Comparing GPDC to the ACO REACH Model

Beginning in 2023, the GPDC Model will be redesigned and renamed the ACO REACH Model. ACO REACH will enable CMS to test an ACO model that can inform the Medicare Shared Savings Program and future models and includes important changes to the GPDC Model in three areas: 1) Advancing Health Equity to Bring the Benefits of Accountable Care to Underserved Communities; 2) Promoting Provider Leadership and Governance; and 3) Protecting Beneficiaries and the Model with Enhanced Participant Vetting, Monitoring and Greater Transparency. This table highlights the policy changes that CMS expects will improve the model for beneficiaries and address health equity.

	Original Global and Professional Direct Contracting (GPDC) Model (PY2021–PY2022)	ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023–PY2026)
MODEL GOALS	• Improve beneficiary access to providers who are personally engaged in their healthcare delivery. • Provide strong incentives to improve quality of care by shifting payment away from fee-for-service towards value-based capitated payments. • Allow organizations with prior ACO experience, innovative organizations taking risk in MA or Managed Medicaid, and organizations that focus on complex beneficiary populations to participate.	• Improve the focus on: – Promoting health equity and addressing historical healthcare disparities for underserved communities. – Continuing the momentum of provider-led organizations participating in risk-based models. – Protecting beneficiaries and the model with more participant vetting, monitoring and greater transparency.
TIMELINE	• The GPDC Model originally consisted of 6 performance years (PYs): PY2021 through PY2026.	• The policy changes and new name (ACO REACH Model) will take effect at the start of PY2023 and continue through PY2026.
PARTICIPANTS	• Model participants are called Direct Contracting Entities (DCEs), but are equivalent to ACOs.	• Model participants referred to as REACH ACOs.
GOVERNANCE	• Participating providers generally must hold at least 25% of the governing board voting rights. • Each DCE's governing board must include a beneficiary representative and a consumer advocate, though these representatives may be the same person and neither is required to hold voting rights.	• Participating providers generally must hold at least 75% of the governing board voting rights. • Each REACH ACO governing board must include a beneficiary representative and a consumer advocate, who must hold governing board voting rights and must be different people.
HEALTH EQUITY	• No policies explicitly promoting health equity.	• Requirement for all REACH ACOs to develop a Health Equity Plan that must include identification of health disparities and specific actions intended to mitigate the health disparities identified. • Introduction of a health equity benchmark adjustment to better support care delivery and coordination for patients in underserved communities. • Requirement for all ACOs to collect beneficiary-reported demographic and social needs data. • New Benefit Enhancement to increase the range of services that may be ordered by Nurse Practitioners to improve access.
APPLICATION	• Participants began in PY2021 or deferred to PY2022 due to the Public Health Emergency. • Next Generation ACOs were able to apply for PY2022. • Application scoring criteria focused on the following five domains: (1) organizational structure; (2) leadership and management; (3) financial plan and risk-sharing experience; (4) patient centeredness and beneficiary engagement; and (5) clinical care.	• Application period opening in Spring of 2022 for participation beginning in PY2023. • New ACO REACH application scoring criteria considers, in addition to the five GPDC domains: – 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/parent companies. – GPDC participants must agree to meet all the ACO REACH requirements by January 1, 2023 in order to continue participating in ACO REACH.
DISCOUNT FOR GLOBAL	• Global DCEs receive 100% of gross savings/losses. A discount is applied to the benchmark before gross savings/losses are calculated, which helps guarantee shared savings for CMS. There is no discount for Professional DCEs. • Original discount levels originally planned for the benchmarks of Global DCEs: PROFESSIONAL: N/A / N/A / N/A / N/A / N/A / N/A GLOBAL: 2% / 2% / 3% / 4% / 5% / 5% (PY2021 / PY2022 / PY2023 / PY2024 / PY2025 / PY2026)	• Reduced discount rate for Global ACOs to 3-3.5% beginning in PY2023 will further CMS' goal of increasing participation in full risk FFS initiatives. PROFESSIONAL: N/A / N/A / N/A / N/A / N/A / N/A GLOBAL: 2% / 2% / 3% / 3% / 3.5% / 3.5% (PY2021 / PY2022 / PY2023 / PY2024 / PY2025 / PY2026)
QUALITY WITHHOLD	• The quality withhold applied to the benchmarks of both Professional DCEs and Global DCEs is 5%.	• Quality withhold for both Professional ACOs and Global ACOs is reduced to 2%.
RISK ADJUSTMENT	• Two policies protect against risk coding growth: – The "Coding Intensity Factor" (CIF) limits risk score growth across the entire model. The CIF applies to all DCEs to limit risk score growth to the average prior to the start of the model. – A "Risk Score Growth Cap" limits a DCE's risk score growth to +/- 3% over a 2-year period. The DCE-specific caps on over-coding ensure DCEs are coding appropriately and limit gaming.	• Two changes to the "Risk Score Growth Cap" further mitigate potential inappropriate risk score gains: – Adopt a static reference year population for the remainder of the model performance period. – Cap the REACH ACO's risk score growth relative to the DCE's demographic risk score growth, so the +/- 3% cap is appropriately adjusted based on demographic changes in the underlying population over time. (Currently risk score cap is based on HCC growth—this would cap HCC growth relative to demographic growth.)
MONITORING/ COMPLIANCE[2]	• Robust monitoring of all DCEs includes: – Monitoring for levels of care provided, – Compliance audits conducted throughout the year, – Investigation of beneficiary complaints, and – Collection of beneficiary surveys (CAHPS)[1] annually to measure changes in beneficiary satisfaction.	• Additional monitoring and compliance efforts and analytics will: – Assess annually whether beneficiaries are being shifted into or out of MA. – Examine ACO's risk score growth to identify inappropriate coding practices. – Monitor for noncompliance with prohibitions against anti-competitive behavior and misuse of beneficiary data. – Increase use of data analytics to monitor use of services over time and compared to a reference population to assess changes in beneficiaries' access to care, including stinting on care. – Review marketing materials regularly to ensure information on the Model is accurate and beneficiaries understand their rights and freedom of choice. – Verify annually that REACH ACO websites are up to date and provide required information. – Audit annually REACH ACO contracts with providers to learn more about their downstream arrangements and identify any concerns. – Investigate on a rolling basis any beneficiary and provider complaints and grievances in coordination with 1-800-Medicare, the Innovation Center liaison on models in the Medicare Beneficiary Ombudsman team, CMS regional offices, and others as appropriate.
BENEFITS AND PROTECTIONS FOR MEDICARE BENEFICIARIES	• Benefits (applies to all Performance Years of the model) include: – A higher quality of care and greater clinical support and care coordination for beneficiaries. – "Benefit Enhancements" and "Beneficiary Engagement Incentives" offered under the model (e.g., telehealth, post-discharge home visits and waiver of the homebound requirement, Part B cost-sharing support, concurrent care for beneficiaries that elect hospice care). • Beneficiary protections (applies to all Performance Years of the model): – All aligned beneficiaries retain full Original Medicare benefits and can see any Medicare physician. – Beneficiaries are proactively notified on an annual basis of their alignment to a DCE/ACO and that their benefits have not changed. – Beneficiaries retain all FFS Medicare channels for raising concerns or reporting complaints.	

[1]Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2]Additional information on compliance activities, including vetting, monitoring, auditing, and analytics forthcoming.