INSTITUTE FOR ADVANCING HEALTH VALUE
AT WESTERN GOVERNORS UNIVERSITY

In-Depth Analysis of Final Cohort Joining the ACO REACH Model in 2023

INTELLIGENCE BRIEF | OCTOBER 2022

This brief builds on our series of GPDC/ACO REACH intelligence by considering the incoming final cohort of ACO REACHs within the context of the model's history, analyzing the roster relative to GPDC's current participants, and sharing expectations for the future.

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Last month, the Centers for Medicare & Medicaid (CMS) quietly released the names of the 110 provisionally-accepted organizations selected to join the ACO Realizing Equity, Access, and Community Health (REACH) Model in 2023 – the first performance year of the model following its transition from Global Professional Direct Contracting (GPDC) to ACO REACH.

This group of provisionally accepted ACOs represent the final cohort that will be allowed to enter the sophisticated CMS Innovation Center (CMMI) demonstration, after the agency redesigned and reopened the model for a final application cycle earlier this year. As part of its efforts to revise GPDC's design and requirements to better reflect Biden-Harris Administration priorities and address stakeholder concerns, CMS committed to greater transparency throughout the implementation of the ACO REACH model. This early release of the provisional ACO participant list—along with other information on the application process and results—are a reflection of that commitment.

Previous Institute briefs describe the design of the GPDC model, compare the elements of this more advanced CMMI ACO model to the Medicare Shared Savings Program (MSSP), and analyze the organizations who participated in GPDC's first Implementation Period (IP1) as well as those who elected to begin in April 2021. **This brief builds on that series of GPDC/ACO REACH intelligence by considering the incoming final cohort of ACO REACHs within the context of the model's history, analyzing the roster relative to GPDC's current participants, and sharing expectations for the future.**

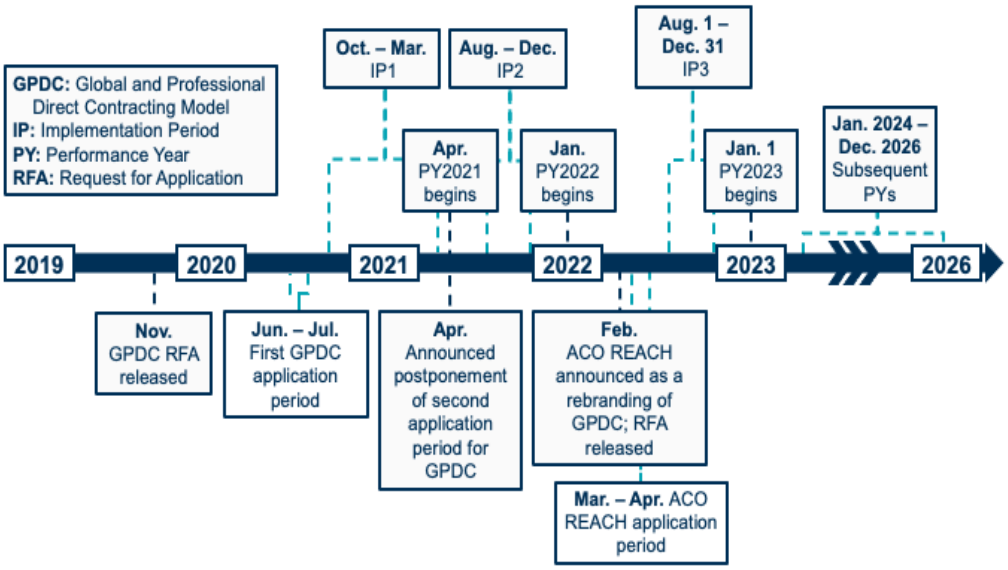
Background

SHORT RECAP OF MODEL TIMELINE

The Direct Contracting model was initially announced in April 2019 as part of the Primary Cares Initiative and expected to begin Spring 2020. Due to a series of pandemic- and politically-induced delays, the model's timeline has been complicated to follow (See Figure 1).

Following the first application period in the summer of 2020, selected applicants had multiple options regarding the timing of their participation in the model. These organizations—called Direct Contracting Entities (DCEs) until January 2023, after which they will be called REACH ACOs—were given the option to begin their first performance year in April 2021 or defer until January 2022 due to the Public Health Emergency or to finish out the final performance year of the Next Generation ACO model prior to its sunset at the end of 2021. Additionally, DCEs were given the option to join early under a voluntary, six-month Implementation Period (IP) to enroll beneficiaries and prepare for the performance year.

Figure 1: GPDC to REACH ACO Timeline



Across the various starting options for the first cohort, the model had 99 active DCEs as of February 2022 when CMS finally revealed the long-awaited reopening of the revised ACO REACH Model for a final application period.

ACO REACH APPLICATION ANALYSIS

As part of the changes from GPDC to ACO REACH, CMMI introduced new criteria and expectations for applicant selection, including a new assessment for program integrity risks. While the revised ACO REACH model would still allow non-traditional entities – like health plans and physician enablement companies – the opportunity to participate, CMMI expressed a strong interest in attracting more provider-led entities with experience providing direct patient care as well as organizations focused on underserved communities. CMS did not indicate how many new ACOs would be chosen to participate but the agency did advise that not all qualified applicants would be accepted.

Comparison of Applicant Pool to Provisionally Accepted REACH ACOs

In the spirit of greater transparency—and given the robust public interest in the model—CMS shared more information on the application process than is typical for CMMI demonstrations. The RFA drew a total of 271 completed applications , with only 128 (47%) provisionally accepted to join the ACO REACH Model – a lower acceptance rate compared to prior Innovation Center models.

Tables 1 and 2 compare the ACO types and risk tracks of the 271 applicants with the 128 provisionally accepted ACOs. Standard ACOs—providers with substantial experience serving Medicare beneficiaries—comprised nearly 60% of the applicant pool and were disproportionately selected to join the model. While 53% of Standard ACO applicants were provisionally approved, only 37% of New Entrant and 38% of High Needs ACO applicants were accepted.

TABLE 1: APPLICANTS VS ACCEPTED BY ACO TYPE

ACO Type	Applicants (271)	Accepted (128)
Standard	160 (59%)	85 (66%)
High Needs	54 (20%)	20 (16%)
New Entrant	57 (21%)	23 (18%)

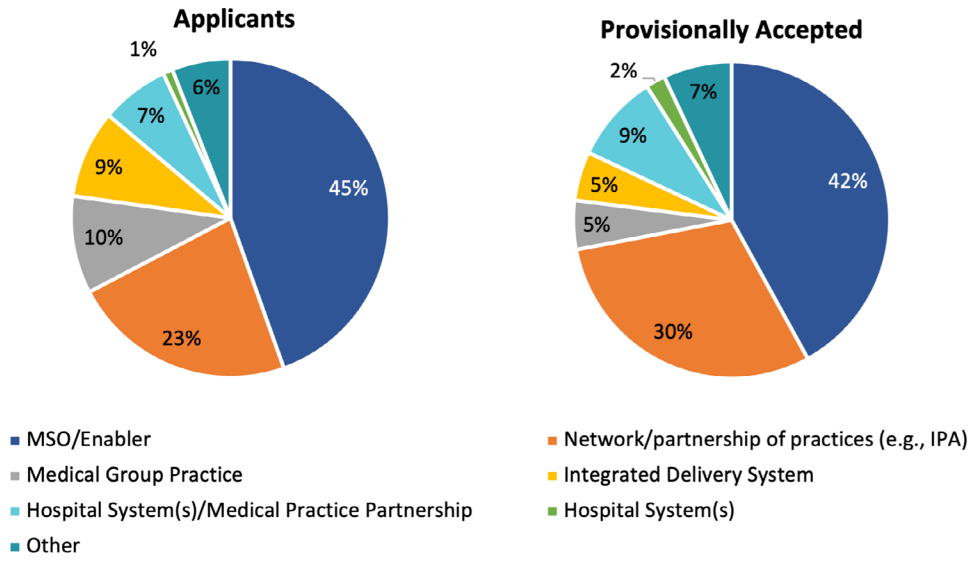
**Totals may not add up to 100% due to rounding*

TABLE 2: APPLICANTS VS ACCEPTED BY RISK TRACK

Risk Track	Applicants (271)	Accepted (128)
Global	182 (67%)	92 (72%)
Professional	86 (32%)	36 (28%)

**Totals may not add up to 100% due to rounding*

Figure 2: Self-Reported Organization Type Among Applicants vs. Accepted



CMMI also shared information on the self-reported organization type among applicants and provisionally accepted ACOs (Figure 2). While one of the major goals of ACO REACH relative to GPDC was CMMI also shared information on the self-reported organization type among applicants and provisionally accepted ACOs (Figure 2). While one of the major goals of ACO REACH relative to GPDC was attracting more provider-led entities, non-provider entities remained highly interested in the model, with 45% of the 271 applications submitted by VBP enablers/MSOs/conveners. More interestingly, 54 of the 128 (42%) applicants selected by CMS were self-reported MSOs/conveners. To be accepted into the sophisticated CMMI model, applicants were judged on their organizational readiness, financial plan and risk-sharing experience, clinical care model, and data and HIT capabilities. In addition to population health management chops, applicants were evaluated for program integrity risks including screenings of proposed leadership teams, parent companies or other ownership interests. Following this rigorous screening process—which was designed to alleviate concerns regarding potential conflicts of interest among MA-focused payers or vendors—CMMI still provisionally accepted more MSO/Enablers than any other applicant type. The section below further analyzes the incoming cohort of REACH ACOs, providing additional color on the sponsoring entities engaged in the model.

Following CMS' original announcement in July 2022 that 128 ACOs had been provisionally accepted for PY2023, 18 unknown ACOs withdrew from the model. CMS will not publish the list of 18 dropouts or indicate why the organizations elected to withdraw after being provisionally accepted. When comparing the 128 originally announced as provisionally accepted to the list of 110 released last month, no particular ACO Type or Risk Track was more likely to drop out (Tables 3 & 4).

TABLE 3: ACO TYPE AMONG ORIGINALLY ACCEPTED VS REMAINING

ACO Type	Applicants (271)	Accepted (128)
Standard	85 (66%)	71 (65%)
High Needs	20 (16%)	19 (18%)
New Entrant	23 (18%)	20 (17%)

**Totals may not add up to 100% due to rounding*

TABLE 4: RISK TRACK AMONG ORIGINALLY ACCEPTED VS REMAINING

Risk Track	Applicants (271)	Accepted (128)
Global	92 (72%)	81 (74%)
Professional	36 (28%)	29 (26%)

**Totals may not add up to 100% due to rounding*

Analyzing the Provisionally Accepted ACOs

The newly announced cohort of provisionally accepted REACH ACOs represent those selected to join the model for PY2023, with 34 of those 110 ACOs electing to join early for the optional IP3 (August to December 2022). This section analyzes the 110 provisionally accepted ACOs in comparison to the 99 DCEs currently participating in the GPDC model and assesses IP3 participants relative to prior implementation periods.

ACCEPTED REACH ACOS VS CURRENT DCES

While CMS has released more information on the incoming cohort than prior years, the details published on the provisionally accepted ACOs are limited. At the time of this analysis, CMS has released only the legal name, ACO type, and risk track for the 110 REACH ACOs. CMS also published the state footprints for 34 of the 110 ACOs who elected to join early for IP3.

To better understand the breakdown of the incoming ACO cohort, particularly in comparison to the 99 active DCEs currently in the program, researchers at Leavitt Partners gathered additional information on the 110 provisionally accepted ACOs using publicly available sources and drawing inferences from the limited available information and a long history tracking the accountable care movement. The analysis below is based on data reported by CMS (i.e., ACO type and risk track), as well as additional information gathered manually (i.e., sponsoring entity type). Some information, including ACOs' chosen payment mechanisms (e.g., Total Care Capitation vs Primary Care Capitation), selected Benefit Enhancements/Beneficiary Engagement Incentives, and state footprints will remain unknown until CMS publishes this data in early January 2022.

High-level Comparison by ACO Type & Risk Track

Tables 5 and 6 offer a high-level comparison of the GPDC cohort with the incoming cohort of 110 provisionally accepted REACH ACOs. Among the 99 current DCEs, Standard ACOs are the most common (79%) relative to New Entrant or High Needs ACOs. Interestingly, while Standard ACOs still represent the majority of the ACO REACH cohort, the provisionally accepted REACH ACOs will include a larger share of High Needs and New Entrant ACOs relative to GPDC. Because CMMI did not publish the same granular applicant data for GPDC, we cannot confirm whether the DC RFA drew similar levels of interest from New Entrant and High Needs applicants who were not selected to participate, or if these organizations were more interested and/or prepared to apply for the ACO REACH model.

TABLE 5: ACO TYPE AMONG ACTIVE DCES VS ACCEPTED REACH ACOS

ACO Type	Model	
	GPDC (99)	REACH (110)
Standard	78 (79%)	71 (65%)
High Needs	8 (8%)	20 (18%)
New Entrant	13 (13%)	19 (17%)

TABLE 6: RISK TRACK AMONG ACTIVE DCES VS ACCEPTED REACH ACOS

Risk Track	Model	
	GPDC (99)	REACH (110)
Global	72 (73%)	81 (74%)
Professional	27 (27%)	29 (26%)

**Totals may not add up to 100% due to rounding*

Despite the growth in New Entrant and High Needs ACOs, the new cohort did not see a change in the share of ACOs choosing Global over Professional. Among the changes made to ACO REACH, CMS modified elements of the financial methodology to attract more provider-led entities to the model. These adjustments—including reducing the quality withhold, introducing the health equity benchmark adjustment, and risk score changes—may have attracted additional applicants, but organizations appear to be as ready for global risk under ACO REACH as they were with GPDC. Notably, under ACO REACH, the discount applied to the Global benchmark is reduced in PY2023-2026 to 3-3.5%, down from 4-5% under GPDC. Without this change to the Global track, ACO REACH may have had fewer Global ACOs.

Figure 3: Segmenting the Market

- **Provider-led** – ACOs run by organizations involved in the direct provision of care, including traditional incumbent providers and new entrants.
- **Payer-led** – ACOs run by insurers or their subsidiaries, including payer-owned providers and professional services arms.
- **Enabler-led** – ACOs run by organizations who support providers in the transition to value in exchange for a portion of the savings, including MSOs, physician conveners, and VBP enablement companies.

Comparing Cohorts by Sponsoring Entity Type

The GPDC and ACO REACH models are designed to allow new types of organizations who have not previously engaged in CMMI models to participate, including health plans and even vendors. These nontraditional ACO sponsors often have sophisticated infrastructures and administrative/financial/operational capabilities, leveraging their resources and experience to recruit and support networks of providers. To analyze participation by sponsoring entity type, we segmented DCEs/ACOs into three broad categories—**provider-led, payer-led, and enabler-led** organizations—though the lines are increasingly blurry and many hybrids exist.

The 99 DCEs include a diverse group of organizations with many blurred lines across the three segments. The amount and type of engagement from non-provider organizations in GPDC, including many investor-owned entities, helps to explain industry concerns over transparency and compliance. To address this, CMS implemented a number of changes to ACO REACH requiring more balanced governance and transparency into ACO ownership and financial interests.

Despite industry concerns, CMS decided to continue to allow participation from non-provider organizations, but the breakdown of REACH ACOs looks differently than the DCE cohort in some important ways.

- **Difference #1: A lot less payer activity** – The GPDC model saw considerable payer-led activity. Among the 99 active participants, more than 10% are led and/or owned by payers, including engagement from 4 of the 5 largest national payers and significant interest among MA-focused insurtech companies.

This group of payer-led DCEs epitomize the blurred lines across the three segments, with examples of payer-owned provider entities (e.g., Humana's CenterWell, Bright Health's NeueHealth, and Optum-owned CareMount and Reliant Medical Group), payer-owned enablers (e.g., Cigna's CareAllies, Aetna's ActiveHealth, and Centene's Collaborative Health Systems), in addition to payer-owned DCEs (e.g., Humana, Alignment, and Clover).

Among the new cohort of provisionally accepted REACH ACOs, there is very little apparent payer-led activity. At this time, the only identifiable payer-led ACO appears to be an additional ACO from Bright Health's subsidiary, NeueHealth, who's already running DCEs called Physicians Plus ACO, LLC and Physicians Plus. NeueHealth's current DCEs operate in California, Florida, Illinois, Missouri, and Ohio. According to the organization's website, with its new REACH ACO, Neue plans to grow its activity in those existing states as well as in North Carolina and Texas. While there may be additional payer-led ACOs identified with more information from CMS, the decrease in payer activity relative to GPDC is clear.

- **Difference #2: More, and slightly different, provider engagement** – Despite the controversies surrounding the GPDC model, the majority of the 99 current participants are provider-led, representing a mix of incumbents, advanced primary care upstarts, and other provider types. Nearly two-thirds of the 99 DCEs are owned and/or operated by a provider of some sort, including JVs between providers and other organizations like enablement companies. This pattern of activity continued into the ACO REACH model.
  - **Traditional provider entities/incumbent providers** –At least 18 former NGACOs elected to join GPDC, with most of those organizations beginning in PY22 after finishing out their final performance year in the Next Generation ACO model. After analyzing the former NGACOs, we identified an additional 40+ NGACOs that would seemingly qualify to join the ACO REACH model and with fewer hurdles than GPDC (e.g., lower quality withhold, reduced discount, etc.) as the incentives for these experienced ACOs to enter the model were improved under ACO REACH. Unsurprisingly, the new cohort of provisionally accepted ACOs includes several notable former MSSP and NGACO participants. For example,

Torrance Memorial Integrated Physicians was formerly in the Next Generation Model before moving to the ENHANCED track of the MSSP in 2022 when NGACO expired. The CIN is now back in CMMI's most sophisticated ACO program as a Standard ACO in the Professional track. Other former NGACOs now participating in ACO REACH include Allina Health System, Carilion Clinic's Doctors Connected, CHESS, Franciscan Missionaries of Our Lady Health System Clinical Network, Reliance ACO, and multiple Prospect ACOs.

The provisionally accepted cohort also includes a number of former MSSP ACOs who have now "graduated" into Medicare's more advanced accountable care model, ACO REACH, where they can benefit from prospective revenue and additional flexibilities unavailable to those in the MSSP. Notable former MSSP ACOs include health system-led ACOs (e.g., Advocate Aurora, Ochsner, etc.), CINs involving hospitals and physician groups (e.g., Beaumont ACO [AKA Oakwood ACO], Centrus Health of Kansas City, etc.) and ACOs comprised of IPAs or independent practices (e.g., RGV ACO, Hudson Heights, Greater Genesee County ACO, Commonwealth Primary Care ACO, National Physician Administrative Services [DuPage Medical Group], and Optimum NY Independent Practice Association [Great Lakes Integrated Network]).

Notably, the provisionally accepted ACOs also include a greater number of FQHC-led ACOs including Medical Home Network, Ocean Management Services, Community Care Cooperative, North East Medical Service, Comprehensive Community Health Centers, and Arizona Best Care Network. These FQHC groups span all ACO types, including Standard, New Entrant, and High Needs, with a couple taking full risk under the Global track.

- **Upstart providers** – In addition to traditional incumbent providers who are working to transition from FFS to value, GPDC and ACO REACH are attractive models for provider entities whose business models were designed for value-based payments from the beginning. Of the 99 current DCEs, a large handful are run by advanced primary care companies who often assume global risk for MA populations, including DCEs run by Oak Street, Iora, Cano Health, ConcertoCare, CityBlock, Equality, and others. While the new cohort of provisionally accepted ACOs includes fewer new advanced primary care entrants, the ACO REACH model will gain notable organizations like ChenMed, whose ACO is currently listed under the name Dedicated US Holdings. What appears to be ChenMed's REACH ACO is a New Entrant ACO in the Global risk track, and because of its early start in the IP3, the state footprint indicates the ACO will span eight states. Another notable primary care disruptor recently acquired by Amazon, OneMedical, will join the ACO REACH model in 2023. Its subsidiary, Iora Health, is already participating in the GPDC model with a large multi-state footprint. The new OneMedical ACO will be limited to California. AbsoluteCare ACO, which operates in six markets and has a particular focus on high-needs populations and LGBTQ+ patients, will join the model under new leadership.

  Additional upstart providers joining the ACO REACH model include senior-focused home health providers, like Upward Health and WellBe Accountable Care Partners, along with value-based provider organizations focused on specific populations, like Homeward Health which focuses providing care to beneficiaries in rural areas.

- **Difference #3: Enablers remain highly interested in the model, but more often in collaboration with provider partners** – Arguably the "squishiest" category, enabler-led DCEs/ACOs are run by entities that support providers in the transition to value without acquiring or assuming common ownership. Enablers assist providers in adopting risk-based contracts by streamlining administrative functions, supplying technology, and providing expertise, among other functions. Like the other segments, there are many subcategories and nuances within the VBP enabler space – an area that Leavitt Partners and the Institute is tracking closely.

  As is the case with the 99 DCEs, the provisionally accepted enabler-led ACOs include the widest range of organization types, many with experience serving Medicare APMs and other value-based programs. The

enabler-led ACO segment includes many MSOs in the traditional sense, along with new upstart organizations created specifically to participate in the model and other programs like it.

- **VBP enabler vendor partners** – The GPDC cohort includes significant activity from VBP enablers like agilon and VillageMD, with both groups representing multiple DCEs. Notably, agilon, who is historically focused on supporting independent providers with value-based MA contracts, will continue to expand its presence with two more REACH ACOs in 2023. If all of agilon's DCEs matriculate into the ACO REACH model, the organization will have 10 ACOs. While VillageMD does not appear to be sponsoring any new ACOs, another organization who similarly offers both VBP enablement services and owns care delivery assets, P3 Health Partners, will join the model. VBP enabler OnBelay Health Solutions will expand its footprint in the model, adding an additional ACO (OBHS ACO 1, LLC).

  Other notable enabler entrants include familiar names like Lumeris, who will apply its Medicare APM expertise and experience serving health systems to support two Standard ACOs bearing Global risk. Additionally, Pearl Health will run two Standard ACOs with multi-state footprints, one in the Global and the other in the Professional track and Vytalize will enter with two REACH ACOs, both High Needs Population and in the Global risk track. Two additional upstart enablers, Upstream and Honest Medical, are founded and led by former CMMI officials. Upstream, an NC-based VBP enabler led by Sanjay Doddamani, will support three REACH ACOs. Honest Medical Group, a VBP enabler founded by former CMMI lead Adam Boehler that partners with IPAs and health plans under joint venture (JV) agreements, will support at least two REACH ACOs in PY2023.

- **Provider-owned enablers** – Like the cohort of 99 DCEs, the group of provisionally accepted ACOs include a number of provider-owned enablers. Existing DCEs in this category include Intermountain's Castell and Genuine Health Group, who leveraged their success in prior Medicare APMs to develop new professional services organizations. Similarly, the incoming cohort of ACOs will include several provider-owned enablement companies like CHESS, Mirra Reach, Prime ACO, and multiple ACOs from PSW (e.g., LEGION ACO, LIVELY ACO, HYGEIA ACO, and Medallion Health). Advanced Management USA and Palm Beach ACO, who've had great success in other Medicare APMs, will run at least three REACH ACOs. Compared to GPDC, many more REACH ACOs are comprised of JVs or other partnerships between enablement organizations and provider entities – likely a reflection of CMMI's new governance and oversight requirements for REACH ACOs.

- **Enablers historically focused on other programs or populations** – Notably, the new cohort includes ACOs led by unexpected enabler organizations. For example—Aledade, a large, successful VBP enabler historically focused on supporting independent practices in the MSSP—will be joining the ACO REACH model in 2023. The organization is known for its successful track record in the MSSP, but Aledade's practices now cover as many MSSP ACO lives as they do in other value-based contracts with MA, commercial, and Medicaid plans. The REACH ACO, called Aledade Accountable Care 128, LLC, is joining under the full risk Global track.

  Lastly, the model will include ACOs run by VBP enablers focused on specific high-needs populations. These include Mainstreet, a rural-focused enabler founded by former CMMI director Brad Smith; Belong Health, with expertise supporting D-SNP plans; and hospice-focused enabler Cyft, who appears to be sponsoring four new High Needs Population ACOs.

Analyzing the IP3 Entrants

34 of the 110 provisionally accepted ACOs elected to join early for the optional six-month Implementation Period. IP3 will run from Aug-Dec 2022 and allow ACOs the opportunity to aggregate lives, improve network strategy, and prepare to engage in the advanced ACO REACH model prior to its official start.

- **Where are They Located?**
  While CMS did not release the market footprints of all provisionally accepted ACOs, we do know the locations of the 34 in IP3 (Figure 4). The states with the most known ACO activity include NY (11), FL (9), and TX (9). This geographic spread somewhat mirrors the dispersion of the 99 current DCEs (Figure 5).

Figure 4: Provisionally Accepted IP3 Participant Presence by State

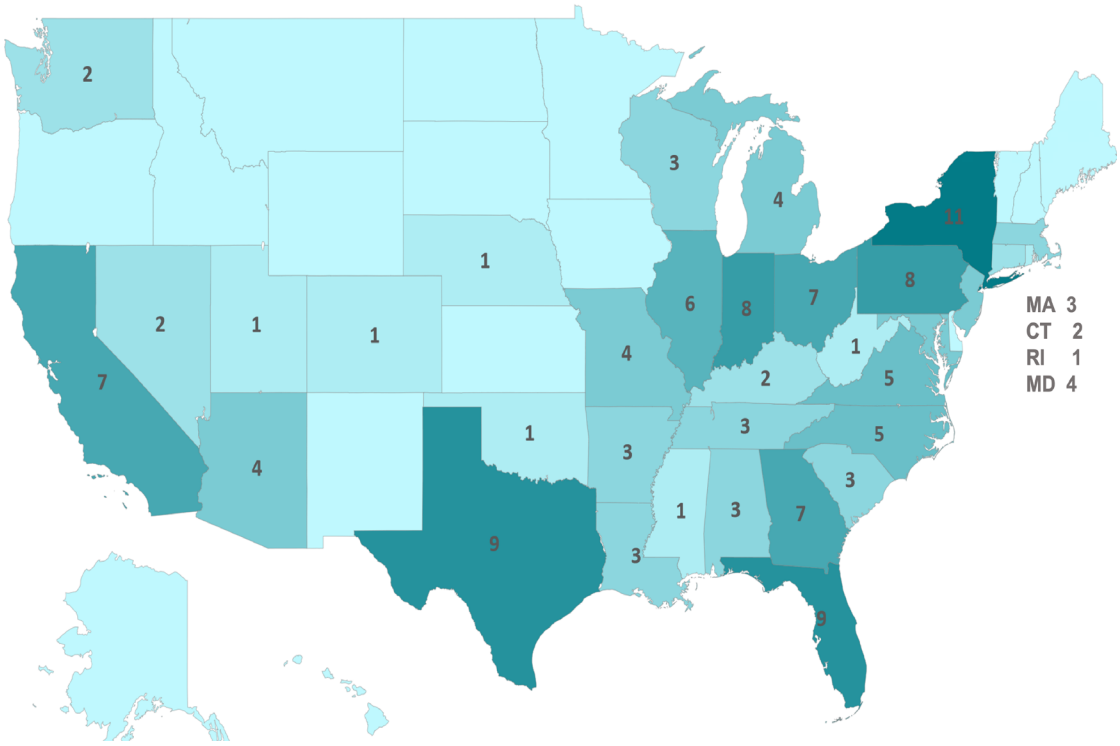
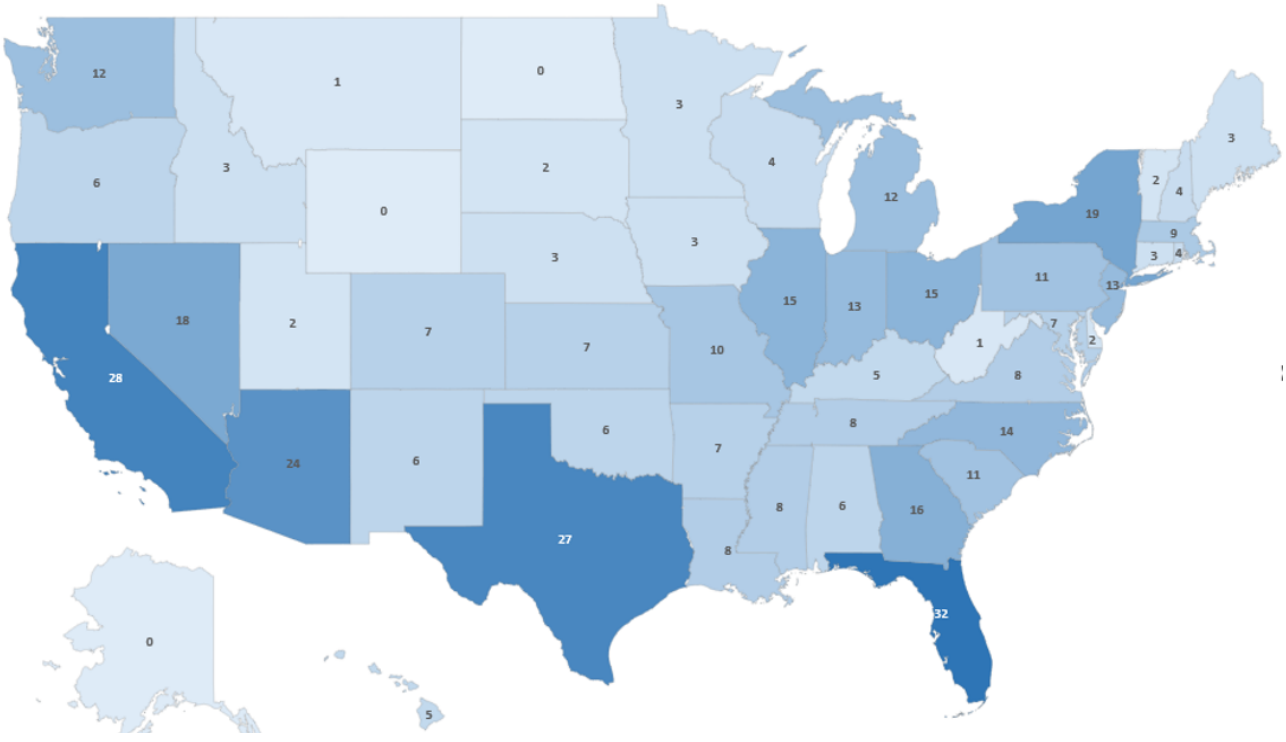


Figure 5: 99 Active DCEs by State



Note: States with at least 1 county listed on the DCE's Core Service Area; this is self-reported by the DCE as counties in which their DC Participant Providers have physical office locations; counties / states may be listed where the DCE does not actually have aligned beneficiaries.

How do They Compare to the Broader 2023 Cohort?

Expectedly, the 34 IP3 ACOs have a disproportionate share of High Needs and New Entrant ACOs (Table 7). This is understandable as these are the organizations who would likely need additional prep time prior to engaging. Table 7 shows the breakdown by risk track, with a slightly higher share of IP3 ACOs in the Global full-risk option. When analyzing the sponsoring entity types of IP3 participants compared to the broader cohort of provisionally accepted ACOs, the breakdown of provider-, payer-, and enabler-led ACOs match the makeup of the full group.

TABLE 7: ACO TYPE AMONG ALL PROVISIONALLY ACCEPTED VS IP3

ACO Type	Provisionally Accepted (110)	IP3 Participants (33)
Standard	71 (65%)	15 (45%)
High Needs	20 (18%)	9 (27%)
New Entrant	19 (17%)	9 (27%)

TABLE 8: RISK TRACK AMONG ALL PROVISIONALLY ACCEPTED VS IP3

Risk Track	Provisionally Accepted (110)	IP3 Participants (33)
Global	81 (74%)	26 (78%)
Professional	29 (26%)	7 (21%)

**Totals may not add up to 100% due to rounding*

Implications

When CMS announced it would be revising and reopening GPDC under the name ACO REACH for a final application cycle, many in the industry welcomed the news. While the changes did not fully satisfy all concerns, industry reactions to the updates were overwhelmingly positive. The opportunity to join the GPDC/ACO REACH model is something many organizations have been anxiously awaiting since CMS announced the postponement of the second application cycle in April 2021.

> *"CMS' commitment to fixing, not cancelling, GPDC is heartening to VBP proponents – building on the momentum of the value movement and renewing faith in CMMI as a reliable vehicle for advancing value transformation through thoughtful APM pilots that participants can invest in."*
>
> *–Eric Weaver, Executive Director, Institute for Advancing Health Value*

However, not all organizations who were interested in the CMMI model were selected to join. The updates to ACO REACH from GPDC—namely, the increased focus on provider leadership, prioritization of entities with direct patient care experience, particularly in underserved communities, greater oversight and transparency into ACO ownership and conflicts of interest, and incorporation of health equity into model design and participant planning—were reflected in the cohort of 110 provisionally accepted ACOs.

While CMMI accepted roughly the same proportion of Global vs Professional ACO applicants as the current participants (with just under 75% of DCEs/ACOs in the Global risk track), the incoming group includes more High Needs and New Entrant ACOs relative to GPDC. Despite this increase in the number of non-Standard ACOs, the new cohort also welcomes more incumbent provider organizations moving from NGACO or MSSP. This uptick in "familiar faces" could be due to the methodology changes to ACO REACH making the model more favorable relative to GPDC, the aims of CMMI application reviewers to prioritize these organizations, and/or the strength of their applications after many years under accountable care.

Similarly, the new group of provisionally accepted ACOs, and the self-reported applicant data, shows a strong sustained interest in the model from VBP enablers, including organizations with existing DCEs and/or a strong track record supporting ACOs in the MSSP and NGACO. The new cohort also includes upstart enablers created specifically for the ACO REACH model. Regardless of the enablement partner's Medicare APM history, ACOs of this type seem to include more explicit involvement/co-ownership from provider organizations.

One notable difference between the 99 DCEs and the 110 REACH ACOs is the lack of payer-led ACOs. The substantial drop in payer participants or partners signals an intentional choice by CMMI. While these organizations may have the aligned infrastructures and capabilities for a model like ACO REACH – which requires ACOs to negotiate downstream value-based contracts and administer payments to network providers – many model critics cited the potential for gaming by payers who also own MA products. Given these conflicts, or even the perception of such conflicts of interest, CMMI seems to have deprioritized payer-owned ACO applicants in the selection process.

Figure 6: High-Level Similarities and Differences

How did the updates to ACO REACH from GPDC influence the new cohort?

- Same breakdown of Global vs Professional risk, but new cohort includes more High Needs and New Entrant ACOs
- Among Standard ACOs, greater participation from "familiar ACO faces" as more provider organizations moved from NGACO or MSSP
- Far fewer payer-led ACOs in new cohort
- Sustained interest (and acceptance) from VBP enabler-led ACOs, though more often with explicit provider partners/co-owners

Regardless of the specific participant breakdown, the ACO REACH model signifies a significant step forward for the value movement, representing the next generation of APMs untethered from a FFS chassis and a vehicle for engaging thousands of providers in accountable care and reaching millions of Medicare beneficiaries. While the number of total covered lives is unknown (including the size of the population served by the current 99 DCEs or the projected future lives covered by the incoming cohort) it's expected to be substantial – helping to contribute to CMS' goal to have all Medicare beneficiaries in accountable care relationships by 2030.

> *"As one of the first models focused on incentivizing value-based care entities for underserved communities, the implications of the ACO REACH model underscore the current administration's focus on health equity and the overall movement toward increasingly provider-centric organizations and models," said Molly Kane, Corporate Strategy and Policy Manager at Bamboo Health, a healthcare technology solutions company focused on fostering care collaboration and providing information and actionable insights across the entire continuum of care. "To ensure success under the ACO REACH model, and ultimately the ever-changing value-based care landscape, participating ACO organizations will need to implement scalable, broadly applicable strategies aimed at maximizing revenue and shared savings. These objectives can be accomplished through a focus on beneficiary engagement tactics that support retention and proactive care, processes maximizing quality scores, as well as investments in care management resources to minimize avoidable utilization."*
>
> *–Molly Kane, Corporate Strategy and Policy Manager at Bamboo Health*

Looking Ahead

Time will tell how many of the 99 active DCEs and 110 provisionally accepted REACH ACOs matriculate into ACO REACH. CMS plans to release the final list in January 2023 after Model Performance Period Participation Agreements (MPP PAs) are signed. Current DCE participants may be forced to exit the program if the new requirements for participation are too onerous to overcome (see Figure 7). While most DCEs are expected to comply with the new model requirements, some organizations may decide to withdraw from the model for other reasons. As a new, sophisticated CMMI model, some attrition is expected.

Figure 7: ACO REACH Compliance Requirements for Current DCEs

What changes must DCEs make to matriculate into ACO REACH?

- Restructure the governing body. One of the criticisms of GPDC was the shift away from the historically provider-led governance model. Under ACO REACH, the makeup of the governing body reverts to the requirements seen under previous CMS models: 75% Participating Providers, up from only 25% under GPDC. The revision also adds stronger beneficiary representation in the form of two distinct beneficiary and consumer advocates with voting rights.
- Ensure that the participant list reflects a heterogenous population. ACO REACH requires that no more than 50% of a REACH ACOs beneficiary population come from specified medical sub-population. GPDC had several renal-dominant ACOs that CMS would prefer to see in the more targeted Kidney Care Choices model.
- Resolve market overlap. A High Needs Population ACO cannot co-exist in the same market as a Standard or New Entrant ACO owned by the same sponsoring organization.
- Incorporate health equity considerations. REACH ACOs must define health equity goals, assess opportunities to address health disparities, and develop a health equity plan.

As discussed above, 18 unknown ACOs elected to withdraw after being provisionally accepted to the model. The reason for their withdrawal is unknown, but industry observers may expect a few additional departures from provisionally accepted REACH ACOs who elect to "leave" the program before the MPP PAs are signed and the January 1, 2023 start date. Some organizations may have jumped on the opportunity to apply for the ACO REACH model in its final application cycle without fully modeling their projected performance or determining their chosen path forward. Others may find the recently proposed MSSP updates an enticing opportunity to remain in a proven Medicare ACO model that requires less financial risk and less sophisticated forecasting capabilities.

As with its predecessors, the Pioneer and Next Generation ACO models, ACO REACH is a new, largely untested pilot. Although many design elements have been carried over from previous model demonstrations, ACO REACH is implementing several novel methodologies. It will take time for CMMI to "work out the kinks," and for ACOs to learn how to succeed under this complex new model. However, some REACH ACOs, after working to make the final application window, may now have had more time to understand the model and forecast their projected performance and risk exposure. Already, some criticisms of the model have emerged as organizations have had more time to delve into the details, including potentially unfavorable outcomes to benchmarks resulting from major differences between projected and observed cost trends and issues with the choice of proxy calculation – the Area Deprivation Index (ADI) – to establish health equity adjustments. There may be organizations who find that they are unwilling to continue in the model after better understanding it.

> *"As we look toward the future of the healthcare industry, we can glean a lot from the changes CMS implemented through the switch to the ACO REACH model and what these changes signify for the future of care collaboration," said Vatsala Kapur, Head of Government Affairs at Bamboo Health. "With an eye to health equity, we are now at a point where the focus of healthcare IT needs to shift from simply enabling a foundational level of interoperability to realizing the value that actionable interoperability can deliver to providers in support of value-based care models such as ACO REACH. The ability to seamlessly collaborate on patients offers the promise of making the lives of providers easier and more efficient to decrease care gaps, improve patient health, and reduce total cost of care."*
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> *–Vatsala Kapur, Head of Government Affairs at Bamboo Health*

As new entities enter the ACO REACH model, some will succeed and other may fail. While only time will tell its true impact on the healthcare industry, the difference for ACO REACH model participants will be on how they execute on the ground level. Participants that employ care coordination strategies and resources, particularly those that provide real-time information on patient care events and help support proactive patient engagement and care interventions, will be poised for the most success. This is because real-time notifications on patients' care events across acute and post-acute settings, plus interactive performance dashboards on utilization, readmissions, and multi-visit patients, can help ACO provider organizations achieve a variety of benefits. Examples include the ability to enable rapid post-discharge follow ups to support beneficiary engagement strategies for increasing voluntary alignment and beneficiary retention; power strategies and care team workflows to minimize avoidable hospital and post-acute utilization and potential readmissions; and ensure timely post-discharge follow ups to support transitional care management workflows and engagement for preventative services. As we continue to analyze these implications, the emphasis on care coordination will continue to be important for all patients, particularly those in high-risk populations, but the benefits will only be fully realizable with the help of care management resources and tools that support this and future value-based care payment models.

The ACO REACH model is an integral component of CMS's strategy to redesign primary care as a platform to drive reductions in costs while addressing the issue of health equity in our country. In addition, the model is an opportunity for participants to drive consistent revenue, improve patient outcomes, and lower global utilization and costs. As participants prepare for ACO REACH, several key considerations should be reviewed to help ensure success. Specifically, participants should evaluate care coordination strategies and resources, particularly those that provide real-time information on patient care events and help support proactive patient engagement and care interventions. Collaborating across the care continuum, especially for nontraditional participants in the ACO REACH model will be a critical driver to truly support proactive patient engagement and care interventions. Interoperability will be something that can no longer be a checkbox item for true health equity – it must result in actionable information that drives better healthcare. Figuring out the interoperability challenges is no small task, especially for smaller organizations that may not have the technical infrastructure required.

Additional information on the REACH ACOs that ultimately begin participation in January 2023 will be forthcoming, including Beneficiary Enhancement selections and capitation payment mechanisms. The required Health Equity Plans will also be published and should provide interesting insight into the differing ways REACH ACOs plan to address health equity within their assigned beneficiary population.
The Institute will continue to monitor and provide updates on ACO REACH participants and performance.

About the Institute

The Institute for Advancing Health Value (the Institute) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the Institute serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the Institute, visit advancinghealthvalue.org. The Institute is formerly known as the Accountable Care Learning Collaborative (ACLC).

About Bamboo Health

Bamboo Health is committed to tackling the problem of incomplete patient data that has historically plagued all providers across the care continuum. Bamboo Health works with its customers to implement strategies for ACO REACH success, including real-time notifications on patients' care events across the acute and post-acute settings, and interactive dashboards on care events for high-risk, high-utilization populations. Bamboo Health helps implement strategies that help drive voluntary beneficiary alignment, engage beneficiaries to support retention, create processes that help maximize quality scores, ensure care coordination and manage care journeys.