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ACO REACH Model

OVERVIEW

On February 24th, the Center for Medicare and Medicaid Innovation (CMMI) announced the redesign of the Direct Contracting program under the new title of "ACO Realizing Equity, Access, and Community Health" (ACO REACH). CMMI also released an accompanying Request for Applications (RFA) for new applicants to participate in ACO REACH starting in 2023. At that time, the 99 currently operating Direct Contracting Entities (DCEs) must convert into REACH ACOs or leave the program.

Although the design of ACO REACH is fundamentally similar to that of GPDC, notable new elements include:

- New requirements on governance and organizational history, meant to ensure that REACH ACOs are provider-led and their ownership is aligned with CMMI's vision;
- Modifications to the financial parameters of the model, which will increase the funds available to REACH ACOs but further limit potential increases in population risk scores;
- New health equity initiatives, including a benchmark adjustment for ACOs who have more high-need individuals attributed and a requirement to develop a Health Equity Plan and collect social needs data; and
- Additional plans by CMMI to monitor REACH ACOs to ensure compliance.

The below document summarizes the ACO REACH model. Underlined text denotes changes from the GPDC model RFA (note that some material that is new to the RFA was already contained in the existing GPDC Participation Agreement), except where a whole section is marked "(New)". A briefer summary that only contains new changes in ACO REACH is available here.

The full RFA is available here.

ACO REACH APPLICATION

The ACO REACH model is part of a strategy by the CMS Center for Medicare and Medicaid Innovation (CMMI) to "use the redesign of primary care as a platform to drive broader health care delivery system reform." Compared to the Medicare Shared Savings Program (MSSP) ACOs, new types of entities may apply, and entities may have a lower number of aligned Medicare fee-for-service (FFS) beneficiaries than was permitted under previous models.

There are three types of REACH ACO:

1. **Standard**: ACOs comprised of organizations that generally have experience serving Medicare FFS beneficiaries, including dually eligible beneficiaries, that will rely on voluntary alignment and claims-based alignment.
2. **New Entrant**: ACOs comprised of organizations that have not traditionally provided services to a Medicare FFS population. CMMI expects these ACOs will primarily rely on voluntary alignment.
3. **High Needs Population**: ACOs that serve Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries, who are aligned to the ACO through voluntary alignment or claims-based alignment.

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Each ACO must further select from two options for risk-sharing and payment:

1. **Professional**: 50% shared savings/losses and a Primary Care Capitation (PCC), generally equal to 7% of the Performance Year (PY) Benchmark.
2. **Global**: 100% shared savings/losses and either PCC or Total Care Capitation (TCC), which is equal to the entire portion of the PY Benchmark attributable to the ACO's providers.

Further details on the model's financial mechanisms are in the Financial Methodologies section below.

Application Process and Timeline (New)

The REACH ACO model will extend for four years, through 2026. In general, policies will not vary based on the cohort in which the ACO started (2021, 2022, or 2023). As a result, CMMI is changing references to performance years (which are aligned with the calendar year) from "Performance Year 1" (PY 1) to "Performance Year 2021" (PY2021).

New organizations interested in becoming a REACH ACO may apply from March 7th to April 22nd. This is currently the only application window CMMI intends to conduct. Existing DCEs will not need to reapply, but they will need to comply with new ACO REACH requirements. Depending on the volume of applications received, CMMI may choose to limit the total number of selected REACH ACOs.

CMMI seeks to identify applicants with demonstrated success (1) providing direct patient care and/or (2) furnishing high-quality care to underserved communities. It has expanded, updated, and restructured the application questions and scoring to emphasize these qualities.

An approximate crosswalk of the application scoring is below.

GPDC RFA	ACO REACH RFA
Organizational Capacity: 10 points **Leadership and Management**: 20 points	**Organizational Readiness**: 15 points - Incorporation, License, and Structure - Leadership Team - Governing Body - Oversight and Representation - Information on Expected Participant/Preferred Providers - Disclosures - Information on Partners/Vendors
Financial Plan and Risk-Sharing Experience: 20 points	**Financial Plan and Risk-Sharing Experience**: 35 points - Revenue Sources (clinical and non-clinical) - Risk-Sharing Experience - Implementation Plan (including health equity)
Patient Centeredness & Beneficiary Engagement: 25 points **Clinical Care**: 25 points - Clinical Process Improvement (10 points) - Care Coordination (10 points)	**Clinical Care Model**: 35 points - Care Coordination - Population Health - Care Management - Beneficiary Engagement - Patient Centeredness - Community Engagement
- Data Capacity (5 points)	**Data and HIT Capability**: 15 points - Technical Capability - Data and HIT to Inform Clinical Care (including collection of data to address health disparities)

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Third Implementation Period (New)

All selected REACH ACOs will be able to participate in an optional third Implementation Period (IP3) from August 1, 2022 through December 31, 2022. Unlike in previous IPs, ACOs will not be able to receive beneficiary-identifiable data during IP3. Instead, ACOs in IP3 will be focused only on conducting voluntary alignment outreach activities to meet their enrollment thresholds. Voluntary alignments received during IP3 will be effective as of January 1, 2023.

MODEL DESIGN

Eligible Providers and Suppliers

A REACH ACO must be a legal entity able to contract with CMS and with a network of providers. Each ACO's network must have a core set of "Participant Providers" who are committing to beneficiary care improvement. Participant Providers must agree to receive capitated payments from the ACO, and their claims history will drive claims-based alignment to the ACO. A provider may be a Participant Provider in only one ACO.

ACOs may also include "Preferred Providers," who also agree to contribute towards the ACO's goals, but who do not drive claims-based alignment and who are not required to receive capitated payments from the ACO. Both kinds of providers may participate in ACO Benefit Enhancements.

An ACO's Participant Providers may include, but are not limited to:

- Physicians or other practitioners in group practice arrangements;
- Networks of individual practices of physicians or other practitioners;
- Hospitals employing physicians or other practitioners;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs); and
- Critical Access Hospitals (CAHs).

Model Options

The Standard Option is similar to CMMI's previous ACO models, particularly the Pioneer ACO and Next Generation ACO models, which included population-based payment models. The New Entrant and High Needs Population options enable other types of organizations who may not have a history of participating in Medicare FFS or CMMI models to do so. These may include organizations with significant experience in Medicare Advantage (MA) or Medicaid managed care. These two options will require fewer aligned beneficiaries, particularly at the beginning of the demonstration period.

The High Needs Population Option should involve enhanced care coordination services specific to a chronically ill, frail population with complex needs, which may be based on the model of care employed by PACE plans in Medicare.

To participate in the New Entrant Option, less than 50% of an ACO's Participant Provider NPIs/TINs may have prior experience in a total cost of care CMMI model, including the Maryland Primary Care Program and the Vermont All-Payer ACO, and the ACO cannot have been eligible to align more than 3,000 beneficiaries through claims-based alignment in any of the base years (2017 through 2019). If the ACO passes this threshold, it may elect to apply as a Standard ACO.

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Service Area

To be aligned to an ACO, a beneficiary must live in a county in the ACO's service area, which includes:

1. **Core Service Area**: Counties in which the ACO's Participant Providers have physical office locations.
2. **Extended Service Area**: Includes counties contiguous to the Core Service Area.

These are also the areas in which the ACO may conduct marketing activities. The Service Area may be updated on a quarterly basis if new office locations are added, which may change Prospective Plus Alignment and expand permissible areas for marketing activities. Regardless of the type of ACO, the Core Service Area can consist of non-contiguous counties and counties in multiple states.

If an ACO's clinical care model does not rely on physical practice locations (e.g., mobile clinicians), or for a High Needs Population ACO, CMS may approve an alternative service area definition.

Organizational Structure, Governance, and Program Integrity (New)

Under ACO REACH, CMMI intends to conduct a more rigorous Program Integrity (PI) screening process, although the underlying requirements are similar. Under GPDC, the PI screening included:

- A review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- A review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- A review of any civil or criminal actions related to participation in a federal health care program.

New items added in ACO REACH include:

- A requirement for more detailed disclosures of the financial and compliance history of all persons who are owners or controllers, key executives (defined the same way as in GPDC), equity partners, or expected Participant or Preferred Providers in the proposed ACO;
- A requirement to disclose whether any individuals or entities in the applicant's governing body have an ownership interest in the ACO; and
- Potential review of demographic data for program integrity activities. For example, CMS may seek to identify discriminatory behavior in marketing activities.

Other governance requirements that have been enhanced under ACO REACH include:

- Each ACO governing body must have a Medicare beneficiary and a separate consumer advocate, each of whom must have voting rights. Beyond this, CMMI "strongly encourages" additional beneficiary participation in advising the ACO.
- At least 75 percent control of the ACO's governing body must be held by Participant Providers or their designated representatives. This is a return to the level of participant governance required for MSSP ACOs and Next Generation ACOs. Like previous models, REACH ACOs may seek an exception from CMS if they demonstrate that they will involve providers in governance.

Under GPDC, CMS provided Stark and Anti-Kickback Law waivers to cover certain activities of participants, and the Anti-Kickback safe harbor for CMS initiatives was also available. However, CMS has not yet determined what fraud and abuse waivers it may issue for REACH ACOs. In New York, ACOs may also need to consider the possible application of New York's "mini-Stark" law.

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Overlap with Other CMMI Models and MIPS/APMs

In general, providers may only participate in one CMMI model involving shared savings at a time. CMMI also does not permit providers to participate in multiple models with similar payment structures, even if they do not involve shared savings. These restrictions apply only to Participant Providers of an ACO. An entity may be a Preferred Provider in one or more REACH ACOs and a Participant Provider in one REACH ACO or a participating provider in one MSSP ACO.

Specifically, a REACH ACO's Participant Providers may not simultaneously participate in:

- The Primary Care First model;
- The Vermont All-Payer ACO model;
- The Kidney Care Choices (KCC) model;
- The Independence at Home model; or
- The Maryland Primary Care Program.

GPDC did not specify limits on the composition of an aligned population. However, REACH ACOs are intended to serve either a "general, heterogeneous population" or a subpopulation that is **not** otherwise covered by a CMMI total cost of care model (whether current or announced). CMMI will not accept ACOs whose participants would be primarily composed of providers who serve such a subpopulation, or whose aligned population is more than 50% composed of individuals in such a population.

Currently, the only such model is the KCC model. As such, CMMI will not accept applications from ACOs whose participants would "primarily" be renal disease providers, and an ACO whose aligned population becomes more than 50% composed of individuals with chronic kidney disease (CKD) and/or end-stage renal disease (ESRD) would be subject to remedial action.

All ACO REACH options will be considered Advanced Alternative Payment Models (APMs) for the purposes of Qualifying APM Participant (QP) determinations. If a provider participating in an ACO REACH does not qualify as a QP, ACO REACH will count as an APM for MIPS scoring.

Solvency Requirements

An ACO must be able to repay any shared losses or other owed funds that it accrues. ACOs must provide a financial guarantee, in the form of funds in escrow, a line of credit, or a surety bond, equal to:

- **Professional ACOs**: 2.5% of their benchmark (for that PY)
- **Global ACOs receiving Primary Care Capitation**: 3% of their benchmark
- **Global ACOs receiving Total Care Capitation**: 4% of their benchmark

These amounts are unchanged from those specified in the GPDC Participation Agreement. CMS will notify each ACO of the required amount of the guarantee each year and will withhold payments until the ACO submits documentation of meeting the guarantee.

REACH ACOs may also need to comply with applicable state licensure requirements regarding risk-bearing entities. In New York State, 10 NYCRR 1003.5 (available here) specifies that Medicare ACOs that take more than 10 percent risk on their benchmark must, among other conditions, maintain a reserve of 25 percent of their maximum possible loss.

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Health Equity Plan (New)

CMMI has established a new requirement that, in PY 2023, all REACH ACOs must develop and implement a Health Equity Plan. CMMI will provide a template for the Plan, which must be used by ACOs. An ACO's plan will:

- Identify health disparities within the ACO's aligned population;
- Define health equity goals; and
- Establish a plan to implement the ACO's health equity strategy, which must include metrics by which to monitor and evaluate progress.

ACOs will then be required to periodically report to CMS on progress implementing their Health Equity Plans.

If the ACO's plan involves actions that involve protected classes of beneficiaries, they will be required to show that the action is necessary, including by submitting substantiating data, and cannot be performed in a protected class-neutral way.

Marketing

ACOs may provide marketing materials and hold outreach events as permitted by law, but must submit all such materials and activities to CMS for review. ACOs may not conduct marketing activities to their aligned population to recruit them into MA or other Medicare managed care products. Similarly, they may not target marketing efforts to individuals already enrolled in Medicare managed care.

All Participant Providers must have a prominent display stating that the provider participates in the ACO REACH model, and that beneficiaries retain all Medicare FFS benefits and rights. CMS will provide a template for such displays. In general, ACOs are subject to applicable law around beneficiary incentives. ACOs may offer the defined Beneficiary Engagement incentives (see below) as well as certain in-kind incentives, similar to Special Supplemental Benefits for the Chronically Ill (SSBCI) in MA. These may include medication and transportation vouchers, wellness program memberships and classes, electronic devices, phone applications, or meal programs. Such incentives must meet the following conditions:

- There is a reasonable connection between the items or services and the medical care of the beneficiary.
- The items or services are preventive care items and services, or advance a clinical goal for the beneficiary.
- The item or service must not be covered by Medicare (at the time that the item or service is provided).
- The item or service must be provided directly by the ACO or an ACO provider.
- The item or services may not be provided, in part or in whole, as a reward for voluntarily aligning with the ACO.

Once beneficiaries are aligned, ACOs must inform them what that means in terms of care they will receive and how to opt out of data sharing. In particular, the ACO must make all beneficiaries aware of any Benefit Enhancements (where applicable) that will be available to them. CMS will approve such communications before use.

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Benefit Enhancements

ACOs may offer the following Benefit Enhancements to their aligned beneficiaries:

- **Cost Sharing Support for Part B Services**: ACOs may allow their network providers to waive Part B cost-sharing requirements for Part B services (except prescription drugs and DMEPOS), in whole or in part. The ACO would then make payments to their providers to cover the cost-sharing not collected.
- **Chronic Disease Management Rewards**: ACOs may provide gift cards to aligned beneficiaries, up to $75 per year, to incentivize participation in a chronic disease management program.
- **3-Day Skilled Nursing Facility Rule Waiver**: ACO network providers may receive a conditional waiver of the three-day inpatient stay requirement prior to admission to a skilled nursing facility (SNF), acute-care hospital, or critical access hospital with swing-bed approval for SNF services.
- **Asynchronous Telehealth**: ACO network providers may receive a conditional waiver to provide dermatology and ophthalmology services using asynchronous store and forward technologies. Network providers are also not subject to the rural geographic area requirement and related restrictions on Medicare telehealth services provided to ACO beneficiaries.
- **Post-Discharge Home Visits**: ACO network providers may receive a conditional waiver of the requirement for direct supervision to allow payment for certain home visits furnished to eligible, non-homebound beneficiaries by auxiliary personnel.
- **Care Management Home Visits**: ACO network providers may receive a conditional waiver of the requirement for direct supervision to allow for payment for certain home visits that are furnished to eligible beneficiaries in advance of potential hospitalization.
- **Home Health Homebound Requirement**: ACO network providers may provide home health services to aligned beneficiaries who are not homebound, but who have certain specified conditions.
- **Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit**: Global ACO network providers may continue to provide curative care to beneficiaries who would otherwise be required to give up that right when electing the Medicare Hospice benefit.

CMS is also making a new benefit enhancement available for PY 2023:

- **Nurse Practitioner (NP) Services Benefit Enhancement**: NPs who are network providers in an ACO may receive a waiver to expand their scope of practice as follows:
    - *Hospice*: NPs may provide the initial 90-day certification that a beneficiary is terminally ill and in need of hospice care (the medical director of the hospice would continue to provide periodic ongoing certifications).
    - *Diabetic Shoes*: NPs may document and certify that a beneficiary needs diabetic shoes without involvement of a physician.
    - *Cardiac Rehabilitation*: NPs may establish, review, and sign written care plans for cardiac rehabilitation.
    - *Home Infusion*: NPs may establish, review, and sign a plan of care for home infusion (including the type, amount, and duration).
    - *Medical Nutrition*: NPs may refer patients for medical nutrition therapy.

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BENEFICIARY ALIGNMENT

Alignment Eligibility

Beneficiaries will be considered alignment-eligible in a given month for ACO alignment if they meet the following criteria:

- Are enrolled in both Medicare Parts A and B;
- Are not enrolled in an MA plan, or other Medicare health plan;
- Have Medicare as the primary payer;
- Are a resident of the United States;
- Reside in a county included in the ACO's service area.

Alignment Hierarchy

CMS will prospectively align beneficiaries to each ACO for each performance year. Beneficiary alignment is used to determine an organization's historical baseline expenditures for purposes of calculating the Performance Year Benchmark. Beneficiaries may be aligned to an ACO in two ways:

1. **Claims-based Alignment**: Beneficiaries are aligned based on the amount of primary care services received from a Participant Provider.
2. **Voluntary Alignment**: Beneficiaries designate a Participant Provider as the main source of care.

If a beneficiary can be aligned to two different providers (i.e., voluntarily aligned to one provider but claims-aligned to another), the voluntary alignment will take precedence over claims-based alignment.

If a beneficiary can be aligned to multiple CMMI models, CMMI will use a cross-agency hierarchy to resolve such conflicts. CMMI will specify any initiatives that take alignment precedence over the ACO REACH model each year.

Claims-Based Alignment

Claims-based alignment will be performed prospectively for each PY, based on historical claims for certain primary care services furnished by the Participant Providers, as identified by their TIN/NPI combination. Specifically, CMS will align a beneficiary to a ACO if the beneficiary has historically received a majority of their Primary Care Qualified Evaluation and Management (PQEM) services from the ACO's Participant Providers during a two-year alignment lookback period. The current list of PQEM services is available in the PY2022 Financial Operating Guide.

Alignment will generally be based on PQEM services provided by primary care specialists. However, if less than 10% of the total allowable charges for PQEM services to a beneficiary are provided by such specialists, then that beneficiary's alignment may be based on PQEM services provided by certain non-primary care specialists. This list may be updated by CMMI annually. The current list of eligible specialties includes psychiatrists, OB/GYNs, physical medicine and rehabilitation specialists, and others. The full list is available in the PY2022 Financial Operating Guide.

For Federally Qualified Health Centers (FQHCs) and Rural Health Clinics, all services are treated as services provided by primary care specialists, for purposes of the alignment algorithm.

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Voluntary Alignment

Beneficiaries may voluntarily align with an ACO by designating a Participant Provider affiliated with the ACO as their primary clinician or main source of care. Designations may be made electronically on Medicare.gov, or by completing a paper-based Voluntary Alignment Form. In recognition of the increasing use of telehealth, ACOs may also accept Voluntary Alignment Forms submitted through a patient portal, subject to audit. If a beneficiary seeks voluntary alignment via both electronic and paper-based, the most recent valid attestation will take precedence. To be "valid," the attestation must have been made within two years of the start of the PY, or the designated Participant Provider must have furnished a PQEM service to the beneficiary in that time period. Beginning in the IP, ACOs may perform outreach to ask beneficiaries to affirm their care relationships with the ACO.

During an ACO's Final Financial Settlement, CMMI will retroactively remove any voluntarily-aligned beneficiaries who did not receive any service from a Participant or Preferred Provider in the ACO **and** who did receive a PQEM service from a provider in the ACO's service area who is *not* in the ACO.

ACOs will have two choices for the frequency of prospective alignment:

1. **Prospective Alignment**: All alignment (claims-based and voluntary) is completed once per year prior to the start of each performance year.
2. **Prospective Plus Alignment**: Claims-based alignment is completed annually in advance, but voluntary alignment is updated on a quarterly basis throughout the performance year. As a result, an ACO's performance year benchmark may change during the year.

Beneficiaries may choose to change their primary care provider and other providers at any time, and ACOs must inform beneficiaries that they have this freedom of choice.

High Needs Beneficiary Alignment

For individuals to be aligned to a High Needs Population ACO, they must also be dual-eligible or at risk of becoming dual-eligible, and meet at least one of the following conditions:

1. Have one or more developmental or inherited conditions or congenital neurological anomalies that impair their mobility or neurological condition. These include conditions such as:
   - Cerebral palsy;
   - Cystic fibrosis and other metabolic developmental disorders;
   - Mobility impairments and paralysis;
   - Multiple sclerosis and transverse myelitis;
   - Muscular dystrophy;
   - Spina bifida and other congenital disorders of the nervous system; or
   - Spinal cord injury.

   CMS has provided a current ICD-10 code list in the PY2022 Financial Operating Guide (available here) and will provide updates, if any, annually;
2. Have a CMS-HCC risk score of 3.0 or greater;
3. Have a CMS-HCC risk score between 2.0 and 3.0, **and** two or more unplanned hospital admissions in the last 12 months; or
4. Show signs of frailty, as evidenced by a claim submitted by a provider or supplier specifically for a hospital bed or transfer equipment for use in the home.

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The GPDC RFA indicated that High Needs Population DCEs could be further limited to a specific, clinically defined subpopulation, but this text has been removed in the ACO REACH RFA.

HCC risk scores are the sum of a demographic-based component and a diagnosis-based component. The demographic component is based on age, gender, and similar information, while the diagnosis component is assigned to certain categories (the HCCs), based on ICD codes through review of claims data. A beneficiary may be assigned to any number of HCCs based on their documented conditions. Scores also vary based on whether the beneficiary is in the community or an institution; and, within the community, whether the beneficiary is (1) a full dual eligible, partial dual eligible, or Medicare only, and (2) eligible due to age or disability.

In general, for individuals in the community, the demographic component of the score is less than 1.0. As such, individuals must have serious and/or multiple diagnoses that qualify them to be assigned to HCCs with a significant score in order to have a total HCC score of 2.0 or higher. HCC scores are normalized to equal 1.0 on average. Generally, since patients with low risk scores often have no utilization, most providers' patient populations have an average risk score of higher than 1.0.[1] Among the Medicare population, in any given year, roughly 5% to 8% of individuals have HCC scores of greater than or equal to 3.0, and an additional 7% to 10% of individuals have HCC scores between 2.0 and 3.0.

Minimum Beneficiary Alignment Threshold

ACOs will be required to have a minimum number of aligned beneficiaries in advance of each PY:

	Minimum Number of Aligned Beneficiaries by ACO Organization Type		
	Standard ACO	New Entrant ACO	High Needs Population ACO
PY2023	5,000	2,000	500
PY2024	5,000	3,000	750
PY2025	5,000	5,000 (at least 3,000 claims-based)	1,200
PY2026	5,000	5,000 (at least 3,000 claims-based)	1,400

Standard ACOs must also have had at least 3,000 beneficiaries that would have been aligned during at least one base year (2017 through 2019). Conversely, New Entrant ACOs must **not** have had 3,000 beneficiaries aligned in any base year.

[1] For example: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5436972/ or https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/07/Average-Beneficiary-CMS-Hierarchical-Condition-Category-HCC-Risk-Scores-for-Rural-and-Urban-Providers.pdf

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FINANCIAL METHODOLOGIES

As described above, ACO REACH offers two options for risk-sharing:

- **Professional**: Partial shared risk of 50% of savings/losses, with risk corridors.
- **Global**: Full risk sharing of 100% of savings/losses, with broader risk corridors.

All REACH ACOs will have "first dollar" risk. no minimum savings or loss rate before the ACO earns savings or owes losses.

Benchmarking

Each ACO has a PY Benchmark calculated each year, which represents total expected costs on a per-beneficiary per-month (PBPM) basis. The PY Benchmark forms the basis of the ACO's PCC or TCC capitation payments (described above).

For Standard ACOs, there are separate methodologies to determine the benchmark for claims-aligned beneficiaries and the benchmark for voluntarily aligned beneficiaries. These two benchmarks will be combined (weighted by eligible beneficiary months) to make the ACO's final PY Benchmark. This process will be applied separately for Aged and Disabled (A&D) and ESRD pools and then combined into an overall Total Benchmark Expenditure.

For New Entrant and High Needs Population ACOs, the voluntarily aligned methodology will be used for all beneficiaries through PY2025, after which a modified version of the claims-aligned methodology will be incorporated.

An ACO's Total Benchmark Expenditure may then be subject to the following adjustments, which are described further in the section "Adjustments," to create the final PY Benchmark.

- The 2% quality withhold, for all REACH ACOs;
- The discount factor of between 2% and 3.5%, for ACO that elect to receive the Global risk sharing option;
- The retention withhold of 2% during the ACO's first year, if it elects not to provide a separate financial guarantee; and
- Potential adjustments based on significant changes to the trend factor.

Benchmarking for Claims-Aligned Beneficiaries

CMS will calculate the claims-aligned component of the PY Benchmark through the following process:

1. Establishing the ACO's historical baseline spend in the baseline period (2017 to 2019);
2. Applying a prospective trend factor;
3. Performing risk adjustment; and
4. Blending the baseline with regional expenditures using the ACO REACH/KCC Rate Book.

The ACO's historical baseline spend. This is defined as the combined Medicare Parts A and B expenses attributed to beneficiaries who would have been claims-aligned to the ACO in base years (BYs) 2017, 2018, and 2019, based on the ACO's Participant Providers for that year. These base years will not change throughout the life of the model. As such, baseline spend will not be "rebased." However, when the ACO's attribution changes each year, the benchmark will be recalculated for the new set of claims-aligned beneficiaries but will still use the same baseline period.

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Because of population turnover, an ACO may not have sufficient claims history to construct historical baseline expenditures for a given base year. If so, CMS will exclude those years from the calculation (with the one or two remaining years weighted at 100% or at 33%/67%, respectively).

Trending the historical baseline forward. For each base year, historical expenditures will be trended forward and adjusted for regional risk and geographic cost variation:

- For the annual trend factor, CMS will use the USPCC growth trend, adjusted to remove uncompensated care costs and add in hospice costs. Each base year will be trended forwarded independently, using the A&D or dialysis-only ESRD USPCC growth trends, as applicable.
- An ACO's risk score will be a weighted average of the risk scores of all aligned beneficiaries. Expenditures will be standardized by dividing the trended baseline expenditure for each base year by the risk score.
- The trended, risk-standardized baseline expenditure for each base year is then adjusted to reflect the anticipated impact of changes in the regional Geographic Adjustment Factors (GAFs) applied to payment amounts under the Medicare fee-for-service (FFS) payment systems.

The final baseline will be a single weighted average of the three years' expenditures after the above adjustments (10% weight for 2017; 30% weight for 2018; and 60% weight for 2019).

Risk adjustment. A risk score will be calculated for each beneficiary using the prospective CMS-HCC risk adjustment model. (High Needs Population ACOs will use the concurrent CMMI-HCC model and the prospective ESRD model.) CMS expects to continue applying the 2020 model in PY2023, but this will be specified in the ACO Participation Agreement.

In each PY, risk scores will be prospectively normalized by an estimate of the average risk score of the National Reference Population in that PY. During reconciliation, CMS will then use several approaches to make further adjustments to control potential risk score growth, described further below under "Risk Score Adjustments."

Blending with the regional rate. The ACO's final historical baseline will then be modified by blending it with the regional rate in each base year as calculated from the Rate Book to form the final PY Benchmark. The blend will be weighted as follows:

- **PY2021-22**: 65% historical and 35% regional
- **PY2023**: 60% historical and 40% regional
- **PY2024**: 55% historical and 45% regional
- **PY2025-26**: 50% historical and 50% regional

However, any increases or decreases to the baseline benchmark due to the regional component will be capped on the upside at 5% of the United States Per Capita Cost (USPCC) growth trend and on the downside at -2% of USPCC.

If a BY is not usable for a given ACO, the regional rate for that BY will also be disregarded.

Benchmarking for Voluntarily Aligned Beneficiaries

This approach applies to voluntarily aligned beneficiaries in a Standard ACO and for all beneficiaries in a New Entrant or High Needs Population ACO (even those who are claims-aligned). However, if a High Needs Population ACO's alignment exceeds 3,000 beneficiaries, it will use the Standard ACO

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benchmarking methodology for claims alignment, although otherwise it will continue to operate as a High Needs Population ACO.

For these beneficiaries, CMMI will not use claims history to determine a benchmark. Instead, from PY 2021-24, only the regional rates will be used to establish the historical baseline for these beneficiaries. The benchmark will be based on a PBPM weighted average of the county (for A&D) or state (for ESRD) rates in the Rate Book.

Standard ACOs may expect that most of their voluntarily aligned members who remain aligned will (also) be claims-aligned in following years. In such cases, the member's benchmarking will be treated as claims-aligned for benchmarking purposes.

For New Entrant and High Needs Population ACOs, starting in PY2025, CMS will begin to use a blended rate for beneficiaries who were originally voluntarily aligned but who now have a claims history with the ACO. This blended rate will be calculated in a similar way as for claims-aligned beneficiaries above, but will use a different baseline period:

- In PY2025, the baseline period will encompass CY 2021, CY 2022, & CY 2023, which will be weighted at 10%, 30%, and 60%, respectively.
- In PY2026, the baseline period will encompass CY 2022, CY 2023, & CY 2024, which will be weighted at 10%, 30%, and 60%, respectively.

Benchmark Adjustments

Health Equity Adjustment (New)

Starting in PY2023, CMS will apply a flat adjustment to increase the benchmarks of ACOs that serve higher proportions of underserved beneficiaries. Underserved beneficiaries will be measured by a combination of geography and dual eligibility:

- The percentile of the Area Deprivation Index associated with the Census block in which the beneficiary's residence is located (a score between 0 and 99 points); and
- The beneficiary's Medicaid status (25 points).

Scores may thus range from 0 points to 124 points. CMS will stratify all beneficiaries based on this score and assign them to deciles. The adjustment will then be applied as follows:

- For each aligned beneficiary in the top-scoring 10%, an ACO's benchmark will be increased by a flat $30 PBPM. Given the scoring system, this decile will likely be composed almost exclusively of dual eligibles.
- For any aligned beneficiary in the bottom 50%, an ACO's benchmark will be reduced by $6 PBPM.

In general, almost all Census blocks in New York City outside of the Bronx are ranked below 50 in the Area Deprivation Index. Conversely, most Census blocks upstate are ranked above 50.

Risk Score Adjustments

During reconciliation, the following retrospective corrections will be applied to an ACO's benchmark:

Normalization. For all ACOs, a retrospective correction will be applied during reconciliation to update the estimated normalization factor to the actual factor.

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Symmetric 3% Cap on Growth. For Standard and New Entrant ACOs, CMS will apply a symmetric ±3% cap on changes in risk scores. Under GPDC, the cap applied on a rolling two-year lag. For example, in PY2023, an ACO's average normalized risk score will not increase or decrease by more than 3% compared to that ACO's average normalized risk score in PY2021.

Starting in PY 2024, the cap will no longer be applied on a rolling basis. Instead, the ACO's average risk score in that PY will be compared to its risk score in a single static reference year (not yet specified) for the rest of the demonstration. Growth will then be capped to ±3% compared to that ACO's changes in demographic risk scores (i.e., the component of HCC based on age, sex, Medicaid status, and Medicare eligibility category).

For example, if an ACO's demographic risk score growth is 1% between the reference year and performance year, that ACO's average risk score may not be higher than the reference year's by more than 4% or lower by more than 2%. This will limit total risk score growth over the remaining length of the demonstration.

Under GPDC, High Needs Population entities were not subject to this cap. This is not specified in the ACO REACH RFA. More information will be released in the Risk Adjustment methodology paper.

Model-Level Adjustment. A Coding Intensity Factor (CIF) is then applied to ensure that risk scores across all ACOs nationally increase at the same rate as risk scores for the National Reference Population. For the CIF calculation, the base year reference population will remain 2019 throughout the model lifespan. The CIF does not apply to voluntarily aligned beneficiaries who would not meet the standards for claims-based alignment, but it does apply to those who meet both standards. The ACO REACH RFA states that the CIF will continue in PY2023 (but does not specify beyond that).

Under ACO REACH, CMS intends to continue monitoring risk scores and may implement additional measures "if an unacceptable level of coding intensity is identified."

Quality Withhold

A portion of each ACO's Performance Year Benchmark will be held "at risk," dependent on the ACO's performance on a predetermined set of quality measures and continuous improvement/sustained exceptional performance (CI/SEP). This quality incentive will be structured as a withhold of the PY benchmark. In PY2021 and 2022, this was set at 5% of the PY benchmark. Starting in PY2023, the withhold will be reduced to 2% of the PY benchmark.

ACOs may earn back the withhold based on their performance on the ACO REACH quality measure set and CI/SEP. CI/SEP criteria will be introduced in PY2023 for ACOs in the 2021 or 2022 cohorts, and in PY2024 for ACOs in the 2023 cohort. The amount an ACO earns back will correspond to the ACO's Total Quality Score multiplied by 2%. If the ACO is subject to and does not pass CI/SEP criteria, the re-earned amount will be reduced by half.

Starting in PY2023 for ACOs in the 2021 or 2022 cohorts, and in PY2024 for ACOs in the 2023 cohort, a High Performers Pool (HPP) will be used to incentivize continuous improvement on quality measures. The HPP will be funded from the quality withholds not earned back by the ACOs who do meet CI/SEP criteria. (Funds not earned by ACOs not meeting CI/SEP will be retained by CMS.) HPP funds will be distributed to the highest performing ACOs or who meet improvement criteria. The methodology will be shared in a future document.

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Global Discount Factor

The amount that a Global ACO receives from CMS will be further decreased by a discount factor of:

- **PY 2021-22**: 2% of the Total Benchmark Expenditure
- **PY 2023-24**: 3% of the Total Benchmark Expenditure
- **PY 2025**-26: 3.5% of the Total Benchmark Expenditure

This is intended to represent CMS's share of savings.

Retention Withhold

CMS has incentivized ACOs to remain in the program for at least two years by applying a retention withhold of 2% of the Total Benchmark Expenditure. Going forward, this applies to the 2023 cohort. New ACOs must either apply the retention withhold or secure a retention guarantee of the same amount (which may be added to the ACO's financial guarantee). This amount will be earned back by the ACO if they continue to participate in PY2024.

Retrospective Trend Adjustments

CMS may apply a retrospective trend adjustment to account for differences between the projected USPCC for the Medicare FFS population as a whole and the observed expenditure trend for ACO REACH alignment-eligible beneficiaries, if the difference in a PY is more than 1 percentage point. This adjustment would be applied separately to the A&D and ESRD benchmarks. CMS may also update trends based on the publication of a more recent USPCC.

Payment Mechanisms

All REACH ACOs will be required to receive monthly capitated payments for some or all services provided by their Participant Providers, using one of the options below.

On a quarterly basis, CMS may adjust the amount of any monthly payment, with the aim of avoiding cash flow issues that might result from significant differences between estimated and actual beneficiary months.

Total Care Capitation

ACOs in the Global risk sharing option may select TCC to receive a PBPM capitated payment based on the full estimated total cost of care for the ACO's aligned population.

Under TCC, Participant Providers will be required to agree to prospective 100% claims reductions. As such, CMS will not pay for each claim submitted by participating providers (although providers will continue to submit claims). Instead, the ACO reimburses the providers according to its contracted rates and structure. Preferred Providers may elect to receive a TCC payment and may choose the amount of their fee reduction (between 1% and 100%).

The monthly TCC capitation amount will be one-twelfth of the PY Benchmark. The amount paid under TCC will be adjusted by a TCC Withhold, representing the portion of the monthly TCC that will offset the expected payments that CMS will make to providers and suppliers who serve the aligned beneficiaries but are **not** participating in the TCC arrangement. This withhold could comprise a majority of the total cost of care, especially if few or no hospitals are included in the ACO.

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Primary Care Capitation

Any ACO may select PCC to receive a PBPM capitated payment for primary care services provided (the same services used for claims-based alignment). The PCC amount replaces FFS payments for primary care services furnished by ACO providers. The PCC is paid to the ACO prospectively on a monthly basis, who is then responsible for entering into payment arrangements with its Participant Providers (and, if applicable, Preferred Providers) to reimburse them for providing primary care services to aligned beneficiaries.

The ACO's Participant Providers may choose not to have the full amount of their FFS primary care claims reduced immediately. In PY2023, they must elect a reduction of at least 10%, and in PY 2024, the reduction must be at least 20%. Starting in PY2025, all such claims must be reduced by 100%.

Preferred Providers are not required to participate in PCC, but if they do, they may choose a reduction of any amount between 1% and 100%. These requirements only apply to Participant Providers who provide primary care services.

The PCC amount received by the ACO will generally be equal to 7% of the estimated total cost of care for the ACO's aligned population, even though the ACO's actual primary care service expenditures will vary. This is because the PCC includes two components:

Base PCC. This represents the actual primary care services that the ACO's Participating Providers (and Preferred Providers who opt in) provide to the ACO's aligned beneficiaries. This amount will be calculated based on the primary care claims submitted for PCC-eligible services submitted by these providers during a lookback period. This is generally the first 9 months of the prior calendar year. For example, in PY2023, the lookback period would be January through September 2022.

For each provider, the total amount of such claims is multiplied by the amount that that provider elected to reduce their FFS claims. This amount is then divided by the total claim-based payment for all covered services to produce the Base PCC Percentage. The ACO's Base PCC will be this percentage of the PY Benchmark.

Enhanced PCC. This represents a supplemental payment the ACO may use to provide enhanced services. Enhanced PCC will be recouped at the end of the Performance Year during reconciliation.

The Enhanced PCC amount will generally be the difference between the Base PCC amount and 7% of the PY Benchmark. If the Base PCC is greater than 5% of the PY Benchmark, the Enhanced PCC will be 2%. In the calculation of the Enhanced PCC, CMS will assume a 100% fee reduction for all Participant Providers, to ensure that the Enhanced PCC is not artificially increased.

Providers may elect to receive less than the maximum amount of Enhanced PCC.

Advanced Payment Option

ACOs that choose Primary Care Capitation may also elect to use the Advanced Payment Option (APO), a similar reimbursement model for non-primary care services. The purpose of APO is to improve cash flow and allow for innovative payment models between the ACO and other providers.

Under this option, the ACO would contract with providers to have CMS transfer a portion of their FFS payments for non-primary care services to the ACO, as a monthly capitated payment. Providers may choose a claims reduction from 1% to 100%. CMS will continue to pay them the remaining amount

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through traditional FFS, while the ACO would disburse the APO amounts to providers based on their negotiated terms.

The APO amount is estimated by CMS based on historical utilization, but is not a risk-based capitation payment. If actual claims are higher or lower than the advanced amount, CMS will reimburse the underpayment or withhold any overpaid amount from future payments.

Financial Reconciliation

On an annual basis, the Medicare Parts A and B expenditures for aligned beneficiaries will be compared to an ACO's PY Benchmark to determine an ACO's savings or losses.

Final Financial Reconciliation for costs above or below the benchmark will be conducted for all ACOs approximately six months after the PY has ended.

Starting in PY 2022, ACOs will also have the option to select Provisional Financial Reconciliation, which will be conducted shortly after the end of the PY and allow a timelier distribution of estimated shared savings.

The below table outlines the timeline for the provisional and full financial reconciliations:

	Provisional Financial Reconciliation	Full Financial Reconciliation
Target Date	January 31st of the year after the Performance Year	July 31st of the year after the Performance Year
Claims Included in Reconciliation	Performance Year expenditures incurred through June 30th	Performance Year expenditures incurred through December 31st
Claims Run-out	Through December 31st of the Performance Year	Through March 31st of the year after the Performance Year
Risk Scores	Initial risk scores	Final risk scores

Risk Corridors

The aggregate amount of savings or losses that ACOs in Global or Professional options may experience will be constrained by a series of risk corridors. Within these risk bands, ACOs will be eligible for a decreasing proportion of shared savings or losses, as the difference from the benchmark increases:

	Professional Option		Global Option	
	Gross Savings / Losses as a Percent of Final PY Benchmark	Shared Savings / Shared Losses	Gross Savings / Losses as a Percent of Final PY Benchmark	Shared Savings / Shared Losses
Risk Band 1	Less than 5%	50%	Less than 25%	100%
Risk Band 2	Between 5-10%	35%	Between 25-35%	50%
Risk Band 3	Between 10-15%	15%	Between 35-50%	25%
Risk Band 4	Greater than 15%	5%	Greater than 50%	10%

For example, if an ACO participating in the Professional Option were to experience total costs 20% higher or lower than the risk-adjusted benchmark, it would receive or owe 5.25% of the benchmark total. If an ACO participating in the Global Option were to experience total costs 20% higher or lower than the benchmark, it would receive or be liable for the entire 20% difference from the benchmark, minus any optional stop loss or reinsurance it purchased.

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Stop-Loss Arrangements

Both Global and Professional Options will feature optional stop-loss arrangements for rare, catastrophic expenses that may put financial strains on ACOs. The stop-loss arrangement must be selected by the ACOs prior to the start of each Performance Year.

CMS will develop stop-loss attachment points prospectively, based on expenditure data derived from a national reference population of Medicare FFS beneficiaries. Starting in 2023, the stop-loss will offer residual-based reinsurance. Attachment points will be determined on a beneficiary-specific basis, based on predicted spending for that beneficiary, rather than a fixed point for all high-cost beneficiaries. ACOs will continue to retain liability for a portion of expenditures above each beneficiary's attachment point.

To pay for this protection, CMS will apply a PBPM stop-loss "charge" to the ACO's Performance Year Benchmark, based upon the amount of stop-loss that would have been incurred in the ACO's baseline period (i.e., the percent of expenditures in excess of predicted spend above the applicable attachment point for each beneficiary during the baseline period).

QUALITY AND DATA COLLECTION

Quality Measures

Quality performance by REACH ACOs will be assessed based on claims-based quality measures and on information from Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs surveys. Currently, and in PY2023, CMS expects to monitor the following measures:

- Claims-based:
  - Risk-Standardized, All Condition Readmission
  - All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
  - Timely Follow-up after Acute Exacerbations of Chronic Conditions
  - (for High Needs Population ACOs only) Days at Home for Patients with Chronic, Complex Conditions
- Survey-based:
  - CAHPS Summary Survey Measures

All measures will be pay-for-performance, with the exception that, for High Needs Population ACOs, CAHPS Summary Survey Measures will be pay-for-reporting. A Total Quality Score will be calculated based on these measures, which will be used to determine the ACO's quality withhold (above).

Demographic Data Collection (New)

To help CMS monitor health disparities, beginning in PY2023, REACH ACOs will be required to collect and submit beneficiary-reported demographic data on an annual basis. ACOs must seek to collect all elements in the current version of the Core Data for Interoperability standard (USCDI v2), such as:

- Race;
- Ethnicity;
- Language;
- Gender identity; and
- Sexual orientation.

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This data will be used by CMS to monitor health disparities and to compare ACO performance on cost and quality across specific subpopulations of beneficiaries. Beneficiary submission of information is voluntary. ACOs may document a beneficiary's choice not to disclose information (e.g., "Prefer not to say") and receive credit for reporting.

In PY2023, ACOs will be rewarded for successfully reporting this data with a bonus to their Total Quality Score of up to 10 percentage points (which will correspond to as much as 0.2% of the PY Benchmark). The bonus will be determined based on the percentage of beneficiaries with at least 6 months of alignment for whom the ACO successfully reports all required data. The bonus may not cause the Total Quality Score to exceed 100%. There will currently be no penalty for non-submission.

ACOs are also encouraged, but not required, to collect beneficiary-level data on social determinants of health (SDOH), using the CMS-provided questionnaire. CMS expects to include submission of such data as a component of quality performance in future years.