Physicians for a National Health Program Policy Primer:

What's the difference between the Medicare Direct Contracting and REACH programs? Four things to know

The Centers for Medicare and Medicaid Services (CMS) announced a rebranding effort for the controversial Direct Contracting (DC) Program, renaming it "ACO REACH" effective Jan. 1, 2023. REACH retains all of DC's fatal flaws, but now includes major giveaways to profit-seeking REACH middlemen that will open the door to increased profiteering in marginalized communities. As one industry analyst put it, "the reforms are one part a public relations exercise ... and one-part modest revisions that should not tangibly impact the for-profit entities currently participating in the Model." Below is a summary of the significant changes from DC to REACH.

1. More profit and less risk for REACH middlemen

Compared to DC, REACH gives middlemen less financial risk for health costs and quality, and more potential for profit at the expense of Traditional Medicare and its beneficiaries.

- Reduced "discounts:" When a middleman spends less on care, Medicare is entitled to a small "discount," or a portion of that savings; CMS takes the discount upfront as prepayment of the savings the middleman is expected to generate. **CMS reduced the discount from 5% in DC to 2% in REACH**, with a gradual increase to 3.5%. This change allows REACH middlemen to keep more of their Medicare payments as profit.

- Reduced quality withholds: In DC, CMS withholds 5% of a DCE's upfront payment as a "quality withhold," allowing DCEs earn back the 5% if they meet certain quality measures. **CMS cut the quality withhold from 5% in DC down to 2% in REACH**, reducing the penalties for not meeting quality standards and allowing middlemen to keep more of their Medicare payments as profit — a double win for the industry and an implicit statement that REACH middlemen will not be able to meet quality measures.

2. Superficial nod to equity that may lead to profiteering in underserved communities

CMS introduced several equity incentives that do not hold REACH middlemen accountable for improving equity. These incentives encourage profit-seeking middlemen to target vulnerable beneficiaries, a dangerous proposition for communities with enormous untreated health needs.

- No-strings-attached bonus for enrolling vulnerable beneficiaries: CMS created a "Health Equity Benchmark Adjustment" to incentivize REACH middlemen to enroll underserved beneficiaries, determined by residence and Medicaid eligibility. **CMS will give REACH**

middlemen an additional $30/month ($360/year) for each beneficiary in the top decile of the Benchmark, *regardless of how much care each beneficiary receives.*

- New "upcoding" opportunities for demographic factors: Like DC and Medicare Advantage, CMS will pay REACH middlemen a flat fee per enrollee, based on the enrollee's "risk score" (determined by the number and severity of the beneficiary's diagnoses) incentivizing middlemen to fraudulently "upcode" diagnoses to increase revenues. While CMS says it will introduce guardrails to limit upcoding, **it will also allow middlemen to grow beneficiaries' risk scores — and revenues — by adding demographic factors not related to diagnoses.** *Inflated risk scores increase Medicare's payments to middlemen but do not require them to provide additional care.*

- "Fill-in-the-blanks" equity plan: CMS requires REACH middlemen to submit their own health equity "plans," but only *after* applicants have been approved for the program, so the plans are not measurable or enforceable. To make it easier on applicants, CMS provides them with a sample fill-in-the-blank worksheet as a template.

- All carrots — and no sticks — for reporting data: CMS will require REACH middlemen to collect and report enrollees demographic data, and encourage (but not require) them to document social determinants of health. CMS will not hold middlemen accountable for improving equity, but will reward them for demographics reporting by providing a 10 percentage point bonus to their Total Quality Score, **increasing their ability to earn back more of the "quality withhold" and receive a "quality bonus payment," which potentially increase profits.** CMS will not reduce the Quality Score for non-submission.

3. Lip service to scrutiny, but free pass for current Direct Contracting Entities

CMS says they will examine the history of each applicant's owners, executives, investors, and participating providers, a shocking admission that the agency *did not* scrutinize the owners and managers of the 99 DCEs currently managing seniors' care. As long as current DCEs meet requirements of the DC and REACH program (i.e., drafting an equity plan), the 99 DCEs do not need to re-apply to participate in REACH. And like DC, CMS will allow virtually any type of company — from private equity investors to commercial insurers — to participate.

4. Increased provider governance — with a catch

Each REACH middleman's board must include 75% voting rights for participating providers (up from 25% in DC); as well as a beneficiary and consumer representative. However, **any REACH applicant can seek an exception to this rule at the CMS's discretion**, as long as they explain how they'll "involve Participant Providers in innovative ways in ACO governance." REACH middlemen may also **pay board members for their service**, which may compromise board members' independence. Regardless of board makeup, REACH middlemen will ultimately have to answer to their investors.

Physicians for a National Health Program (pnhp.org) is a nonprofit research and education organization whose more than 25,000 members support single-payer Medicare for All reform. For more information about Medicare REACH and privatization, please contact info@pnhp.org