ACO Realizing Equity, Access, and Community Health (REACH) and Kidney Care Choices Models

PY2024 ACO REACH/KCC Rate Book Development

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Reference Documents

Title
ACO REACH Model: Financial Operating Guide: Overview
ACO REACH Model: Capitation and Advanced Payment Mechanisms
ACO REACH and Kidney Care Choices Models: Risk Adjustment
ACO REACH Model: Financial Settlement Overview
Kidney Care Choices Model: Financial Operating Guide: Overview

Acronyms

A&D	Aged & Disabled
ACO	Accountable Care Organization
BY	Base year
CKCC	Comprehensive Kidney Care Contracting
CKD4/5	Stage 4 and 5 Chronic Kidney Disease
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DoD	Department of Defense
ESRD	End-Stage Renal Disease
FFS	Fee-for-service
FIPS	Federal Information Processing Standard
GAF	Geographic Adjustment Factors
HCC	Hierarchical Condition Category
KCC	Kidney Care Choices
KCE	Kidney Contracting Entity
MA	Medicare Advantage
PBPM	Per beneficiary per month
PY	Performance year
REACH	Realizing Equity, Access, and Community Health
USPCC	United States per capita costs
VA	Veterans Administration

Table of Contents

1.0 Overview of ACO REACH/KCC Rate Book

This document describes the construction of the Rate Book used by both the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model[1] and the Comprehensive Kidney Care Contracting (CKCC) Options within the Kidney Care Choices (KCC) Model. The ACO REACH and KCC Models use the Rate Book to calculate the expenditure benchmark for ACO REACH and KCC entities.[2] The ACO REACH/KCC Rate Book is broadly similar to the Medicare Advantage (MA) Rate Book which establishes county-level payment rates for MA Plans for Aged & Disabled (A&D) beneficiaries and state-level payment rates for End-Stage Renal Disease (ESRD) beneficiaries.[3]

The differences between the ACO REACH/KCC Rate Book and the MA Rate Book are also highlighted in this document. The ACO REACH/KCC Rate Book removes factors applied to the MA Rate Book that are not relevant in the ACO REACH and the KCC Models (such as fee-for-service [FFS] spending quartiles, quality bonus payment percentage for star ratings), adds components of Medicare FFS expenditures that are not included in the MA Rate Book but are relevant in the ACO REACH and the KCC Models (such as hospice services), and mirrors ACO REACH[4] eligibility requirements. The Appendix summarizes the major differences between the ACO REACH and MA Rate Books.

The ACO REACH/KCC Rate Book establishes county rates that are the product of: (1) A National Conversion Factor which is an estimate of the expenditure per beneficiary per month (PBPM) of beneficiaries eligible to participate in the ACO REACH; and (2) A County Relative Cost Index which reflects the difference between the Expenditure PBPM of ACO REACH beneficiaries living in each county and the national average expenditure PBPM of all ACO Reach beneficiaries.

Section 2 describes the calculation of the ACO REACH/KCC Rate Book National Conversion Factor.

Section 3 addresses the construction of the County Relative Cost Indices.

[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 redesign 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**.

[2] The benchmarking methods are described in the ***ACO REACH Model: Financial Operating Guide: Overview*** paper and the ***Kidney Care Choices Financial Operating Guide: Overview*** **paper**.

[3] The MA Rate Book development methodology is available at **https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data**.

[4] Both the ACO REACH and KCC Models will use the same National Conversion Factor to construct benchmarks. The National Conversion Factor will include expenditures for beneficiaries who meet ACO REACH eligibility criteria. Medicare beneficiaries will not be required to meet the KCC Model's additional eligibility requirements in order to have their expenditures contribute to the National Conversion Factor.

Section 4 describes additional adjustments to county expenditures intended to make the benchmarks comparable to performance period expenditures.

Section 5 describes how the components described in Section 2, 3 and 4 are combined into the production of the final ACO REACH/KCC Rate Book.

2.0 ACO REACH/KCC Rate Book National Conversion Factor

2.1 FFS Expenditure

The ACO REACH/KCC Rate Book is developed using the ACO REACH/KCC Rate Book base years (BYs), which are the three most recent years for which complete Medicare FFS claims data are available. The National Conversion Factor is calculated from the most recent BY, and all three BYs are used to estimate regional variation in Medicare FFS expenditures (County Relative Cost Indices – see Section 3). Construction of the ACO REACH/KCC Rate Book generally excludes the calendar year (CY) prior to the Performance Year (PY). This differs from the MA Rate Book, which uses the five years of data ending two years before the year for which the MA Rate Book is used. **Table 2.1** gives CYs that will be used as the ACO REACH/KCC Rate Book's BYs to develop the ACO REACH/KCC Rate Book for each PY of the model.

Table 2.1. Construction of ACO REACH/KCC Rate Book

Performance year	Calendar year	ACO REACH/KCC Rate Book base years *Data used for ACO REACH/KCC Rate Book development*
2021[1]	2021	2017, 2018, 2019
2022[2]	2022	2017, 2018, 2019
2023[3]	2023	2019, 2020, 2021
2024[4]	2024	2020, 2021, 2022
2025	2025	2021, 2022, 2023
2026	2026	2022, 2023, 2024

[1] Performance Year 2021 only included the last 9 months of CY2021. However, the Rate Book published rates that were applicable to a full 12-month calendar year.
[2] The PY2022 rates had to be set before the impact of the COVID-19 Public Health Emergency on relative county-level spending in CY2020 could be assessed using complete data. Because the impact was potentially material, CMS determined that for PY2022 county rates would continue to be based on experience in 2017 through 2019.
[3] For PY2023, CMS determined that despite the COVID-19 Public Health Emergency, CYs 2020 and 2021 were appropriate to use as BYs for the Rate Book.
[4] For PY2024, CMS has determined that despite the COVID-19 Public Health Emergency, CYs 2021 and 2022 were appropriate to use as BYs for the Rate Book. CMS will notify ACOs of any changes to the BYs used for each subsequent PY prior to publication of the ACO REACH/KCC Rate Book.

Note that CMS is continuing to monitor the potential impact of COVID-19 on BYs for use in the ACO REACH/KCC Rate Book and may revise BYs used for a subsequent PY prior to the start of that PY. An analysis of the PY2020 and PY2021 ACO REACH reference population data found:

- Year-over-year correlations in county relative cost indices observed in 2020 and 2021 were consistent with pre-COVID data
- The distributions of county relative cost indices observed in the 2020 and 2021 data were consistent with pre-COVID data
- Annual variation in county-relative cost indices did not vary systematically compared to variation observed in pre-COVID years

For PY2023, CMS determined that 2020 and 2021 were appropriate to use as BYs despite any impacts of COVID-19 on patterns of utilization and expenditure (variations in county relative cost indices were within the expected or normal range of variation).

CMS made the same determination for PY2024 for the inclusion of 2021 and 2022 as BYs. CMS will determine the BYs that will be used for each PY prior to the publication of the ACO REACH/KCC Rate Book for each year.

The expenditure included in the ACO REACH/KCC Rate Book—referred to as ACO REACH/KCC Expenditure—includes all FFS Medicare claim payment amounts, plus sequestration amounts, plus reductions made to provider payments due to participation in alternative payment arrangements (outlined in Table 2.2), minus hospital uncompensated care payments, minus expenditures for over-the-counter COVID-19 tests[5]. This differs from the MA Rate Book, which includes uncompensated care costs but excludes claims related to hospice care. ACO REACH/KCC Expenditures are defined the same way for A&D and ESRD populations (further defined in Section 2.2). For the ESRD population, costs associated with transplants that are captured through Medicare FFS claims are included; additional costs such as organ procurement are not. Any changes to the ESRD MA rates that may come to the MA program in future years will not change the definition of ACO REACH/KCC Expenditures for the ESRD population for the ACO REACH/KCC Rate Book.

Table 2.2. Reductions to Provider Payments due to Participation in Alternative Payment Arrangements Accounted for in the ACO REACH/KCC Expenditure

Alternative Payment Arrangement	Associated Model
Population-Based Payments or All-Inclusive Population-Based Payments	Next Generation Accountable Care Organization Model
Total Care Capitation or Primary Care Capitation	ACO REACH Model
Comprehensive Primary Care Payments	Comprehensive Primary Care Plus Model
Capitated Payments	KCC Model
Population-Based Payments	Primary Care First Model

The MA Rate Book includes shared savings and care management fee payments that are attributable to Innovation Center models and other CMS programs (*Innovation Payment Adjustments*). These adjustments are also added or subtracted to the claims expenditure when constructing the ACO REACH/KCC Rate Book. Consequently, the ACO REACH/KCC Rate Book reflects the shared savings and losses from other CMS Accountable Care Organization models, including ACO REACH and CKCC, and the payment mechanisms from the KCC Model (the Adjusted Monthly Capitation Payment and the Quarterly Capitation Payment). However, the ACO REACH/KCC Rate Book will not include Kidney Transplant Bonus payments under the KCC Model.[6] In cases where Innovation Center payments are not available for a BY, amounts are projected using historical experience.

[5] Over-the-counter COVID-19 tests were covered during 2022 but are included in neither the baseline nor performance period expenditures and are therefore excluded from the data used to construct the PY2024 Rate Book.

[6] Due to the different BYs between the MA Rate Book and the ACO REACH/KCC Rate Book, typically only BY1 and BY2 of the ACO REACH/KCC Rate Book use the exact innovation adjustments from the corresponding CY from the most recently available FFS data files released with MA Rate Book. For example, in PY2024, the 2020 and 2021

The differences in the expenditures included in the ACO REACH/KCC Rate Book and the MA Rate Book are presented in **Table 2.3**.

Table 2.3. ACO REACH/KCC Expenditure compared with MA Rate Book Expenditure

Expenditure Category	ACO REACH/KCC Rate Book	MA Rate Book
FFS Claim Payment Amounts	Included	Included
Sequestration amounts	Included	Included
Reductions made to providers due to alternative payment arrangement participation	Included	Included
Adjustments for Innovation Center models and other CMS programs	Included	Included
FFS Expenditure for beneficiaries enrolled in a managed care plan	Not Included	Not Included
Uncompensated care payments	Not Included[1]	Included
Hospice Care for FFS Beneficiaries	Included[2]	Not Included

CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MA = Medicare Advantage.

[1] Uncompensated Care payments under the inpatient prospective payment system (IPPS) are not included in either the benchmark or performance year expenditures in the ACO REACH Model. Please see the PY2024 Financial Operating Guide: Overview paper for more details.

[2] Hospice care is not covered by Medicare Advantage and is therefore excluded from the MA Rate Book calculations; hospice care is included in the ACO REACH benchmark and performance year expenditures, however, and is therefore included in the ACO REACH/KCC Rate Book.

2.2 ACO REACH/KCC Rate Book Eligibility

The ACO REACH/KCC Rate Book incorporates expenditures for Medicare beneficiaries eligible to participate in ACO REACH. ACO REACH Model eligibility for Medicare beneficiaries is determined for each month of the three ACO REACH/KCC Rate Book BYs (2020, 2021, and 2022 for PY2024). A beneficiary month is eligible for the ACO REACH Model if it meets all the following criteria on the first day of the month:

- The beneficiary is alive.
- The beneficiary is enrolled in Part A.
- The beneficiary is enrolled in Part B.
- The beneficiary is enrolled in Traditional FFS Medicare (for example, not enrolled in MA).
- Medicare is not secondary to coverage under a group health plan.
- The beneficiary is a U.S. resident.

The beneficiary months that meet these criteria are referred to as the ACO REACH National Reference Population. The ACO REACH/KCC Rate Book uses ACO REACH's eligibility criteria, rather than the KCC Model's more restrictive eligibility criteria, to determine beneficiary expenditures that will contribute to the ACO REACH/KCC Rate Book.

adjustments would be the same dollar amounts for each county as those used in the MA Rate Book. Because adjustments for what would be BY3 (for example, 2022 for PY2024) are not available before the ACO REACH/KCC Rate Book is published for a given PY, the ACO REACH/KCC Rate Book applies the same adjustments from BY2 in BY3 for innovations models that are active in BY3.

The Medicare beneficiaries that contribute to the ACO REACH/KCC Rate Book differ from the beneficiaries whose experience is used to construct the MA Rate Book. Unlike the ACO REACH/KCC Rate Book, the MA A&D Rate Book is based on the experience of all Medicare FFS beneficiaries. The MA ESRD Rate Book is based on the experience of all FFS beneficiaries except those who do not have Medicare as their primary payer. Table 2.4 summarizes the differences between the MA Rate Book and the ACO REACH/KCC Rate Book.

Table 2.4. ACO REACH National Reference Population compared with MA Rate Book Population Inclusion Criteria

ACO REACH/KCC Rate Book	MA Rate Book (Aged & Disabled)	MA Rate Book (Dialysis End-Stage Renal Disease)
Alive on the first day of the month	*Consistent Approach*	*Consistent Approach*
Enrolled in Part A and in Part B	All FFS beneficiaries (enrolled in Part A *or* Part B)	All FFS beneficiaries (enrolled in Part A *or* Part B)
Enrolled in Traditional FFS Medicare (for example, not enrolled in MA)	*Consistent Approach*	*Consistent Approach*
Medicare listed as primary payer	All FFS Beneficiaries (including those with Medicare as a secondary payer)	All FFS Beneficiaries (including those with Medicare as a secondary payer)
Is a U.S. resident	*Consistent Approach*	*Consistent Approach*

FFS = fee-for-service; MA = Medicare Advantage.

For the ACO REACH/KCC Rate Book, a month is classified as ESRD if the beneficiary received dialysis services as renal replacement therapy for chronic kidney failure during the month or received a kidney transplant in the past three months, including the month of transplant. All other months accrue to the A&D experience for the ACO REACH/KCC Rate Book. A beneficiary-month is assigned to a county based on the Federal Information Processing Standard (FIPS) county code where the beneficiary resides in either: (1) the first month within a CY that a beneficiary meets ACO REACH eligibility criteria or (2) the FIPS county code where the beneficiary resides in the first month where there is a record for that beneficiary.

2.3 Construction of National Conversion Factor

The National Conversion Factor is constructed using a combination of the ACO REACH/KCC Expenditure data and the ACO REACH eligibility data.

The calculation of the National Conversion Factor is performed for the most recent BY used to construct the ACO REACH/KCC Rate Book and is conducted separately for the A&D and ESRD populations. The ACO REACH/KCC Rate Book National Conversion Factor is calculated by dividing the ACO REACH/KCC Expenditures for the ACO REACH National Reference Population by the number of beneficiary months included in the expenditures.

The National Conversion Factor calculated for the most recent BY is then trended forward to the PY using an Adjusted OACT FFS USPCC trend (with the removal of uncompensated care payments and

addition of hospice expenditures) to determine the National Conversion Factor for the PY. For example, in PY2024, a National Conversion Factor will be calculated using 2022 data and trended forward to PY using the growth rate in Adjusted FFS USPCC[7] from 2022 through 2024.

[7] The Adjusted FFS USPCC trend is based on the FFS USPCC developed by CMS and used in the development of the Medicare Advantage rate book. Prior to 2024, indirect medical education (IME) associated with the MA program was included in the estimate of the FFS USPCC due to reporting conventions. Beginning in 2024, MA IME will be phased out of the estimate of the FFS USPCC incrementally over a three-year period. The Adjusted FFS USPCC trend reflects this phase-out of MA IME, consistent with the phase-out applied to the FFS USPCC projection.

3.0 County Relative Cost Indices

The County Relative Cost Index is similar to the average geographic adjustment (AGA) in the MA Rate Book. The County Relative Cost Indices are based on the ratio of the PBPM expenditure for the county, adjusted to reflect differences in the Performance Year[8] Geographic Adjustment Factors (GAFs) that CMS applies when calculating FFS payments and standardized for the risk of beneficiaries living in the county, and the ACO REACH National Reference Population PBPM expenditure. The County Relative Cost Indices therefore reflect changes in relative cost in the same county between BY and PY.

Three rates are calculated for each county in each PY: one for ESRD experience and two for Aged & Disabled experience. County rates are "standardized" to remove differences across counties in the average risk or expected expenditure of beneficiaries living in the county, as discussed in Section 3.2.

Section 3.1 discusses the development of the GAFs. Section 3.2 discusses the risk score models used to construct the three county rates. Section 3.3 describes the calculation of the County Relative Cost Indices.

3.1 Construction of GAFs

Medicare FFS claim payment amounts are adjusted to reflect geographic variations in the cost of doing business. These adjustments vary by FFS payment system and include Area Wage Indices that are used by the various Prospective Payment Systems and the Geographic Practice Cost Indices that are applied by the Physician Fee Schedule. These geographic adjustments vary and are updated annually. The ACO REACH/KCC Rate Book includes a GAF Index for each county which estimates the combined impact of changes in the geographic adjustments that were applied to historical expenditures in each of the three years used to construct the rate book and the geographic adjustments that will be applied in the performance year. Separate GAF indices are calculated for the A&D and ESRD Benchmarks.

To develop the GAF Index, claims data for each of the ACO REACH/KCC Rate Book's BYs are repriced using the most recently published FFS geographic price adjustments. Generally, these will be the geographic price adjustments that are used in the year prior to the ACO REACH/KCC performance year. For example, in developing the 2024 ACO REACH/KCC Rate Book, claims for 2020, 2021, and 2022 were repriced using the FFS geographic adjustments that are applied in CY2023.[9]

Repricing claims is a two-step process. First, the impact of the geographic adjustments that were made in the CY in which the claims were incurred is removed, resulting in a GAF-Standardized Payment (the

[8] Technically, the GAF adjustment makes use of the Geographic Adjustment Factors applied by Medicare when calculating FFS payments in the year prior to the ACO Reach/GPDC Performance Year because the Performance Year GAF's are not published until after the ACO Reach Rate Book is published.

[9] In December 2023, an updated version of the 2024 ACO REACH/KCC Rate Book was published using CY2024 geographic adjustments applied to IPPS and OPPS claims and CY2023 geographic adjustments for all other claim types. The 2024 policy differs from policy in previous years because the final FY2024 Area Wage Index for the IPPS and OPPS results in a material and atypical change in inpatient and outpatient hospital payment for services provided in CY2024.

payment that would have been made if no GAF had been applied). Second, the GAF-Standardized Payment is repriced using the most recently published FFS geographic adjustments to calculate a GAF-Adjusted Payment. The repricing of claims is "budget neutral" in the sense that the total repriced claim payment amounts must be equal, at the national level, to the original claim payment amounts. Because GAF adjustment reflects regional variation in claim payment amounts, no adjustment is applied to the National Conversion Factor which represents payment at the national level.

For each year, the repriced claims, regardless of where the beneficiary received the service, are summed by beneficiary county of residence, separately for beneficiary months that accrue to the A&D and ESRD Benchmarks. Finally, PY GAF Trend Indices are calculated for each county for A&D and for each state for ESRD, in each CY. GAF Trend Indices are calculated as follows:

$$GAF\ Trend\ Index = \frac{GAF\ Adjusted\ Expenditure}{Incurred\ Expenditure}$$

A total of three GAF Trend Indices are used for each benchmark (Aged & Disabled / ESRD), one for each BY, as shown in **Table 3.1**, using PY2024 as an example.

Table 3.1. GAF Indices used for ACO REACH PY2024[1]

Calendar Year	PY GAF Index
2020	$\frac{\text{2020 Expenditure Adjusted to 2023}}{\text{2020 Incurred Expenditure}}$
2021	$\frac{\text{2021 Expenditure Adjusted to 2023}}{\text{2021 Incurred Expenditure}}$
2022	$\frac{\text{2022 Expenditure Adjusted to 2023}}{\text{2022 Incurred Expenditure}}$

GAF = Geographic Adjustment Factors; PY = performance year.

[1] For PY2024, the Geographic Adjustment Factors used for the PY GAF Index are 2024 for IPPS and OPPS claims and 2023 for all other claim types. Depending on the Rate Book publication timeline, the PY GAF will generally be repriced based upon PY_{N-1}.

The ESRD rates utilize a second GAF adjustment in order to account for county-level variation in Area Wage Indices within a state. This second index estimates the amount by which county-level spending PBPM would differ from state-wide spending because of differences between the Medicare FFS PY GAF Indices that are used to calculate payments for services provided to beneficiaries residing in the county in the performance year. This is referred to as the ESRD County PY GAF Adjustment and is applied to the statewide ESRD rate in order to determine a county-specific ESRD rate. The ESRD county rates reflect the average expenditure PBPM in the state during the baseline period adjusted for the impact of county-level FFS GAF factors.

The PY GAF Index calculates the impact of the PY GAF by comparing Medicare PBPM expenditures during the performance year to what they would have been if no geographic adjustment had been applied in the performance or baseline year. This adjustment is calculated as:

$$PY\ GAF\ Index = \frac{GAF\ Adjusted\ Expenditure}{GAF\ Standardized\ Expenditure}$$

Cross-sectional variation in Medicare FFS PBPM expenditures by county within a state is then calculated as follows:

$$ESRD\ County\ PY\ GAF\ Adjustment = \frac{County\ ESRD\ PY\ GAF\ Index}{Statewide\ Average\ ESRD\ PY\ GAF\ Index}$$

For certain smaller counties, there may not be available baseline data to calculate a county-level GAF adjustment for ESRD rate. In these scenarios, the following hierarchy is used to determine the ESRD county rate:

1. If the county is part of a Core-Based Statistical Area (CBSA), a CBSA rate is assigned to the county. This CBSA rate is calculated as the eligible month-weighted average of the GAF-Adjusted County Rates for other counties within the CBSA.
2. If the county is not part of a CBSA, the county rate is equal to the state rate for the county.

3.2 Risk Scores Used for ACO REACH/KCC Rate Book Standardization

To develop the ACO REACH/KCC Rate Book, risk scores are used to standardize expenditures so that the County Relative Cost Indices do not reflect differences in the health status of beneficiaries residing in each county. The county-level expenditures are risk standardized so that it reflects the estimated expenditure PBPM of an ACO REACH eligible beneficiary with a risk score of 1.0 in each year.

The county-level risk scores used in the development of the ACO REACH/KCC Rate Book will be calculated using a risk score methodology consistent with the MA Rate Book in the performance year.[10] However, for each CY used in the ACO REACH/KCC Rate Book construction, risk scores will be normalized with respect to the ACO REACH National Reference Population to account for any difference in the average risk score within this specific population. The ACO REACH Reference Population Normalization Factor applied in the ACO REACH/KCC Rate Book development is simply:

$$ACO\ REACH\ Reference\ Population\ \ Normalization\ Factor_{Year} = \frac{1}{Average\ ACO\ REACH\ Reference\ Pop\ Risk\ Score\ Produced\ by\ Payment\ Year\ Model_{Year}}$$

This will ensure that the risk scores used to develop ACO REACH and KCC Benchmarks and calculate payment will reflect the cost of beneficiary care relative to the average cost of a beneficiary eligible for the models.

Risk standardization of the ACO REACH/KCC Rate Book is achieved by dividing the county rates by the three-year weighted average risk score for each county.

The ACO REACH/KCC Rate Book uses three different types of risk scores:

1) CMS-HCC A&D prospective risk scores

[10] The one exception is the risk scores used for A&D beneficiaries in High Needs Population ACOs. See Section 5.2 for additional details.

   a. Used to calculate the county rates that apply to experience accruing to the Aged & Disabled Benchmark for Standard and New Entrant ACOs in the ACO REACH Model and for CKD4/5 in the KCC Model.
2) CMMI-HCC A&D concurrent risk scores
   a. Used to calculate the county rates that apply to experience accruing to the Aged & Disabled Benchmark for High Needs Population ACOs in the ACO REACH Model.
3) CMS-HCC ESRD prospective risk scores
   a. Used to calculate the county rates that apply to experience accruing to the ESRD benchmark for all ACO types in the ACO REACH Model and CKCC.

These three risk scores will be used to develop the three different County Relative Cost Indices for each county.

For additional details on these risk scores, see the **ACO REACH and KCC Models: Risk Adjustment** document.

3.3 County Relative Cost Indices

The County Relative Cost Index for each BY is the ratio of the GAF-adjusted and risk-standardized ACO REACH/KCC Expenditure PBPM of each county to the national average (weighted by eligible months) risk-standardized ACO REACH/KCC Expenditure PBPM in that year.

The process of calculating the final County Relative Cost Index for each county is illustrated in **Table 3.2**. For each ACO REACH/KCC Rate Book BY, the county-level ACO REACH/KCC Expenditure PBPM is multiplied by the GAF Index for that county for that ACO REACH/KCC Rate Book BY and divided by the ACO REACH Reference Population PBPM for that ACO REACH/KCC Rate Book BY. The result is the ACO REACH/KCC Rate Book BY County Index. Then, each of those county indices are averaged and divided by both the 3-year weighted average of the normalized risk scores and the national average geographic adjustment.

Table 3.2. Illustration of County Relative Cost Indices for three counties, Performance Year 4

Inputs	County A	County B	County C
2020 County ACO REACH/KCC Expenditure PBPM	$982	$1,032	$892
TIMES: 2020 GAF Index	0.982	0.984	0.986
DIVIDE BY: ACO REACH National Reference Population PBPM 2020[1]	$980	$980	$980
EQUALS: 2020 County Index	0.984	1.036	0.897
2021 County ACO REACH/KCC Expenditure PBPM	$1,003	$1,108	$901
TIMES: 2021 GAF Index	1.036	1.038	1.040
DIVIDE BY: ACO REACH National Reference Population PBPM 2021[1]	$990	$990	$990
EQUALS: 2021 County Index	1.050	1.162	0.947
2022 County ACO REACH/KCC Expenditure PBPM	$960	$1,190	$924
TIMES: 2022 GAF Index	0.991	0.993	0.995
DIVIDE BY: ACO REACH National Reference Population PBPM 2022[1]	$995	$995	$995
EQUALS: 2022 County Index	0.956	1.187	0.924
AVERAGE: 2020, 2021, and 2022 County Indices (calculated above)	0.997	1.129	0.923
DIVIDE BY: 3-Year Weighted Average Normalized Risk Scores	0.830	1.060	0.982
DIVIDE BY: National Index[2]	0.989	0.989	0.989
EQUALS: County Relative Cost Index	**1.215**	**1.076**	**0.950**

ACO REACH = ACO Realizing Equity, Access, and Community Health; GAF = Geographic Adjustment Factors; KCC = Kidney Care Choices; PBPM = per beneficiary per month.

[1] ACO REACH National Reference Population PBPM is equivalent to the National Conversion Factor for a single ACO REACH/KCC Rate Book Base Year

[2] National Index: The national average geographic adjustment, calculated as a weighted average of all the County Relative Cost Indices (uses 2020 enrollment). Dividing by this factor will ensure that the national average geographic adjustment is 1.0 across the 3 years.

For the ESRD Benchmark, ACO REACH/KCC Expenditures, the GAF Index, and risk scores are calculated at the state level. Therefore, the County Relative Cost Indices for the ESRD Benchmark reflect state averages. In a subsequent step, the County GAF Adjustment is applied to ESRD rates to account for differences in Area Wage Indices within each state.

4.0 Adjustments to County Rates

As with the MA Rate Book, several additional adjustments are applied to the county rates to achieve policy goals and improve accuracy for the model. Each of the adjustments described below are applied at the county level. The following equation illustrates the components of the county-level rates and how these additional adjustments are applied to produce the final rates.

$$County\ Rate\ =\ (National\ Conversion\ Factor)\ \times\ (County\ Relative\ Index)$$
$$\times\ (Zero\ Claims)\ \times\ (VADOD)\ \times\ (KAC)\ \times\ (Credibility\ Adjustment)$$

Zero Claims Adjustment
The proportion of beneficiaries in the Puerto Rico FFS population incurring no FFS claims in each county is significantly higher than in the rest of the United States. To account for the disproportionate number of beneficiaries with no FFS claims in Puerto Rico, CMS Office of the Actuary (OACT) applies a factor to the standardized per capita FFS costs in Puerto Rico. For purposes of making this adjustment to the MA Rate Book, OACT evaluated experience exclusively for beneficiaries that are enrolled in both Parts A and B and are not also eligible for Veterans Administration (VA) coverage.

The same logic applies to the ACO REACH and KCC Models (beneficiaries with no FFS claims are less likely to be enrolled in an ACO/Kidney Contracting Entity (KCE) since claims-based alignment and voluntary alignment require some interaction with healthcare providers), and the percentage adjustment that is applied to the standardized Puerto Rico FFS rates in the MA Rate Book is also applied to Puerto Rico FFS rates in the ACO REACH/KCC Rate Book.

VA/Department of Defense (DoD) Adjustments
The ACO REACH/KCC Rate Book applies the same VA and DoD (U.S. Family Health Plan) adjustments to the county level PBPM FFS rates using the ratios reported in the MA Rate Book corresponding to the model PY. This adjustment removes the impact of VA/DoD beneficiaries' experience on the county-level rates because these beneficiaries have care expenditure patterns that vary from FFS beneficiaries who are not covered by VA/DoD benefits. As with the zero claims adjustment above, this is included in the ACO REACH/KCC Rate Book because the same logic applies to ACO REACH and the KCC Model as to MA.

Kidney Acquisition Cost (KAC) Factor
Starting in 2021, the 21st Century Cares Act excludes organ acquisition costs for kidney transplants from MA capitation rates. Consistent with the MA program, the ACO REACH/KCC Rate Book excludes these costs from the final rates. The KAC factor removes expenses related to kidney acquisition at the county-level.

Credibility Adjustments
Although 3 years of experience are used to set County Relative Cost Indices, expenditures in small counties may have sufficient volatility that additional experience should be incorporated in setting the county benchmark. Similar to the MA Rate Book,[11] a credibility adjustment will be applied to small

[11] See the file *Medicare_FFS_Glossary_2024.pdf* (included in the *FFS Data 2021* download from the CMS website: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data)

counties in the ACO REACH/KCC Rate Book. For counties with fewer than 1,000 members, county experience is blended with experience from the applicable Medicare Core Based Statistical Area (CBSA). If a county is not associated with a CBSA, the county experience will be blended with statewide experience.

The credibility formula[12] applied is:

$$Credibility\ (Z) = \sqrt{\frac{Average\ A\ \&\ B\ Beneficiaries}{1000}}$$

The credibility-adjusted county rate is then:

$$Credibility\ Adjusted\ PBPM = Pre\text{-}Credibility\ PBPM^{13} \times\ Z + CBSA\ PBPM \times (1 - Z)$$

Once the county-level rates are adjusted to account for credibility, a second adjustment is applied to counties with credibility less than 1.0 in order to maintain budget neutrality relative to the pre-credibility adjusted rates.[14] These budget neutrality factors are calculated at the state level.

$$Credibility\ Budget\ Neutral\ Factor_{State} = \frac{a}{b}, where$$

$$a = \sum_{all\ ctys\ cred<1} (Pre\text{-}Credibility\ PBPM \times Average\ Part\ A\ \&\ B\ Enrollment)$$

$$b = \sum_{all\ ctys\ cred<1} Credibility\ Adjusted\ PBPM \times Average\ Part\ A\ \&\ B\ Enrollment$$

[12] In the credibility formula, average A & B Beneficiaries corresponds to the average number of FFS beneficiaries enrolled in Parts A & B in a given county, during the applicable year. For purposes of the credibility adjustment, we consider only beneficiaries in the ACO REACH National Reference Population.

[13] Pre-Credibility PBPM = (National Conversion Factor) x (County Relative Index) x (Zero Claims) x (VADOD) x (1 – KAC Factor)

[14] The budget neutrality adjustment is needed to prevent the credibility adjustment from resulting in rates that would, if applied to the entire ACO REACH-eligible population, result in a national average payment rate that is higher or lower than the average payment rate prior to applying the credibility adjustment.

5.0 Final Performance Year ACO REACH/KCC Rate Book

The ACO REACH/KCC Rate Book is comprised of three rates for each county. There are two rates for the A&D ACO REACH National Reference population: one based upon the CMS-HCC prospective risk scores (for A&D beneficiaries in Standard and New Entrant ACOs and CKD4/5 beneficiaries in KCEs), and one based upon the CMMI-HCC concurrent risk scores (for A&D beneficiaries in High Needs Population ACOs). There is also a rate for the ESRD ACO REACH National Reference population based upon the CMS-HCC prospective risk scores for ESRD beneficiaries in all types of ACOs and KCEs.

5.1 Construction of Final County Rate

Aged & Disabled county rates are the product of the National Conversion Factor and the County Relative Cost Index. This is illustrated in **Table 5.1**.[15] Each rate is the regional rate component of the benchmark that would apply to a beneficiary with a risk score of 1.000.

Table 5.1. Construction of A&D ACO REACH/KCC Rate Book

County	County Relative Cost Index	National Conversion Factor	Calculation	County Rate
County A	0.953	$850.00	= $850.00 x 0.953	$809.63
County B	1.190	$850.00	= $850.00 x 1.190	$1,011.84
County C	0.936	$850.00	= $850.00 x 0.936	$795.94
County D	0.833	$850.00	= $850.00 x 0.833	$708.22
County E	0.909	$850.00	= $850.00 x 0.909	$772.99

ESRD county rates are the product of the National Conversion Factor, the State Relative Cost Index, and the County GAF Adjustment, as illustrated in **Table 5.2**. Each rate is the regional rate component of the benchmark that would apply to a beneficiary with a risk score of 1.000.

Table 5.2. Construction of ESRD ACO REACH/KCC Rate Book

County	State Relative Cost Index	National Conversion Factor	County GAF Adjustment	Calculation	County Rate
County A	0.953	$7300.00	0.9839	= $7300.00 x 0.953 x 0.9839	$6,844.89
County B	0.953	$7300.00	0.9616	= $7300.00 x 0.953 x 0.9616	$6,689.76
County C	0.953	$7300.00	1.0215	= $7300.00 x 0.953 x 1.0215	$7,106.47
County D	1.019	$7300.00	0.9950	= $7300.00 x 1.019 x 0.9950	$7,401.51
County E	1.019	$7300.00	1.0152	= $7300.00 x 1.019 x 1.0152	$7,551.77

[15] The adjustments to county rates described in Section 4 are omitted from this calculation for illustrative purposes.

5.2 Use of the ACO REACH/KCC Rate Book in ACO REACH and KCC Model Financial Operations

As described above, there are three rates per county in the ACO REACH/KCC Rate Book. The use of each county rate is summarized by ACO/KCE type in **Table 5.2**.

Table 5.3. ACO REACH/KCC Rate Book rates and use in ACO REACH and Kidney Care Choices Models

County rate	Risk scores	ACO/KCE type	Use
A&D	CMS-HCC Prospective	Standard ACO	• Regional blend in benchmark for claims-aligned A&D beneficiaries (PY2021–2026) • Benchmark for voluntarily aligned A&D beneficiaries (PY2021–2024) • Regional blend in benchmark for voluntarily aligned A&D beneficiaries (PY2025, PY2026)
		New Entrant ACO	• Benchmark for all A&D beneficiaries (PY2021–2024) • Regional blend in benchmark for all A&D beneficiaries (PY2025, PY2026)
		CKCC	• Regional blend in benchmark for all aligned Chronic Kidney Disease beneficiaries (PY2021–2025)
ESRD	CMS-HCC Prospective for ESRD	Standard ACO	• Regional blend in benchmark for claims-aligned ESRD beneficiaries (PY2021–2026) • Benchmark for voluntarily aligned ESRD beneficiaries (PY2021–2024) • Regional blend in benchmark for voluntarily aligned ESRD beneficiaries (PY2025, PY2026)
		New Entrant ACO	• Benchmark for all ESRD beneficiaries (PY2021–2024) • Regional blend in benchmark for all ESRD beneficiaries (PY2025, PY2026)
		High Needs Population ACO	• Benchmark for all ESRD beneficiaries (PY2021–2024) • Regional blend in benchmark for all ESRD beneficiaries (PY2025, PY2026)
		CKCC	• Regional blend in benchmark for all aligned ESRD beneficiaries (PY2021–2025)
A&D	CMMI-HCC Concurrent	High Needs Population ACO	• Benchmark for all A&D beneficiaries (PY2021–2024) • Regional blend in benchmark for all A&D beneficiaries (PY2025, PY2026)

A&D = Aged & Disabled; CMS = Centers for Medicare & Medicaid Services; CKCC = Comprehensive Kidney Care Contracting; CMMI = Center for Medicare & Medicaid Innovation; ACO REACH = ACO Realizing Equity, Access, and Community Health; ACO = Accountable Care Organization; ESRD = End-Stage Renal Disease; HCC = Hierarchical Condition Category; KCC = Kidney Care Choices; KCE = Kidney Contracting Entity; MA = Medicare Advantage; PY = Performance Year

The benchmarking methodologies for the ACO REACH and KCC Models, including the incorporation of the ACO REACH/KCC Rate Book into the benchmark, are detailed in the ***ACO REACH Model: Financial***

Operating Guide: Overview paper and the *Kidney Care Choices Financial Operating Guide: Overview* paper, respectively.

Appendix

Appendix Table 1. Differences between MA Rate Book and ACO REACH/KCC Rate Book

Feature	MA Rate Book	ACO REACH/KCC Rate Book	Reason for difference
Base years used to develop County Relative Cost Indices	5 base years, 2-year interval between base year 5 and the performance year	3 base years, 1-year interval between base year 3 and the performance year	This change aligns the number of years used to develop both the historical and regional components of the ACO REACH and KCC financial benchmarks.
Expenditure	Removes hospice care expenditure for FFS beneficiaries	Includes hospice care expenditure for FFS beneficiaries; removes uncompensated care payments	Hospice care is provided under the ACO REACH and KCC Models, so hospice expenditures are included in the county rates. Uncompensated care is not included in expenditures for the ACO REACH and KCC Models so are removed from the county rates.
Reference sample	All FFS beneficiaries (A&D: enrolled in Part A *or* Part B, ESRD: enrolled in Part A *and* Part B), not enrolled in MA; for ESRD, must have Medicare as primary payer	Beneficiaries must be enrolled in Part A and Part B, *not* enrolled in MA, have Medicare listed as the primary payer, and be a U.S. resident	This change aligns the reference sample for the ACO REACH/KCC Rate Book to the population of Medicare beneficiaries eligible to participate in the ACO REACH and KCC Models.
Geographic Adjustment Factors	County level expenditures are adjusted using Geographic Adjustment Factors		Not applicable
Risk scores used to develop County Relative Cost Indices	Normalized risk scores, calculated using the payment year risk adjustment model, are used to risk-standardize base year expenditures. Average county level PBPM indices are risk-standardized based on the weighted average normalized risk scores		Not applicable
Puerto Rico adjustment	Zero Claims Adjustment to counties in Puerto Rico		Not applicable
Veterans Administration/ Department of Defense adjustment	County-level per beneficiary per month adjustment to remove the impact of Veterans Administration/Department of Defense beneficiaries' experience on county-level rates		Not applicable

Feature	MA Rate Book	ACO REACH/KCC Rate Book	Reason for difference
Credibility adjustment	For counties with fewer than 1,000 members, county experience is blended with experience from the applicable Core-Based Statistical Area		Not applicable
GME adjustment	Adjustment to remove GME expenditures from MA county rates	GME is not included in county rates	Not applicable
IME adjustment	Adjustment to phase-out IME expenditures from MA county rates	IME is included in county rates without a phase-out	IME expenditures are included in ACO REACH and KCC Model Benchmarks and therefore need to be in the county rates for consistency.
Kidney Acquisition Cost adjustment	Adjustment to remove Kidney Acquisition Costs from county rates		Not applicable
Quartile adjustment	Statutory adjustment to county rates based on rate quartile	Not applied to county rates	There is no statutory requirement to adjust rates based on quartiles for the ACO REACH or KCC Models, nor are there specific ACO REACH or KCC Model policy goals achieved by including them in the ACO REACH/KCC Rate Book.
Quality bonus	Adjustment to county rates based on MA organization achievement of quality standards	Not applied to county rates	There is no quality bonus payment mechanism in the ACO REACH or KCC Models.

FFS = fee-for-service; ACO REACH = ACO Realizing Equity, Access, and Community Health; GME = Graduate Medical Education; IME = Indirect Medical Education; KCC = Kidney Care Choices; MA = Medicare Advantage.