communications or activities related to Medicare Advantage or any other Medicare managed care plan."[26]

3. **Dispute Resolution Mechanism [Section 18.02(D)]:** Pursuant to the 2022 Agreement, an ACO could request reconsideration of a CMS decision that would be mitigated by a "Reconsideration Official" whose decision was final. The 2023 Agreement adds an additional layer of review whereby either the ACO or CMS may request review of the Reconsideration Official's decision by the CMS Administrator; such a request must be submitted within 30 days of receipt of the Reconsideration Official's decision, and the decision whether to review the request is left to the discretion of the CMS Administrator.[27] If the CMS Administrator grants a request for review, both parties will be permitted to submit a brief, and the record will otherwise consist of the evidence previously submitted to the Reconsideration Official.[28] The decision of the CMS Administrator will be final and binding.[29]

d. Key Financial Methodology Changes

1. **Demographic Risk Score [Appendix B(IV)]:** Beginning in 2024, CMS is implementing two changes to the model's risk adjustment methodology:

(1) The risk score calculation will be modified to a Demographic Risk Adjustment Model, which accommodates changes in the demographic characteristics of each ACO's aligned population over time. CMS will calculate risk scores using the demographic risk score model currently applied to the Medicare Shared Savings Program (MSSP). This model predicts beneficiary expenditures using demographic variables that include age, gender,

original reason for entitlement code (OREC), and Medicaid dual status; there are no HCCs in the model specification.

(2) The risk score growth cap for PY2024 will shift from a rolling reference year to a static reference year for growth rate calculations. For 2023, the risk score growth cap will continue to be applied for each Performance Year relative to an annual rolling risk score reference year (reference year = 2021). However, for PY2024 the reference year will be static for growth rate calculations, and the growth cap reference year for PY2024, PY2025, and PY2026 will be 2022 in all cases.

2. **Quality Withhold [Appendix B(V)(B)]:** Beginning with PY2023, CMS will reduce from 5% to 2% the quality withhold applied to an ACO's Performance Year Benchmark. For the remainder of the model, the 2% quality withhold will be tied to quality performance, with all measures evaluated as "pay-for-performance."

3. **Discount [Appendix B(V)(C)]:** CMS is implementing a reduction in the mandatory "discount" applied to Global ACOs. Instead of applying a discount that was set to grow to 5% of an ACO's Performance Year Benchmark, the discount will be set at 3% for PY2023–PY2024 and increase to 3.5% for PY2025–PY2026.

4. **Health Equity Benchmark Adjustment [Appendix B(V)(E)]:** Starting with the 2023 Performance Year, CMS has altered the ACO benchmark calculation to incorporate a "Health Equity Benchmark Adjustment." CMS will calculate the Health Equity Benchmark Adjustment by assigning each Beneficiary an "Equity Score" based on the Beneficiary's area deprivation index (a function of the Beneficiary's residence) and Medicaid eligibility.[30] The ACO's Health Equity Benchmark Adjustment will be determined based on a formula that, in essence, rewards ACOs based on the number of Beneficiaries with Equity Scores at or above the 90th percentile of Equity Scores among Beneficiaries aligned to any REACH ACO in the applicable Performance year, and penalizes ACOs for the number of Beneficiaries with Equity Scores at or below the 50th percentile of all REACH ACO Beneficiaries.[31] Specifically, for each aligned beneficiary, a beneficiary-month level benchmark adjustment is calculated based on these percentile scores. For each aligned month for each beneficiary with a score in the 90th+ percentile, CMS will add $30 to the ACO benchmark; for each month for each beneficiary scoring below the 50th percentile, CMS will deduct $6 from the ACO benchmark. This adjustment will apply to an ACO's Benchmark after the Retrospective Trend Adjustment, Discount, Quality Withhold, and Retention Withhold, as applicable.

5. **Financial Settlement / Stop Loss Adjustments [Appendix B(VI)]:** ACO REACH will continue to include two cost-mitigation policies: (1) risk corridors; and (2) stop-loss insurance. While there are no changes to the mandatory risk corridors policy, CMS made significant revisions to the optional stop-loss insurance.

   Starting in PY2023, the attachment points will be based on *expenditure residuals*, which is the difference in actual total spending and a predicted spending value, calculated for each beneficiary based on regional spending and beneficiary risk scores. Specifically, the Stop-Loss Residual Expenditure is comprised of two components—the Performance Year Expenditure a beneficiary accrues over the course of the Performance Year and the predicted expenditure for the beneficiary in the Performance Year. The predicted expenditure will be calculated as the Performance Year Ratebook Rate (based on county of residence) for the beneficiary, times the beneficiary risk score, times the total months of enrollment in the Performance Year. The stop-loss payout is the amount of the expenditure residual that surpasses the attachment point.

   CMS will continue to apply a per-beneficiary-per-month stop-loss "charge" to the ACO's Performance Year Benchmark. This charge is based on the percent of expenditures above each of the ACO's attachment points in the baseline period.

1. This summary does not address every difference between the 2022 Agreement and the 2023 Agreement. For a complete list of changes, please refer to the CMS correspondence dated December 6, 2022 (Subject: "Updated: Sharing the Final ACO REACH Model Participation Agreement for PY 2023 Starters") and the accompanying redline comparing the 2022 and 2023 Agreements.
2. 2023 Agreement Sections 3.02(B)(1-2).
3. 2023 Agreement Section 3.03(B)(6).
4. *Id.*
5. *Id.*
6. For example, under the 2022 Agreement, a five-member Governing Body composed of one participant provider, a Beneficiary Representative, a Consumer Advocate, and two other individuals would have been considered to have 33% control by participant providers. Under the 2023 Agreement, the exact same board would be considered to have 60% control. Also see here for CMS issued comparison chart of the differences between the ACO REACH and GPDC Model requirements.
7. 2023 Agreement Section 3.02(A)(4).
8. 2023 Agreement Sections 5.04(H)(2-3).
9. 2023 Agreement Sections 3.03(C-D).
10. 2023 Agreement Section 3.03(E).
11. 2023 Agreement Section 4.03(A)(9)
12. 2023 Agreement Section 5.10(A).
13. 2023 Agreement Section 5.10(B).
14. 2023 Agreement Section 5.10(H).
15. 2023 Agreement Appendix T(II).
16. 2023 Agreement Appendix T(II-III).
17. 2023 Agreement Appendix T(I).
18. 2023 Agreement Section 10.12(C).
19. 2023 Agreement Sections 5.08(B), 5.08(E), and Appendix T(IV)(B)(4).
20. 2023 Agreement Table E.
21. The additional CPT Codes include 99424-99427, and 99437.
22. The newly clarified CPT Codes include 99421-99425, and the newly added CPT code is G2058.
23. 2023 Agreement Section 5.04(F).
24. 2023 Agreement Section 5.04(J)(3).
25. 2023 Agreement Section 17.01(A)(17).
26. 2023 Agreement Section 6.02(E).
27. 2023 Agreement Sections 18.02(D)(1); 18.02(D)(3)(a).
28. 2023 Agreement Sections 18.02(D)(3)(b); 18.02(D)(5)(a)
29. 2023 Agreement Section 18.02(D)(5)(c).
30. 2023 Agreement Appendix B(V)(E)(3).
31. 2023 Agreement Appendix B(V)(E)(4-7); note that the formula also accounts for the number of months each Beneficiary was aligned to the ACO during the Performance Year.