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

PY2025 Financial Settlement Overview

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Reference Documents

ACO REACH Model: Financial Operating Guide: Overview
ACO REACH Model: Capitation and Advanced Payment Mechanisms
ACO REACH and Kidney Care Choices Models: Rate Book Development
ACO REACH and Kidney Care Choices Models: Risk Adjustment
ACO REACH Model: Quality Measurement Methodology
GUIDE Model: Payment Methodology Paper

Acronyms

A&D	Aged & Disabled
ACO	Accountable Care Organization
APO	Advanced Payment Option
BY	Base Year
CI/SEP	Continuous Improvement/Sustained Exceptional Performance
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
ESRD	End-Stage Renal Disease
FFS	Fee for Service
GAF	Geographic Adjustment Factors
GPDC	Global and Professional Direct Contracting
GSF	Geographic Standardization Factor
GUIDE	Guiding an Improved Dementia Experience (GUIDE) Model
HEBA	Health Equity Benchmark Adjustment
HPP	High-Performance Pool
MA	Medicare Advantage
PBPM	Per Beneficiary Per Month
PCC	Primary Care Capitation
PY	Performance Year
REACH	Realizing Equity, Access, and Community Health
TCC	Total Care Capitation
USPCC	United States Per Capita Cost

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1.0 Introduction

This document is one in a series of documents that provide Accountable Care Organizations (ACOs) with the necessary details to understand the financial aspects of the ACO Realizing Equity, Access, and Community Health (REACH) Model. This document describes the approach for the ACO REACH Settlement process (also referred to as Financial Settlement) by which the Centers for Medicare & Medicaid Services (CMS) determines the Shared Savings/Losses for an ACO at the conclusion of a performance year (PY). This is done by accounting for differences between the Benchmark Expenditure and PY Expenditure, after applying risk-mitigation strategies such as Stop-Loss Reinsurance and Risk Corridors. The ACO then assumes responsibility for the difference according to its elected Risk Arrangement. **Table 1** provides a high-level overview of the different options available to ACOs dependent on their Risk Sharing and Payment Arrangements.

Table 1: Differences in Global and Professional Risk Arrangements

Risk Arrangement	**Global**		**Professional**
Capitation Arrangement	Total Care	Primary Care	Primary Care
Advanced Payment Option	Not Available	Optional	
Provisional Settlement	Optional		
Stop-Loss Reinsurance	Optional		
Risk Corridors	Mandatory: Global Schedule		Mandatory: Professional Schedule

Section 2 provides an overview of the timing and data used in both Provisional and Final Settlement. Section 3 details the mechanics of the Financial Settlement process. Section 3.1 shows the calculation of the Benchmark Expenditures and Adjustments. Section 3.2 shows the calculation of the PY Expenditure. Section 3.3 shows the calculation of Gross Savings/Losses and Shared Savings/Losses after the application of risk corridors. Section 4 details the process of Settlement and calculation of Total Monies Owed. Section 5 details information relating to the Financial Guarantee. Appendix A shows a long-form Settlement example. All examples in this paper are illustrative.

2.0 Timing of Settlement

Final Settlement for PY2025 and subsequent PYs will occur approximately 7-8 months following the conclusion of the PY. However, ACOs have the option to elect a Provisional Settlement, with a target date of approximately 1 month following the conclusion of a PY. **Tables 2 and 3** detail the differences between Provisional and Final Settlement:

Table 2: Provisional and Final Settlement

Data/Timing	Provisional Settlement	Final Settlement
Date for Settlement	February 28 of the calendar year following the performance year	July/August of the calendar year following the performance year
Claims Included in Settlement	Performance Year Expenditure incurred through December 31	Performance Year Expenditure incurred through December 31
Claims Run-out	Through December 31 of the performance year	Through March 31 of the calendar year following the performance year
Risk Scores	Interim risk scores for January through December[1]	Final risk scores

[1] CMS will use the most recently available risk scores in Provisional Settlement calculations.

Table 3: Timing of Provisional and Final Settlement for PY2025

Performance Year		Provisional Settlement	Final Settlement
PY2025	Target Date[1]:	February 28, 2026	July/August 2026
	Uses Claims Incurred:	01/01/2025–12/31/2025	01/01/2025–12/31/2025
	Run-out Period End Date:	12/31/2025	03/31/2026

1. These dates for Settlement are targets; the actual timing for release of Settlement reports and processing of settlement may occur later.

PY = performance year.

2.1 Provisional Settlement

Provisional Settlement is an optional process that will allow ACOs the ability to receive/pay a portion of their Shared Savings/Losses prior to the Final Settlement. Because Provisional Settlement occurs in February closely following the end of the PY, experience through December 31st of the PY is included in the Provisional Shared Savings/Losses calculation with no additional runout. Additionally, Provisional Settlement will use Interim beneficiary risk scores in the calculation of Provisional Shared Savings/Losses.

Because quality scores relating to the earn back of the two percent Quality Withhold will not be available at the time of Provisional Settlement, a stand-in 100% quality score will be used. For subsequent PYs, if available, the stand-in score will be the actual score received in the previous PY (for instance, the stand-in score for PY2025 will be the actual quality score from PY2024, if / once it is available).

2.2 Final Settlement

Final Settlement will compute Shared Savings/Losses using the full PY claims data, with a 3-month run-out period ending March 31 following the PY. Final Settlement is based on the risk adjusted Performance Year Benchmark using the final risk scores for the PY in the calculation of Shared Savings/Losses. At the time of Final Settlement, the final quality score for the PY will be available.

Because Provisional Settlement uses incomplete claims and alignment data for a partial PY, interim risk scores, and a stand-in quality score, there may be considerable differences between the Shared Savings/Losses calculated at the Provisional Settlement and the Shared Savings/Losses calculated at the Final Settlement. As a result, there will be an adjustment in the calculation of Total Monies Owed (see **Table 16**) to address any difference in the calculation of Shared Savings/Losses between the Settlements.

3.0 Components of Settlement

The Settlement process determines Shared Savings/Losses by comparing the calculated Total Benchmark Expenditure for a given ACO's aligned population to the actual expenditures of that ACO's aligned population over the course of a PY, accounting for various risk-mitigation methods such as Stop-Loss Reinsurance and Risk Corridors. This section details the calculation of total PY Expenditure, Gross Savings/Losses, the application of risk-mitigation methodologies, and the value of Shared Savings/Losses.

3.1 Benchmark Expenditure

Prior to the beginning of each PY, a Financial Benchmark ('Benchmark Expenditure') is calculated for each ACO and adjusted based on PY alignment and risk score information. The process for determining an ACO's Benchmark Expenditure is detailed in Section 4 of the ***ACO REACH Model: Financial Operating Guide: Overview*** paper.

3.1.1 Benchmark Adjustments

Depending on the elected risk arrangement, several adjustments are made to the Benchmark Expenditure prior to Provisional and/or Final Settlement. These adjustments are detailed in the ***ACO REACH Model: Financial Operating Guide: Overview*** document, but are discussed generally here for context:

Discount

Because ACOs electing the Global Risk Arrangement retain up to 100 percent of Shared Savings/Losses, a discount is applied to the Benchmark to ensure savings are also generated for CMS. Consequently, for ACOs in the Global Risk Arrangement, the Benchmark Expenditure is reduced by a set percentage based on the performance year, detailed in **Table 4**. Because ACOs electing the Professional Risk Arrangement share any savings (or losses) with Medicare, no discount is applied to the Benchmark for those ACOs.

Table 4: Schedule of Discounts by Risk Arrangement

Risk Arrangement	PY2025	PY2026
Global	3.5%	4%
Professional	N/A	

PY = performance year.

Quality Withhold

Each PY, CMS withholds a portion of the Benchmark Expenditure from ACOs in both the Professional and Global Risk Arrangements. This withhold is held "at-risk," meaning it can be earned back by the ACO by reporting and/or sufficiently performing on a set of pre-determined quality measures and Continuous Improvement/Sustained Exceptional Performance (CI/SEP) metrics. For PY2025 and subsequent years, the withhold amount will be two percent of the ACO's Benchmark Expenditure.

At the end of the PY, ACOs receive a single quality score from 0 to 100 percent. This score is a weighted average of the ACO's performance in several categories, including pay-for-performance and pay-for-reporting criteria. The weights of these categories will vary PY to PY. In addition, performance on CI/SEP criteria will be used to determine whether the ACO is eligible for the full two percent earn back or eligible only for a maximum of a one percent earn back. CMS will continue to implement the High-Performers Pool (HPP) bonus to further incentivize high performance and continued improvement. For more information on the calculation of quality scores and the application of CI/SEP criteria, see the ***ACO REACH Model: Quality Measurement Methodology***. For a given quality score, the ACO will earn that percentage of its Quality Withhold back onto the Benchmark.

Retrospective Trend Adjustment

Prospective Benchmarks in ACO REACH are based on the trend in the adjusted United States Per Capita Cost (USPCC). As this adjusted USPCC trend is prospective, it may meaningfully diverge from the observed expenditure trend for the ACO REACH National Reference Population[1]. If, in a given PY, the observed expenditure trend for the ACO REACH National Reference Population differs from the prospective adjusted USPCC trend by more than one percentage point, CMS may apply a retrospective trend adjustment (RTA) to the preliminary benchmarks. To increase predictability of the impact of the RTA for REACH ACOs, CMS will apply a symmetric corridor and cap to the RTA depending on the degree to which the prospective trend factor is over or understated. There will be three symmetric RTA corridors: (+/-) 0-4%, (+/-) 4-8%, and greater than (+/-) 8% of the total cost of care benchmark, with corresponding levels of risk accepted by REACH ACOs in each corridor of 100%, 50%, and 0% application levels, respectively.

Table 5: Symmetric RTA Risk Corridors

Magnitude of RTA	Portion of RTA accruing to the ACO	Portion of the RTA accruing to CMS
Between -4% to 4%	100%	0%
Between -8% and -4% or 4% and 8%	50%	50%
Less than -8% or more than 8%	0%	100%

[1] CMS will also adjust the USPCC trend to account for adjustments to expenditures due to Significant, Anomalous, and Highly Suspect (SAHS) Billing, or the removal of over-the-counter COVID_19 tests during the public health emergency.

Health Equity Benchmark Adjustment

In the pursuit of improving health equity in ACO REACH, CMS has implemented a Health Equity Benchmark Adjustment. This adjustment is intended to help mitigate the disincentive for ACOs to serve historically underserved communities by accounting for historically suppressed spending levels for these populations (specifically by performing a PBPM Benchmark adjustment for each aligned beneficiary). This Benchmark adjustment will apply to an ACO's Benchmark after the Retrospective Trend Adjustment, Discount, and Quality Withhold, as applicable. The details for how ACO REACH will calculate this Benchmark adjustment are provided in the ***ACO REACH Model: Financial Operating Guide: Overview*** paper.

3.1.2 Calculation Example

Table 6 serves as an example of the Discount and Quality Withhold applied to an ACO's Benchmark, should they select either Professional or Global Risk Arrangements:

Table 6: Calculation of Benchmark Expenditure after Discount, Earned Quality, and HEBA

		Global	Professional
Benchmark Expenditure with Initial Adjustments		**(in dollars)**	**(in dollars)**
1	Benchmark Expenditure for All Aligned Beneficiaries[1]	$150,000,000	$150,000,000
Calculation of Discount Rate		**Global**	**Professional**
2	Discount Rate	3.5%	N/A
3	Total Discount	$5,250,000	
4	**Benchmark Expenditure for All Aligned Beneficiaries After Discount (Line 1–Line 3)**	**$144,750,000**	**$150,000,000**
Calculation of Earned Quality Withhold		**Global**	**Professional**
5	Quality Withhold (0.02 x Line 1)	$3,000,000	$3,000,000
6	Quality Score	95%	95%
7	**Earned Quality Withhold (Line 5 x Line 6)**	**$2,850,000**	**$2,850,000**
8	Net Impact of Quality Withhold (Line 5 – Line 7)	$150,000	$150,000
9	**Benchmark Expenditure for All Aligned Beneficiaries After Discount and Earned Quality (Line 4–Line 8)**	**$144,600,000**	**$149,850,000**
Application of Health Equity Benchmark Adjustment		**Global**	**Professional**
10	Health Equity Benchmark Adjustment	$750,000	$750,000
11	**Benchmark Expenditure for all Aligned Beneficiaries After Discount, Earned Quality, and HEBA (Line 9 + Line 10)**	**$145,350,000**	**$150,600,000**

1. Here, the Benchmark Expenditure for All Aligned Beneficiaries includes adjustments for the Retrospective Trend, where applicable.

3.2 Performance Year Expenditure

The Performance Year Expenditure (PY Expenditure) is the total payment that Medicare has made for services provided to ACO-aligned beneficiaries during months in which they were alignment eligible and aligned to the ACO. The PY Expenditure is the sum of the capitation payments made to the ACO for services within the scope of their respective capitation arrangement and the fee-for-service (FFS) payments made to providers. Because the Benchmark is calculated on a pre-sequestration basis, the PY

Expenditure will also be calculated on a pre-sequestration basis for the purposes of calculating Shared Savings/Losses. Sequestration will be re-applied in the calculation of Shared Savings/Losses (See **Table 17**).

3.2.1 Capitation Payments

All ACOs are required to participate in one of the Capitation Payment Mechanisms: Total Care Capitation (TCC) or Primary Care Capitation (PCC). The TCC or Base PCC Payments made to the ACO during the PY, including any adjustments to those payments made during or after the PY, will be included as capitation payments in the calculation of the PY Expenditure. More details on the Capitation Payment Mechanisms can be found in the ***ACO REACH Model: Capitation and Advanced Payment Mechanisms*** document.

3.2.2 Claims Payments to Participant, Preferred, and Non-ACO Providers

In addition, beneficiaries aligned to an ACO will continue to receive services not covered by capitation. For those services, the total amount of FFS claims for a given provider type is inclusive of the total claim payment amounts, plus amounts withheld due to sequestration, plus reductions made to provider payments due to participation in the Advanced Payment Option (available to ACO's electing the Professional Option) or other alternative payment arrangements, minus Uncompensated Care Payments to hospitals under the Inpatient Prospective Payment System. This section describes the claims payments to each type of provider.

Payments to Participant Providers

In an ACO that has elected TCC, Participant Providers will continue to receive FFS payment on eligible claims that are exempt from the TCC reduction, generally because the beneficiary opted out of data sharing or the claim contains data related to substance abuse.

In an ACO that has elected PCC, Participant Providers will continue to receive FFS payments for any portion of eligible Primary Care claims billed by Primary Care Specialists that are not subject to PCC reduction, as well as FFS payments on eligible claims that are not for Primary Care Capitation services.

In an ACO that has also elected the Advanced Payment Option (APO), FFS claims reductions associated with APO payments are included in the PY Expenditure. Providers participating in APO will continue to receive FFS payment for any portion of claims not reduced as well as for claims not eligible for APO, such as those for beneficiaries electing to opt-out of claims sharing or those related to substance abuse. In addition, any amounts withheld from FFS provider payment as part of APO will be included in calculation of PY Expenditure.

Payments to Preferred Providers

Because Preferred Providers are not required to participate in capitation and those that do have the option to reduce any portion of claims (1-100%), any unreduced claims for services provided by a Preferred Provider will be included in FFS payments.

Payments to Other Providers

Payments made to non-ACO providers (providers who are not Participant Providers or Preferred Providers and are by definition not participating in the capitation arrangement) are also included in the

PY Expenditure.

Table 7 shows an example calculation of the Total PY Expenditure:

Table 7: PY Expenditure

	PY Expenditure	Global (in dollars)	Professional (in dollars)
12	**Capitation Payments**	$10,000,000	$10,000,000
13	Participant Provider Claim Payments	$1,003,442	$1,003,442
14	Preferred Provider Claim Payments	$33,435,084	$33,435,084
15	Non-ACO Provider Claim Payments	$91,355,457	$91,355,457
16	**Total FFS Payments (Sum Lines 13, 14, and 15)**	$125,793,983	$125,793,983
17	**PY Expenditure (Line 12 + Line 16)**	**$135,793,983**	**$135,793,983**

PY = performance year.

3.2.3 Stop-Loss Reinsurance

Stop-Loss Reinsurance is a risk-mitigation strategy that is optional for all ACOs, regardless of their selected risk arrangement. If chosen, the Stop-Loss arrangement must be selected by an ACO at the beginning of the PY; ACOs may change their election at the beginning of any subsequent PY. Stop-Loss is designed to protect ACOs from financial liability for individual beneficiaries with extremely high, outlying expenditures. For 2025, the Stop-Loss reinsurance option will use a residual approach that considers beneficiary PY Expenditure relative to Predicted Expenditures (PY Expenditure less Predicted Expenditure is referred to as the "Residual Expenditure"). ACO protection from expenditures begins once a beneficiary's Residual Expenditure passes a prospectively developed Attachment Point. Once the beneficiary's Residual Expenditure exceeds the Attachment Point, the amount that is paid out by CMS under the Stop-Loss arrangement will increase as the expenditure incurred by the beneficiary increases according to a set schedule, referred to as Stop-Loss bands.

The Stop-Loss arrangement is comprised of four components: Residual Expenditure, Attachment Point, Payout, and Charge, all of which will be detailed in this section.

Shared Experience between ESRD and AD months

For every beneficiary, Residual Expenditures, Attachment Points, and Charges will be estimated for both the ESRD and AD Benchmarks, and will then be combined together via month-weighted averaging to arrive at a single, beneficiary-level value for each of the above variables. A single payout amount will then be calculated using these beneficiary-level values.

Stop-Loss Residual Expenditure

The Stop-Loss Residual Expenditure is comprised of two components—the PY Expenditure a beneficiary accrues over the course of the PY, and the predicted expenditure for the beneficiary in the PY. In PY2025, the predicted expenditure will be calculated as the PY Ratebook Rate (based on county of residence) for the beneficiary, times the beneficiary risk score, times the total months of enrollment in the PY, times the GAF trend factor:

$$Predicted\ Expenditures = ACO\ Benchmark\ Ratebook\ Rate \times Beneficiary\ Risk\ Score \times Regional\ Baseline\ Adjustment \times Months\ of\ Alignment\ in\ PY \times GAF\ Trend\ Factor$$

Stop-Loss Attachment Point

A Stop-Loss Attachment Point will be prospectively established for the entire model prior to the beginning of the PY. The Attachment Point is calculated by simulating the Stop-Loss model for the Reference Population in each of the three reference years. In each simulation, the Attachment Point is set such that the total model payout for each year is equal to a set percentage of the total spend for the year—for PY2025, CMS will target 2% of total model spend. After the Attachment Points in each base year are determined, the Attachment Point from the most recent RY is trended to PY dollars to arrive at the PY Attachment Point.

Stop-Loss Charge

After the Attachment Points in each of the three reference years are determined, each ACO will have stop-loss simulated for each reference year, using the respective Attachment Point for that year and the beneficiaries that would have been aligned to the ACO in each reference year. The payout percentages (equivalent to the total stop-loss payout divided by the total reference year expenditure) from each base year are then simple-averaged together to arrive at the Average Payout Percentage, which will be multiplied by the risk adjusted, PY-trended reference year expenditure and aligned months to determine the total Stop-Loss Charge.

If CMS determines that an ACO's historical claims experience is insufficient for determining a Stop-Loss Charge in the PY, then the 3-year Average Payout Percentage will instead be calculated based on the historical experience of beneficiaries in the ACO REACH National Reference Population in the counties where the ACO's aligned beneficiaries reside in the PY. CMS will calculate a 3-year average payout percentage and average reference year expenditure for each county using the same 3-year reference period. For counties with insufficient claims experience to determine a historical stop-loss payout percentage and reference year expenditure, CMS will use the cumulative experience of beneficiaries in the state across counties with insufficient claims experience to calculate the Stop-Loss Charge.

Table 8: Stop-Loss Charge Calculation

	Calculation of Stop-Loss Charge	**Value**
1	Average Reference Year Expenditure PBPM, GAF-Adjusted & Trended to PY	$946.97
2	Number of Aligned Eligible Months in PY	132,000
3	ACO Average Risk Score in PY[1]	1.16
4	Total Trended, Risk- and GAF-Adjusted Reference Year Expenditure	$145,000,000
5	3-Year Average Payout Percentage	2.03%
	RY1 Aggregate Payout Percentage	1.96%
	RY2 Aggregate Payout Percentage	2.09%
	RY3 Aggregate Payout Percentage	2.05%
6	**PY Stop-Loss Charge (Line 4 x Line 5)**	**$2,940,000**

1. The Stop-Loss Charge will be calculated using the final PY risk scores for aligned beneficiaries. For quarterly reporting, interim risk scores will be used based on the most recently available risk scores at the time.

ACO = Accountable Care Organization; GSF = Geographic Standardization Factor; PBPM = per beneficiary per month; PY = performance year; RY = Reference Year

Stop-Loss Payout

In 2025, the Stop-Loss arrangement will use a residual approach to the calculation of the Stop-Loss payout. Beneficiaries who accrue enough expenditure such that their Residual Expenditure is greater than the Attachment Point will receive Stop-Loss coverage on the Residual Expenditure beyond the Attachment Point.

For PY2025, CMS will also apply a band schedule to all payouts under the Stop-Loss option. Stop-Loss bands are a progressive coinsurance schedule in which CMMI will cover a certain percentage of the expenditure within the band, increasing as beneficiary spending moves into higher bands.

Table 9: Stop-Loss Payment Schedule

Stop-Loss Band	Start band	End band	Stop-Loss Payout Rate
Band 1	Beneficiary Attachment Point	200% of Beneficiary Attachment Point	80%
Band 2	200% Beneficiary Attachment Point	No Upper Limit	100%

These calculations are progressive and occur only once the beneficiary has passed their Attachment Point. For example, assume an ACO with a beneficiary with $400,000 of Residual Expenditure and a combined AD and ESRD Attachment Point of $150,000. There will be no stop-loss coverage on the first $150,000. The Residual Expenditure between $150,000 and $300,000 will be covered at 80%, meaning CMS will cover $120,000. The remaining Residual Expenditure between $300,000 and $400,000 will be covered at 100%, which means CMS will cover the entire $100,000. This payout schedule is detailed in **Table 10**.

Table 10: Illustration of the Calculation of the Stop-Loss Payout for an Individual Beneficiary

	Calculation of Stop-Loss Payout for Individual Beneficiary	Value
1	Attachment Point	$150,000
2	Predicted Spend	$100,000
3	Actual Spend	$500,000
4	**Residual Expenditure (Line 3 - Line 2)**	**$400,000**
	Below Attachment Point	$150,000
	Risk Band 1 (100% to 200% of AP)	$150,000
	Risk Band 2 (Beyond 200% of AP)	$100,000
5	**Total Payout**	**$220,000**
	Risk Band 1 (80% Payout)	$120,000
	Risk Band 2 (100% Payout)	$100,000

AP = Attachment Point.

Stop-Loss Payout Adjustment Factor

To ensure that the Stop-Loss is budget neutral across the model, in 2025 CMS will apply a retrospective adjustment factor to Stop-loss payouts called the Stop-Loss Neutrality Factor.

At Final Settlement, CMS will calculate the Stop-Loss Neutrality Factor as the following:

$$\textbf{Stop Loss Neutrality Factor} = \frac{\sum_{a=1}^{A} c_a}{\sum_{a=1}^{A} p_a}$$

Where $\sum_{a=1}^{A} c_a$ and $\sum_{a=1}^{A} p_a$ are the sum of all charges and payouts across all ACOs a, respectively. This factor is then directly applied to the Stop-Loss payout of each ACO. This factor is symmetric in its adjustment; when total payouts are greater than total charges for a given PY, the Stop-Loss Neutrality Factor will serve as a reduction factor to bring down payouts to be equivalent to charges at the model level; alternatively, in years where total charges are greater than total payouts, the Stop-Loss Neutrality Factor will amplify stoploss payouts.

Table 11 shows the application of Stop-Loss to the PY Expenditure. The Stop-Loss option is a virtual payment—no actual cash flows are made to/from CMS for Stop-Loss Charges and Payouts. Instead, the charge will be represented as an increase to the PY Expenditure, and the payout will be represented as a reduction to the PY Expenditure.

Table 11: Application of Stop-Loss

	Application of Stop-Loss	Global	Professional
18	PY Expenditure	$135,793,983	$135,793,983
19	Stop-Loss Charge	$2,940,000	$2,940,000
20	Total Stop-Loss Payout	$2,900,000	$2,900,000
21	Stop-Loss Neutrality Factor	0.93	0.93
22	Adjusted Stop-Loss Payout	$2,697,000	$2,697,000
23	Net Impact of Stop-Loss (Line 22-Line 19)	($243,000)	($243,000)
24	**PY Expenditure after Stop-Loss (Line 18 + Line 23)**	**$135,550,983**	**$135,550,983**

PY = performance year.

3.3 Gross Savings/Losses and Shared Savings/Losses

Gross Savings/Losses are calculated by subtracting an ACO's PY Expenditure, adjusted for Stop-Loss, from its Total Benchmark Expenditure. CMS may also make adjustments to prevent duplication in Shared Savings payments for beneficiaries participating in other Shared Savings programs or initiatives. In PY2025, CMS will exclude the respite G-codes and infrastructure payments attributable to the CMS Guiding an Improved Dementia Experience (GUIDE) Model from the performance period total expenditure amount. The GUIDE care management G-codes will be included in performance period expenditures. At Preliminary and Final Settlement, CMS will also reduce any GUIDE duplicative HCPCS billed for overlapping beneficiaries from the PY expenditure to arrive at the final Gross Savings/Losses

figure.[2] Gross Savings/Losses will then have risk corridors applied to arrive at Shared Savings/Losses.

Under both Global and Professional risk arrangements, Risk Corridors (bands) are applied to Gross Savings/Losses to mitigate the risk of large savings or losses to CMS and participants. As absolute values of the Gross Savings/Losses increase, the ACO will retain a progressively smaller portion of the total savings or will be responsible for a progressively smaller portion of the total losses.

3.3.1 Risk Corridors: Global Option

Table 12 shows the Risk Corridors applied to an ACO that has selected the Global Option.

Table 12: Percentage Savings/Losses, Global Option

Corridor	Corridor 1	Corridor 2	Corridor 3	Corridor 4
Percent of Benchmark*	Up to 25%	25%–35%	35%–50%	More than 50%
Savings/Losses Rate	100%	50%	25%	10%

*For all aligned beneficiaries after the application of the Discount, Quality Withhold and Quality Withhold earn back, and HEBA.

Under the Global Option, an ACO will be responsible for a higher portion of Shared Losses but will also retain a higher portion of Shared Savings. **Table 13** shows an example of the application of Risk Corridors in the calculation of Shared Savings/Losses.

[2] For detailed methodology of GUIDE model payments, refer to the ***GUIDE Model: Payment Methodology Paper*** document.

Table 13: Calculation of Shared Savings/Losses, Global Option

	Calculation of Gross Savings (Losses)	**Global**
23	PY Expenditure after Stop-Loss	$135,753,983
24	Benchmark Expenditure After Discount, Earned Quality and HEBA (Line 13)	$146,100,000
25	**Gross Savings (Losses) (Line 24–Line 23)**	**$10,346,017**
	Calculation of Shared Savings (Losses)	**Global**
26	Savings (Losses) Retained by ACO	$10,346,017
	Retained Savings (Losses) in Corridor 1	*$10,346,017*
	Retained Savings (Losses) in Corridor 2	*$-*
	Retained Savings (Losses) in Corridor 3	*$-*
	Retained Savings (Losses) in Corridor 4	*$-*
27	Sequestration Amount (2% x Line 27)	$206,920
28	Savings (Losses) Retained by ACO, net of Sequestration (Line 28–Line 29)	$10,139,097

CMS = Centers for Medicare & Medicaid Services; ACO = Accountable Care Organization; PY = performance year.

In this example, the ACO had Gross Savings of $10,346,017. Because the Shared Savings for the period is entirely within the first corridor, the ACO's Shared Savings for the year will be 100 percent of their Gross Savings.

3.3.2 Risk Corridors: Professional Option

Table 14 shows the Risk Corridors applied to an ACO that has selected the Professional Option.

Table 14: Percentage Savings/Losses, Professional Option

Corridor	**Corridor 1**	**Corridor 2**	**Corridor 3**	**Corridor 4**
Percent of Benchmark*	Up to 5%	5% to 10%	10 to 15%	More than 15%
Savings/Losses Rate	50%	35%	15%	5%

*For all aligned beneficiaries after the application of the quality withhold and quality withhold earn back.

Under the Professional Option, an ACO will be responsible for a lower portion of Shared Losses but will also retain a lower portion of Shared Savings. **Table 15** shows the same example of the application of Risk Corridors in the calculation of Shared Savings/Losses, this time for an ACO participating in the Professional Option.

Table 15: Calculation of Shared Savings/Losses, Professional Option

	Calculation of Gross Savings (Losses)	Professional
23	PY Expenditure after Stop-Loss	$135,753,983
24	Benchmark Expenditure After Discount, Earned Quality and HEBA (Line 13)	$150,600,000
25	**Gross Savings (Losses) (Line 24–Line 23)**	**$14,846,017**
	Calculation of Shared Savings (Losses)	**Professional**
26	Savings (Losses) Retained by ACO	$6,325,606
	Retained Savings (Losses) in Corridor 1	$3,765,000
	Retained Savings (Losses) in Corridor 2	*$2,560,606*
	Retained Savings (Losses) in Corridor 3	*$-*
	Retained Savings (Losses) in Corridor 4	*$-*
27	Sequestration Amount (2% x Line 27)	$296,920
28	Savings (Losses) Retained by ACO, net of Sequestration (Line 28–Line 29)	$6,028,686

CMS = Centers for Medicare & Medicaid Services; ACO = Accountable Care Organization; PY = performance year.

In this example, the ACO had Gross Savings of $14,846,017. The ACO's retained savings for the year (pre-sequestration) will be calculated as follows:

$$0.5\ (0.05\ \times \$150{,}600{,}000\ ) + 0.35\ (0.0486\ \times \$150{,}600{,}000\ ) = \$6{,}028{,}686$$

4.0 Settlement and Calculation of Total Monies Owed

After the calculation of Shared Savings/Losses is completed, CMS will calculate the Total Monies Owed. For PY2025, CMS will calculate and apply Total Monies Owed at both Provisional and Final Settlement. In the calculation of Total Monies Owed at Provisional Settlement for PY2025 (which begins in CY2026), CMS will adjust the preliminary Shared Savings/Losses amount by the following:

1. Under (over) payments from capitation. Differences in final beneficiary alignment and risk scores, shifts in utilization patterns, and claims processing errors may lead to significant over or under payments throughout the PY. Any (over) payments not adjusted for throughout the PY will be adjusted for here. For more information on the calculation of capitation payments and year-end payment adjustments, see ***ACO REACH Model: Capitation and Advanced Payment Mechanisms*** paper.

2. Adjustments for ACOs participating in EPCC and/or APO. At the conclusion of the PY, CMS will recoup the Enhanced PCC Payment Amount in full. For ACOs also electing the APO, the APO Payment will be reconciled against actual claims reductions for the year. If the reduction in FFS claims was greater than the APO payment made, the difference will be paid to the ACO. If the reduction in FFS claims was less than the APO payment made, the difference will be recouped by CMS.

At Final Settlement, CMS will adjust the Final Shared Savings/Losses amount by the following:

1. Money already distributed to (received from) the ACO at the time of Provisional Settlement. At the time of Provisional Settlement, incomplete claims, alignment, and quality data will be used in the calculation of Shared Savings/Losses and Total Monies owed. As such, the estimate of Provisional Shared Savings/Losses and Total Monies owed may be materially different than the

Final Shared Savings/Losses amount. Consequently, Final Shared Savings/Losses will be settled as if it were an "adjustment" to the amount already paid out to, or received from, the ACO at the time of Provisional Settlement.

2. Contributions from the High Performers Pool incentive, if applicable. For more information on the calculation of the High Performers Pool, see ***ACO REACH Model: Quality Measurement Methodology***.

Table 16 shows an example of the calculation of Total Monies Owed.

Table 16: Calculation of Total Monies Owed

	Shared Savings Adjustments	**Value**
1	Provisional Settlement Shared Savings (Losses)	$4,456,540
2	Final Settlement Shared Savings (Losses)	7,930,727
3	**Shared Savings (Losses) Owed (Line 2–Line 1)**	**$3,474,187**
Additional Adjustments		
4	Under (Over) Payments from Payment Arrangements	$160,700
	Capitation Under (Over) Payment	$160,700
	Enhanced PCC Repayment[1]	-
	APO Adjustment[1]	-
5	High-Performers Pool Incentive[2]	$100,000
6	**Adjustments Owed**	$560,700
7	**Total Monies Owed (Line 3 + Line 6)**	**$4,034,887**

1. The example in Table 16 is that of an ACO electing the TCC Capitation Mechanism. As a result, no adjustments need be made for Enhanced PCC or APO.
2. For more information on the calculation of the High-Performers Pool payout, see *ACO REACH Quality Measurement Methodology* paper.

APO = Advanced Payment Option; PCC = Primary Care Capitation.

5.0 Settlement Adjustment for Late Fee Reductions

After the calculation of Total Monies Owed at Final Financial Settlement, CMS will calculate a Settlement Adjustment to account for any claims that were reduced by the claims processing systems after the run-out for the performance year. CMS shall calculate the Late Fee Reduction Adjustment for each ACO as an adjustment to the Capitation or Advanced Payment Mechanism elected by the ACO in that PY. For ACOs that elect TCC or APO, CMS shall calculate the Late Fee Reduction Adjustment as the difference between the amount of TCC / APO Fee Reductions based on March 31 of the subsequent PY, and a claims run-out period. For ACOs that elect PCC, CMS shall calculate the Late Fee Reduction as the difference between the PCC Fee Reductions based on March 31 of the subsequent PY, and a claims run-out period that is multiplied by the marginal risk sharing rate elected by the ACO, i.e., Global or Professional. If the absolute value of the net amount of Late Fee Reductions calculated is greater than or equal to $1,000, then CMS shall calculate a new component of Other Monies Owed to adjust Final Financial Settlement.

CMS shall calculate the Late Fee Reduction, at most, two times, and will be contingent on the $1,000 threshold. The first time will occur one year after Final Financial Settlement for a PY, coinciding with the issuance of the subsequent PY's Final Financial Settlement. The second time will occur two years after the Final Financial Settlement for a PY, coinciding with the subsequent the Final Financial

Settlement for PY+2. For PY 2025 and later model years, this adjustment shall be applied to all ACOs.

Table 17: Tentative Timing of First and Second Post-Settlement Adjustments

Performance Year	First Settlement Adjustment		Second Settlement Adjustment	
	Timing of adjustment	Anticipated run-out	Timing of adjustment	Anticipated run-out
2022	Fall 2024	01/01/2022 – 05/31/2024 ~29 months	Fall 2025	01/01/2022 – 05/31/2025 ~ 41 months
2023	Fall 2025	01/01/2023 – 05/31/2025 ~29 months	Fall 2026	01/01/2023 – 05/31/2026 ~41 months
2024	Fall 2026	01/01/2024 – 05/31/2026 ~29 months	Fall 2027	01/01/2024 – 05/31/2027 ~41 months
2025	Fall 2027	01/01/2025 – 05/31/2027 ~29 months	Fall 2028	01/01/2025 – 05/31/2028 ~41 months
2026	Fall 2028	01/01/2026 – 05/31/2028 ~29 months	Fall 2029	01/01/2026 – 05/31/2029 ~41 months

6.0 Financial Guarantee

To ensure CMS is able to recoup potential Shared Losses, Total Monies Owed, and accrued interest, ACOs are required to hold a financial guarantee, which must be updated annually and will be held at longest through 24 months following the end of the ACO's final PY. ACOs may choose the form of securing the financial guarantee between funds placed in escrow, a line of credit, or a surety bond.

The amount required for the Financial Guarantee associated with a given Performance Year will depend on the risk arrangement and payment mechanism that the ACO has elected. **Table 18** shows the Performance Year guarantee required for an ACO as a percentage of its Benchmark, based on its elected risk arrangement and capitation mechanism:

Table 18: Financial Guarantee Requirements as Percentage of Benchmark

Risk Arrangement	Primary Care Capitation Payment	Primary Care Capitation Payment + Enhanced Primary Care Capitation and/or Advanced Payment	Total Care Capitation Payment
Professional	2.5%	For PY 2025: 4.0 % For PY 2026: 3.75 %	N/A
Global	3.0%	For PY 2025: 4.0 % For PY S2026: 3.75 %	4.0%

The size of the guarantee that an ACO has secured must correspond to the number of unreconciled performance years at the time that the guarantee is furnished. For example, in March of the Performance Year, an ACO would need to have a Financial Guarantee in place that reflects the amount

due for that ongoing Performance Year as well as the amount due for the prior Performance Year, given the latter will not be reconciled until Final Settlement later that August/September.

However, an exception will be made if an ACO elects Provisional Settlement and pays any associated Shared Losses for the prior Performance Year before the deadline passes to furnish the ongoing Performance Year's Financial Guarantee. In such an instance, the ACO need only have its guarantee reflect the amount due for the ongoing Performance Year.

Take the example of an ACO that has a Financial Guarantee in place for PY2024 that totals $5 million, and an amount due for PY2025 that totals $6 million. If the ACO elects Provisional Settlement for PY2024 and pays any associated Shared Losses by the deadline to supply the PY2025 Financial Guarantee, then the total amount due would be limited to just the $6 million due for PY2025. If the Financial Guarantee amount decreased from the prior Performance Year (e.g. if it was $4 million for PY2025), if Provisional Shared Losses are paid, the ACO would have the choice to reduce their secured Financial Guarantee to the lower amount of the ongoing Performance Year.

In this same example, if the ACO did not elect Provisional Settlement or did not pay any associated Shared Losses by the Financial Guarantee deadline, then the amount due by that deadline would be $11 million. In this instance, upon Final Settlement for PY2024 in August/September of 2025, if the ACO successfully paid all Total Monies Owed, only then could the ACO update their Financial Guarantee to reflect the PY2025 amount of $6 million.

If an ACO does not furnish its due Financial Guarantee, in accordance with the above conditions, by the deadline communicated by CMS, CMS will begin withholding capitation payments immediately. Additionally, if CMS must draw on a Financial Guarantee due to non-payment of Shared Losses, Total Monies Owed, and/or accrued interest, the ACO has 60 days from the date that the Financial Guarantee is drawn by CMS to replenish their guarantee. If the ACO has not replenished the guarantee in the allotted 60-day period, CMS will begin withholding capitation payments and may terminate the ACO's participation from the model.

Appendix A: Long-Form Settlement Calculation

Table A.1 shows the entire Final Settlement process for the same ACO for both Professional and Global Risk Arrangements.

Table A.1: Full Settlement Calculation

		Global	Professional
Benchmark Expenditure with Initial Adjustments		**(in dollars)**	**(in dollars)**
1	Benchmark Expenditure for All Aligned Beneficiaries[1]	$150,000,000	$150,000,000
Calculation of Discount Rate		**Global**	**Professional**
2	Discount Rate	3.5%	N/A
3	Total Discount	$5,250,000	
4	**Benchmark Expenditure for All Aligned Beneficiaries After Discount (Line 1–Line 3)**	**$144,750,000**	**$150,000,000**
Calculation of Earned Quality Withhold		**Global**	**Professional**
5	Quality Withhold (0.02 x Line 1)	$3,000,000	$3,000,000
6	Quality Score	95%	95%
7	**Earned Quality Withhold (Line 5 x Line 6)**	**$2,850,000**	**$2,850,000**
8	Net Impact of Quality Withhold (Line 5 – Line 7)	$150,000	$150,000
9	**Benchmark Expenditure for All Aligned Beneficiaries After Discount and Earned Quality (Line 4–Line 8)**	**$144,600,000**	**$149,850,000**
Application of Health Equity Benchmark Adjustment		**Global**	**Professional**
10	Health Equity Benchmark Adjustment	$750,000	$750,000
11	**Benchmark Expenditure for all Aligned Beneficiaries After Discount, Earned Quality, and HEBA (Line 9 + Line 10)**	**$145,350,000**	**$150,600,000**
PY Expenditure		**Global**	**Professional**
12	Capitation Payments	$10,000,000	$10,000,000
13	Participant Provider Claim Payments	$1,003,442	$1,003,442
14	Preferred Provider Claim Payments	$33,435,084	$33,435,084
15	Non-ACO Provider Claims	$91,355,457	$91,355,457
16	**Total FFS Payments (Sum Lines 13:15)**	$125,793,983	$125,793,983
17	**PY Expenditure (Line 12 + Line 16)**	**$135,793,983**	**$135,793,983**
Application of Stop-Loss		**Global**	**Professional**
18	PY Expenditure	$135,793,983	$135,793,983
19	Stop-Loss Charge	$2,940,000	$2,940,000
20	Total Stop-Loss Payout	$2,900,000	$2,900,000
21	Stop-Loss Neutrality Factor	0.93	0.93
22	Adjusted Stop-Loss Payout	$2,697,000	$2,697,000
23	Net Impact of Stop-Loss (Line 22-Line 19)	($243,000)	($243,000)
24	**PY Expenditure after Stop-Loss (Line 18 + Line 23)**	**$135,550,983**	**$135,550,983**

	Calculation of Gross Savings (Losses)	Global	Professional
25	PY Expenditure after Stop-Loss	$135,550,983	$135,753,983
26	Benchmark Expenditure After Discount, Earned Quality and HEBA (Line 11)	$145,350,000	$150,600,000
27	**Gross Savings (Losses) (Line 26–Line 25)**	**$9,799,017**	**$14,846,017**
	Calculation of Shared Savings (Losses)	**Global**	**Professional**
28	Savings (Losses) Retained by ACO	$9,799,017	$6,325,606
	Retained Savings (Losses) in Corridor 1	*$9,799,017*	$3,765,000
	Retained Savings (Losses) in Corridor 2	*$-*	*$2,560,606*
	Retained Savings (Losses) in Corridor 3	*$-*	*$-*
	Retained Savings (Losses) in Corridor 4	*$-*	*$-*
29	Sequestration Amount (2% x Line 28)	$195,980	$126,512
30	Savings (Losses) Retained by ACO, net of Sequestration (Line 28–Line 29)	$9,603,037	$6,199,094

1. Here, the Benchmark Expenditure for All Aligned Beneficiaries includes adjustments for the Retrospective Trend, where applicable.
ACO = Accountable Care Organization; FFS = fee for service; PY = performance year.