ACO Realizing Equity, Access, and Community Health (REACH) Model

Financial Methodology Updates Webinar

CMS/CMMI
March 28, 2022

Agenda

Agenda for Today

ACO REACH Financial Overview

- *Benchmarking*
- *Capitation Payment Mechanisms*

Financial Methodology Features

- *Discount & Quality Withhold*
- *Health Equity Benchmark Adjustment*
- *Residual Stop-Loss Reinsurance*
- *PY2024 Risk Score Growth Cap*

This webinar is primarily intended to introduce the new financial features in ACO REACH, with some background on key finance concepts. CMS will publish methodology papers outlining all aspects of the ACO REACH Model financial methodology this summer. In the meantime, CMS has published detailed methodology papers and webinars covering benchmarking, capitation, risk adjustment, and other topics for the Global & Professional Direct Contracting Model, that can serve as a reference for all financial features that remain unchanged in the ACO REACH Model: https://innovation.cms.gov/innovation-models/gpdc-model

Additional information on these and other financial methodology features will be provided in detailed specification papers to be released in Summer 2022

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Benchmarking Overview

What is the Benchmark?

- The benchmark is a **Per Beneficiary Per Month (PBPM) dollar amount** against which a REACH Accountable Care Organization (ACO) is held accountable for performance year (PY) Medicare FFS expenditures for its aligned beneficiaries
- The benchmark is inclusive of the **total cost of care** for Medicare Parts A & B services (Part D is not included)
- Separate benchmarks will be set for the Aged & Disabled (A&D) and ESRD beneficiary entitlement categories
- CMS compares expenditures incurred in the performance year for beneficiaries aligned to a REACH ACO against the benchmark to **determine shared savings or shared losses** during reconciliation

The method for calculating the benchmark varies depending on the type of REACH ACO and how beneficiaries are aligned to the ACO (claims-based or voluntary alignment)

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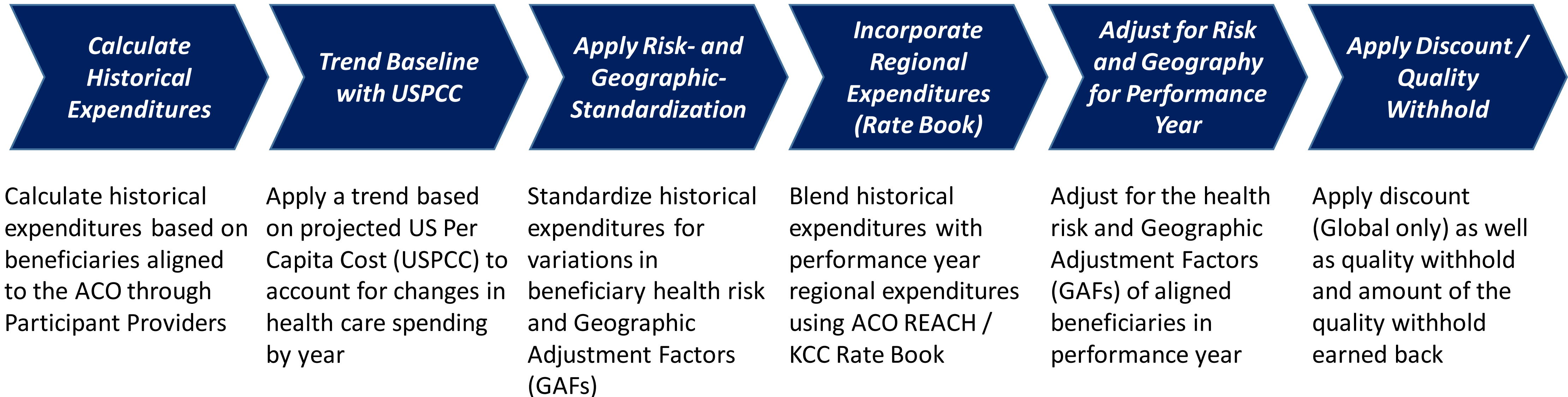
Benchmarking Approaches

<table>
<tr><th>ACO Type</th><th colspan="2">Standard ACO</th><th>New Entrant ACO</th><th>High Needs ACO</th></tr>
<tr><th>Alignment Option[1]</th><th>Claims-Based Alignment</th><th>Voluntary Alignment</th><th>Both Options</th><th>Both Options</th></tr>
<tr><td>PY1</td><td rowspan="6">Standard Benchmarking Approach using historical expenditures for beneficiaries that would have aligned to the ACO in the base years (CY17 – CY19)</td><td colspan="3" rowspan="4">Regional Benchmarking Approach that does not use historical expenditures, instead composed entirely of the ACO REACH / KCC Rate Book for the PY (this approach uses only the final three steps from the following slide)</td></tr>
<tr><td>PY2</td></tr>
<tr><td>PY3</td></tr>
<tr><td>PY4</td></tr>
<tr><td>PY5</td><td colspan="3" rowspan="2">Modified Standard Benchmarking Approach using recent historical expenditures (PY2021 – PY2024, as applicable) for beneficiaries aligned to the ACO</td></tr>
<tr><td>PY6</td></tr>
</table>

1. Beneficiaries who could be aligned to the same ACO via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking

How is the Benchmark Calculated?

The benchmarking methodology generally includes the following steps, but will be applied differently depending on the type of ACO and how beneficiaries are aligned to the REACH ACO



The health equity benchmark adjustment will be applied to the benchmark after the benchmark has been calculated following all of the above steps (and is not subject to the discount or quality withhold).

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Payment Mechanism Policies

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Capitation Payment Mechanisms

ACOs must select one of the two Capitation Payment Mechanisms. The available Capitation Payment Mechanisms vary based on the Risk Option selected by the ACO.

	Mechanism	Description	Availability
1	**Primary Care Capitation (PCC)**	Monthly capitation payments for primary care services furnished to aligned beneficiaries.	*Available for Global and Professional*
2	**Total Care Capitation (TCC)**	Monthly capitation payments for all services furnished to aligned beneficiaries.	*Available for Global Only*

Capitation payments (and associated claims reductions) apply only for Participant Providers, and Preferred Providers that opt in to fee reductions.

*In PY2021, the average capitation payment represented **2.5% of TCOC***

Advanced Payment (APO)

Advanced payments function in a similar way to the population-based payments in the Next Generation ACO model.

Advanced Payment is an optional payment mechanism, only available to ACOs that select the PCC capitation payment.

Advanced Payments are a cash flow mechanism to prospectively pay ACOs the value of the non-primary care claims we estimate their Participant Providers and Preferred Providers will submit.

ACOs can negotiate with their Participant Providers and Preferred Providers to agree to FFS Medicare claims reduction (between 1 – 100% of FFS claims). In exchange, CMS will pay the ACO a prospective per beneficiary per month (PBPM) payment representing the estimated value of the reduced FFS claims and reduce FFS claims payments made to providers through the Medicare payment systems by the difference.

Unlike the Capitated Payment Mechanisms, the value of Advanced Payments made to ACOs will be reconciled against the actual value of the Medicare FFS claims after the Performance Year

PCC and APO are complementary – a given service will be subject to either, but not both

	Professional claims		Institutional claims	
	Primary Care Specialists	**All other specialties**	**FQHCs[1] and RHCs[2]**	**All other institutional providers**
Primary Care-Based Services	PCC	APO	PCC	APO
All other services	APO	APO	PCC	APO

- **Primary Care-Based Services**: PQEM codes used for alignment (see Financial Overview paper for comprehensive list)
- **Primary Care Specialists**:

Code	Specialty[1]
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

1. FQHC = Federally Qualified Health Center
2. RHC = Rural Health Clinics
3. For Instructions for Viewing Individual Practitioner Status and Specialty Type in PECOS, please see this link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf

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PCC Requirements

- Primary Care Capitation (PCC) is available to ACOs in either Global or Professional risk options
- ACOs that select PCC are also able to select the Advanced Payment Option (APO)
- Participant Providers and Preferred Providers in ACOs that select PCC and / or APO are subject to the following flexibilities and requirements:

Primary Care Capitation

PY	Participant Providers	Preferred Providers
PY2021	Optional; 1-100%	Optional; 1-100%
PY2022	Mandatory; 5-100%	Optional; 1-100%
PY2023	Mandatory; 10-100%	Optional; 1-100%
PY2024	Mandatory; 20-100%	Optional; 1-100%
PY2025	Mandatory; 100%	Optional; 1-100%
PY2026	Mandatory; 100%	Optional; 1-100%

Advanced Payment Option (if selected by ACO)

PY	Participant Providers	Preferred Providers
PY2021	Optional; 1-100%	
PY2022	Optional; 1-100%	
PY2023	Optional; 1-100%	
PY2024	Optional; 1-100%	
PY2025	Optional; 1-100%	
PY2026	Optional; 1-100%	

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TCC Requirements: Apply to all FFS Claims

	Total Care Capitation Available in Global Only		
	Participant Providers	Preferred Providers	Non-Participating Providers
What FFS claims are capitated?	All FFS Claims - ***Mandatory***	Portion of FFS Claims (0 – 100%) ***- Optional***	None – claims paid FFS
What FFS claims payments are eligible for advanced payment?	None	None	None – claims paid FFS

Applies for all PYs

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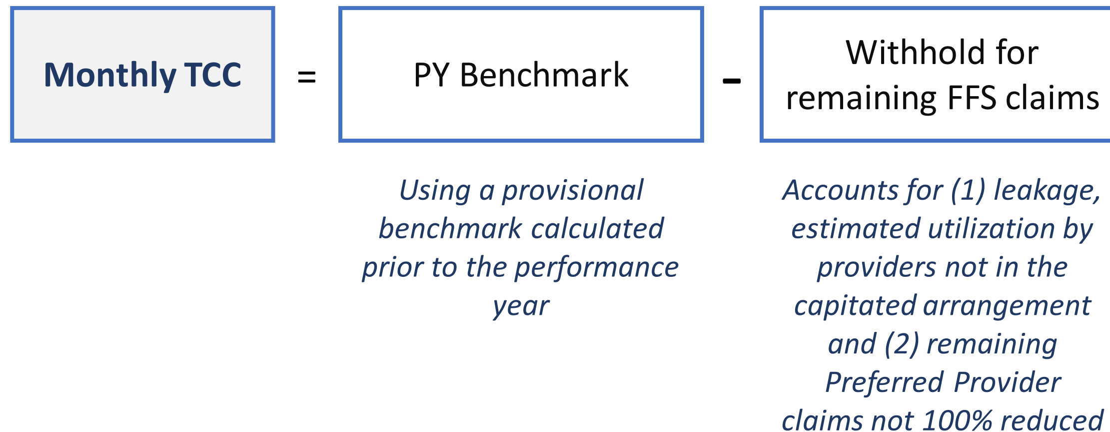
Initial Capitation Amounts Received by REACH ACOs

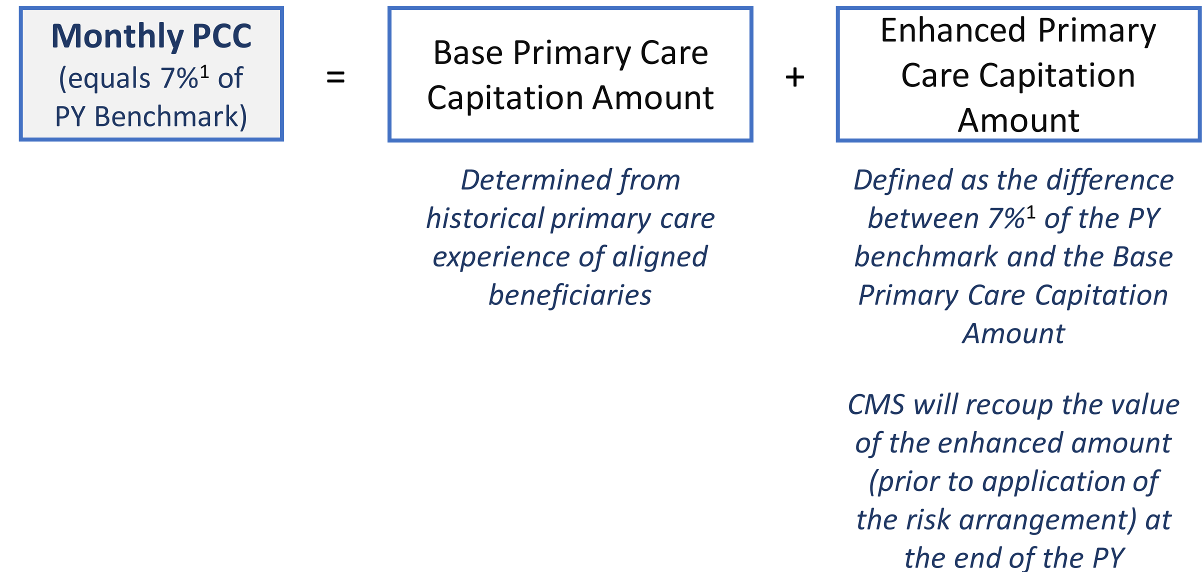
Total Care Capitation

ACOs receive monthly amount representing estimated total cost of care less a withhold



Primary Care Capitation

ACOs receive 7%[1] of the benchmark, divided between the *Base Primary Care Capitation* and *Enhanced Primary Care Capitation*, which enables REACH ACOs to invest in expanding their primary care capabilities



1. While the default PCC amount is 7% of the benchmark, it may be higher or lower depending on ACO preference and historical utilization patterns; as such, the Enhanced PCC amount may not always equal 7% of the PY Benchmark – the Base PCC amount

Enhanced / Base PCC Selection

While the default PCC Percentage is 7% of the benchmark, certain flexibilities are allowed

Setting the Base PCC Percentage

Base PCC (% of benchmark) = [PCC-eligible claims-based payments (CBP) in lookback period[1] X Reduction amounts elected by participating providers] / [Total CBP for aligned beneficiaries in lookback period]

- Base PCC amount is allowed to be >7% of the benchmark, if historical Primary Care utilization exceeds 7% of CBP
- PCC participation and reduction amounts elected by Participant Providers and Preferred Providers are reflected in Base PCC

Steps for selecting the Enhanced PCC Percentage

- **Step 1:** In late 2022, ACO elects the maximum Enhanced PCC desired.[2]
- **Step 2:** Prior to PY, CMS quantifies and shares the ACO's CBP for PCC services, indicating the ACO's maximum Enhanced PCC allowed.[3] Once shared, the ACO is able to revise its maximum Enhanced PCC if desired (Step 1).
- **Step 3:** Enhanced PCC is set as the lower of Step 1 or Step 2 (i.e., what ACO elects and what CMS allows). This amount is set for the remainder of the PY.

CBP for PCC Services (A)	Enhanced Percentage Range (B)	Maximum Total Percentage (A+B)
0 to 5%	0 to (7% - A)	7%
> 5%	0 to 2%	A + 2%

Note that ACOs with greater than 5% Base PCC Percentage may still receive up to 2% Enhanced, and that ACOs may choose a reduced Enhanced PCC Percentage if desired.

1. Per above, PCC-eligible claims are defined as (1) PQEM services billed by Primary Care Specialists participating in PCC (for Professional claims) or all services billed by Federally Qualified Health Centers and Rural Health Clinics (for Institutional claims)
2. Enhanced PCC 'floor' = 0% (ACOs can elect not to receive it)
3. Enhanced PCC 'ceiling' = the higher of 2% OR 7% - CBP PCC % (PCC participation and reduction amounts elected by Participant Providers and Preferred Providers are NOT reflected in CBP PCC %)

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Discount & Quality Withhold

ACO REACH Discount & Quality Withhold

The ACO REACH Model Discount & Quality Withhold amounts will be lower than those initially proposed under the GPDC Model; beneficiary minimums and other glide path features for ACO REACH are unchanged

Performance Year	Global Discount	New Entrant / High Needs Beneficiary Minimums[1]	New Entrant / High Needs Benchmark[2,3]	Quality Withhold Amount	Quality Withhold Basis
2021	*2%*	*1000 / 250*	*Regional Rate*	*5%*	*1% Performance, 4% Reporting*
2022					
2023	*3%*	*2000 / 500*		*2%*	*2% Performance*
2024	*3%*	*3000 / 750*		*2%*	*2% Performance*
2025	*3.5%*	*5000 / 1200*	*Blend of Regional Rate & Baseline*	*2%*	*2% Performance*
2026	*3.5%*	*5000 / 1400*		*2%*	*2% Performance*

The Global Discount has been reduced to 3% and 3.5% in PY2024-PY2026 from the proposed 4% and 5% in GPDC

The Quality Withhold has been reduced to 2% from the initial 5% withhold in GPDC

1. New Entrant ACOs and High Needs Population ACOs must meet increasing minimum beneficiary threshold counts for each Performance Year
2. New Entrant ACOs and High Needs Population ACOs will use a benchmarking methodology based entirely on the regional rate from the ACO REACH/KCC Rate Book unless the ACO has sufficient claims history to use the Standard ACO approach; beginning in PY5, this methodology will blend the regional rate with a baseline composed of recent historical expenditures
3. New Entrant and High Needs Population ACOs with > 3,000 claims-aligned beneficiaries will use the same benchmarking approach as Standard ACOs

Health Equity Benchmark Adjustment

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Health Equity Benchmark Adjustment

ACO REACH includes a benchmark adjustment that increases benchmarks for ACOs serving higher proportions of underserved beneficiaries

CMS will stratify all beneficiaries aligned to ACO REACH using a composite measure of underservice that incorporates a combination of[1]:

Area Deprivation Index	Dual Medicaid Status
*Area-level measure of **local socioeconomic factors** correlated with medical disparities and underservice*	*Beneficiary-level measure of **economic challenges affecting individuals'** ability to access high quality care*

Percentile Score from 1-100

25 Point Adjustment for Full or Partial Dual Eligibility

Percentile	Adjustment
91st – 100th Percentile (Top Decile)	***+$30 PBPM Adjustment***
51st – 90th Percentile (Middle 4 Deciles)	*No Adjustment*
1st – 50th Percentile (Bottom 5 Deciles)	*-$6 PBPM Adjustment*

1. CMS may explore other variables to include in this assessment and will notify applicants prior to the start of PY2023 if any other variables are included.

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Residual Stop-Loss Reinsurance

Residual Stop-Loss Reinsurance (Optional)

ACOs have the option to participate in a Residual Stop-Loss Reinsurance arrangement, designed to reduce REACH ACOs' risk for individual beneficiaries with significantly higher than predicted expenditures

- CMS will be adjusting its approach to stop-loss reinsurance in ACO REACH to better protect ACOs against significantly higher than *predicted expenditures* at the beneficiary level
- This approach uses the difference between actual and predicted expenditures, or the *residual expenditures* for each beneficiary
- The Stop-Loss Payout for a beneficiary is based on the difference between a beneficiary's residual expenditures and the national residual attachment points
- The Stop-Loss Charge is calculated based on the average Stop-Loss Payout the ACO would have received in three reference years (RYs)
- The net impact of Stop-Loss Reinsurance will be the difference between the Stop-Loss Charge and Stop-Loss Payout

Residual Stop-Loss Approach*

Stop Loss Payout	=	***Residual Expenditure***	***vs.***	***Residual Attachment Points***		
Residual Expenditure	=	***PY Expenditure***	–	***Predicted Expenditure***		
Predicted Expenditure	=	***Benchmark Regional Rate***	***x***	***Risk Score***	***x***	***# of Months***

**These calculations will be done at the beneficiary level*

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Risk Adjustment & PY2024 Risk Score Growth Constraints

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Risk Adjustment

CMS uses risk adjustment to adjust payments based on the demographics and health risk of a beneficiary

Risk scores are derived for a beneficiary using a combination of **demographic** and **disease-based** factors

Demographic Factors
Age, Disabled Status, Medicaid Status, etc.

Disease-Based Factors
ICD-9/10 codes on claims are mapped to Hierarchical Condition Categories (HCCs)

The average Medicare beneficiary with average expenditures will have a risk score equal to 1.0. Sicker beneficiaries with predictably higher costs of care will generally have a higher risk score (e.g.,1.5 or 2.0).

Risk Adjustment Models

ACO REACH makes use of two risk adjustment models for Aged & Disabled beneficiaries[1]

CMS-HCC Prospective Model

Used for Standard and New Entrant ACOs

The risk model is based on diagnoses from the prior year and expenditures from the current year

It was designed for Medicare Advantage (MA) and has been applied to adjust payment for numerous CMMI models including Next Generation ACO and Comprehensive ESRD Care, as well as the Shared Savings Program, CMS' Medicare ACO program

CMMI-HCC Concurrent Model

Used for High Needs Population ACOs

The risk model is based on diagnoses and expenditures from the current year

It was designed for the ACO REACH Model, and is intended to improve payment accuracy for small populations of complex, high-risk beneficiaries

1. ESRD beneficiaries in all ACO types will use the CMS-HCC ESRD risk adjustment model

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Risk Score Growth Constraints

- Risk score growth in ACO REACH will be limited by a retrospective Coding Intensity Factor (CIF) combined with a symmetric 3% cap
- Risk scores will be normalized, after which the ACO-level cap will be applied (initially for Standard and New Entrant ACOs only), and finally the program-wide CIF will be applied to all ACO beneficiaries

ACO-Level Cap[1]

At the ACO level, risk scores will be limited from growing / declining by greater than 3% relative to each entity's historical risk scores

Coding Intensity Factor[2]

At the program level (across all ACOs), risk scores will be reduced by a CIF if growth outpaces the National Reference Population

These policies are designed to address the potential for changes in coding behavior driven by participation in the ACO REACH Model

1. The ACO-level cap will initially apply only for Standard ACOs and New Entrant ACOs; however, High Needs Population ACOs may be subject to a cap later starting in PY2024, if excessive coding growth is observed
2. The CIF will apply for all ACO types, assuming sufficient sample size, for each risk adjustment model used; thus, for Aged & Disabled beneficiaries, one CIF will apply for Standard ACOs and New Entrant ACOs based on the CMS-HCC risk adjustment model and another CIF will apply for High Needs Population ACOs, which use the CMMI-HCC concurrent model

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ACO-Level Symmetric 3% Growth Cap

- A symmetric 3% cap will be applied to ACO-specific risk score growth
- The cap will be applied separately for the A&D and ESRD populations
- Initially, the cap will be applied to Standard and New Entrant ACOs; High Needs Population ACO risk score growth will be monitored initially and a cap may be applied beginning in PY2024
- Voluntarily aligned beneficiaries that do not also meet the claims alignment algorithm will not be subject to the cap in their first year of alignment[1]
- *For PY2021 through PY2023, risk score growth will be measured relative to each ACO's historical risk scores in a rolling reference year two years prior*
- ***Beginning in PY2024, the reference year will be fixed at CY2022 in order to better constrain ACOs exhibiting progressively higher risk score growth***

Historical Reference Year for ACO-Level Cap

	Reference Year [1,2]
PY2021	2019
PY2022	2020
PY2023	2021
PY2024	**2022**
PY2025	**2022**
PY2026	**2022**

1. The cap will not incorporate experience from voluntarily aligned beneficiaries in their first year of alignment, as the ACO's providers have not served them historically – however, once a beneficiary is aligned for a second year or via claims alignment, their experience will be included in the cap
2. CMS continues to monitor the potential impact of COVID-19 on reference years for applying the symmetric cap. For example, CMS may determine that 2021 is not appropriate to use as a reference year for PY2023 and instead use PY2020 to avoid biases introduced by claims with CY2020 dates of service.

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Demographic Adjustment to Cap Application

Beginning in PY2024, the application of the symmetric risk score growth cap will be adjusted to limit risk score growth relative to growth in an ACO's independently calculated demographic risk score

- ACO-level demographic risk scores will be calculated using a demographic risk adjustment model (used in Medicare Shared Savings Program)
- By directly linking the application of the risk score growth cap to the independently calculated ACO-level demographic risk score growth, the cap should better account for changes in beneficiary health status beyond the +/-3% limit
- ***Increases or decreases in the ACO-level demographic risk score, which is calculated without diagnoses, will be accounted for in applying the symmetric 3% cap***

Illustrative Example of Symmetric Cap with Demographic Adjustment

RY Risk Score (HCC)	PY Risk Score (HCC)	HCC Risk Score Growth	Demog. Risk Score Growth	Current Capped Risk Score	Demog.-Adjusted Capped Risk Score
1.0	1.1	+10%	+2%	1.03 (+3%)	1.05 (+5%)
1.0	1.1	+10%	-1%	1.03 (+3%)	1.02 (+2%)
1.0	0.9	-10%	+3%	0.97 (-3%)	1.0 (+0%)

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Coding Intensity Factor

- A Coding Intensity Factor (CIF) adjustment will be retrospectively applied at the program level to ACO risk scores before final reconciliation
- If risk scores in a Performance Year across all REACH ACOs have increased by a greater rate than the National Reference Population risk scores, a uniform CIF will be applied to all ACO risk scores to adjust for that increased rate of growth
  - For example, if the normalized risk score across all ACOs is 100.5% of the historical reference risk score across all ACOs, then PY risk scores will be divided by a CIF of 100.5% to account for the increased growth rate
- For A&D beneficiaries, one CIF will be applied to risk scores for Standard and New Entrant ACOs (which use the CMS-HCC model) and another will be applied to risk scores for High Needs Population ACOs (which use the CMMI-HCC model)
- For ESRD beneficiaries, a separate CIF will be applied across all ACO types
- Voluntary aligned beneficiaries that do not also meet the claims alignment algorithm will not be subject to the CIF[1]

Historical Reference Year for Coding Intensity Factor

	Reference Year
PY2021	2019
PY2022	2019
PY2023	2019
PY2024	2019
PY2025	2019
PY2026	2019

1. The CIF will not incorporate experience from voluntarily aligned beneficiaries, as they are not present in the reference population – however, once a beneficiary is also aligned via claims alignment, their experience will be included

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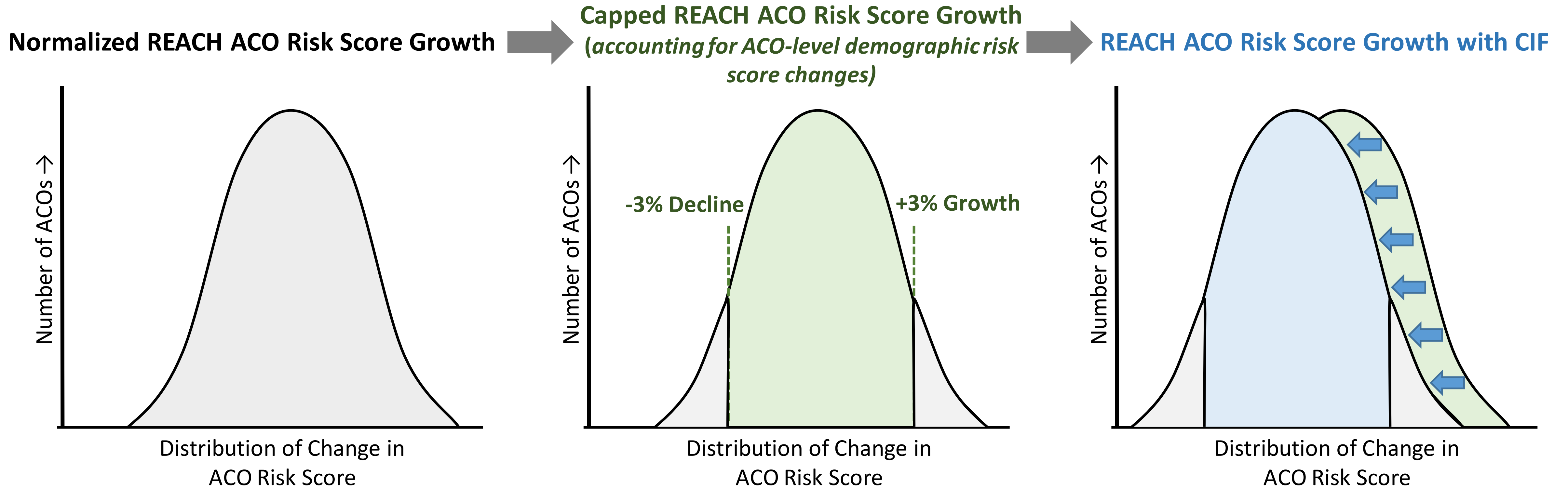
Normalization, Symmetric 3% Cap and CIF Risk Score Adjustments



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Upcoming Webinars and Questions

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Upcoming Webinars

Webinar	Date
ACO REACH Application Office Hours	Tuesday, March 29, 4:00 – 5:00 PM ET Register here.
ACO REACH Health Equity Webinar	Tuesday, April 5, 4:00 – 5:00 PM ET Register here.
ACO REACH General Office Hours	Tuesday, April 12, 3:00 – 4:00 PM ET Register here.

Contact Information and References

ACO REACH Webpage:

https://innovation.cms.gov/innovation-models/aco-reach

ACO REACH Request for Applications:

https://innovation.cms.gov/media/document/aco-reach-rfa

ACO REACH/GPDC Comparison Table:

https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison

ACO REACH Summary Graphic:

https://innovation.cms.gov/media/document/aco-reach-graphic

Email: ACOREACH@cms.hhs.gov

Questions

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