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ACO REACH tweaks help smaller group practices promote health equity.

Thomas H. Bernard, an attorney and shareholder with Baker Donelson in Baltimore, says the practice usually doesn't have a duty to defend the provider in the case of unlawful activities. "I have seen situations where a partner is criminally charged and then the other partners will come in and with him or her and they throw out," he says. "That's part of the reason people are moving away from certain partnership agreements. There can be a huge liability risk to the entity in cases like this."

So things may be different if it's not a criminal matter, Bernard explains. Property authorized law enforcement activities may be allowed under state law to perform undercover stops, even if they compromise sensitive health care laws. But not every investigation is criminal, and not all investigations are law enforcement.

Consider an example from 2019: Joseph Davis, M.D., has been fighting a Florida Department of Health complaint based on his alleged failure to obtain "appropriate medical justification" for medical marijuana prescriptions to write for his cancer agency. Part of Davis' defense is that the agents broke the law with their subpoena and were not exempt because they were not authorized law enforcement officers.

In such a case, the subpoena may be illegal and the case may be tossed, Bernard says. "From the Department of Health, when they do civil investigations, usually can't sue doctors. It's normally considered not a certified law enforcement agent in an authorized criminal investigation," Bernard notes. "In the federal government, a law enforcement agent is referred to as an 'LE' and that comes with unique authorities. Because if they're not law enforcement, if they're not trained, you never know — people could draw guns. There needs to be coordination. It could go serious."

If any agency asks for your cooperation in writing, "you're going to want to know what agencies are involved and whether they're coordinated with law enforcement," Bernard says. "If I were advising a company, I would want to make sure of that before we decide ourselves. If it's an employee and the employer's involved in some kind of deception, you might violate union rules or other employment laws."

If you find government agents writing around your providers, "the first thing I would tell the medical practice to do is conduct its own investigation and take appropriate action against the employee," Brodman advises. "The entity could be at risk for malpractice charges, if nothing else, if they are put on notice that some questionable practices are being engaged in by one of their employees and they don't act."

If the request for cooperation comes with a request for documents, remember that, as in the case with subpoenas, protected health information usually can't be surrendered without patient consent even when demanded by government agencies, notes Fred Wilson, senior legal counsel and health care and health systems practice lead at Troutman Law in Cleveland. With that in mind, he says to consult your lawyers. [PBN 2/28/22](#) — [By Editor \[@decisionhealth\]\(#\)](#)

RESOURCES

- Florida Department of Health administrative complaint against Joseph C. Davis, M.D., May 1, 2019 www.doh.state.fl.us/Doc/Doc/2019/004729/1/004729AC-080819-1405140.PDF

Value-based care

ACO REACH tweaks help smaller group practices, promote health equity

Experts are getting a closer look at the ACO REACH model CMS suddenly unveiled in February, and it's looking good for ACOs who don't have unlimited financial resources, as well as for the advancement of CMS' health equity cause.

After months of controversy over the CMS Global and Professional Direct Contracting (GPDC) model from the Center for Medicare and Medicaid Innovation (CMMI), CMS announced Feb. 24 that, starting in 2023, the program would be transformed into the Accountable Care Organization (ACO) Realizing Equity, Access and Community Health (REACH) model, or ACO REACH. Its participants would be called ACOs instead of Direct Contracting Entities (DCE) ([PBN 2/28/22, 3/7/22](#)).

Since the announcement, CMMI has issued a request for applications, which are due by April 22, 2022, and must be submitted by portal ([see resources, below](#)). Applicants may include current GPDC entrants who want to remain in the program when it turns into ACO REACH, as well as new groups interested in value-based design.

Take a look at ACO Reach details

Experts have parsed the technical details announced by CMMI. The lowering of the quality withhold from 5% to 2%, for example, is a break for ACOs, especially those who can't afford to invest too much up front, explains Lauren Patrick, president and CEO of qualified registry Healthmonix in Malvern, Pa. This is meaningful because critics, such as Sen. Elizabeth Warren (D-Mass.), had complained about

well-funded private equity interests' potential domination of the program.

"CMS holds back a percent of the savings to be adjusted based on the quality scores on quality measures that CMMI/CMS have included in the program," Patrick explains. "For example, the current Global DCE would get 95% of their savings regardless of their performance on the quality metrics. Then the remaining 5% would be based on how well quality metrics are achieved."

By lowering the withhold, CMMI may reduce some entrants' anxiety over quality measures. "Providers find it difficult to gather quality metrics and even harder to perform well," she says. "So any reduction in the dependence on quality measures is considered a 'win' by the providers."

The "benchmark discount" adjustment — for Global DCEs, it went from 2% to 5% over six years, whereas it now goes from 2% to 3.5% for Global ACOs — is another break for less-well-funded entrants, because it lowers the benchmark that the provider group is being measured against.

And the addition of a "static year summary" to the risk adjustment plan for the program, which only allows risk scores to go up or down 3%, is meant to "prevent additional 'gaming'" of risk adjustment, which was a concern of GPDC critics because it "allows the total risk score to rise or fall additionally if the population in the group changes — that is, if a group added some older patients or patients with significant diseases," Patrick says. Thus, an ACO can't lock in a high-risk factor and then dump sicker patients to take advantage.

Ashley Ridlon, vice president of health policy at Evolent Health in Arlington, Va., notes that some of the program features are similar to other models from CMS and CMMI. The "coding intensity factor," for example, "looks at how risk coding is going in your population versus the broader Medicare population to see if it's excessive," Ridlon says, "and that's something we're familiar with for Medicare Advantage."

But the changes in ACO REACH tilt the field more toward the smaller provider. "Entities become the payers for those providers per whatever agreement they have," Ridlon says. "That takes a lot of infrastructure as well as more outreach to get beneficiaries into your population. I think the concern was this attracts new entrants with a lot more capital while provider groups would face a little bit more of a challenge."

The equity angle

"Health equity," an area of focus that CMS has emphasized in recent rulemaking, is prominent in the ACO

REACH literature ([PBN 8/2/21](#)). But details on how the program will actually improve equity remain forthcoming.

"CMMI solicited a ton of input from the stakeholder community on health equity with a number of RFIs [requests for information] across multiple agencies," Ridlon says. "This is the first glimpse we're seeing into where they want to take that."

Among the features to watch will be an upcoming health equity benchmark. "They want to see more ACO entities in areas that are currently being underserved," Ridlon says. "They're looking at the demographics of the model population, to see if they're reflective of the communities that they're in. They want to make sure there are incentives to motivate those entities to serve parts of the country not currently being served and serve beneficiary populations that are more reflective of their communities. This could draw in new provider types with experience serving underserved populations."

In addition to requiring 75% provider representation on each REACH ACO's governing board — up from 25% under GPDC — CMS is requiring that boards have at least two "beneficiary advocates." The ACO also must have a health equity plan and collect health equity data for CMS.

"There are gaps in what people can obtain as far as access to health care services goes, so the concept of this is good," says Christopher J. Kutner, a partner in the health services practice group at Rivkin Radler LLP in Uniondale, N.Y. "The challenge is engaging individuals to advocate for their own health care. Unfortunately, in underserved communities, where people may have two jobs or one-parent families, maybe they don't know the questions to ask."

John Dickey, COO at Acclivity Health in Jacksonville, Fla., expects that "over time CMS will increase the relative importance of health equity in determining model performance. In early years they will take a 'carrot' approach and move to a 'stick' in later years as organizations will have had time to prepare and make any necessary changes for compliance."

"For example, in 2023 ACOs participating in the ACO REACH model will be eligible to receive positive quality performance adjustments for collecting and submitting data on health equity," Dickey says, "but there is no penalty for failing to report. In later program years there will be." — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- CMMI, ACO REACH request for applications: <https://innovation.cms.gov/media/document/aco-reach-rfa>
- CMMI, ACO REACH application portal: <https://innovation.cms.gov/innovation-models/aco-reach>