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

PY2023 Financial Operating Policies: Capitation and Advanced Payment Mechanisms

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Reference Documents

Title
ACO REACH Model: Financial Operating Guide: Overview
ACO REACH and Kidney Care Choices Models: Rate Book Development
ACO REACH and Kidney Care Choices Models: Risk Adjustment
ACO REACH Model: Financial Settlement Overview

Acronyms

ACO	Accountable Care Organization
APA	Alternative Payment Arrangement
APO	Advanced Payment Option
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
FFS	Fee-for-service
PBPM	Per Beneficiary Per Month
PCC	Primary Care Capitation
PIP	Periodic Interim Payments
PY	Performance Year
REACH	Realizing Equity, Access, and Community Health
SSMs	Shared Systems Maintainers
TCC	Total Care Capitation

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1.0 Introduction

This document provides a detailed description of the payment mechanisms of the ACO Realizing Equity, Access, and Community Health (REACH)[1] Model: Total Care Capitation (TCC); Primary Care Capitation (PCC); and the optional Advanced Payment Option (APO).

REACH Accountable Care Organizations (ACOs) will receive a capitated payment for certain Part A and B services covered under the fee-for-service (FFS) program of original Medicare provided by Participant Providers and those Preferred Providers who elect to participate in the payment mechanism(s). These payment mechanisms are designed to give REACH ACOs flexibility through prospective monthly payments to support population health, including investments in technology, resources, care delivery, or innovative value-based payment arrangements with their providers. The amount of the capitated payment made by CMS to the REACH ACO will partially depend on the risk arrangement option and capitation payment mechanism selected by the REACH ACO. The two risk arrangement options that a REACH ACO may choose from are the Global Option and the Professional Option:

1. The Global Option is a full risk option with 100 percent Shared Savings/Shared Losses. REACH ACOs that choose the Global option may choose either the TCC payment mechanism or the PCC payment mechanism. REACH ACOs choosing the PCC payment mechanism also have the option to participate in the APO.

2. The Professional Option is a lower-risk option with 50 percent Shared Savings/Shared Losses. REACH ACOs that choose the Professional Option are required to participate in the PCC payment mechanism and have the flexibility to also participate in the APO. TCC is not available for REACH ACOs selecting the Professional Option.

All REACH ACOs must have a Capitation Payment Mechanism. The three Payment Mechanisms are TCC, PCC, and APO:

1. Under Total Care Capitation (TCC), the capitated payment to the REACH ACO applies to all Medicare Part A & B services to aligned beneficiaries that are provided by Participant Providers and by a portion of Medicare Part A & B services to aligned beneficiaries that are provided by Preferred Providers who have opted into the capitation arrangement. The TCC payment amount will reflect the estimated total cost of care for services provided by the Participant Providers and Preferred Providers to the REACH ACO’s aligned population. The TCC payment mechanism is only available to REACH ACOs that have selected the Global Option.

2. Under Primary Care Capitation (PCC), the capitated payment to the REACH ACO applies to primary care Part A & B services to aligned beneficiaries that are provided by certain Participant Providers and Preferred Providers who have opted into the capitated arrangement. The default PCC payment amount will be equal to 7 percent of the REACH ACO’s benchmark, although, as

[1] The ACO REACH model is a redesigned version of the Global and Professional Direct Contracting (GPDC) Model, which began on April 1, 2021. The ACO REACH Model begins on January 1, 2023 and runs through 2026. For completeness and context, this paper may refer to policies in PY2021 and PY2022 of the GPDC Model. For more information on the ACO REACH Model, see https://innovation.cms.gov/innovation-models/aco-reach.

described in Section 2.2, under certain circumstances a REACH ACO may have a lower or higher PCC payment amount than the default. The PCC payment mechanism is required for all REACH ACOs that have selected the Professional Option for risk sharing arrangement.

As mentioned, REACH ACOs that select the PCC payment mechanism also have the option to select the APO to receive an advanced payment for claims not subject to PCC.

3. Under the Advanced Payment Option (APO), the supplemental payment to the REACH ACO applies to the subset of services to aligned beneficiaries not covered by PCC. For primary care specialist Participant Providers and Preferred Providers who opt into the APO arrangement, the payment will cover only non-primary care services. For non-primary care specialist Participant Providers and Preferred Providers who opt into the APO arrangement, the payments will cover all services (more detail on provider eligibility for PCC is provided in Section 2.2.2). Each individual Participant Provider or Preferred Provider may choose a claim reduction amount between 1 and 100 percent (integer values only) for the APO payment.

The Payment Mechanisms (TCC, PCC, and APO) available in each risk arrangement are shown in **Table 1**.

Table 1. ACO REACH risk arrangements and payment mechanisms available for selection by the REACH ACO.

<table>
<tr><th rowspan="2">**Payment Mechanism** elected by the REACH ACO[1]</th><th colspan="2">**Risk Arrangement** elected by the REACH ACO</th></tr>
<tr><th>**Global Option (Full Risk)**</th><th>**Professional Option (Partial Risk)**</th></tr>
<tr><td>**Total Care Capitation (TCC)**</td><td></td><td></td></tr>
<tr><td>… Scope of Capitation Payment</td><td>All services provided by participating providers[2]</td><td rowspan="3">Not Available</td></tr>
<tr><td>… Capitation payment *replaces* FFS payment[3]</td><td>Yes</td></tr>
<tr><td>… Capitation payment reconciled against FFS payment[4]</td><td>No</td></tr>
<tr><td>**Primary Care Capitation (PCC)**</td><td></td><td></td></tr>
<tr><td>… Scope of Capitation Payment</td><td>Primary Care[5]</td><td>Primary Care[5]</td></tr>
<tr><td>… Capitation payment *replaces* FFS payment[6]</td><td>Yes</td><td>Yes</td></tr>
<tr><td>… Capitation payment reconciled against FFS payment[4]</td><td>No</td><td>No</td></tr>
<tr><td>**Advanced Payment Option (APO)**</td><td></td><td></td></tr>
<tr><td>… Scope of Advanced Payment</td><td>Non-primary care services[7]</td><td>Non-primary care services[7]</td></tr>
<tr><td>… FFS provider payment[8]</td><td>Reduced</td><td>Reduced</td></tr>
<tr><td>… Advanced payment reconciled against FFS payment[9]</td><td>Yes</td><td>Yes</td></tr>
</table>

[1] The REACH ACO elects which payment mechanism(s) to participate in, after which each Participant Provider and Preferred Provider may individually elect the claims reduction amount for each payment mechanism.

[2] The capitation payment under TCC applies to any eligible Part A and Part B service provided to an aligned beneficiary by a Participant Provider or a Preferred Provider electing to participate in TCC, with certain exceptions (e.g., claims that contain any substance abuse service or claims from beneficiaries who have opted out of data sharing will not be included – see Section 4.3 for a complete list). These exceptions apply to all payment mechanisms (TCC, PCC, and APO).

[3] A Participant Provider in TCC receives no FFS payment for covered services provided to REACH ACO-aligned beneficiaries. A Preferred Provider can elect to reduce a portion of their claims (1-100%, integer values only).

[4] The TCC payment is not reconciled against FFS payments that would otherwise have been made, and only the TCC payment amount is included in the financial settlement. FFS payments to which TCC is not applied will also be included in financial settlement.

[5] The capitation payment under PCC applies to specified primary care services, which are generally defined services with a primary care CPT/HCPCS code provided by a provider who is a primary care specialist. More detail of the definition can be found in Section 2.2.

[6] Both Participant Providers and Preferred Providers can individually elect to reduce a portion of their primary care claims (1-100%, integer values only), though Participant Providers' elections have a certain floor dependent on the PY (see details in Section 2). Participant Providers and Preferred Providers will continue to receive payments on a FFS basis for claim amounts not applicable to the PCC capitation payments.

[7] The APO is available only to REACH ACOs that have selected PCC. This optional arrangement allows REACH ACOs to receive monthly advanced payments equivalent to the estimated value of FFS claims, based upon agreed upon FFS reductions for services provided by Participant Providers and Preferred Providers *not* covered by the PCC payments. APO will only apply to non-primary care FFS claims from Participant Providers and Preferred Providers in the REACH ACO who are primary care specialists, and to all FFS claims from Participant Providers and Preferred Providers who are not primary care specialists.

[8] Reduction in FFS payments for APO is between 1-100% (integer values only), as agreed to by a) the REACH ACO and b) Participant Providers and Preferred Providers.

[9] Advanced Payments are reconciled against actual FFS claims reductions during Final Financial Settlement.

2.0 Payment Mechanisms

2.1 TCC

The TCC payment is a per beneficiary per month (PBPM) capitated payment for all Medicare Part A and Part B services provided to REACH ACO-aligned beneficiaries by all Participant Providers and by those Preferred Providers who have opted into the capitated arrangement. The TCC payment amount will reflect the estimated total cost of care for the REACH ACO's aligned population for services provided by REACH ACO providers participating in the capitation mechanism.

Under TCC, Participant Providers will be required to agree to 100 percent FFS claims reductions. Preferred Providers are not required to enter into the TCC arrangement. Participant and Preferred Providers added during the performance year (PY) are not able to elect FFS claims reductions, with the exception of Participant Providers impacted by a TIN change during the PY. Preferred Providers that do opt into TCC may individually select a lower claims reduction amount (1–100 percent, integer values only). **Table 2** summarizes the percent claims reduction allowed by provider type under TCC. CMS will continue to pay Preferred Providers their remaining portion of FFS claim amounts.

To ensure the REACH ACO has sufficient cash flow to fund value-based activities and compensate downstream providers, CMS adds to the first monthly payment of each PY an amount that is equal to 20% of the REACH ACO's first monthly payment. CMS will subtract the TCC-accelerated payments (i.e., the 20% increase) paid in the first monthly payment from the December payment.

Table 2. Percent claims reduction by provider type under TCC.

Provider Type	Requirements	Claims Reduction
Participant Providers	Required	100%
Preferred Providers	Optional. May also individually choose the claims reduction amount.	1–100% (integer values only)

2.1.1 Monthly TCC Payment

The monthly TCC payment amount reflects an estimated total cost of care, and it is equal to the Monthly Performance Year (PY) Benchmark amount minus a withheld amount to account for the portion of care that is not furnished by providers participating in TCC (see below for full explanation).

$$Monthly\ TCC\ Payment = Monthly\ PY\ Benchmark - TCC\ Withhold$$

2.1.2 Monthly PY Benchmark

For each REACH ACO, the Monthly PY Benchmark amount equals its prospective PBPM Benchmark multiplied by the expected eligible beneficiary-months for a given month. For detailed methodologies of the Benchmark Calculations or Beneficiary Alignment, refer to the ***ACO REACH Model: Financial Operating Guide: Overview*** document.

2.1.3 TCC Withhold

Because it is expected that a portion of the total cost of care for aligned beneficiaries will be for services provided by providers and suppliers not participating in the TCC arrangement, CMS will withhold a portion of the monthly TCC amount to avoid the need for significant year-end recoupments from the REACH ACOs. Thus, the withhold for remaining FFS claims accounts for (1) estimated service volume provided by providers not in the capitated arrangement and (2) remaining Preferred Provider claims that are not 100 percent reduced during the PY. This withhold will be referred to as the TCC Withhold.

The TCC Withhold for each REACH ACO is estimated prior to the start of each PY. To estimate the TCC Withhold, CMS will identify all Part A and B claims from beneficiaries who would have been aligned through claims to the REACH ACO during the lookback period. The initial lookback period for the TCC Withhold will generally be the first 9 months of the prior calendar year (CY), to allow for claims runout. For example, in PY2023, the initial lookback period would be the first 9 months of 2022, and in PY2024, the initial lookback period would be the first 9 months of 2023.[2]

CMS will calculate the total cost of care for claims-aligned beneficiaries in the lookback period and identify the portion of the total cost associated with non-REACH ACO providers or the remaining non-reduced claims amount from Preferred Providers who choose less than 100 percent claims reduction. This latter non-reduced amount is counted toward the TCC Withhold and is then expressed as a percentage of the total cost for the lookback period, i.e., the Withhold Percentage. Finally, the prospective, risk-adjusted, PBPM Benchmark is multiplied by the Withhold Percentage to estimate the risk-adjusted PBPM TCC Withhold amount.

CMS will monitor and update the TCC Withhold amount quarterly throughout the PY, as claims become available, to avoid substantial over-payments or under-payments during Financial Settlement. See **Section 3** for more details.

During the Financial Settlement, the actual PBPM TCC Withhold amount is updated based on PY claims to reflect the actual portion of the total cost of care for aligned beneficiaries associated with non-TCC providers or the remaining non-reduced amount from Preferred Providers who choose less than 100 percent claims reduction. Any over-payments or under-payments to the REACH ACO due to the difference between the actual and estimated TCC Withhold amounts will be recouped or reimbursed as part of the settlement process. See **Section 3.5** for more details. The full details can be found in the ***ACO REACH Model: Financial Settlement Overview*** document.

2.1.4 Initial TCC Payments for REACH ACOs with Limited Claims Experience

We expect to be able to establish a reliable Withhold Percentage for most REACH ACOs, including those with limited claims experience in the lookback period. However, some REACH ACOs may not have sufficient claims history in the lookback period to establish a reliable Withhold Percentage. The minimum number of claims-aligned beneficiaries in the lookback period in order to establish a Withhold

[2] Note that CMS will monitor the historical lookback period to ensure that it is sufficiently predictive; if the experience is not sufficiently predictive, CMS may update the Withhold Percentage calculation using additional claims runout or an alternative lookback period.

Percentage will vary by REACH ACO type. For Standard REACH ACOs, a minimum of 3,000 claims-aligned beneficiaries is required in the lookback period for PY2023; for New Entrant REACH ACOs, a minimum of 1,000 claims-aligned beneficiaries is required in the lookback period for PY2023; and for High Needs Population REACH ACOs, a minimum of 250 claims-aligned beneficiaries is required in the lookback period for PY2023. Note that these thresholds may change in subsequent years.

If CMS determines that the REACH ACO does not have sufficient claims history for CMS to calculate a reliable estimated TCC Withhold Percentage prior to the performance year, CMS will not make monthly TCC Payments or reduce FFS claims subject to TCC Payment reductions for the first two quarters of the performance year.[3]

CMS will use the claims experience from the first quarter of the performance year to calculate the REACH ACO's TCC Withhold Percentage, with 2 months of claims run-out, such that payments are updated after the first 6 months of the performance year. For PY2023-PY2026, payments will be updated beginning the third quarter of the CY.

At this point, CMS will begin making monthly TCC payments and reduce FFS claims subject to TCC payment reductions for the remainder of the performance year.

The historical Medicare FFS claims from the applicable lookback period are used to calculate the TCC Withhold Percentage based on payment for all covered services furnished to the ACO REACH Beneficiaries in the lookback period who were aligned to the REACH ACO during the performance year through claims-based alignment or voluntary alignment.

For the REACH ACO's second performance year and each subsequent performance year, if CMS determines that the REACH ACO does not have sufficient claims history to calculate a reliable TCC Withhold Percentage, CMS may, at its sole discretion, use a REACH ACO's TCC Withhold Percentage from the prior performance year as the current performance year's estimated TCC Withhold Percentage, in order to avoid a six-month delay in the implementation of TCC.

[3] Note that, if CMS Determines that the REACH ACO does not have sufficient claims history in the lookback period, no accelerated payments (i.e., no 20% bump) will be made to that REACH ACO at any point in the performance year.

2.2 PCC

The PCC payment mechanism is available to REACH ACOs who have elected either Global or Professional risk arrangement options. The PCC payment is a PBPM capitated payment for primary care services provided by Participant Providers and Preferred Providers who have opted into the capitated arrangement with the REACH ACO and are considered primary care specialists based on their specialty codes (more detail in **Section 2.2.2**). The default PCC payment amount will be equal to 7 percent of the estimated total cost of care for the REACH ACO's aligned population (i.e., 7 percent of the monthly PY benchmark). We use the term "default" PCC payment amount because under certain circumstances the REACH ACO will have the flexibility to choose a lower/higher PCC payment amount (see **Section 2.2.3** below for details). PCC is required for all REACH ACOs in the Professional Risk option. REACH ACOs that have selected the Global Risk option may choose between PCC and TCC.

For PY2023-PY2026, Participant Providers must have some portion of their eligible claims reduced via PCC, while Preferred Providers have the option to opt-in of PCC. **Table 3** summarizes the participation requirements for Participant Providers and Preferred Providers under PCC. The floor for Participant Providers will be 10 percent for PY2023, 20 percent for PY2024, and 100 percent for PY2025 and PY2026. This requirement only applies to Participant Providers that bill PCC-eligible services, as defined in **Table 4**. The percent claims reduction elected by each primary care specialist is applied to the total cost of primary care services provided by the same provider, and thus affects the monthly PCC payment amount a REACH ACO receives. For primary care specialists, CMS will pay providers their remaining FFS claim amounts for primary care services and fully reimburse them under FFS for their non-primary care claims, unless the claim amounts are eligible for APO reductions. For more details, please refer to Section 2.3.

Table 3. Requirements and percent claims reduction allowed by provider type under the PCC Payment Mechanism.

Payment Mechanism Elected by the REACH ACO	Participant Providers	Preferred Providers
PCC	Must Participate starting PY2023[1,2] PY2023: Primary Care Claims Reduction 10-100% PY2024: Primary Care Claims Reduction 20-100% PY2025: Primary Care Claims Reduction 100% PY2026: Primary Care Claims Reduction 100%	Optional for all PY's If selected, 1-100% Claims Reduction, all PY's

[1] Participant Providers added during the performance year by PCC REACH ACOs are not able to elect PCC FFS claims reductions, with the exception of existing Participant Providers impacted by a TIN change.
[2] Participant Providers in REACH ACOs that have selected the PCC payment mechanism for PY2023 must elect to participate in PCC and have a fee reduction amount of at least 10% selected in 4i for PY2023, but only if the Participant Provider bills PCC-eligible services, as defined in Table 4.
In order for a provider to terminate claims reductions for TCC/PCC/APO during the performance year, the Participant or Preferred Provider must terminate their participation in the model
Note: Claims reduction amounts must be integer values only.

Participant Providers and Preferred Providers added during the performance year are not able to elect PCC FFS claims reductions, with the exception of existing Participant Providers impacted by a TIN change during the performance year.

2.2.1 Default Monthly PCC Payment

The default monthly PCC payment is 7 percent of the REACH ACO's prospective monthly PY Benchmark. This payment amount is comprised of a Base PCC Amount and an Enhanced PCC Amount:

$$\begin{aligned} Default\ Monthly\ PCC\ Payment &= 7\%\ of\ Prospective\ Monthly\ PY\ Benchmark \\ &= Base\ PCC\ Amount + Enhanced\ PCC\ Amount. \end{aligned}$$

The PY Benchmark for a REACH ACO is calculated using the same method whether the REACH ACO is participating in PCC or TCC. For a detailed description of the PY Benchmark calculation, refer to the ***ACO REACH Model: Financial Operating Guide Overview*** methodology paper.

2.2.2 The Base PCC Amount

The Base PCC Amount is an estimated payment intended to approximate the primary care-based services provided to aligned beneficiaries by the Participant Providers and Preferred Providers participating in PCC.

To calculate the Base PCC Amount, CMS uses the list of beneficiaries who would have been aligned through claims to the REACH ACO in the lookback period. The lookback period for the Base PCC Percentage will generally be the first 9 months of the prior CY to allow for claims runout. For example, in PY2023, the initial lookback period would be the first 9 months of 2022, and in PY2024, the initial lookback period would be the first 9 months of 2023.[4] The historical claims from the lookback period are used to (1) calculate the total claim-based payment for all covered services, regardless of provider affiliation; and (2) identify the portion of claims subject to PCC provided to aligned beneficiaries, i.e., primary care services expenditure by each Participant Provider that is a primary care specialist or Preferred Provider that is a primary care specialist and opted into PCC.

CMS defines primary care-based services as claim lines from professional claims for Evaluation and Management (E/M) office visits for both new and established patients using the current procedural terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes described in **Table B.6.3** of the ***ACO REACH Model: Financial Operating Guide Overview*** methodology paper. The primary care-based service must also be provided by a provider whose principal specialty in the Provider Enrollment, Chain and Ownership System (PECOS) is included in **Table B.6.4** of the ***ACO REACH Model: Financial Operating Guide Overview*** methodology paper. A provider's specialty is determined based on the CMS Specialty Code recorded on the claim. For institutional claims, only services billed by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), regardless of CPT/HCPCS or provider specialty, are eligible for PCC payments. This flexibility was created for FQHC and RHC facilities because

[4] Note that CMS will monitor the historical lookback period to ensure that it is sufficiently predictive; if the experience is not sufficiently predictive, CMS may update the Base PCC Percentage calculation using additional claims runout or an alternative lookback period.

these organizations are specifically designed to provide primary care to the populations they serve. **Table 4** summarizes the claims eligible for reductions for each payment mechanism.

This method of defining primary care-based services for the purpose of PCC may be subject to revision from PY to PY. For example, CPT/HCPCS codes for primary care services may be updated from year to year to maintain consistency with the Medicare Shared Savings Program or the Medicare Physician Fee Schedule, along with other changes to support the policy intent of PCC. CMS will notify REACH ACOs of such changes via a revised version of this document.

Table 4. Claims eligible for reductions for each payment mechanism.

	Professional Claims		Institutional Claims	
Type of Services	**Primary care specialists[2]**	**All other specialties**	**FQHCs and RHCs**	**All other institutional providers**
Primary care-based services[1]	PCC	APO	PCC	APO
All other services	APO	APO	PCC	APO

[1] Table B.6.3 of the ***ACO REACH Model: Financial Operating Guide Overview*** methodology paper
[2] Table B.6.4 of the ***ACO REACH Model: Financial Operating Guide Overview*** methodology paper

After primary care services are identified, the payment amounts for claims subject to PCC (per **Table 4**) are aggregated to the provider level. CMS will apply the claims reduction percentage elected by each Participant Provider and Preferred Provider to the provider-level claim payment amounts. The total reduced primary care payment amount is then calculated as a percentage of the total claim-based payment for all covered services. This percentage is referred to as the Base PCC Percentage. Finally, the prospective, risk-adjusted, PBPM Benchmark is multiplied by the Base PCC Percentage to estimate the risk-adjusted PBPM Base PCC amount. The Base PCC Amount that a REACH ACO receives is simply the Base PCC Amount PBPM multiplied by the projected eligible months for a given month.

2.2.3 The Enhanced PCC Amount

The purpose of the Enhanced PCC Amount is to provide an upfront, additional payment for REACH ACOs to invest in and expand their primary care capabilities. As mentioned in the introduction to **Section 2.2**, although the Default Monthly PCC Payment is equal to 7 percent of the prospective Monthly PY Benchmark, a REACH ACO can choose a lower or higher PCC payment based on its choice of an Enhanced PCC Amount, depending on the circumstances described below. At the start of each PY, a REACH ACO will learn of its Base PCC Percentage, and the range of Enhanced PCC Percentages that it can choose from. REACH ACOs in their first performance year will be able to make an updated Enhanced PCC Percentage election following the release of their prospective Alternative Payments Arrangement (APA) report, and prior to release of the APA report for the second quarter, by a deadline established by CMS.

When calculating the Base PCC Amount to pay to REACH ACOs on a monthly basis, CMS will factor in the claims reduction percentages agreed to by each Participant Provider and Preferred Provider. However, when calculating the Enhanced PCC Amount a REACH ACO is entitled to, CMS will assume a 100 percent claims reduction amount for all Participant Providers and actual claims reduction as elected by Preferred

Providers. This ensures that a REACH ACO's Enhanced PCC Payment is not artificially increased due to lower claims reduction elections by Participant Providers. If 3 percent of the REACH ACO's historical claims expenditures are determined to be for PCC-eligible services and that REACH ACO elects 100 percent claims reduction, its Base PCC Amount will be 3 percent and its Enhanced PCC Amount will be 4 percent. However, if that REACH ACO's Participant Providers elect (on average) only 50 percent claims reduction, the Base PCC Payment will be 1.5 percent and the Enhanced PCC Payment will remain 4 percent.

If a REACH ACO chooses to receive an Enhanced PCC Amount, it can request an amount no more than the difference between 7 percent of the PY Benchmark and what the Base PCC Amount would have been with 100 percent claims reduction for all Participant Providers, unless that amount is less than 2 percent of the PY Benchmark, in which case the REACH ACO is allowed to request an Enhanced PCC Amount up to 2 percent of the PY Benchmark. That means that in cases where a REACH ACO's Base PCC Amount (assuming 100 percent claims reduction for Participant Providers) is greater than 5 percent of the PY Benchmark, the REACH ACO may still request an Enhanced PCC Amount up to 2 percent of the PY Benchmark, even though the sum of the Base PCC Amount and the Enhanced PCC Amount may exceed 7 percent of the PY Benchmark. The REACH ACO also has the option to not receive an Enhanced PCC Amount at all, in which case the PCC Payment will equal the Base PCC Amount. If a PCC REACH ACO does not elect an Enhanced PCC Percentage, that election will be defaulted to 7%.

For example, assume that a REACH ACO's monthly PY Benchmark is $1,000 PBPM and that the Base PCC Amount is determined to be $40 PBPM, as calculated from historical claims. The $40 PBPM Base PCC Amount is 4 percent of the monthly PY Benchmark ($40/$1,000). Since 7 percent of the monthly PY Benchmark is $70 (7 percent of $1000), the REACH ACO may receive an Enhanced PCC Amount no larger than $30 PBPM, which is 3 percent of the monthly PY Benchmark (7 percent minus 4 percent). The REACH ACO may choose an Enhanced PCC Amount equal to 3 percent, less than 3%, or may choose to not receive an Enhanced PCC Amount at all, in which case the REACH ACO will receive a Monthly PCC Payment of $40. In summary, in this example, the Monthly PCC Payment for the REACH ACO has a minimum of $40 and a maximum of $70.

In the scenario where the REACH ACO's Base PCC Amount already exceeds 7 percent of the monthly PY Benchmark, the REACH ACO may receive an Enhanced PCC Amount no larger than 2 percent of the monthly PY Benchmark. For example, assume that a REACH ACO's monthly PY Benchmark is $1,000 PBPM and that the Base PCC Amount is determined to be $80 PBPM, as calculated from historical claims. The $80 PBPM Base PCC Amount is 8 percent of the monthly PY Benchmark ($80/$1,000), which is greater than 7 percent of the monthly PY Benchmark. In this case, the REACH ACO may still receive an Enhanced PCC Amount no larger than 2 percent of the monthly PY Benchmark, which is $20. The REACH ACO may choose to not receive an Enhanced PCC Amount at all, in which case the REACH ACO will receive a Monthly PCC Payment of $80. In summary, in this example, the Monthly PCC Payment for the REACH ACO has a minimum of $80 and a maximum of $100. Regardless of the Enhanced PCC Amount received, the value of the Enhanced PCC Amount is recouped in full by CMS at the end of the PY and is not considered in any Shared Savings/Losses calculations (for details, refer to the ***ACO REACH Model: Financial Settlement Overview*** document).

2.2.4 Initial PCC Payments for REACH ACOs with Limited Claims Experience

We expect to be able to establish a reliable Base PCC Percentage for most REACH ACOs, including those with limited claims experience in the lookback period. However, some REACH ACOs may not have sufficient claims history in the lookback period to establish a reliable Base PCC Percentage. The minimum number of claims-aligned beneficiaries in the lookback period in order to establish a Base PCC Percentage will vary by REACH ACO type. For Standard REACH ACOs, a minimum of 3,000 claims-aligned beneficiaries is required in the lookback period for PY2023; for New Entrant REACH ACOs, a minimum of 1,000 claims-aligned beneficiaries is required in the lookback period for PY2023; and for High Needs Population REACH ACOs, a minimum of 250 claims-aligned beneficiaries is required in the lookback period for PY2023. Note that these thresholds may change in subsequent years.

If CMS determines that the REACH ACO does not have sufficient claims history for CMS to calculate a reliable Base PCC Percentage, CMS will continue to reduce FFS claims for PCC Eligible Services furnished to ACO REACH Beneficiaries by PCC Payment-participating Participant Providers and Preferred Providers by the PCC Fee Reduction percentage specified in their Fee Reduction Agreement, while making monthly PCC Payments to the REACH ACO equivalent to 7% of the performance year Benchmark shared with the REACH ACO in advance of the performance year and updated on a quarterly basis.

CMS will use the claims experience from the first quarter of the performance year to calculate the REACH ACO's Base PCC Percentage, with 2 months of claims run-out, such that payments are updated after the first 6 months of the performance year. For PY2023-PY2026, payments will be updated beginning the third quarter of the CY.

The historical Medicare FFS claims from the applicable lookback period are used to calculate the Base PCC Percentage based on payment for all covered services furnished to the ACO REACH beneficiaries in the lookback period who were aligned to the REACH ACO during the performance year through claims-based alignment or voluntary alignment.

CMS will then calculate an estimated annual Base PCC Payment Amount based on this Base PCC Percentage and the most recent available performance year benchmark.

Based on this estimated annual Base PCC Payment Amount, CMS will determine the monthly Base PCC Payment amounts that should have been made during each month of the performance year up to that point, which CMS will use to determine what portion of the monthly PCC Payments made during the first six months of the performance year were Base PCC Payments or Enhanced PCC Payments. These Base PCC Payments and Enhanced PCC Payments will be subject to adjustments in future quarters and during Final Settlement.

2.3 APO

REACH ACOs that elect PCC will have additional flexibility to contract with Participant Providers and Preferred Providers under an additional payment mechanism, the APO. This optional payment mechanism is only available to REACH ACOs that select the PCC capitation payment, is designed to serve as a cash flow to the REACH ACO, and is not factored into Shared Savings/Losses. The Advanced Payments will only apply to non-PCC-eligible services. **Table 5** distinguishes the claims eligible for PCC and those eligible for APO. Participant and Preferred Providers, regardless of PCC participation, are still eligible to opt into the APO if their REACH ACO also selects APO for the performance year.

Table 5. Definition of professional services that applies to PCC and APO. *(Note: same as **Table 4**)*

	Professional Claims		Institutional Claims	
Type of Services	**Primary care specialists[2]**	**All other specialties**	**FQHCs and RHCs**	**All other institutional providers**
Primary care-based services[1]	PCC	APO	PCC	APO
All other services	APO	APO	PCC	APO

[1] Table B.6.3 of the ***ACO REACH Model: Financial Operating Guide Overview*** methodology paper
[2] Table B.6.4 of the ***ACO REACH Model: Financial Operating Guide Overview*** methodology paper

Under the APO mechanism, REACH ACOs can enter into arrangements whereby CMS would reduce APO-eligible claims payments for REACH ACO-aligned beneficiaries for participating Participant Providers and Preferred Providers. The reduced claims payments can be between 1 and 100 percent (integer values only) of the value of the FFS claims payment amount. In return, CMS would make a monthly Advanced Payment to the REACH ACOs equivalent to the estimated value of the FFS claims reductions for APO-eligible services. Participant and Preferred Providers added during the performance year are not able to elect APO FFS claims reductions, with the exception of existing Participant Providers impacted by a TIN change during the performance year.

The calculation of the APO payment amount is estimated by CMS based on historical utilization of APO-eligible services to beneficiaries that would have been aligned through claims to Participant Providers, as opposed to the PCC-eligible services used in the calculation of the Base PCC Amount. Unlike the Base PCC Amount, these APO payments will be reconciled against actual FFS claims reductions at Final Financial Settlement.

For a REACH ACO participating in APO, all of the Participant Providers and Preferred Providers can each individually choose whether to opt into APO, and if so, at what percent claims reduction. The elected percent reduction may change from year to year, but this information must be submitted by the REACH ACO prior to each PY. At the end of each PY, the APO payment will be reconciled against the FFS payment that was withheld from the provider’s FFS payment.

Finally, a REACH ACO can choose not to opt into APO, in which case no REACH ACO provider will be able to participate in APO. **Table 6** summarizes the participation requirements for Participant Providers and Preferred Providers under APO.

Table 6. Requirements and percent claims reduction allowed by provider type under the APO Payment Mechanism.

Payment Mechanism Elected by the REACH ACO	Participant Providers	Preferred Providers
APO (Option only available if PCC is also elected)	Optional If selected, 1-100% for all PYs	Optional If selected, 1-100% for all PYs

In order for a provider to terminate claims reductions for TCC/PCC/APO during the performance year, the Participant or Preferred Provider must terminate their participation in the model
Note: Claims reduction amounts must be integer values only.

2.3.1 Insufficient Claims History to Calculate a Reliable PBPM APO Amount

We expect to be able to establish a reliable PBPM APO Amount for most REACH ACOs, including those with limited claims experience in the lookback period. However, some REACH ACOs may not have sufficient claims history in the lookback period to establish a reliable PBPM APO Amount. The minimum number of claims-aligned beneficiaries in the lookback period in order to establish a PBPM APO Amount will vary by REACH ACO type. For Standard REACH ACOs, a minimum of 3,000 claims-aligned beneficiaries is required in the lookback period for PY2023; for New Entrant REACH ACOs, a minimum of 1,000 claims-aligned beneficiaries is required in the lookback period for PY2023; and for High Needs Population REACH ACOs, a minimum of 250 claims-aligned beneficiaries is required in the lookback period for PY2023. Note that these thresholds may change in subsequent years.

If CMS determines that the REACH ACO does not have sufficient claims history for CMS to calculate a reliable PBPM APO Amount prior to the performance year, CMS will not make monthly APO Payments or reduce FFS claims subject to APO Payment reductions for the first two quarters of the performance year.

CMS will use the claims experience from the first quarter of the performance year to calculate the REACH ACO’s PBPM APO Amount, with 2 months of claims run-out, such that payments are updated after the first 6 months of the performance year. For PY2023-PY2026, payments will be updated beginning the third quarter of the CY.

At this point, CMS will begin making monthly APO Payments and reduce FFS claims subject to APO Payment reductions for the remainder of the performance year.

The historical Medicare FFS claims from the applicable lookback period are used to calculate the PBPM APO Amount based on payment for all Covered Services furnished to the ACO REACH Beneficiaries in the lookback period who were aligned to the REACH ACO during the performance year through Claims-Based Alignment or Voluntary Alignment.

For the REACH ACO’s second performance year and each subsequent Performance year, if CMS determines that the REACH ACO does not have sufficient claims history to calculate a reliable PBPM APO Amount prior to a performance year, CMS may, at its sole discretion, use a REACH ACO’s PBPM APO Amount from the prior performance year as the current performance year’s PBPM APO Amount, in order to avoid a six-month delay in the implementation of APO.

3.0 Quarterly Updates to Payments

CMS determines beneficiary alignment and calculates the monthly capitated payments to the REACH ACO in advance of each quarter. Because of the quarterly cycle, the prospective monthly payment the REACH ACO receives will be for all beneficiaries aligned for the quarter, and assumes continued alignment for the entire 3 months. However, a beneficiary may lose alignment if the beneficiary loses Part A or Part B coverage, joins a Medicare Advantage plan, loses Medicare as the primary payer, moves out of the Extended Service Area, or dies before or during the payment quarter. Beneficiaries failing to meet any of these eligibility criteria on the first day of a month are not eligible for payment reduction in that month. A beneficiary may also become newly aligned due to Prospective Plus Alignment. Because the PY benchmark is first calculated prior to the PY (prospectively), if the changes in aligned beneficiary counts are not accounted for, then the monthly prospective payment amounts (for TCC, PCC or APO) will lose precision.

Additionally, in the case of TCC, the Withhold Percentage is calculated based on the historical baseline period, which may be different than the actual proportion of services subject to the TCC Withhold in the PY (e.g., if there is an increase in care provided to aligned beneficiaries by Participant Providers or Preferred Providers). If this Withhold Percentage is significantly different between the baseline period and the PY, the Monthly TCC Payment may be over- or under-estimated.

Due to these limitations of a purely prospective estimate for monthly capitated payments and to avoid substantial end-of-PY fund transfers, CMS will update the capitated payments prior to every quarter based on the beneficiary experience in the current quarter. To account for the changes in beneficiary alignment and the actual portion of expenditures incurred outside of the capitation arrangement (TCC only), before each quarterly payment cycle (starting with the second quarter of each PY), CMS will recalculate the capitated payments for the upcoming quarter. The over- or under-payments from prior quarters will be spread out over the remaining months in the PY as of report production (i.e., over- or under-payment amounts will be divided by 9 in Q2 APAs, 6 in Q3 APAs, and 3 in Q4 APAs). **Table 7** summarizes the adjustments to be made during each quarterly payment update.

Table 7. Prospective and retrospective adjustments by payment mechanism.

Quarterly adjustment	Prospective adjustment for the number of aligned beneficiaries in next quarter	Retrospective adjustment for the number of aligned beneficiaries in prior quarter(s)	Update % of total cost of care subject to capitation	Update based on updated benchmarks (e.g., as risk scores move from preliminary to final)
TCC	Yes	Yes	Yes (Withhold Percentage)	Yes
PCC	Yes	Yes	No (Base PCC Percentage)	Yes
APO	Yes	Yes	No[1]	No[1]

(1) CMS will monitor for meaningful discrepancies between APO payments and FFS claims reduced under APO (e.g., >5% of payments made). We reserve the right to (but are not required to) adjust quarterly payments if the amount paid meaningfully diverges from the amount reduced during the year.

3.1 Updating the Projected Eligible Months for the Upcoming Quarter

At the end of every quarter in PY, CMS will have a new alignment file that reflects the actual alignment in each month of that quarter. To continually adjust for the changes in alignment, CMS will assume a "retention rate" that predicts the percentage of eligible months left at the start of the next month, compared with the start of the prior month. The retention rate will be based on the last year of the lookback period used to calculate the capitated payments, and is updated annually. It is calculated as the average of the retention rate for each month during the lookback period (January to February, February to March, March to April, etc.). For PY2023-PY2026, this will be the average of 8 retention rates, as the lookback period spans January – September of the prior year[5].

$$\begin{aligned} &\textit{Average retention rate per month} \\ &\qquad = 1/N \sum_{m=1}^{N} (\textit{eligible months at start of } m+1)/(\textit{eligible months at start of } m) \end{aligned}$$

The average monthly retention rate is then multiplied by the actual eligible months in the current month to calculate the updated projected eligible months in the upcoming month.

$$\begin{aligned} &\textit{Projected eligible months in upcoming month} \\ &\qquad = \textit{Actual eligible months in current month} \times \textit{retention rate} \end{aligned}$$

For example, Q2 payments are updated in March, by which time the actual eligible months in Q1 are known (because eligibility determinations are made on a monthly basis, beneficiaries eligible on the first of the month are considered eligible for that month). The updated projected eligible months in April are then equal to the actual eligible months in March multiplied by the monthly retention rate.

For REACH ACOs participating in Primary Care Capitation, if CMS determines that the REACH ACO does not have sufficient claims history for CMS to calculate a reliable retention rate prior to the performance year, CMS will use the retention rate for beneficiaries in the ACO REACH National Reference Population to project the number of beneficiaries for the first two quarters of the PY. For High Needs Population REACH ACOs, however, CMS will assume a retention rate of 100% due to the small populations and potential impact on cash flow. Once CMS calculates the Base PCC Percentage using experience from the PY, CMS will also calculate a retention rate for the REACH ACO based on the same lookback period from the PY.

3.2 Accounting for the Loss/Gain of Beneficiary Alignment in the Past Quarters

Using the actual eligible months from the current quarter, we can determine whether a beneficiary lost or gained alignment during the current quarter. Using the actual eligible months, CMS will calculate how much a REACH ACO was overpaid or underpaid the in that quarter due to differences in actual versus

[5] If CMS uses a full 12-month CY for a subsequent PY, the retention rate will be the average of the 11 retention rates in the lookback period.

expected number of eligible beneficiary-months and apply that amount to the upcoming quarter's payments to reflect previous over- or under-payments.

The over- or under-payment in Q4 will not be applied to Q1 of the upcoming PY, to avoid mixing payments in two different PYs. Instead, the over- or under-payment in Q4 will be accounted for during the Financial Settlement of that PY. As a result, there will be three adjustments for over- or under-payments during the PY, and again for the Provisional and Final Financial Settlement.

3.3 Updating the Withhold Percentage (TCC only)

The Withhold Percentage throughout the PY is updated to reflect the changes in the aligned population and the associated changes in utilization in and outside of the REACH ACO. The re-estimation of the Withhold Percentage will be based on the most recent claims from the PY, as they become available. For example, at the end of PY Q2, CMS will look at the actual alignment in PY Q1, examine accrued claims from aligned beneficiaries during Q1, and re-estimate the Withhold Percentage for PY Q3. Because of the 3-month runout period of claims, the Withhold Percentage will be updated twice in a full PY—at the end of Q2 (Q1 claims would be available) for Q3 payments and at the end of Q3 (Q1-Q2 claims would be available) for Q4 payments.

The updated Withhold Percentage can then be used to calculate capitated payments for the upcoming quarter, and update any over- or under-payments in the current quarter, which will be deducted or added to the upcoming quarter's payments. A payment floor will be utilized in Q2, Q3, and Q4 to ensure that after accounting for over- or under-payments, monthly payment amounts do not fall below 75% of the prior quarter's average monthly payment. Note that if recoupment of over-payments is constrained by this payment floor, the unrecouped balance is carried forward to be reconciled with any additional under- or over-payments in subsequent quarters and/or with determination of shared savings/losses at financial settlement.

3.4 Updating the PBPM Benchmark

The PBPM Benchmark changes throughout the PY as additional information on alignment and beneficiary risk scores becomes available. CMS will use the PBPM Benchmark from the most recently available Quarterly Benchmark Report to calculate capitated payments for the upcoming quarter, and to update any over- or under-payments in the current quarter, which will be deducted or added to the upcoming quarter's payments. Because Quarterly Benchmark Reports are published after each quarter, the PBPM Benchmark will be updated twice in a full PY— before making Q3 payments (Q1 Benchmark Report would be available) and before making Q4 payments (Q2 Benchmark Report would be available).

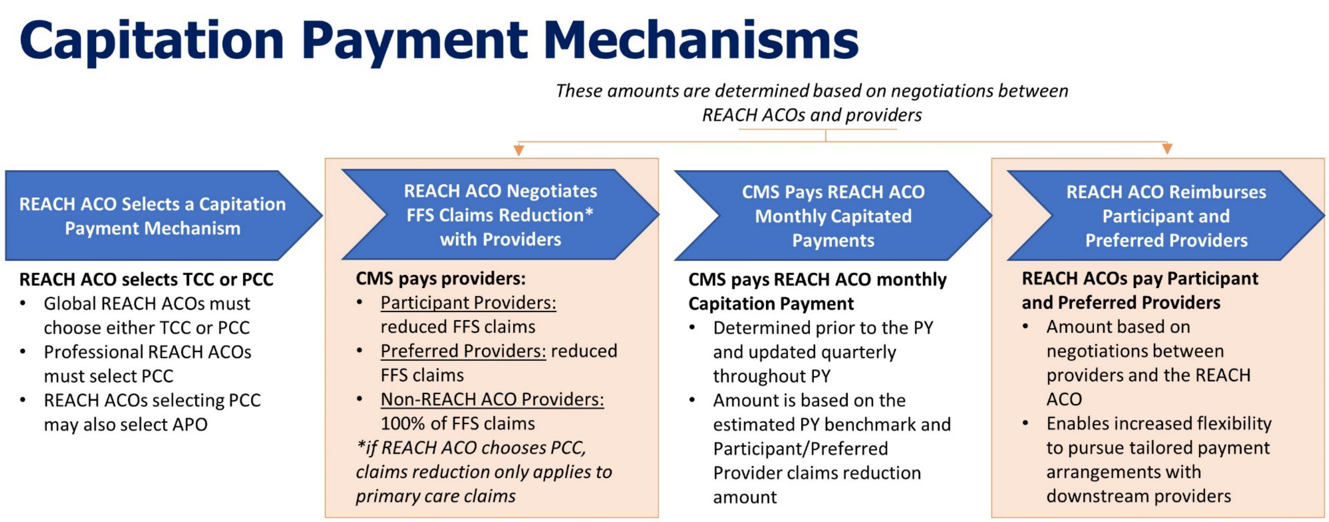
3.5 Final Retrospective Adjustments at Financial Settlement

At final Financial Settlement, CMS will make final retrospective adjustments for the payments made during the PY to determine the Total Monies Owed, after Shared Savings/Losses calculations. Final retrospective adjustments reflecting actual PY beneficiary alignment will apply to all payment mechanisms. For APO, payments will be reconciled against the actual APO reductions made on claims during the PY at the time of Financial Settlement. For TCC, the actual Withhold Percentage will be calculated using all PY claims during Financial Settlement. For PCC, the only retrospective adjustment to the payments made to the REACH ACO will be beneficiary alignment counts.

4.0 Capitation Payments Flow

Figure 1 below summarizes the overview of payment flow under the capitation payment mechanisms. A REACH ACO selects a capitation payment mechanism, in addition to selecting the risk arrangement option. The REACH ACO then negotiates with individual Participant Providers and Preferred Providers on the percent FFS claims reduction under the capitation. CMS will pay REACH ACOs monthly capitated payments, which are determined prior to the PY, and will continue to pay the remaining claims by Participant Providers and Preferred Providers and all claims by non-associated providers on a FFS basis. Upon receiving the monthly capitated payments from CMS, the REACH ACOs will reimburse Participant Providers and Preferred Providers based on prior negotiations between the REACH ACO and the providers.

Figure 1. Payment flow overview



4.1 Claims Submission

Regardless of payment option, all providers must continue to submit all claims for aligned beneficiaries to the Shared System Maintainers (SSMs) in accordance with standard Medicare FFS claims processing rules and procedures. Claims data supports monitoring, evaluation, and quality measurement.

4.2 Claims Processing and Reprocessing

When a claim is submitted to the SSMs, the SSMs adjudicate the claim and determine the payment amount to the provider(s). If a claim is for a service rendered to an aligned beneficiary by an aligned Participant Provider or Preferred Provider who has opted into any of the payment mechanisms (for TCC, PCC, or APO), based on the monthly updated provider and beneficiary alignment lists that the SSMs receives, the SSMs will reduce the Otherwise Payable Amount (OPA). The OPA is the amount the provider would have received from Traditional Medicare, i.e., the amount after accounting for beneficiary cost-sharing and the application of sequestration that will be subject to alternative payment reductions, which accounts for the percent claims reduction elected by the provider and reimburses the provider the remaining amount after the reduction.

Because the SSMs receives the monthly provider and beneficiary alignment lists prior to the start of a given month, the SSMs do not learn of a beneficiary's actual alignment status during the month until the next provider and beneficiary alignment lists are available. In cases where *a beneficiary has lost alignment during that month*, the SSMs would be reducing the OPA as if the beneficiary was still aligned, when the provider should have received the total OPA. In these cases, CMS will instruct the SSMs to re-process and re-adjudicate the claim, and reimburse the provider the OPA.

This process of claims reprocessing works similarly in the event that a Participant Provider or Preferred Provider terminates his/her agreement with the REACH ACO during a given month. The services provided to aligned beneficiaries by the provider during this month are still eligible for reduction. Starting the next month, if any claims are erroneously reduced, CMS will instruct the SSMs to re-process and re-adjudicate the claims for services provided to aligned beneficiaries on or after the first day of that next month, and reimburse the provider the OPA. Providers added to the provider list during the PY are not eligible to participate in payment mechanisms and do not contribute to prospective monthly payment amounts. In addition, CMS reserves the right to adjust payments for a REACH ACO if a significant number of the Participant Providers or Preferred Providers participating in capitation are removed from the REACH ACO during the performance year.

In other cases, where *a beneficiary has become newly aligned* (e.g., because of Prospective Plus Alignment), CMS will establish a deadline before each quarter for the REACH ACO to submit the list of voluntarily aligned beneficiaries. Beneficiaries' effective alignment date is on the first date of the subsequent quarter, which will be on or after the date the SSMs receive the updated alignment file. If the list is submitted after this deadline, the voluntarily aligned beneficiaries will not be considered aligned until the subsequent quarter.

Finally, through the SSMs, all REACH ACOs will receive a weekly snapshot of all eligible Part A and B claims reduced and adjudicated in the prior week. This snapshot is known as the Weekly Claims Reduction File (CRF). This file may serve a number of purposes to REACH ACOs, from helping facilitate tailored payment arrangements between providers and REACH ACOs to improving beneficiary engagement. This file will include fields related to the type and amount of claim reduction, beneficiary cost-sharing amounts, the linkage of an original claim to its adjustment, the source and type of a retrospective adjustment to a claim, and other relevant claim metadata.

4.3 Claims Processing Precedence Rules

The Innovation Center produces mandatory and voluntary models that test alternative approaches to provider compensation under the FFS program, including episode-based payments, pay-for-performance, population-based payment and global budgets. Certain models adjust the OPA, similar to ACO REACH, or otherwise take priority in terms of how the claims processing system adjudicates the claim because they are rendered by providers associated with a mandatory model. While situations when claims overlapping with two models are generally rare, it is necessary to proactively create and maintain instructions for how the claims processing system should adjudicate these claims to ensure that both models are carried out as designed. **Table 8** presents the claims processing rules that correspond to ACO REACH for PY2023, where the first column corresponds to the name of an Innovation Center model or CMS demonstration, and the second column indicates whether the other model or ACO REACH takes precedence. For example, in the event an ESRD facility or managing clinician is practicing at a randomly selected geographic area associated with ETC, but is also a provider participating in ACO REACH who elected TCC, PCC, or APO, then that provider's care, if rendered to an aligned beneficiary would be adjusted based on the ETC model, and not ACO REACH. These rules will be updated as models retire or are subsequently implemented and CMS will notify ACO REACH participants of any updates when available.

In addition to the exclusions listed below, claims that are ineligible for TCC, PCC, or APO reductions include claims from aligned beneficiaries who opted out of data sharing, claims that contain substance and alcohol abuse services, claims from providers who have elected to receive Periodic Interim Payments on institutional claims, operating outlier amounts, operating Disproportionate Share Hospital payments, operating Indirect Medical education payments, Medicare new technology add-on payments, and islet isolation add-on payments.

Table 8. Claims processing precedence rules with other models and demonstrations.

Model / HCPC / TOB	Who has precedence / processing rules?
Bundled Payments for Care Improvement Advanced (BPCI-A)	ACO REACH
Comprehensive Care for Joint Replacement (CJR)	ACO REACH
End-Stage Renal Disease (ESRD) Treatment Choices (ETC)	ETC
Radiation Oncology (RO)	RO
Oncology Care Model (OCM) HCPCS codes G9473 or G9678	OCM
Veteran's Medicare Remittance Advice (VA MRA)	VA MRA

4.4 CMS Payments to REACH ACOs and REACH ACO Payments to Providers

Prior to each quarter, CMS will calculate the monthly capitated payments for each REACH ACO for the upcoming quarter, updated with the adjustments described in **Section 3**. CMS will distribute directly to the REACH ACOs the monthly TCC or PCC payments and, if applicable, the APO payments. CMS will continue to reimburse REACH ACO Providers for services that are not applicable to the payment mechanisms on a FFS basis.

For REACH ACOs participating in TCC, to ensure REACH ACOs have sufficient cash flow to fund value-based activities and compensate downstream providers (e.g., if PY care patterns are meaningfully different than care patterns in the lookback period), CMS will add to the first month's payment of the PY an amount that is equal to 20 percent of the first month's payment. This additional amount will be deducted from the last month's payment of the PY. Note that this is not applied for REACH ACOs participating in PCC because the Enhanced PCC component offers increased cash flow to fund value-based activities and compensate downstream providers.

After the REACH ACO receives the monthly capitated payments from CMS, the REACH ACO is responsible for distributing the payments to its Participant Providers and Preferred Providers, based on agreements between the REACH ACO and each of its providers.

REACH ACOs should be aware of the potential impact that the quarterly payment updates (see **Section 3**) and the claims reprocessing (see **Section 4.2**) may have on the monthly capitated payments received from CMS, and thus its payments to its providers. The payment update for the upcoming quarter may include over- or under-payments to the REACH ACO from the previous quarter. The claims reprocessing due to beneficiary alignment changes in the previous quarter will also result in payment changes that a provider will directly receive from the SSMs. It is the REACH ACO's and its providers' mutual responsibility to have an agreement on how to reconcile these payment adjustments.

5.0 Financial Settlement

At settlement, CMS compares the PY expenditure against the REACH ACO's benchmark to determine shared savings or losses.

The PY expenditure is the total payment that has been made by Medicare for services provided to REACH ACO-aligned beneficiaries during months in which they were aligned to the REACH ACO. It is equal to the payments made to the REACH ACO for services within the scope of the capitation payment (either via TCC or PCC), plus the FFS payments made to providers by the Medicare Administrative Contractors, including any reduction in FFS payments made under the APO (after they have been reconciled against actual reductions). The PY expenditure will then have the optional stop-loss payout and charge applied to it, when applicable.

The PY expenditure with stop-loss payout and charge applied to is then compared to the Total Benchmark Expenditure. The difference between the two terms is the Gross Savings/Losses, which can be expressed as the Gross Savings/Losses PBPM or as a percentage of the Total Benchmark Expenditure.

For detailed methodology of the Financial Settlement, refer to other specification papers such as the ***ACO REACH Model: Financial Settlement Overview*** document.