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ACO REACH MODEL:

IMPLICATIONS FOR PROVIDERS AND PLANS

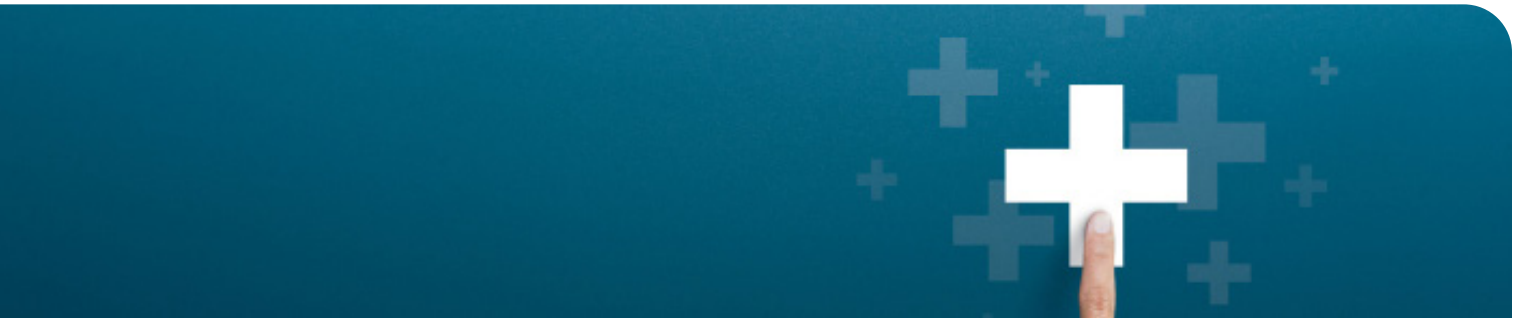
The Centers for Medicare and Medicaid Services (CMS) Innovation Center recently provided long- awaited clarification on the status of the Direct Contracting program. CMS has formally canceled the Geographic Direct Contracting Model (Geo) and is phasing out the Global and Professional Direct Contracting Models (GPDC) at the end of 2022. Current program participants will automatically transition to the newly created ACO REACH (Accountable Care Organization Realizing Equity, Access, and Community Health) Model (assuming they meet new model requirements). CMS has issued a Request for Applications (RFA) for new participants to enroll in the ACO REACH Model beginning in Performance Year 2023. The RFA will open on March 7, 2022, and applications are due April 22, 2022.

CONSIDERATIONS FOR PROVIDERS

CMS has indicated that (at this time) this will be the only application round for ACO REACH, which runs through the 2026. While the Innovation Center could change this approach, it creates an imperative for organizations to quickly respond to the Application, though the seven-week window will make it very difficult for organizations to respond "from scratch" without considerable effort and resources.

Organizations that were considering applying to the second Application round of GPDC should review their previous Application and identify programmatic model changes that will require updates to their original responses (see Five Critical Things to Know About ACO REACH below). For other interested organizations, the most expedient path is to evaluate partnership options with existing Direct Contracting Entities (DCEs).

The ACO REACH Model represents an opportunity for provider groups to capture risk-aligned economics related to improved healthcare quality and lower cost. For hospitals and health systems, it represents an opportunity to partner with such provider groups to focus on high acuity referrals while relieving staffing and financial pressures for lower-acuity patient volume.



CONSIDERATIONS FOR HEALTH PLANS / NON-PROVIDER ORGANIZATIONS

While health plans and non-provider organizations are not able to contract directly for this Model, it is essential to consider the strategic implications of the ACO REACH Model in the local market. For example:

- Which provider groups / systems might consider participation in the ACO REACH Model given current capabilities and sophistication related to risk assumption and participation in existing CMS programs (e.g., Primary Care First, Medicare Shared Savings Program)?
- What is the role of health plans to enable strategic alignment to critical provider partners and overall value-based payment strategies?
- What is the impact of the ACO REACH Model on the health plan's existing government program lines of business?

Furthermore, health plans that have a provider affiliate / subsidiary could enter the program directly through this avenue, assuming ACO REACH program requirements are met.

Five Critical Things to Know About ACO REACH

1. Governance Changes

In evolving to ACO REACH, CMS has signaled that it desires provider participation and governance. For example, governance requirements have increased to Participant Providers maintaining 75% control of the ACO's governing body (vs. 25% under GPDC). In ACO REACH, governing boards must include a beneficiary representative and consumer advocate, and they must be different people with voting rights (vs. same person and no voting rights under GPDC). Non-provider groups may seek an exception by demonstrating innovative ways of involving Participant Providers in ACO governance.

2. Transformation through Primary Care

CMS clarified its intent that ACO REACH is a primary care-focused program, which aligns with its overall strategy to reform healthcare delivery through the redesign of primary In the RFA, CMS is explicit that organizations with 50% of beneficiaries with conditions targeted by other CMS initiatives (e.g., kidney care) or whose Participant / Preferred Providers are specialists will not satisfy the requirements of the ACO REACH Model.

3. Emphasis on Health Equity

Given CMS's strategic refresh, one of the prominent features of the ACO REACH Model is the promotion of and requirement for health equity. With this emphasis, existing DCEs who wish to transition to ACO REACH or new program participants must have capabilities related to health equity, including the creating a Health Equity Plan and collecting and reporting on beneficiaries' social determinants of health information. Such activities will represent development of new capabilities and expansion of monitoring capabilities for many organizations.

4. Medicare Advantage (MA) Scrutiny

CMS has indicated that one of its mechanisms to strengthen compliance and monitoring of ACOs will be an annual assessment of beneficiaries shifting into or out of Medicare Advantage. While CMS has not provided any benchmarks that would trigger action or the resulting enforcement, it is a clear warning to organizations that viewed Direct Contracting as an opportunity to grow affiliated / owned MA business.

5. Capping Risk Score Adjustments

CMS announced two critical changes for risk adjustment; both seek to prevent abuse or gaming. Under the ACO REACH Model, CMS will adopt a static reference year population to impede risk score growth across performance years and a "demographic risk score growth" measure to restrict risk score growth based on the veritable health status of beneficiaries. These changes will place greater emphasis on ACOs' ability to effectively manage medical cost for favorable program economics.

We have partnered with healthcare organizations to evaluate, design and launch programs enabling the shift to value-based care. We are happy to share our perspectives and discuss the implications that ACO REACH Model may have on your organization and market.

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