MILLIMAN WHITE PAPER

ACO REACH: Direct Contracting 2.0

What to "grab" from CMMI's latest innovation

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The Center for Medicare and Medicaid Innovation (CMMI) announced revisions to its current Medicare Fee-for-Service (FFS) Global and Professional Direct Contracting (GPDC) model, now called the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model.[1]

ACO REACH (REACH) builds on the principles and methodology set forth in the existing GPDC model to reflect the current administration's priorities, incorporate stakeholder feedback, and improve participant experience. REACH's stated goals include "improving the quality of care for people with Medicare through better care coordination, reaching and connecting healthcare providers and beneficiaries, including those beneficiaries who are underserved."[2]

Applications for the new REACH model must be submitted to CMMI during the application window spanning March 7, 2022, and April 22, 2022. Existing ACOs (previously referred to as Direct Contracting Entities or DCEs) will be able to continue their participation in REACH without submitting an application during this window but will be required to have a strong compliance record and agree to meet all REACH model requirements.

Program overview

BACKGROUND

GPDC was designed as an alternative risk model to the Pathways Medicare Shared Savings Program (MSSP).

This model attracted a number of continuing Next Generation ACO participants—CMMI's sunsetting total-cost-of-case Medicare Fee-for-Service (FFS) model—as well as a number of MSSP ACOs and first-time participants in both 2021 and 2022. In the program's first performance year (PY), 2021, there were 53 participating DCEs followed by an additional 49 DCEs[3] that joined as a second cohort in 2022. The GPDC program was then closed to new applicants in the spring of 2021.

What's changing?

In the new REACH model, CMMI has made several program adjustments to build on the concepts introduced in GPDC and revised them to align with current priorities. CMMI has published its own table[4] highlighting differences between the two models, with which we encourage interested ACOs to familiarize themselves.

In the section below (and shown in Figure 1), we outline a handful of what we believe are key changes to the model versus GPDC and discuss the implications of the changes on existing DCEs as well as prospective REACH ACOs. The benchmarking and attribution methodology in the REACH model is similar to the methodology implemented in the GPDC model. While the changes discussed below will have an impact on the settlement calculation and some organizational requirements, the model methodology remains largely unchanged from GPDC.

[1] CMS (February 24, 2022). CMS Redesigns Accountable Care Organization Model to Provide Better Care for People With Traditional Medicare. Press release. Retrieved March 14, 2022, from https://www.cms.gov/newsroom/press-releases/cms-redesigns-accountable-care-organization-model-provide-better-care-people-traditional-medicare.

[2] CMS. ACO REACH. Retrieved March 14, 2022, from https://innovation.cms.gov/innovation-models/aco-reach.

[3] CMS. ACO REACH. Retrieved March 14, 2022, from https://innovation.cms.gov/media/document/gpdc-model-participant-summary.

[4] CMMI. Comparing GPDC to the ACO REACH Model. Retrieved March 14, 2022, from https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison.

CHANGE TO RISK ADJUSTMENT

Starting in 2024, REACH will adopt a *static reference year population* for the purpose of applying the ±3% risk score cap. The ±3% cap is compared to the cumulative risk score growth. In other words, the growth cap is 3% in total, not 3% per year. The static reference population and reference time period has not yet been defined, but we know that 2024 through 2026 will all use one single year as the reference year. Also, the 3% risk score cap will be calculated *relative to the ACO's demographic risk score growth.*

Under GPDC, the risk score cap was applied relative to a reference year that was continuously rolled forward such that it was always two years before the performance year (e.g., for PY2022, the 3% risk score cap would be applied relative to a 2020 reference year).

Why this matters: This limits the opportunity for REACH ACOs to generate shared savings through increased risk score coding.

In GPDC, DCEs can generate savings through appropriately capturing risk scores beyond the risk score cap on a two-year delayed basis.

> 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 for the ACO's average CMS-HCC prospective risk adjustment model or the CMMI-HCC concurrent risk adjustment model risk score growth will constrain growth between -2% to +4%
>
> --CMS's example of risk adjustment[2]

Under the REACH methodology, any risk score improvements in excess of the risk score cap (3%, relative to the reference-year demographic risk score for aligned beneficiaries) will not be recognized in the benchmark. This change moves the treatment of risk ratio caps in the direction of MSSP, where normalized risk ratios are calculated (and capped) relative to the third benchmark year. This methodology change may shift the focus of model participants away from increasing risk scores by more accurately capturing diagnoses to improve settlement calculations. However, the continued use of a coding intensity factor to further control coding growth among all REACH ACOs means ACOs that do not keep up with model-wide coding trends will receive negative adjustments to their benchmark.

In addition, because the 3% risk score cap will be calculated relative to any change in the demographic risk score over that same time period, an ACO's risk score will not be penalized (or rewarded) for shifts in its aligned population (to the degree the risk score is reflected as a change in the demographic risk score). This change helps protect ACOs that include providers with evolving beneficiary pools from being unfairly impacted by the risk score cap.

REDUCED GLOBAL DISCOUNT SCHEDULE

CMS has revised the benchmark discounts for REACH ACOs participating in the Global option to 3% in 2024 and 3.5% in 2025-2026 (a reduction from the 4% 2024 discount and 5% 2025-2026 discounts in the GPDC model).

Why this matters: DCEs that may have hesitated to consider the Global option, due to the increasing discount, may consider revisiting the option. Under ACO REACH, the Global discount will require REACH ACOs to reduce expenditures each year in order to generate shared savings, but the required expenditure reduction is now a lower threshold. While a reduction in the discount makes the Global option more appealing, the discount is still a notable obstacle to overcome in relation to the Professional option. See the tables in Appendix A for a comparison of the shared savings and loss parameters between various CMMI models along with brief commentary.

Similar to the GPDC program, ACOs participating in the REACH program under the Professional model have the option to transition to the Global option in later participation years but will not be able to move from the Global option to the Professional option.

REDUCTION IN QUALITY WITHHOLD

The quality withholds have been reduced to 2% of benchmark (compared to 5% under GPDC).

Why this matters: This change reduces the impact that an ACO's quality score has on the benchmark (and thus overall performance).

For example, a DCE in 2023 with a 90% quality score would realize an effective 0.5% benchmark reduction under GPDC:

- 5% (quality withhold)
+ 90% * 5% (earned back quality withhold)
= 0.5%

While in REACH that same quality score would reduce the ACO's benchmark by only 0.2%

- 2% (quality withhold)
+ 90% * 2% (earned back quality withhold)
= 0.2%

OPTIONAL STOP-LOSS BECOMES RISK-ADJUSTED

The fixed attachment points from GPDC's optional stop-loss program will be risk-adjusted in the REACH model.

Why this matters: For ACOs with high-acuity (or low-acuity) populations, this change is intended to better align the impact of the optional REACH stop-loss program with their expenditures, compared to the impact on ACOs that attribute a population resembling the average Medicare FFS beneficiary (near a 1.0 normalized risk score).

CHANGE IN GOVERNANCE STRUCTURE REQUIREMENTS

The REACH model includes requirements relating to ACO governance that are modified from what was included in GPDC.

- At least 75% control of each ACO's governing body must be held by Participant Providers or their designated representatives. Previously, under GPDC, this requirement was only 25%.
- The Medicare beneficiary and the consumer advocate serving on the ACO's governing body are not permitted to be the same individual.
- The Medicare beneficiary and the consumer advocate each must hold voting rights.

Why this matters: The increased share of representation and participation of the Participant Providers may drive greater coordination of care, accountability, and collaboration in an ACO.

This change will impact the organizational structure for DCEs and ACOs electing to participate in REACH and may signal CMS' intent to continue to have ACOs governed by provider organizations.

For some ACOs this will require a degree of restructuring but will likely not have a significant impact on the ACO's financial performance or operations.

What's new?

While the REACH program closely resembles the GPDC program in most aspects of its design, some additional features have been added to address the aims of the REACH model, including serving beneficiaries who have historically been underserved and ensuring close connectivity between patients and providers.

NEW HEALTH EQUITY REQUIREMENTS

- All ACOs will be required to develop and implement a Health Equity Plan based on the CMS Disparities Impact Statement[5]
- A new benchmark adjustment will modify the benchmark for ACOs based on the proportion of underserved beneficiaries in each ACO (measured based on a composite measure including Area Deprivation Index and Dual status for each beneficiary)
  - Member-level calculation based on the percentile (relative to the REACH ACO *aligned* population) of the composite measure. In this adjustment, beneficiaries in the *top 10% of aligned beneficiaries receive an upward $30 per beneficiary per month (PBPM) adjustment to their benchmark while the bottom 50% of aligned beneficiaries receive a downward $6 PBPM adjustment to their benchmark.*

Why this matters: This adjustment will impact each ACO differently based on the population of beneficiaries they serve and it is designed to adjust the benchmark to reflect the current level of care provided to those beneficiaries.

Because the percentiles are defined based on all DCE-aligned beneficiaries nationwide, it will be difficult to estimate the impact of the health equity benchmark on a given REACH ACO with data for only that ACO. CMS modeling suggests that most ACOs will see a modest impact to their benchmarks (+/-0.2%), with some outlier ACOs seeing larger adjustments up to +1% or -0.5%.

INCREASED TRANSPARENCY

CMS plans to gather additional information from the ACOs, including data on ownership, leadership, and the governing board to ensure alignment with CMS' goals.

CMS indicates that it will share "aggregate information for all REACH ACOs on quality and financial performance based on operations data and financial benchmarks"[2] on a quarterly basis. Also, information will be shared on the payments being made to ACOs.

Why this matters: Data is the cornerstone to financial monitoring. In addition to monitoring an ACO's performance relative to internal targets and goals, understanding an ACO's performance relative to its peers will allow for additional benchmarking and the ability to better understand and identify areas of opportunity.

[5] Disparities Impact Statement https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf

ADDITIONAL APPLICATION CRITERIA

REACH includes the same five application domains that were included in the GPDC application: (1) organizational structure; (2) leadership and management; (3) financial plan and risk-sharing experience; (4) patient-centeredness and beneficiary engagement; and (5) clinical care.

In addition to these domains, REACH requires the following capabilities:

- Demonstrated strong track record of direct patient care
- Demonstrated record of serving historically underserved communities with positive quality outcomes
- Program integrity risks posed by REACH ACO ownership or parent companies

Why this matters: CMMI may be more restrictive in who participates in the ACO REACH model. These additional application requirements will allow CMMI to gather additional information and ensure that all REACH participants are in alignment with CMMI's goals for the program.

Important application information

APPLICATION WINDOW NOW OPEN FOR NEW APPLICATIONS

CMMI was initially planning to accept applications for new ACOs in PY2022 between January and March of 2021, based on its published timetable.[6] However, in April 2021,[7] the GPDC model was closed to new applicants for PY2022, meaning any entities considering applying to GPDC after the initial PY2021 application period were unable to apply.

With the introduction of REACH, new entities are now able to submit applications. *Any organizations interested in participating in the REACH ACO model (with the exception of existing ACOs) must submit a nonbinding application between March 7, 2022, and April 22, 2022*.

EXISTING GPDC ACOS DO NOT NEED TO REAPPLY BUT MUST MEET NEW REACH REQUIREMENTS

Organizations currently participating in the GPDC model will be permitted to continue participating in the REACH model and must agree to meet all the ACO REACH Model requirements by January 1, 2023, to continue participating. However, current GPDC participants must maintain a "strong compliance record"[2] and agree to meet all the REACH requirements by January 1, 2023, to continue participating in the REACH model.

Closing thoughts

The ACO REACH model represents a rebranding of the existing GPDC model. It includes modest revisions to the assumptions underlying the GPDC benchmarking methodology as well as participation requirements. It has also opened the window for new entities to participate in the program beginning in 2023, which was not an option after CMS stopped accepting GPDC applications in the spring of 2021.

The REACH model will be a good fit for organizations that have experience taking downside risk for Medicare FFS populations, are interested in a higher degree of opportunity to manage those populations, and have a risk tolerance aligned with the upside and downside risk of the ACO REACH program.

Additional resources

Milliman has published several papers on the GPDC model since its announcement in 2020. These publications include details about the key features of the model, including beneficiary alignment, benchmark methodology, and assumptions underlying the financial settlements. We encourage any organizations considering REACH to peruse these publications for additional background on how the program has evolved.

- Direct Contracting: A program summary and comparison with MSSP (Medicare Shared Savings Program) and NGACO (Next Generation Accountable Care Organization) (March 2020)
- Summary of changes to the CMS direct contracting program (December 2020)
- Direct Contracting and the impact of COVID-19 on physicians (January 2021)
- Medicare FFS Direct Contracting: Financial benchmark observations (January 2021)

[6] CMMI. Key Dates for the Direct Contracting Model (Global and Professional). Retrieved March 14, 2022, from https://innovation.cms.gov/media/document/dc-professionalglobal-timeline.

[7] CMS (April 2021). GPDC Model FAQS. Retrieved March 14, 2022, from https://innovation.cms.gov/media/document/gpdc-model-general-faqs.

FIGURE 1: DIFFERENCES BETWEEN GPDC AND ACO REACH

FEATURE	GPDC	ACO REACH	WHY THIS MATTERS
Risk Adjustment Cap:			
Reference Year	Risk scores are capped relative to a reference year that is two years prior to each performance year (i.e., a rolling reference year)	Starting in 2024, the reference year is expected to be locked at 2022 risk scores through the entire Agreement Period	▪ This limits the opportunity for REACH ACOs to generate shared savings through more accurate risk score coding. ▪ Under the REACH methodology, any risk score improvements in excess of the risk score cap (3%, relative to the reference-year demographic risk score for aligned beneficiaries) will not be recognized in the benchmark. ▪ This change moves the treatment of risk ratio caps in the direction of MSSP, where normalized risk ratios are calculated (and capped) relative to the third benchmark year.
Risk Score Growth Cap	The cap will be calculated on a Hierarchical Condition Categories (HCC) risk basis between PY and reference year	The cap will be calculated *relative to the ACO's demographic risk score growth.*	▪ Because the 3% risk score cap will be calculated relative to any change in the demographic risk score over that same time period, an ACO's risk score will not be penalized (or rewarded) for shifts in its attributed population (to the degree the risk score cap is reflected as a change in the demographic risk score).
Global Discount	4.0% discount in 2024 5.0% discount in 2025 and 2026	3.0% discount in 2024 3.5% in 2025 and 2026	▪ DCEs that may have hesitated to consider the Global option due to the increasing discount should revisit the option. ▪ Under ACO REACH, the Global discount will require REACH ACOs to reduce expenditures each year in order to generate shared savings, but the required expenditure reduction is now a lower threshold. ▪ See the tables in Appendix A for a comparison of the shared savings and loss parameters among various CMMI models, along with brief commentary.
Withholds for 2023 or Later	5% "pay for performance"	2% "pay for performance"	▪ This change reduces the impact that an ACO's quality score has on the benchmark (and thus overall performance).
Stop-loss	Attachment points are fixed	Attachment points will be risk-adjusted	▪ For ACOs with high-acuity (or low-acuity) populations, this change will better align the impact of the optional REACH stop-loss program on their expenditures with the impact that is observed by ACOs that attribute a population resembling the average Medicare FFS beneficiary (near a 1.0 normalized risk score).
Governance			▪ The increased share of representation and participation of the participating providers may drive greater coordination of care, accountability, and collaboration in an ACO. ▪ This change will impact the organizational structure for DCEs and ACOs electing to participate in REACH and signals CMS's intent to continue to have ACOs governed by provider organizations. ▪ For some ACOs this will require a degree of restructuring but will likely not have a significant impact on the ACO's financial performance or operations.
Share of governing body held by Participant Providers or designated representatives.	At least 25%	At least 75%	
Beneficiary and consumer advocate:			
-Same individual?	Yes	No	
-Voting rights?	No	Yes	
Health Equity Requirements	Does not exist	Member-level calculation based on decile. Top decile receives upward $30 PBPM adjustment. The bottom five deciles receive downward $6 PBPM adjustment	▪ This adjustment will impact each ACO differently, based on the populations of beneficiaries they serve, and is designed to adjust the benchmark to reflect the current levels of care provided to those beneficiaries. ▪ ACOs will be able to leverage historical Medicare FFS claims data in order to estimate the potential impact of this adjustment on the ACO's benchmark. ▪ CMS modeling suggests that most ACOs will see a modest impact to their benchmark (+/-0.2%), with some outlier ACOs seeing larger adjustments up to +1% or -0.5%.

Appendix A – Comparison of shared savings and loss parameters by ACO option

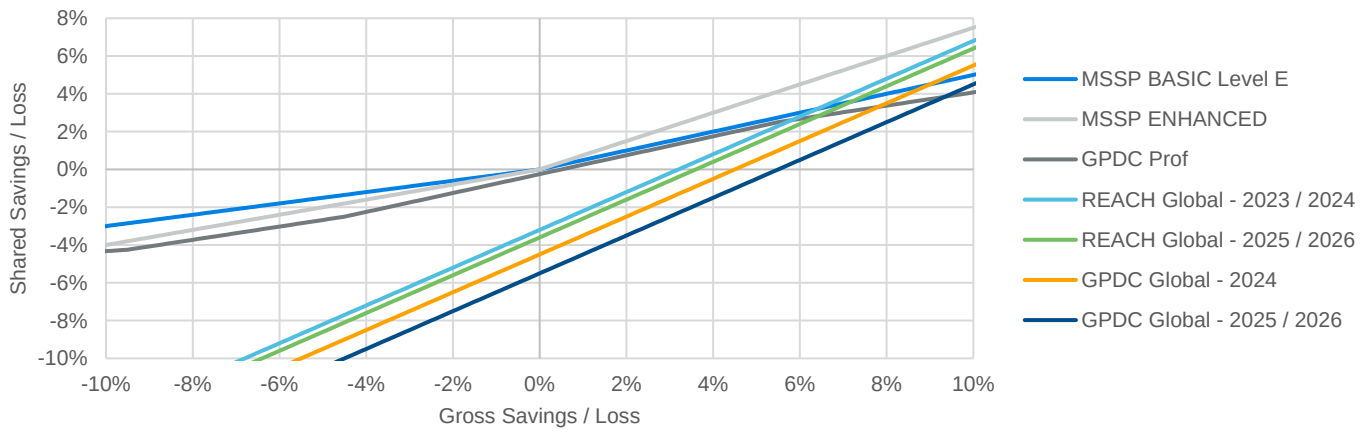
As discussed above, in its restructuring of GPDC into ACO REACH CMMI has reduced the discount schedule for the Global option, while also reducing the quality withhold. These changes reduce the overall downward adjustment applied to an ACO's benchmark before savings can be achieved and make the Global option more appealing under ACO REACH than it was under GPDC. The table in Figure 2 compares the effective total discount under a few scenarios for the prior and revised programs. The reduction in discount plus quality withhold is material for entities considering ACO REACH.

FIGURE 2: DIFFERENCES BETWEEN GPDC AND ACO REACH

	Year	Quality Score	Global DC Model	Discount	Net Quality Withhold	Net downward adjustment to benchmark
Scenario 1	2024	70%	ACO REACH	3.00%	0.60%	3.60%
			GPDC	4.00%	1.50%	5.50%
Scenario 2	2024	90%	ACO REACH	3.00%	0.20%	3.20%
			GPDC	4.00%	0.50%	4.50%
Scenario 3	2025	70%	ACO REACH	3.50%	0.60%	4.10%
			GPDC	5.00%	1.50%	6.50%
Scenario 4	2025	90%	ACO REACH	3.50%	0.20%	3.70%
			GPDC	5.00%	0.50%	5.50%

For any entity considering ACO REACH it is important to consider these adjustments in the broader context of shared savings and loss parameters for the MSSP Pathways program. The graphic in Figure 3 compares gross versus shared savings/losses for MSSP Pathways, GPDC, and ACO REACH. In creating this graphic we have assumed that for Pathways the ACO reaches the quality threshold, and for GPDC or ACO REACH it has earned back 90% of its quality withhold.

FIGURE 3: SHARED VS. GROSS SAVINGS AND LOSSES – A COMPARISON OF PATHWAYS, GPDC, AND ACO REACH WITH 90% QUALITY SCORE



Note: We have not included REACH Professional in Figure 3 explicitly. The trajectory of shared versus gross savings/losses would be very similar to GPDC Professional, with the difference that the net quality withhold after earn-back will be lower under REACH than in GPDC.

It can be helpful to directly compare a more limited set of parameters. Figure 4 compares the shared savings/losses trajectories for MSSP ENHANCED versus the 2024 parameters for ACO REACH (3% discount) and 2024 DC Global (4% discount). Shared savings under ACO REACH are improved relative to DC Global, but gross savings have to be greater than approximately 12% of benchmark before shared savings under ACO REACH exceed MSSP ENHANCED.

FIGURE 4: SHARED VS. GROSS SAVINGS AND LOSSES – MSSP ENHANCED VS. 2023-2024 ACO REACH AND 2024 DC GLOBAL WITH 90% QUALITY SCORE

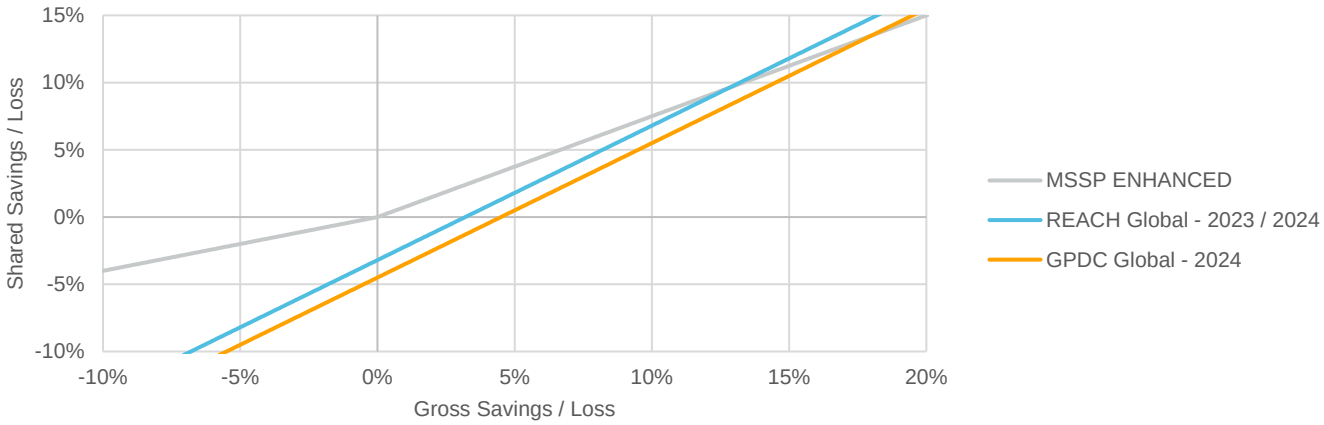
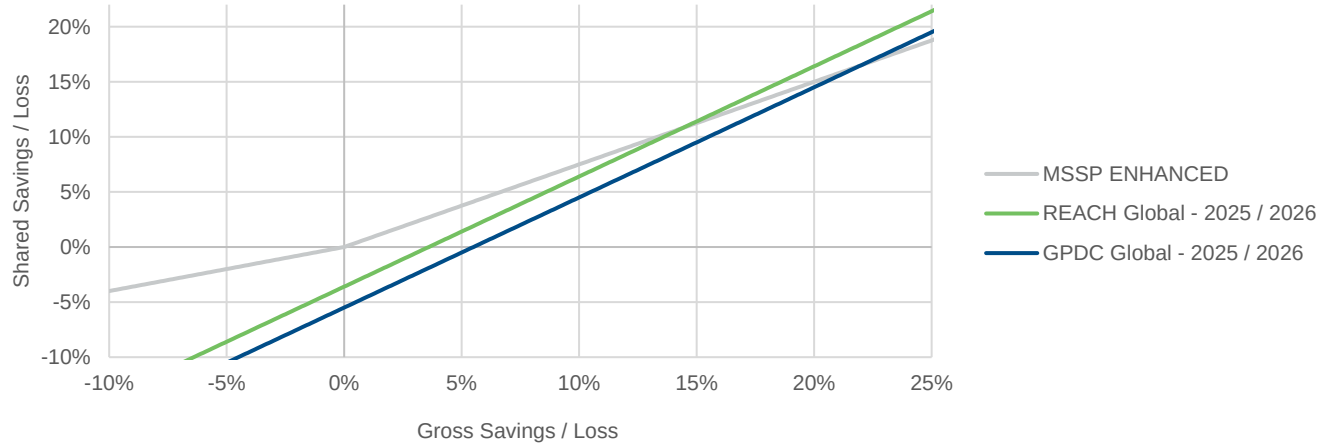


Figure 5 is similar to Figure 4, but with discount parameters for 2025 and 2026. In these years gross savings would have to be equal to or greater than 16% of benchmark before shared savings under ACO REACH exceed MSSP ENHANCED.

FIGURE 5: SHARED VS. GROSS SAVINGS AND LOSSES – MSSP ENHANCED VS. 2025-2026 ACO REACH AND DC GLOBAL WITH 90% QUALITY SCORE



It is important to note that there are many parameters to consider when comparing MSSP and ACO REACH beyond discount, quality withhold, and shared savings parameters. While the benchmarks for MSSP and ACO REACH utilize similar concepts of a fixed benchmark period, regional adjustment, and risk adjustment, the specific details of how the development is implemented may result in materially different benchmarks and in turn materially different opportunities for savings. We encourage any entity considering an application to ACO REACH to perform its full due diligence for how the programs compare for its own ACO or provider organization.

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