Spencer Perlman
240-657-0005
sp@veda-partners.com

CMS's Revision of Its "Direct Contracting" Model is One Part PR Rebranding, One Part Modest Tweak, and Net Neutral in Impact

February 26, 2022

Yesterday after the close, the Centers for Medicare and Medicaid Services (CMS) announced several changes to the Global and Professional Direct Contracting (GPDC) Model that has come under fire from progressive lawmakers and activists as a supposed backdoor "privatization" of fee-for-service (FFS) Medicare. While many industry stakeholders were concerned that CMS might jettison the Model in response to this political pressure, the agency instead made a handful of modest reforms and rebranded it as an Accountable Care Organization (ACO) initiative, newly renamed the "ACO Realizing Equity, Access, and Community Health (ACO REACH) Model."

The agency did make some important substantive changes to the program's goals, priorities, and requirements, but we believe that most of these alterations are modestly impactful and likely will have a net neutral aggregate effect on current and pending GPDC / ACO REACH participants. Indeed, most of the so-called reforms highlighted by the agency in its press releases are largely superficial in nature or merely reiterate preexisting protections for beneficiaries already embedded into the GPDC Model. Thus, in our estimation, the reforms are one part a public relations exercise intended to placate the Biden Administration's critics on the left and one-part modest revisions that should not tangibly impact the for-profit entities *currently* participating in the Model. It is possible, though, that some of the changes to the weighting of certain eligibility requirements for *new participants* may slightly disincentivize the involvement of some for-profit entities without a "demonstrated successful historical experience … providing direct patient care."

Killing Geo, Renaming GPDC

Originally established as a multifaceted initiative under the Trump Administration in late 2020, the "direct contracting" approach initially consisted of two models: the GPDC and the population-based Geographic Direct Contracting Model (Geo). The Biden Administration put Geo on pause shortly after President Biden's inauguration and CMS formally killed the Model in its announcement last evening. Since Geo had never been initiated, its cancellation is both unexpected and unimpactful.

While progressives strongly advocated for CMS to kill the GPDC, too, we do not believe the Administration ever seriously considered ending the Model. The CMS Innovation Center's Director, Liz Fowler, has spoken frequently of her belief that direct contracting can generate important lessons learned for CMS and that capitation is a key tool for fixing the inefficiencies of FFS payment systems. Ms. Fowler discussed in positive terms the Direct Contracting program in a *Health Affairs* podcast in June 2021 and in a subsequent *Race to Value* podcast

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from January 2022. And while she has never been dismissive of progressives' criticisms, she appears to disagree with them.

Thus, the direct contracting concept is being retained, though with a name change and certain reforms that will go into effect on January 1, 2023. The GPDC Model will continue to run through December 31, 2022, at which point it will end, and the new ACO REACH Model will then initiate and run for four years, January 1, 2023 – December 31, 2026. Current participants in the GPDC Model may transition directly to the ACO REACH Model, if they can demonstrate to CMS the ability to meet the new program rules and requirements. Entities wishing to newly participate in ACO REACH must respond to a new Request for Application (RFA) for which CMS is accepting applications from March 7 – April 22, 2022.

What's New? What's the Same?

Figure 1 below lays out the elements of the ACO REACH Model that are new, and those that are the same as the GPDC Model.

Figure 1. How ACO REACH Differs (And Doesn't Differ) From GPDC.

What's Changing/New	What's Staying the Same
✓ Name of the Model	✓ Eligibility Criteria for Participants
✓ Vetting Process for Participants	✓ Eligibility Criteria for Beneficiaries
✓ Governance Structure Requirements	✓ Beneficiary Protections
✓ Health Equity Requirements	✓ Benefit Enhancements
✓ Discount Factor	✓ Risk Sharing Percentages
✓ Quality Withhold	✓ Risk Corridor Parameters
✓ Stop-Loss Methodology	✓ Beneficiary Alignment Methodologies
✓ Risk Score Growth Limit	✓ Benchmark Calculation Methodologies
✓ Monitoring for Compliance	✓ Capitation Payment Methodologies

Sources: CMS, Veda Partners

What's Changing or New?

We discuss in more detail below the substantive changes implemented by CMS, including whether we believe the alterations are net positive or net negative for for-profit participants.

- **Vetting & Scoring Process for Participants (NEGATIVE)**: While the eligibility criteria for entities wishing to participate in the ACO REACH Model are the same as those for the GPDC Model, CMS is tightening its vetting process by enhancing its program integrity (PI) review of applicants. Specifically, the agency will examine the eligibility and history of all owners, executives, equity partners, and participating providers. Such individuals and entities may be disqualified for a history of adverse enrollment actions, delinquent Medicare or

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Medicaid debt, poor performance and compliance in other Medicare models, lack of compliance with Medicare and Medicaid program requirements, suspicious billing or other potential program fraud and abuse, other civil or criminal actions related to integrity, or engagement in anti-competitive practices. Additionally, CMS is altering its scoring of applications to favor entities with a demonstrated successful historical experience in providing direct patient care or care to underserved individuals and communities. In practice, it is possible that these new vetting and scoring procedures could potentially make participation by certain private equity (PE) backed startups more difficult. It appears that CMS is attempting to tilt the playing field in favor of provider-led entities with historical experience in direct patient care, e.g., ACOs, over Medicare Advantage (MA) plans and physician enablement startups, though these latter groups are still fully eligible to apply and, if accepted, participate in the ACO REACH Model.

- **Governance Structure Requirements (NEGATIVE)**: Under the GPDC, participating providers must hold at least 25 percent of the direct contract entity's (DCE) governing board voting rights, and the board must include at least one beneficiary representative and consumer advocate (one person can serve both roles), though such individual is not required to hold voting rights. CMS is implementing two changes to the governance structure requirements in the ACO REACH Model. First, participating providers must hold at least *75 percent* of the ACO's governing board voting rights, and the board must include *both* a beneficiary representative and a consumer advocate, with both such individuals holding voting rights. In practice, this new governance requirement will grant greater power and control over the governance and decision making to providers and leave less power and control in the hands non-clinical entities. This could potentially create conflict between the ACO participating in the Model and the providers holding the majority of the governing board's voting power.

- **Health Equity Requirements (POSITIVE)**: The ACO REACH Model implements four new policies intended to address health equity for historically underserved individuals, populations, and regions. We believe that, in aggregate, these new policies benefit entities participating in the Model, or, at the very least, offer upside potential.

    - First, participating ACOs must establish a Health Equity Plan to identify and address health disparities. While development and execution of the plan could increase costs, we do not believe it likely will have a material impact on participant's economics.

    - Second, CMS is establishing a "Health Equity Benchmark Adjustment" to better incentivize the furnishment of care to historically underserved individuals, populations, and communities. The agency will stratify all ACO REACH beneficiaries using a composite measure of the beneficiary's census block's Area Deprivation Index and the beneficiary's Dual Medicaid Status; for every aligned beneficiary in

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the top decile, the ACO will receive a $30 positive adjustment to the per beneficiary per month (PBPM) amount, and for every aligned beneficiary in the bottom five deciles, the ACO will receive a $6 negative adjustment to the PBPM amount. The goal of the Health Equity Benchmark Adjustment is to financially reward ACOs that are aligned with beneficiaries that reside in historically underserved communities and/or are part of historically underserved population cohorts. Participants that align with beneficiaries in the top decile can benefit financially.

- Third, CMS is requiring participants to collect and report to CMS a range of beneficiary-reported demographic and social needs data. ACOs that report this data will receive a bonus in their Quality Scores, which will improve the likelihood of receiving back more of the quality withhold and/or qualifying for a quality bonus payment.

- Fourth, CMS is establishing a new Benefit Enhancement by allowing Nurse Practitioners (NP) to engage in a range of activities without direct physician supervision. Specifically, NPs may certify the need for hospice care; certify the need for diabetic shoes; order and supervise cardiac rehabilitation; establish, review, sign, and date a home infusion therapy plan of care; and refer beneficiaries for medical nutrition therapy. The purpose of this benefit enhancement is to improve care delivery and coordination in areas with limited access to physicians. We note, too, that ACOs could benefit from using lower-cost NPs to furnish care rather than more expensive physicians.

In aggregate we believe that the Health Equity Requirements represent a net positive for industry. Participants that proactively seek out and secure the financial incentives offered by CMS can potentially receive a meaningful economic benefit.

- **Lower Discount Factor (POSITIVE)**: Under the GPDC Model, Global DCEs receive 100 percent of savings and losses. In order to guarantee savings to the government, CMS applies a "discount factor" to Global DCE benchmarks, with the discount factor growing from 2 percent in 2021 to 5 percent by 2025. The ACO REACH Model is lowering the maximum Global ACO discount factor to 3.5 percent. Thus, benchmarks for Global ACOs will be relatively higher in the ACO REACH Model in 2024 – 2026, meaning participating ACOs can retain a greater share of savings.

- **Lower Quality Withhold (POSITIVE)**: Under the GPDC Model, CMS withholds 5 percent of payments from DCEs and returns a percentage of the withheld amount commensurate with the DCE's performance on Model quality measures. The ACO REACH Model is lowering the quality withhold to just 2 percent. Thus, ACOs will retain a greater percentage of their benchmarks at the outset, and the potential downside risk from relatively lower quality performance is meaningfully reduced.

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- **Stop-Loss Methodology Change (NEGATIVE)**: Under the GPDC, DCEs may opt-in to a stop-loss program that provides reinsurance against beneficiaries with spending above a *fixed attachment point*. In return for the stop-loss protection, DCEs receive a lower benchmark payment, in essence paying a premium for reinsurance coverage. In the ACO REACH Model, the stop-loss option continues to be offered, but payout is made only if a beneficiary's care exceeds its unique *predicted spending attachment*. By shifting from a fixed attachment to a beneficiary-specific predicted spending attachment, CMS is ensuring that stop-loss payments will be funneled only to ACOs with beneficiaries incurring *unexpectedly* high expenditures rather than simply rewarding DCEs with a disproportionately larger cohort of relatively expensive beneficiaries. Thus, on net, we believe this policy change is negative for DCEs/ACOs opting into the stop-loss protection, though we would argue it better reflects the true purpose of reinsurance.

- **Risk Score Growth Cap (NEUTRAL)**: Under the GPDC, CMS has established several policies to protect against coding intensity and risk score growth at the Model and DCE level. First, risk scores are "Normalized" annually so the average risk score of the reference population is always 1.0. Second, CMS has established a "Coding Intensity Factor" (CIF) that limits risk score growth at the Model level to the programmatic rate of growth in the reference year (i.e., 2-years prior). Benchmarks are reduced prospectively for all DCEs by the CIF. Third, at the DCE level, risk score growth is capped at 3 percent versus the reference year (i.e., 2-years prior), meaning each DCE's risk scores can effectively grow only 3 percent every 2-years. In the ACO REACH Model, CMS is retaining the Normalization Factor and CIF, and it is making two changes to the ACO-Level Cap. First, while the cap remains at 3 percent growth, beginning in 2024 it is tied to a static reference year for the remainder of the Model, rather than a rolling reference year. Thus, each ACO's risk score growth in 2024, 2025, and 2026 will be capped at 3 percent above 2022 levels, which represents a headwind for Model participants. However, also in 2024, CMS will calculate ACO-specific total risk score limits in relation to *demographic* risk score growth. In other words, risk score growth in 2024 – 2026 that is tied to demographic changes in aligned beneficiaries is *not* capped, meaning that only diagnoses-related risk score growth is capped. This means that ACOs that are aligned with beneficiaries exhibiting demographic characteristics that generate higher risk scores can secure higher relative payments in the outyears of the Model. In aggregate, we believe these policy changes are neutral for ACO participants.

- **Monitoring for Compliance (NEGATIVE)**: Under the GPDC, CMS monitors DCEs for levels of care provided to beneficiaries, conducts compliance audits, investigates beneficiary complaints, and collects beneficiary surveys to determine rates of satisfaction. In the ACO REACH Model, CMS will expand and intensity its compliance monitoring activities. Specifically, CMS will engage in the following additional activities: assess annually whether beneficiaries are being shifted into or out of Medicare Advantage (MA); monitor for

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noncompliance with the prohibitions against anti-competitive behavior; measure beneficiaries' access to care versus a reference population to assess whether access to care is being restricted; ensure that marketing materials clearly inform beneficiaries of their freedom to opt out of participation in an ACO and to receive care from clinicians not affiliated with an ACO; and audit ACO contracts with providers to "identify any concerns." Most of these additional compliance activities are commonsense and should not have a material impact on ACOs, but in aggregate it represents a ratcheting up of the oversite of participants.

What Remains the Same?

We note that CMS did not make any material changes to the eligibility criteria for participants or beneficiaries, retained the GPDC's beneficiary protections and benefit enhancements (e.g., holistic access to telehealth and home care), and did not alter in any meaningful way the financial methodologies underpinning how the Model compensates participating ACOs. The beneficiary alignment methodologies, risk sharing percentages (upside and downside), risk corridor parameters, benchmark calculations, and capitation payment methodologies in the ACO REACH Model are identical to the those in the GPDC Model. Thus, the financial upside for participants is roughly the same in both models.

On Net, CMS's Changes are Neutral to Industry

Progressive lawmakers and activists hoped to kill CMS's direct contracting models. In practice, the agency made certain superficial changes (e.g., a name change, reiteration of preexisting beneficiary protections), left in place the financial methodologies underlying the GPDC Model that first attracted entities to the direct contracting concept, and implemented certain substantive changes to governance structures, discount factors, risk scores, and oversite that offer puts and takes.

There are undeniably certain changes to the Model that will hinder or challenge certain entities by subjecting them to more intensive vetting, requiring a restructuring of the governance board in a way that surrenders operational control to providers, lessening slightly the value of the stop-loss program, and intensifying the compliance monitoring by CMS. On the other hand, we believe that entities benefit on net from the new health equity requirements, the lower discount factor, and the lower quality withhold. And the impact of the changes to the risk score growth cap is likely neutral.

In aggregate, we believe that the changes to the direct contracting program are neutral in their impact to for-profit entities currently participating in or expressing an interest in the Model. We note, too, that CMS chose not to explicitly cap participation in the program, meaning the addressable market remains substantial. The Biden Administration surely has put its imprint on a Trump Administration initiative, but the underlying framework remains in place and, we

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sp@veda-partners.com

believe, continues to offer meaningful upside if participating entities are able to effectively manage care within the program's parameters.

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240-657-0005
sp@veda-partners.com

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