


CMS-Administered Risk Arrangements (CARA) Factsheet

What is CMS-Administered Risk Arrangements (CARA)?

CARA is a new voluntary initiative for Long-term Enhanced ACO Design (LEAD) Model ACOs under the **Global Risk Option**.

 Through CARA, CMS provides the infrastructure to support a LEAD ACO to **negotiate with a specialist** (also known as a Preferred Provider, under LEAD) to establish an **episode-based risk arrangement (EBRA)**.

The EBRA permits the specialist to take on **financial risk** for aligned beneficiaries that initiate an episode of care.

How CARA Supports Value-Based Care



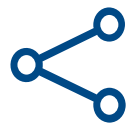
Reduces barriers by sharing data and calculating payment amounts to support ACOs establishing EBRA with specialists.



Allows **specialists to participate in the value-based care framework**, ensuring greater accountability for health care costs.







Helps incentivize ACOs and specialists **to negotiate appropriate target prices** to engage specialists, maintain ACO benchmark integrity, and **support coordinated, high-quality beneficiary care**.



Encourages **whole person care** by fostering stronger relationships with primary-care focused ACOs and specialty-focused Preferred Providers.

Benefits of CARA for LEAD Participants

CARA Participants may receive:

-  Episode data and benchmarks
-  Payment reconciliation data
-  Quality performance data
-  Ongoing support (e.g., webinars, office hours, technical assistance, help desk)

CMS will **ease administrative burden for LEAD ACOs** to work with specialists, by:

- Establishing a **platform to track episode selections**.
- Providing EBRA **standard provisions**.

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How ACOs Participate in CARA

1. When applying to LEAD, select the Global Risk Option.

2. Sign the LEAD Participation Agreement CARA Amendment (LPACA).

3. Access the CARA 4i module to prepare for negotiation between ACOs and specialists.

4. Verify EBRA terms and complete attestation in the CARA 4i platform.

CARA Operational Overview



1. ACOs access CARA module in the 4i platform, and select episodes for participation, identify specialists, and enter negotiated episode target prices with specialists.



2. CMS provides episodic data and pricing information, as applicable, to ACOs to facilitate setting up their own EBRA with Preferred Providers.



3. ACOs and specialists enter into an EBRA.



4. Specialists deliver care, billed through Medicare fee-for-service (FFS).



5. CMS reconciles concurrently with LEAD settlement:

- If **FFS < target price**, the specialist **receives** payment.
- If **FFS > target price**, the specialist **owes** repayment.

Timeline for CARA Implementation*

Quarter 2 of 2027

CARA reports available with target prices, as applicable, for PY 2028

2028

First performance year (episodes trigger)

Mid 2029






First concurrent LEAD-CARA reconciliation

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Episode Options

CARA will offer acute medical and procedural episode-based cost measures (EBCMs) in 2028 and will phase in chronic condition EBCMs in future years.


Current acute, procedural, and chronic condition EBCMs include:

-  **Acute Inpatient Medical Conditions:** sepsis, psychoses and related conditions, intracranial hemorrhage or cerebral infarction, respiratory infection hospitalization, and more.
-  **Common Chronic Conditions:** diabetes, heart failure, chronic kidney disease (CKD), end-stage renal disease (ESRD), asthma/chronic obstructive disease (COPD).
-  **General Surgery Procedures:** melanoma resection, colon and rectal resection, femoral or inguinal hernia repair, lumpectomy, partial mastectomy, and simple mastectomy.
-  **Other Conditions** include musculoskeletal/rheumatologic chronic conditions, oncology chronic conditions, and kidney transplant management.
-  **Other Procedures** include orthopedic, cardiovascular, urologic, ophthalmologic, gastroenterology, and vascular access/renal procedures.

Participation Options


 <u>Default Approach</u>	 <u>Maximal Flexibility (Max Flex)</u>
<ul style="list-style-type: none">+ CMS-constructed EBCMs are used.+ ACOs cannot customize episode construction (e.g., episode triggers, length, inclusions/exclusions), but can specify discounts/premiums to target prices, select quality measures for performance adjustment and performance adjustment specifications, all subject to CMS review.	<ul style="list-style-type: none">+ ACOs can customize episode construction (e.g., trigger codes, length, inclusions/exclusions).+ ACOs selecting Max Flex may partner with external vendors for alternative episode construction methodologies.+ Episode risk parameters, including episode selection and construction parameters, discounts/premiums to target prices, and performance adjustment specifications, will be subject to CMS review.


Default or Max Flex Option Quality Measures


-  Performance adjustments will be based on quality measures – **Q484 Risk-Standardized Admissions** or **other Merit-Based Incentive Payment System (MIPS)-comparable measure**.

Resilience and Independence in a Safe Environment (RISE) to Age in Place Episode

The RISE episode is a falls-prevention focused episode under CARA designed to provide home-based interventions by an interdisciplinary team to identify falls risk and deliver targeted prevention services that help beneficiaries remain safely in their home.


 **Increase activities of daily living (ADLs)** and **decrease acute events** for Medicare beneficiaries at risk of falls through home-based interventions.

 Provide evidence-based, **in-home falls prevention services** for beneficiaries who may not otherwise be able to access home-based support.

 Interdisciplinary **falls prevention care team** of Occupational Therapists (OTs) and Registered Nurses (RNs) who deliver comprehensive fall interventions, such as:



Falls Risk Assessment | Strength Training | Balance Exercises | Communication Plans

 To reduce falls risk, the falls prevention care team, in collaboration with the ACO, may **engage a licensed handyperson** (per state requirements) **for home safety** assessments and modifications (e.g., grab bars, stair lifts).

Key Elements

EPISODE LENGTH

3 months: Required elements (falls risk assessment, medication review, communication/care plan, person-centered goal setting)
6 months: All visits within the tier

PAYMENT STRUCTURE

Initial Visit: OT/RN visit billed through Fee-for-Service (FFS)
Follow-Up Visits: Bundled payments based on acuity tier (low, medium, high)

Billing & Funding:

- OT/RN services → billed by the RISE entity, paid via the Innovation Payment Contractor (IPC)
- Handyperson services → funded by the ACO

QUALITY MEASURE

Days at Home for Patients with Complex, Chronic Conditions