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ACO REACH Model Program Updates – 'Do Nothing' is Not a Strategy

The Centers for Medicare and Medicaid Services (CMS) Innovation Center recently introduced the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model as a redesign of the Global Professional Direct Contracting Model (GPDC). The move represents the Biden administration's first major push to advance its revised strategic priorities particularly around health equity, primary care and risk assumption.

In this update, we summarize recent program updates from CMS and examine the strategic implications for multiple stakeholders, including health plans.

ACO REACH – A Refresher

The stated program goals of ACO REACH are to:

1. Promote health equity and addressing healthcare disparities for underserved populations
2. Continue the momentum of provider-led organizations participating in risk-based models
3. Protect beneficiaries in Original Medicare and the model with more participant vetting, monitoring and greater transparency

Our previous Executive Brief provides an overview of the ACO REACH program and highlights the critical differences between the GPDC and ACO REACH models.

Provider organizations can form REACH ACOs with different participant options based on history / experience serving Medicare beneficiaries and health status of the population served. These REACH ACOs assume risk (either partial or full depending on the risk sharing option selected) for the cost of care for their aligned beneficiaries against an established program benchmark. The program is set to begin on January 1, 2023 and run for four Performance Years through 2026.

Highlights from the ACO REACH Application

Responses to CMS' Request for Applications (RFA) were due April 22nd and CMS issued an announcement with high-level results of the application process. It does not appear that CMS will publicly provide names until entities either sign the Participation Agreement or submit to the Implementation Period Agreement (August 2022).

Program Acceptance and Selection Statistics

~50% accepted

Of the 271 applications received, **CMS provisionally accepted 128.**

80% applied for the **global risk option**

~80% of the **Standard ACOs** that were selected applied for the global risk option (bearing 100% of risk) **vs. 45% of New Entrants and 70% of High Needs.**

Management Services Organizations

The **largest cohort of applicants** (45% of those completing applications and 42% of those accepted) self-reported as **"Management Services Organizations (MSOs) / conveners"** which are defined as organizations that do not include Medicare beneficiaries but instead provide administrative / support services to facilitate the participation of Medicare enrolled providers in value-based care.

Independent Physician Associations

Independent Physician Associations (IPAs) formed the next largest group of completed applications (23%) and **account for ~30%** of those **provisionally accepted.**

Standard ACO

~60% of applications were for the Standard ACO with the remaining split evenly between New Entrant ACO and High Needs Population ACO. A slightly higher number of Standard ACOs were accepted vs. the percentage that applied for the program.

While **10% of medical group practices** completed applications, **only 5% were selected.**

Insights

With only a ~50% acceptance rate, CMS established a high level of rigor for program selection and / or received a high number of unqualified applications. The lower percentage of New Entrant ACOs that were accepted vs. those that applied supports that CMS required strong demonstration of capabilities and / or proof points to be selected as a REACH ACO.

The preponderance of MSO / convener organizations receiving provisional selection signals the continued trend of larger scale organizations having interest in this program and the importance of scale to be successful given the requirements of the program.

Most REACH ACOs sought full risk assumption (with the exception of New Entrants) demonstrating that many organizations have made investments in medical management capabilities and are seeking greater opportunities to monetize this investment over a larger population.

Program Next Steps and Strategic Implications

Organizations fall into three cohorts:

1. Program participants (i.e., REACH ACOs provisionally accepted into the program and GPDC Direct Contracting Entities [DCEs] expected to meet new program requirements)
2. Aspirational REACH ACOs (i.e., applied but were not accepted)
3. Non-participants

We summarize the implications and next steps for each of these cohorts below.

1 ACO REACH Program Participants

Of critical importance for provisionally accepted ACOs are the program deadlines to add both Participant and Preferred Providers for PY2023 by August 4, 2022 and to drop either type of provider by September 9, 2022. Given the ability to drop (but not add) providers, REACH ACOs may cast a wide net to identify preliminary Participant / Preferred Providers.

REACH ACOs will need to develop a comprehensive program plan and management strategy to ensure that all components required for successful execution of the ACO REACH model are in place for PY2023 with particular emphasis on the cost management and beneficiary engagement capabilities. Organizations will need to determine whether a build or partner / buy strategy is best suited based on their degree of capability development and available options in the market (see non-participants).

2 Aspirational REACH ACOs

The scrutiny CMS has placed on program acceptance gives rise to a substantial group of organizations that expressed interest in the program but were not selected. Such organizations should determine whether there is an opportunity to partner with an in-market REACH ACO to serve as a Participant or Preferred Provider and create a risk-based contract structure with the REACH ACO, allowing the organization to realize some of the benefits of ACO REACH without serving as the direct contracting entity.

Alternatively, organizations could determine whether another Innovation Center program or potentially a value-based health plan contract (either Commercial or Medicare Advantage [MA]) could also support value-based care program goals. CMS has set a goal that "All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030," suggesting that VBC will increasingly become a larger part of providers' reimbursement. However, given that organizations cannot concurrently participate in ACO REACH and overlapping CMS Innovation programs, organizations will need to determine the "best fit" path to achieve their strategic and financial objectives related to value-based care.

3 Non-Participants

Even if an organization does not (or cannot, in the instances of non-provider organizations) intend to participate as a REACH ACO or as a Participant / Preferred Provider, it is important to maintain knowledge / connection to how the program is manifesting in the local market. Particularly for MA organizations, a 'do nothing' approach poses significant risk and jeopardizes plans' financial sustainability given the impact FFS has on MA plan's growth aspirations. Furthermore, as ACO REACH will bring more providers into the value-based contracting fold, it is important to consider how this program will impact network strategies.

Health plans can serve as program enablers / conveners to support three key capabilities:

1. **Medical Management:** Plans' medical management capabilities and offerings could support adherence to care management programs and incentives to steer beneficiaries to lower cost and/or high performing participant providers for cost containment success.
2. **Health Equity:** CMS' introduction of a health equity benchmark supports care delivery and coordination of patients in underserved communities. Health plans are well positioned to support ACOs in executing against health equity plans, collecting health equity data and reporting to the CMS.
3. **Analytics Capabilities:** Depending on infrastructure maturity, providers may need help on cost containment analytics and reporting to either remain in the program or stand up their program prior to 2023. Health plan reporting and analytics capabilities could be a meaningful accelerator to readiness.

Path Forward

Immediate next steps should be focused on identifying the providers in a given market that are likely to participate in the ACO REACH model, either as an ACO or as a Participant / Preferred Provider organization. Organizations should also focus on understanding how these providers compare to the health plan's existing value-based program participation. Plans should also review their current value-based capabilities and define and communicate their value proposition for how they can support providers with the ACO REACH model.

HealthScape Can Help

We have collaborated with healthcare organizations to evaluate, design, and launch programs accelerating the shift to value-based care. We look forward to sharing our perspectives on how health plans can further align themselves with their provider partners and power their success under the ACO REACH Model.

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