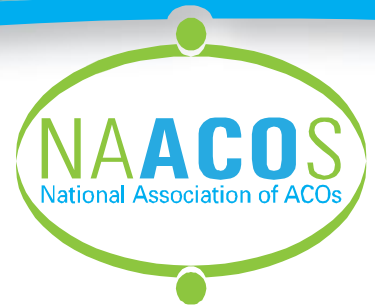




Summary of ACO REACH Financial Specifications

Executive Summary

Late July 2022, the Center for Medicare and Medicaid Innovation (Innovation Center) updated details on the financial specifications for its Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. These details were included in a series of papers available on this CMS [webpage](#). NAACOS offers this resource to help ACOs better understand the details released by CMS. Aside from those previously announced updates, the Innovation Center deviates little from the financial specifications to the Global and Professional Direct Contracting (GPDC) Model. NAACOS [fought hard](#) to keep ACO REACH in the face of opposition and potential termination.

NAACOS has been advocating to help shape the ACO REACH Model and GPDC since its inception. We have met regularly with CMS and written letters to influence its development. We will continue working to secure changes to improve the model, and we request ACOs email us at acoreach@naacos.com to share feedback or questions about the model.

In 2019, NAACOS launched a new [Direct Contracting Taskforce](#) to strengthen our advocacy efforts and to increase provider education and engagement. NAACOS members automatically receive all benefits of the taskforce, which now advocates for improvements to the ACO REACH Model. As part of the taskforce, we continue to develop resources to help members better understand the model.

FINANCIAL MODEL SPECIFICATIONS

Benchmark Calculations

Step 1: Historical Baseline

Historical Baseline Expenditure

First, for beneficiaries aligned to Standard ACOs via claims-based alignment, CMS will use a fixed three-year baseline period: 2017, 2018, and 2019. The baseline will include all Medicare Parts A and B expenditures for these beneficiaries. CMS will then weight the three years, giving greater weight to the most recent base year (10 percent, 30 percent, 60 percent).

Note: For the first four performance years of the model, CMS will not use a historical baseline for New Entrant ACOs and High Needs Population ACOs or for beneficiaries voluntarily aligned to Standard ACOs. Instead, the benchmarking process will start with the application of regional rates (Step 2, below). For the last two years of the model, CMS will use a rolling three-year baseline period: 2021, 2022, 2023 for Performance Year 2025, and 2022, 2023, 2024 for Performance Year 2026.

Application of Prospective Trend

To make the historical baseline applicable to each performance year, CMS next will use its U.S. Per Capita Cost (USPCC) annual growth trend (developed for Medicare Advantage [MA]) to calculate the prospective trend rate for each of the three base years and separately trend forward each base year.

Baseline Standardization

After trending the historical baseline, for each base year comprising the historical baseline, CMS will apply a risk adjustment and a Geographic Adjustment Factor (GAF) adjustment.

Risk Adjustment

CMS will risk standardize the historical baseline by applying an ACO's risk score to each base year. An ACO's risk score will be a weighted average of the risk of all aligned beneficiaries. Details are described in the "Risk Adjustment" section below.

GAF Adjustment

After risk standardizing the historical baseline, CMS will account for regional differences by applying the ACO's regional GAF to each base year. The GAF is a county-specific factor developed by CMS for determining fee-for-service (FFS) Medicare payments.

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NAACOS wants to ensure that the financial methodology offers an equal opportunity for success in the model for both incumbent ACOs and organizations that are new to Medicare shared savings initiatives. We are concerned that using historical expenditures and heavily weighting the most recent base year will make it difficult for incumbent ACOs to succeed. These ACOs are experienced in managing care for their aligned population and have already added efficiency and value to their care models. NAACOS is advocating CMS make changes to the methodology, including flipping the weighting of the base years to give greater weight to the least recent year and adding shared savings earned by an ACO back in for purposes of setting the performance year benchmark.

Step 2: Application of Regional Expenditures

For each base year, CMS will calculate the weighted average of the county rates (or state-level rates for ESRD beneficiaries) based on the new DC/KCC Rate Book, which is an adjusted version of the MA Rate Book. An ACO's region will include all counties in which one or more beneficiaries aligned in the base period reside and will be weighted based on the county rates and number of aligned beneficiaries residing in each county in each of the base years.

ACO REACH/KCC Rate Book

The ACO REACH/KCC Rate Book is based on the same methodology used for the MA Rate Book with adjustments to (1) remove factors applied to the MA Rate Book that are not relevant for ACO REACH (e.g., uncompensated care, FFS spending quartiles, and quality bonus payment percentage for star ratings), (2) add components of Medicare FFS expenditures not included in the MA Rate Book (e.g., hospice services and indirect medical education), and (3) include only the experience of FFS beneficiaries who are eligible to participate in the ACO REACH Model. As with the MA Rate Book, this ACO REACH/KCC Rate Book will establish a county rate for the Aged and Disabled (A&D) beneficiaries and a state-level rate for ESRD beneficiaries.

Regional Blend

Using the weighted county rates from the ACO REACH/KCC Rate Book, CMS will blend the regional expenditures with the historical baseline for each performance year. CMS will limit the adjustment resulting from blending in

regional expenditures to a percentage of the FFS USPPC for each performance year (upward adjustment cap = 5 percent; downward adjustment cap = 2 percent).

For claims-aligned beneficiaries in Standard ACOs		
<u>Performance Year</u>	<u>Historical Baseline Expenditures</u>	<u>Regional Expenditures</u>
PY1/2/3	65%	35%
PY4	60%	40%
PY5	55%	45%
PY6	50%	50%

For New Entrant ACOs, High Needs Population ACOs and voluntarily aligned beneficiaries in Standard ACOs		
<u>Performance Year</u>	<u>Historical Baseline Expenditures</u>	<u>Regional Expenditures</u>
PY1/2/3/4	0%	100%
PY5	55%	45%
PY6	50%	50%

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Based on our initial review of the ACO REACH/KCC Rate Book construction, the approach captures regional expenditures better than the standard MA rate book and is comparable to the Medicare Shared Savings Program (MSSP) regional benchmark. NAACOS has also advocated for CMS to give more weight to the regional rates for all ACOs (and less weight to historical expenditures). We appreciate that the blending of rates increases throughout the model but recommend the blend should start with a higher percentage for regional rates and increase beyond the currently set maximum of 50 percent (for the last performance year).

Step 3: Discounts and Withholds

Discount

For Global ACOs, CMS will apply a discount to each performance year benchmark to ensure savings to the Medicare program. The discount cannot be earned back by an ACO.

<u>Performance Year</u>	<u>Discount</u>
PY3/4	3%
PY5/6	3.5%

Withholds

In addition to the automatic discounts which cannot be earned back, CMS is utilizing withholds in the model. Two percent of an ACO's performance year benchmark is at risk based on quality performance and the entire 2 percent will be based on pay-for-performance.

For an ACO's first year participating in ACO REACH, CMS will also apply a 2 percent "retention withhold" to incentivize ACOs to remain in the model. If an ACO is still participating in the model at the time of final settlement for its first performance year, it will automatically earn back the full amount of the withhold. ACOs may instead choose to post a larger financial guarantee (increasing the required financial guarantee by an additional 2 percent).

For Global ACOs participating in Total Care Capitation (TCC), CMS will apply a TCC Withhold to account for care that aligned beneficiaries may receive from providers outside of the ACO. CMS will project this "spillage" amount based on historical claims data. CMS will reconcile this withhold during settlement.

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NAACOS continues to believe that the discount for Global ACOs is too high, making it difficult for those ACOs (and especially incumbent ACOs that are already high value) to succeed in the model. We appreciate that CMS needs to be guaranteed savings for the Medicare program but will advocate for a smaller discount.

Risk Adjustment

CMS will use aligned beneficiaries' risk scores to risk adjust multiple model components, including the historical baseline, the regional expenditures, and the capitated payments.

For Standard ACOs and New Entrant ACOs, the Innovation Center will use the same CMS-HCC prospective risk adjustment model used in Medicare Advantage. The Innovation Center will use the CMMI-HCC concurrent risk adjustment model for High Needs Population ACOs' A&D beneficiaries and will use the CMS-HCC prospective risk adjustment model for ESRD beneficiaries.

The concurrent risk adjustment model, which is broadly based on the CMS-HCC A&D prospective risk adjustment model, aims to improve payment accuracy for beneficiaries with serious or acute illness in the concurrent year by weighting acute conditions more heavily to better capture a rapid deterioration in health in the current year (events that are hard to predict, like stroke or heart attack). The model also gives weight to demographic indicators.

For Standard and New Entrant ACOs, CMS will apply a four-step risk adjustment process. The first two steps will "normalize" risk scores and the final two steps aim to address "coding intensity." For High Needs Population ACOs, CMS will only apply the first two steps (but stated that it may apply the coding intensity steps in later model years).

Step 1: Prospective preliminary estimated normalization

CMS will apply a normalization factor to ACO risk scores to adjust for changes in risk score growth relative to the risk model's denominator year (currently 2015). The normalization factor is the average risk score of the ACO REACH National Reference Population in that year and ACO risk scores are divided by that factor to get the normalized risk score. This adjustment results in the projected average risk score for the payment year based on the observed historical trend in risk scores for the ACO REACH National Reference Population.

Step 2: Retrospective normalization correction adjustment factor

During final reconciliation of each performance year, CMS will apply a retrospective normalization correction adjustment factor in order to use the actual growth trend measured with observed data. The goal is to calibrate the population-average risk score to 1.0 in a given year.

Step 3: Risk score cap

In an effort to reduce the incentive for coding intensity that does not reflect the true health status burden of an ACO's aligned population, CMS will apply a symmetric +/- 3 percent cap on ACO-level risk score growth (per performance year). Under this policy, the average normalized risk score for the ACO in a performance year will be constrained to be no more than 3 percent above or below the ACO's normalized risk score for the ACO-specific reference population. The reference year for this cap for Performance Year 2023 will be 2021 and for Performance Years 2024-2026 will be 2022.

The Innovation Center will calculate risk scores using the demographic risk score model currently applied to the MSSP. This model predicts beneficiary expenditures using demographic variables that include age, gender, original reason for entitlement code (OREC), and Medicaid dual status; there are no HCCs in the model specification.

Step 4: Retrospective Coding Intensity Factor (CIF) adjustment

During financial reconciliation of each performance year, CMS will apply a model-level adjustment to aligned beneficiary risk scores to limit the risk score growth relative to the baseline period. The retrospective CIF will ensure that the change in normalized payment risk scores across all claims aligned beneficiaries is zero between the most recent baseline year and the performance year.

Note: The experience of voluntarily aligned beneficiaries is not subject to either the cap or the CIF in their first year of alignment.

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The concurrent risk adjustment model appears to be a much better assessor of risk for outlier populations, and we would like CMS to expand its use beyond the High Needs Population ACOs. NAACOS believes that CMS should also use the concurrent risk adjustment model for the high-risk populations in Standard ACOs and New Entrant ACOs.

We also are concerned about application of the CIF (especially since it is applied after the 3 percent cap). If ACOs hit the cap and then CMS applies the CIF, the ACO risk score will be right back to about 1.0. While this is the policy goal CMS wants to achieve, this policy is a departure from MA and makes earning shared savings more difficult for ACOs.

Health Equity Benchmark Adjustment

As part of its commitment to reducing disparities in care, the Innovation Center will apply a Health Equity Benchmark Adjustment to ACO Performance Year Benchmarks beginning in 2023.

Calculation of Beneficiary Scores

The Innovation Center will assign a score to each aligned beneficiary, determined using a composite methodology consisting of both regional and beneficiary-level measures of deprivation and will be applied at the ACO-benchmark level. Notably, the Innovation Center has NOT formalized its previously announced policy for calculating the beneficiary score (a combination of the Area Deprivation Index and status as a Medicare-Medicaid dually eligible beneficiary) but instead states that it will release this methodology in an upcoming revision to the financial papers.

Application of Beneficiary Scores

After scores are calculated for all aligned beneficiaries, the Innovation Center will normalize the scores into percentiles across the aligned population such that the maximum score can be 100, and the minimum score 1.

For each aligned beneficiary, a beneficiary-month level benchmark adjustment is calculated based on these percentile scores. For each aligned month for each beneficiary with a score in the 90th percentile or above, CMS will add \$30 to the ACO benchmark. For each month for each beneficiary scoring below the 50th percentile, CMS will deduct \$6 from the ACO benchmark. There's no adjustment to the benchmark for beneficiaries between the 89th and 50th percentiles. This adjustment will apply to an ACO's Benchmark after the Retrospective Trend Adjustment, Discount, Quality Withhold, and Retention Withhold, as applicable.

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NAACOS continues to advocate for a scoring methodology that appropriately identifies underserved beneficiaries. We also are concerned about the impact of the benchmark adjustment on ACOs: whether the \$6 downward adjustment could unreasonably harm ACOs and whether a \$30 upward adjustment for just the 90th+ decile sufficiently incentivizes ACOs to further extend care into underserved communities.

Conclusion

NAACOS continues to assess the ACO REACH Model, including the financial specification details included in the Innovation Center papers. We will continue advocating for model improvements to implement a meaningful new Medicare accountable care model.