



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

Finance-Focused

Frequently Asked Questions

Version 1

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General Questions

1. Q: What risk-sharing options does the ACO Realizing Equity, Access, and Community Health (REACH) Model offer?

CMS will test two voluntary risk-sharing options in the ACO REACH Model:

1. Professional, a lower-risk option (50% Shared Savings/Shared Losses (SS/SL)); and
2. Global, a full risk option (100% SS/SL).

2. Q: Are REACH Accountable Care Organizations (ACOs) required to participate in Primary Care Capitation (PCC), Total Care Capitation (TCC), or Advanced Payments?

Yes, Standard, New Entrant, and High Needs Population ACOs are required to participate in PCC or TCC, depending on which risk-sharing option they select.

- ACOs who select the Professional risk option must elect PCC.
- ACOs who select the Global risk option must choose either PCC or TCC.
- ACOs in either risk option (Professional or Global) that select PCC may also select the Advanced Payment Option.

3. Q: Why is CMS requiring the Capitation Payment Mechanisms of PCC and TCC for REACH ACOs with Participant Providers or Preferred Providers as part of this model?

Implementation of Capitation Payment Mechanisms is required by model participants. These mechanisms provide ACOs with an opportunity to administer the flow of funds while they manage total cost of care. By giving ACOs the funds to pay for services, ACOs will have greater leverage and increased flexibilities to enter into downstream payment arrangements that can incent providers and suppliers to work together and coordinate care for a defined set of aligned beneficiaries, with the potential to generate better outcomes and lower costs.

In recognition of the challenges posed by coronavirus disease 2019, PCC was optional for Performance Year 2021 (PY2021). Starting in PY2022, Participant Providers must have some portion of their eligible claims reduced via PCC, with a floor of at least 5 percent claims reduction. This floor will increase to 10 percent for PY2023, 20 percent for PY2024, and 100 percent for PY2025 and PY2026. Including Preferred Providers in PCC is optional for all PYs of the model. This policy applies to all ACOs regardless of start date.

4. Q: What are the differences between the Global and Professional Options?

An ACO can choose either option when entering ACO REACH. The table below highlights the differences between the options.

Comparison of the Professional and Global Options

| | Policy | Professional | Global |
|---|------------------|------------------------|-------------------------|
| 1 | Risk Arrangement | 50% of savings/losses. | 100% of savings/losses. |

| | Policy | Professional | Global |
|---|-------------------------------|---|--|
| 2 | Capitation Option | PCC only (generally set at 7% of the PY Benchmark). | Both options available: PCC or TCC |
| 3 | Discount and Quality Withhold | <ul style="list-style-type: none"> • No discount • 5% Quality Withhold in PY2021/2022 • 2% Quality Withhold in PY2023-PY2026 | <ul style="list-style-type: none"> • Discount of 2% in PY2021/PY2022 (increasing to 3% in PY2023/PY2024, and 3.5% in PY2025/PY2026) • 5% Quality Withhold in PY2021/2022 • 2% Quality Withhold in PY2023-PY2026 |

5. What data will CMS provide, including benchmark and historical data, to organizations during the PYs?

CMS plans to make several types of Medicare data available to ACOs participating in ACO REACH. During the Performance Period, each REACH ACO may request the minimum necessary data for their aligned beneficiaries to develop and implement care coordination and quality improvement activities. The data may be used only consistent with the terms of the applicable CMS agreements, including the Participation Agreement, Participant Provider/Preferred Provider Certification forms and Data Use Agreements (DUAs).

CMS will provide those ACOs the opportunity to request detailed claims data. Such claims data will include individually identifiable Claim and Claim Line Feed (CCLF) reports for services furnished by Medicare-enrolled providers and suppliers to aligned beneficiaries during the PY, respectively, as well as historical CCLF files. The historical CCLF files provided at the beginning of a PY will capture a 36-month lookback of claims for newly aligned beneficiaries.

CMS will also provide ACOs, upon request, operational reports on a regular basis. These reports may include but will not be limited to Quarterly and Annual Utilization; Monthly Expenditures; Beneficiary Data Sharing Preferences; Monthly Claims Lag; and Beneficiary Alignment reports.

Finally, CMS will also provide quarterly benchmark reports (QBRs) to ACOs to enable them to monitor their financial performance throughout the PY. The QBRs will not contain individually identifiable data. The same design and data source used to generate the QBRs will also be used for the interim and final reconciliation report.

Benchmarking

6. Q: How is the PY Benchmark calculated?

The benchmark will be developed by using all or the latter three of the following five steps: (1) calculating the ACO’s historical baseline spending for its aligned beneficiary population; (2) trending the historical baseline expenditures forward based on an adjusted version of the U.S. Per Capita Cost (USPCC) growth trend; (3) blending the historical baseline expenditures with regional expenditures using

an adjusted Medicare Advantage Rate Book (referred to as the ACO REACH/KCC Rate Book); (4) making adjustments to the blended expenditures to account for the risk of the aligned beneficiaries; and (5) applying a discount for ACOs that selected the Global Option and withholding a portion of the benchmark “at risk” subject to the ACO’s performance on quality measures. Please consult the Financial Operating Guide Overview paper available on our website for more details. The Financial Operating Guide Overview applies to Standard, New Entrant, and High-Needs Population based ACOs.

7. Q: Why is a discount applied to the benchmark for REACH ACOs that select the Global Option? How is it calculated?

The discount is an adjustment incorporated into the benchmark for ACOs in the Global Option. As ACOs in the Global Option are eligible to retain up to 100% of gross savings, this discount will provide the primary mechanism for CMS to obtain savings from the ACOs participating in this option. CMS will apply the discount to the trended, regionally blended, risk adjusted benchmark. This discount will be set at 2% of the benchmark for PY2021 and PY2022 and increased to 3% for PY2023/PY2024 and 3.5% for PY2025/PY2026, requiring continuous improvement from ACOs in the Global Option. A discount is not applied for the Professional Option.

| PY | Global discount | Professional discount |
|-----------|------------------------|------------------------------|
| 2021 | 2% | N/A |
| 2022 | 2% | N/A |
| 2023 | 3% | N/A |
| 2024 | 3% | N/A |
| 2025 | 3.5% | N/A |
| 2026 | 3.5% | N/A |

8. Q: What is included in the calculation of total cost of care?

All covered expenditures incurred by Medicare, including capitation payments, non-claims-based payments, and FFS claims paid, on behalf of aligned beneficiaries are included as part of total cost of care of the ACO for the relevant PY. This includes all outpatient services, such as primary care and specialist services, skilled nursing facility (SNF) services, Emergency Room (ER) and hospital visits and in-patient services. For beneficiaries who have elected hospice, all care, whether for hospice or non-hospice services, will be included. Note, the Advanced Alternative Payment Models (APM) 5% incentive payment (discussed at <https://qpp.cms.gov/apms/advanced-apms>) will not be included in the Benchmark or counted as part of the Total Cost of Care for an ACO aligned population.

9. Q: Will the benchmark include Medicare Part D prescription drug spending?

The ACO REACH benchmarks will not include Medicare Part D prescription drug spending. However, CMS remains interested in exploring ways in which ACOs can support beneficiaries in their management of and adherence to prescription drugs.

10. Q: Will non-claims-based payments be included as expenditures?

Non-claims-based payments from CMS will be included in the PY Benchmark (and PY expenditures) when they take the place of claims that would have otherwise been paid through FFS. This will include

Capitation Payments or Advanced Payments in ACO REACH. Non-claims-based payments that are independent of claims, such as the infrastructure payments offered in the Next Generation ACO (NGACO) model or Enhanced PCC Payments, will not be included in the benchmark or expenditures.

11. Q: What is the patient financial responsibility for cost sharing in ACO REACH? Do the capitation payment mechanisms or Advanced Payment change this?

ACO REACH does not change cost-sharing responsibility of beneficiaries or Supplemental Payers (regardless of the ACO type, how providers are paid or whether the provider is participating in capitation or Advanced Payment).

CMS is including an optional beneficiary engagement incentive under which a REACH ACO may (but is not required to) enter into a cost sharing support arrangement with its Participant Providers and Preferred Providers, pursuant to which the Participant Providers and Preferred Providers would not collect beneficiary cost sharing amounts (in whole or in part) from categories of aligned beneficiaries and for categories of Part B services (excluding prescription drugs and durable medical equipment) identified by the ACO. For example, a High Needs Population ACO may decide to limit cost sharing responsibilities for certain high needs beneficiaries who need to visit providers on a monthly basis in order to decrease hospital utilization. This would be an optional arrangement that an ACO can pursue.

12. Q: How will CMS calculate the maximum upward and downward adjustment that occurs to the financial benchmark each year when combining baseline and regional expenditures?

CMS will calculate a maximum upward and downward adjustment in the benchmarking methodology that includes a historical baseline component (i.e., Standard ACOs in PY2023). When combining the baseline with the regional expenditures, we will limit the overall upward adjustment from incorporating the regional expenditures to a flat dollar amount equal to five percent of the adjusted FFS United States Per Capita Cost (USPCC) for the PY, and the overall downward adjustment to a flat dollar amount equal to two percent of the adjusted FFS USPCC.

The weighting for the blending of the baseline and regional expenditures will function as follows:

| | PY2021 | PY2022 | PY2023 | PY2024 | PY2025 & PY2026 |
|--|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| Composition of the PY Benchmark | 65% Historical Baseline Expenditures | 65% Historical Baseline Expenditures | 60% Historical Baseline Expenditures | 55% Historical Baseline Expenditures | 50% Historical Baseline Expenditures |
| | 35% Regional Expenditures | 35% Regional Expenditures | 40% Regional Expenditures | 45% Regional Expenditures | 50% Regional Expenditures |

13. Q: Are there any methodological differences for REACH ACOs that join the model in January 2023 vs. those that participated in PY2021 and / or PY2022?

Regardless of the start date for an ACO, the financial methodology will be the same within a given PY. Features such as the baseline period, blend weighting, and ACO REACH/KCC Rate Book will be applied in the same manner for all ACOs in each PY.

14. Q: How will the effects of coronavirus disease 2019 in calendar year 2020 impact benchmarking for 2021 and future PYs?

The 2020 calendar year is not included in the fixed baseline period used to develop benchmarks for Standard ACOs. It was also not included in the years used to develop the ACO REACH/KCC Rate Book for PY2021 or PY2022 as the COVID-19 public health emergency continued to unfold. However, CMS currently intends to use CY2019, CY2020, and CY2021 to develop the ACO REACH/KCC Rate Book for PY2023, in line with the intended use of three recent historical years (with one gap year for runout). CMS analysis indicates that county-level variability in CY2020 and CY2021 is generally consistent with levels of variability in prior calendar years, suggesting that it is more appropriate to use these more recent historical years in the Rate Book.

In addition, regarding risk adjustment impacts, CMS anticipates that the retrospective normalization factor should help account for any changes in coding practices driven by COVID-19, but we will continue to monitor the effects of the pandemic and consider methodological updates as new information becomes available.

15. Q: A number of benchmarking elements (such as beneficiary alignment, risk score normalization, the Coding Intensity Factor (CIF) and the ACO REACH/KCC Rate Book) make use of the ACO REACH National Reference Population. Which beneficiaries are included in this population and how is it different from the FFS population?

The ACO REACH National Reference Population consists of the subset of FFS beneficiaries that meet the eligibility criteria for the Model. The following criteria must be met for a beneficiary month to be eligible:

- The beneficiary is alive on the first day of the month.
- The beneficiary is enrolled in Part A.
- The beneficiary is enrolled in Part B.
- The beneficiary is enrolled in Traditional FFS Medicare (e.g., not enrolled in MA).
- The beneficiary has Medicare listed as the primary payer.
- The beneficiary is a U.S. resident.

Only beneficiaries that meet these criteria can be aligned to ACO REACH, so the same criteria are applied as part of benchmarking in order to generate consistent and accurate benchmarks.

16. Q: How will the Health Equity Benchmark Adjustment impact benchmarking calculations? What is this adjustment intended to address?

ACO REACH will apply a beneficiary-level benchmark adjustment that will increase the benchmark for those ACOs serving higher proportions of underserved beneficiaries. CMS will stratify all aligned beneficiaries using a composite measure that incorporates a combination of Area Deprivation Index and Dual Medicaid Status. Beneficiaries in the top decile on this measure will receive a \$30 PBPM upward adjustment towards the ACO's benchmark, while beneficiaries in the bottom five deciles will receive a smaller \$6 PBPM downward adjustment, allowing a roughly budget neutral impact. This adjustment will not impact other benchmark calculations, and will be finalized after alignment data for the PY is complete and applied at Final Financial Settlement.

The adjustment is intended to mitigate the disincentive for ACOs to serve historically underserved communities by accounting for historically suppressed spending levels for these populations. It is a critical step towards enabling ACOs to serve underserved communities in a manner that reflects their health needs.

ACO REACH/KCC Rate Book

17. Will ACO REACH continue to use the same baseline years (2017, 2018, and 2019) as were used in the GPDC Model?

Yes, for ACOs with the Standard ACO benchmarking methodology, the historical baseline years will be 2017, 2018, and 2019.

For ACOs with the New Entrant or High Needs Population ACO methodology, for PY2023 and PY2024 only the Rate Book is used in benchmarking, without incorporation of the ACO's historical expenditures. However, for PY2025 and PY2026, benchmarks will follow the Standard ACO approach, but using a different baseline period that makes use of the ACO's historical experience within the model (up to three recent PYs, from CY2021 to CY2024, based on whether the ACO has experience within the model).

18. What years are used to construct the ACO REACH/KCC Rate Book? Is the Rate Book based on a fixed baseline period (2017 - 2019) or does that adjust with each PY?

The ACO REACH/KCC Rate Book uses a three-year baseline period to construct the county relative cost indices. The third and most recent year from this baseline period is used to construct the historical National Conversion Factor, which is trended to the PY using an adjusted version of the FFS USPPC trend published by the CMS Office of the Actuary (OACT). This baseline period is not fixed; it will roll forward based on the PY. However, before each PY, CMS evaluates the baseline period to ensure that is appropriate for establishing county rates for a given PY. Final decisions on BYs will be communicated prior to a given PY with the publication of the ACO REACH/KCC Rate Book. The proposed base years for the ACO REACH/KCC Rate Book construction are as follows:

| Performance Year (PY) | Calendar year | ACO REACH/KCC Rate Book base years i.e. data used for ACO REACH/KCC Rate Book development |
|------------------------------|----------------------|---|
| 1 | 2021 | 2017, 2018, 2019 |
| 2 | 2022 | 2017, 2018, 2019 |
| 3 | 2023 | 2019, 2020, 2021 |
| 4 | 2024 | 2020, 2021, 2022 |
| 5 | 2025 | 2021, 2022, 2023 |
| 6 | 2026 | 2022, 2023, 2024 |

19. Q: How do the county rates distinguish between beneficiaries with different eligibility categories and/or different health risks?

The county rates in the ACO REACH/KCC Rate Book are calculated on a risk-standardized basis for the average beneficiary in each county. Separate county rates are provided for Aged & Disabled (A&D) and End-Stage Renal Disease (ESRD) eligibility categories based on precedents in Medicare Advantage and

other CMS programs. Within the A&D and ESRD rates, any additional differences in beneficiary eligibility categories or health risk are reflected in the application of risk adjustment to the county rates; beneficiaries will all have the same county rates, however, they will have different risk scores and thus will contribute different amounts to the benchmark and payment.

Capitation

20. Q: What does CMS mean when indicating that the ACO will be responsible for paying downstream providers? Will all providers and suppliers still bill Medicare and receive payment under current models?

CMS will be making capitated monthly payments directly to each ACO according to the ACO’s PCC or TCC election. Each ACO will be required to have its own payment arrangements with its Participant Providers and Preferred Providers participating in capitation. ACOs must have payment arrangements with Participant Providers and Preferred Providers for any payments subject to capitation or advanced payment. All other claims submitted that are not subject to reductions for capitation or advanced payment will continue to be paid in full by CMS via the FFS claims processing system. Note that all providers (even those participating in the Capitation Payment Mechanism or Advanced Payment Option) are still required to submit claims to CMS for services provided to beneficiaries.

Participant Providers and Preferred Providers receive payments for Part A and Part B services from the REACH ACO and/or CMS based on their contractual arrangement with the ACO. The payments from the ACO may include sub-capitation and other value-based payments. All Participant Providers must participate in the Capitation Payment Mechanism selected by the ACO. Preferred Providers have the option to participate in the Capitation Payment Mechanism. Both Participant and Preferred Providers also have the option to participate in the Advanced Payment Option if the ACO selects Primary Care Capitation.

21. Q: How are ACOs paid in the ACO REACH Model?

Monthly capitated payments will be paid to REACH ACOs. The prospective payments available to ACOs is contingent on their risk-sharing election. If the ACO elects the Professional Risk Option, the ACO must elect Primary Care Capitation, and may optionally chose to receive and Enhanced Primary Care Capitation and/or Advanced Payment Option. If the ACO elects the Global Risk Option, the ACO may elect the above choice set or the ACO can elect Total Care Capitation. If the ACO elects Total Care Capitation, the ACO will receive a 20% increase to their first calendar month’s Total Care Capitation payment (Advanced Total Care Capitation), and a 20% decrease to their last calendar month’s Total Care Capitation. The ACO may only choose one Capitation Payment Mechanism, i.e. PCC or TCC. The payment options are summarized below.

| Mandatory | Optional |
|--|---|
| Base Primary Care Capitation | <ul style="list-style-type: none"> Enhanced Primary Care Capitation Advanced Payment Option |
| Total Care Capitation <ul style="list-style-type: none"> Advanced Total Care Capitation | N/A |

Base PCC, TCC, and APO are all elected at the ACO-level, and in-turn, the ACO must negotiate with their Participant Providers and Preferred Providers to determine the percentage reduction the provider will elect. The percentage reduction elected by the provider will be applied to the Otherwise Payable Amount, i.e. what Medicare would have paid in the absence of the model for the service, and any difference will be paid out to the provider. All Participant Providers and Preferred Providers will continue to submit claims to the Medicare payment systems. In contrast to Base PCC, TCC, and APO, which are based on estimates of spending using a lookback period, Enhanced PCC is elected by the ACO.

Base PCC is intended to cover the primary care based services furnished to aligned beneficiaries by Participant Providers and Preferred Providers participating in PCC.

TCC encompasses all Medicare Part A and B services furnished to aligned beneficiaries by Participant Providers and Preferred Providers who have agreed to participate. Under TCC, CMS will pay the ACO 100% of the PY Benchmark (based on Part A and B services) minus a percentage for services expected to be billed by providers and suppliers not participating in TCC for the care of the aligned beneficiaries based on historical experience. Participant Providers would receive 100% of their Medicare payments from the ACO. Preferred Providers who have elected to participate in TCC would receive between 1-100% of their payments through the ACO; the remainder would be paid through the FFS claims processing system. All Participant Providers and Preferred Providers will continue to submit claims to the Medicare payment systems.

PCC and TCC payments made to each ACO will be factored into shared savings/shared losses calculations.

The Advanced Payment Option (APO) is an optional payment mechanism only available to ACOs that select PCC and functions like the population-based payments available in the Next Generation Accountable Care Organization (NGACO) Model. APO payments are a cash flow mechanism under which CMS prospectively pays ACOs the estimated value of the reduction in Medicare payments for non-primary care claims submitted by Participant Providers and Preferred Providers who have agreed to an FFS claims reduction. ACOs can negotiate with their Participant Providers and Preferred Providers to enter into an arrangement under which they agree to an FFS Medicare claims reduction (between 1 – 100% of FFS claims). In exchange, CMS reduces FFS claims payments made to these providers and suppliers through the Medicare payment systems and pays the ACO a prospective per-beneficiary-per-month (PBPM) payment representing the estimated value of the difference between the reduced FFS claims and the full FFS claims payment amount. Unlike the Capitated Payment Mechanisms, the value of APO payments made to ACOs will be reconciled against the actual value of the Medicare FFS claims for services furnished to aligned beneficiaries after the end of the PY.

22. Q: Are ACOs required to pay their Participant Providers and/or Preferred Providers through their own FFS mechanisms?

No, ACOs may enter into their own downstream payment arrangement with their Participant Providers and Preferred Providers and are not required to pay them FFS. However, any such arrangements must comply with the applicable terms of the ACO REACH Participation Agreement and must be agreed to by both the ACO and the Participant Provider or Preferred Provider, evidenced by a signed written arrangement.

23. Q: Are the capitation payments to ACOs subject to sequestration?

Yes, in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), as amended, CMS will reduce the payments made to ACOs by Congressionally mandated sequestration adjustment at the time. The benchmark and PY expenditures will be calculated on a pre-sequestration basis. However, sequestration will be applied to TCC, PCC, and, if selected, Advanced Payments before they are paid to ACOs; where sequestration will result in a 2% reduction in any capitated payments and Advanced Payments paid by CMS to the ACO. In addition, at Provisional and Final Financial Reconciliation, calculations will be performed on a pre-sequestration basis, however any shared savings payments earned by the ACO will have sequestration applied and be reduced by 2%. Reductions for sequestration will not apply to the recoupment of any shared losses. ***Please note, as a rule of thumb, CMS will always follow the Congressionally mandated changes to sequestration, when applicable.***

24. Q: Will CMS process claims for the capitated population-based payments?

Yes, Participant Providers and Preferred Providers participating in TCC, PCC, or APO payment mechanisms are required to submit claims to CMS as under traditional Medicare. In turn, the ACO will compensate these providers and suppliers for services rendered to ACO-aligned beneficiaries for services that were subject to TCC, PCC, or APO. Depending on the TCC, PCC, or APO percentage reduction election by the provider, CMS will partially or fully (100%) reduce the Otherwise Payable Amount (OPA), i.e. what Medicare would have paid in the absence of the model. If a partial reduction is made to a claims-based payment, the provider will receive the difference between the OPA and the reduction made to the claims-based payment.

25. Q: Why is the PCC set at 7% of the total cost of care? Is there any flexibility around the 7%?

Primary care expenditures are approximately 2-3% of the total cost of care in Medicare FFS. CMS has set the PCC at a higher value (7%) of the PY Benchmark for total cost of care to promote the delivery of enhanced and more comprehensive primary care services. The PCC includes two components, a base PCC amount and an enhanced PCC amount for providing enhanced primary care services. The base PCC amount is calculated based on the actual claim expenditures for primary care services provided to aligned beneficiaries during the lookback period by Participant Providers and Preferred Providers. The enhanced PCC amount is calculated as the difference between 7% and the base primary capitation amount. REACH ACOs that select the PCC option will still be subject to risk sharing against the PY Benchmark, in which all PY expenditures are collectively compared to the benchmark value to determine shared savings/shared losses. CMS will treat the base PCC amount as an expenditure against that benchmark. CMS will recoup the enhanced PCC amount prior to the calculation of shared savings/shared losses.

While we expect PCC to function as described in the RFA and in the paragraph above in general, we acknowledge that there may be specific ACOs that would prefer flexibility in how they receive PCC payments. As such, we are allowing the following flexibilities:

- ACOs whose Participant Providers have historically provided primary care services that exceed 7% of total expenditures for their historically aligned population will be allowed to have their Base PCC amount match that historical amount (e.g., if Base PCC is calculated to be 8%, we will keep it at 8% rather than constrain it down to 7%). Note: we expect this to be rare.
- ACOs for whom Base PCC exceeds 5% will still be entitled to up to 2% Enhanced PCC. This means that total PCC payments can exceed 7% (again, we expect this to be rare). For example, if Base

PCC is calculated to be 6% or 8%, in both cases the ACO would be allowed to receive up to 2% Enhanced PCC. The Enhanced PCC would be fully recouped separate to final reconciliation, just as described in the RFA.

- ACOs will be allowed to elect to receive lower Enhanced PCC payments than they are entitled to. For example, for an ACO whose Base PCC = 3%, Enhanced PCC would be 7% - 3% = 4%. The ACO in this example could receive up to 4% Enhanced PCC but is able to elect a lower amount if they choose (e.g., 0%, 1%, 2% or 3%).

26. Q: How are the discount and quality withhold reflected in capitation payments?

The capitation payment is calculated as a percentage of the benchmark after the application of any discounts and the quality withhold (as well as a projected quality earn back). For example, if the ACO had a projected quality score of 90% based on historical quality scores, the benchmark would be reduced by 2% for the quality withhold, but 1.8% would be assumed to be earned back ($90\% * 2\% = 1.8\%$) for the purposes of calculating the capitation payments, resulting in a benchmark equivalent to 99.8% of the pre-quality withhold benchmark. Only after applying the quality withhold / projected earn back is the capitation payment calculated. For PCC (under most scenarios), the payment is 7% of the benchmark, and would be calculated as 7% of the benchmark reflecting the quality withhold and expected earn back (which in the above example, was equal to 99.8% of the pre-quality withhold benchmark).

27. Q: What are the implications for ACOs when individual providers drop from the ACO within a given PY? Can individual providers (based on their National Provider Identifier (NPI)) be added mid-PY?

Our policy towards addressing provider drops is outlined in [Section 4.2 of our Capitation and Advanced Payments Mechanisms paper](#). If an individual provider drops from the ACO within a given PY, their FFS reductions shall continue until the end of the month, at which point they will be reimbursed on a fully FFS basis. At the end of the quarter, the ACO's monthly capitation payment may be updated to reflect this change. Individual or facility providers may be added during the PY and will be eligible for benefit enhancements. However, all providers added mid-PY are ineligible for payment mechanisms for the duration of that PY. In addition, CMS reserves the right to adjust capitation payments for provider drops, for example a major hospital system dropping from the model. Also, please note that for TCC, the withhold percentage will be updated quarterly. Please see the relevant section within our specification paper at this link: <https://innovation.cms.gov/media/document/gpdc-py2022-cap-adv-pay-mech>.

28. Q: Will an ACO's Participant Providers and those Preferred Providers who elect to participate in the ACO's selected capitation payment mechanism be required to sign and submit a fee reduction agreement with their ACO? What is the timeline for the ACO to submit the fee reduction agreement to CMMI?

Yes, a fee reduction agreement will be required to be signed prior to the start of each PY. The FFS reduction agreement does not need to be submitted to CMS as a matter of course, but will be subject to audit and must be provided to CMS, upon request. This fee reduction agreement will serve as an attestation between the REACH ACO and the entity under whose Tax Identification Number (TIN) the Participant Provider or Preferred Provider bills Medicare, that all providers and suppliers participating in the ACO's selected capitated payment mechanism that bill under that TIN have agreed to participate in

the capitation payment mechanism and to the applicable fee reduction. More information about the timing and requirements related to this fee reduction agreement will be shared in the future.

Risk-Adjustment

29. Q: What is the purpose of the Coding Intensity Factor (CIF) and the ACO-level symmetric 3% cap in risk adjustment?

A goal of CMMI initiatives is to set fair and accurate benchmarks, which requires adjustments to risk scores to account for coding intensity, given their impact on benchmarking. If left unchecked, coding intensity may lead to two different challenges: 1) overpayments resulting from differential coding patterns, and 2) excessive investment in coding intensity activities, where the resources may be better directed at health care services. Measures to limit risk score growth include a program-level Coding Intensity Factor (CIF) and an ACO-level symmetric 3% cap.

- Coding Intensity Factor (CIF). The retrospective CIF will ensure that the change in normalized risk scores across all claims-aligned beneficiaries is zero between the baseline year (2019) and the PY. It will be applied uniformly across ACOs for a given risk adjustment model.
- Symmetric 3% cap. A symmetric 3% cap will be applied to ACO-specific risk score growth only for Standard and New Entrant ACOs in PY2021 and onwards, and beginning in PY2024 for High Needs Population ACOs, if significant risk score growth is observed. Risk score growth will be determined at the ACO-level and the symmetric 3% cap applied for each PY relative to an annual rolling risk score reference year. However, starting in PY2024, the application of the symmetric 3% risk score cap will be modified to: 1) adopt a static reference year population for the remainder of the model performance period (as a substitute for the rolling reference year population), and 2) cap the ACO's risk score growth relative to the ACO's independently calculated demographic risk score growth in determining the ACO-specific 3% risk score cap thresholds.

30. Q: As a result of coronavirus disease 2019, some providers have experienced a reduction in wellness visits and in diagnosis reporting. Since this may impact risk scores, how will this be addressed?

We are continuing to monitor the impact of coronavirus disease 2019 on claims submissions that may affect risk scores calculated using the CMS-HCC prospective risk adjustment model. Diagnoses from 2020 dates of service continue to be submitted on FFS claims and the deadline for the final reconciliation risk score run using these diagnoses will not occur until 2022. In addition, CMS released information regarding the use of diagnoses from telehealth services for risk adjustment in MA and for ACOs. As referenced in the recent Medicare Shared Savings Program related communication, "Final CMS-HCC risk scores will include telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service. Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication." For more information on risk adjustment for ACOs, including the ACO REACH Model, and diagnosis codes identified in a telehealth visit, please see "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing" which can be found at:

<https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf>, Section U - Pp. 93-94. Note that in ACO REACH, we will be calculating risk scores on a different schedule using both the CMS-HCC prospective risk adjustment model (v24) and the CMMI-HCC concurrent risk adjustment model.

31. Q: Why is the CMMI-HCC concurrent risk adjustment model not used for beneficiaries aligned to Standard and New Entrant ACOs that meet the High Needs Population eligibility criteria?

The CMS-HCC prospective risk adjustment model has been analyzed extensively, is well understood and performs well for large populations because it distributes the risk of both high and low expenditures across many beneficiaries. It has been effectively used in NGACO and the Medicare Shared Savings Program. As a result, the prospective model is being used for Standard and New Entrant ACOs. The CMMI-HCC concurrent risk adjustment model appears to be better suited to addressing the challenge of accurately risk adjusting payments for small populations of beneficiaries with complex illnesses and chronic conditions. High Needs Population ACOs have a minimum beneficiary alignment threshold of 250 for PY2021 and PY2022 and 500 for PY2023, which continues to grow in subsequent PYs. In addition, these beneficiaries are subject to highly variable health statuses and highly variable costs (so High Needs Population ACOs are more likely to have small populations of aligned beneficiaries with high expenditure risks). Because of the concurrent nature of the model, acute conditions are weighted more heavily than chronic conditions, while demographic factors receive relatively less weight. Thus, the concurrent model can better capture a rapid deterioration in health in the current year through the occurrence of acute episodes that are difficult to predict or prevent.

32. Q: As a patient panel of beneficiaries from a specific PY continues to be served, over time their risk scores are likely to increase. Will the symmetric 3% cap lead to underpayment as a result of constraining risk score growth?

A cohort or group of beneficiaries on an ACO's patient panel may have a worsening health status over time with increasing risk scores; however, over time the ACO will likely also be aligning new beneficiaries whose risk scores will also contribute to the average risk score for the ACO. In totality, the combined risk scores of the original beneficiary panel and the newer beneficiaries who are added to the patient panel will likely tend to reflect a random distribution of healthier to sicker beneficiaries. Without the introduction of coding intensity, this will have a tendency to stabilize the average population risk score over time from year and year.

The application of the symmetric 3% cap and the CIF is based on a 'cross-sectional' reference population rather than a 'cohort' of beneficiaries. By 'cross-sectional,' we mean that the reference population and PY population are intended to capture equivalent populations at different points in time, rather than to track the same group of aligned beneficiaries over time (which we would call a 'cohort' approach). While the PY-aligned population and reference population may have some beneficiaries in common, it is not necessarily the same population. For example, in PY2021, the symmetric 3% cap reference year was 2019, which means the reference population for the symmetric 3% cap is the set of beneficiaries that would have been aligned via claims in 2019 using the same Participant Providers used in PY2021. As such, while a given set of beneficiaries (or 'cohort') may have risk score increases over time as they age, the reference population should capture an equivalent mix of beneficiaries since it is cross-sectional in nature. For this reason, we do not believe that the tendency of a given cohort's risk scores to increase

over time will unfairly penalize ACOs via the symmetric 3% cap, since the reference population is not based on a cohort.

33. Q: Will there be a Part D risk adjustment model?

There will not be a risk adjustment model to address Part D costs, since Part D costs are not included in ACO REACH benchmarks.

34. Q: Will there be a normalization factor for the High Needs Population ACOs?

If risk scores are calculated for beneficiaries and expenditures in years other than the denominator year or the year in which the risk adjustment model is set, the average population risk score can diverge from a 1.0. Normalization is a mechanism to adjust the population-average risk score back to a 1.0 in any one given year. Since the CMMI-HCC concurrent risk adjustment model will be applied to the High Needs Population ACOs, we will be applying a normalization factor that is tailored to the CMMI-HCC concurrent risk adjustment model. The normalization factor is based on the average risk score for the National Reference Population. The CMMI-HCC concurrent model risk scores will be divided by this normalization factor.

35. Q: Will hospice members be risk adjusted?

Yes, beneficiaries receiving hospice services will be subject to risk adjustment.

36. Q: Why is the symmetric 3% cap applied before the CIF?

The symmetric 3% cap is applied at the ACO level relative to the ACO-specific reference risk score. This holds ACOs with higher coding pattern differentials accountable first at the ACO level by constraining their risk score growth with the symmetric 3% cap. Then, the CIF is applied at the program level to ensure a zero-sum impact of any remaining risk score growth across the program; it must be applied after risk scores have been set for each ACO via the symmetric 3% cap.

37. Q: Can you clarify how the normalization factor, the symmetric 3% cap and Coding Intensity Factor (CIF) will be applied in an example risk score calculation (including how the reference populations will be established)?

CMMI has provided more details with an example on how the normalization factor, the symmetric 3% cap and the CIF will be applied in Appendix C of the DC/KCC Risk Adjustment paper available on the PY2022 GPDC Model website (<https://innovation.cms.gov/media/document/dc-kcc-risk-adjustment-feb2022>). Please note that CMS plans to release an updated paper for PY2023 of the ACO REACH Model during the summer of 2022.

38. Q: What data source(s) will be used by CMS to calculate risk scores in ACO REACH?

Medicare FFS claims data and Medicare Advantage Risk Adjustment Processing System (MA RAPS) data are the sources of diagnosis data for risk scores for PY2021. For PY2022, Medicare FFS claims data and Medicare Advantage encounter data are the sources of diagnosis data for risk scores. We use diagnoses from covered professional, inpatient and outpatient claims. Note that the professional, inpatient and outpatient claims will also be subject to diagnosis filtering (see next question).

39. Q: Are there plans to use different claims filters for the CMS-HCC prospective risk adjustment model and/or the CMMI-HCC concurrent risk adjustment model that will be used in ACO REACH vs the data filtering approach used MA?)

The same filtering approaches, which were used in CY 2021 in MA for FFS claims and encounter data, were used for GPDC in PY2021 and PY2022. For ACO REACH, beginning in PY 2023, we may update the filtering approach to be consistent with MA. Chapter 7 on Risk Adjustment from the Medicare Managed Care Manual provides details on the valid sources of risk adjustment diagnoses. The sources of data include hospital inpatient facilities, hospital outpatient facilities and physicians. Details on the filtering methodology applied to these sources of data are further clarified in this document, which can be found at the following link: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf>

40. Q: Will CMMI provide SAS code to support the CMMI HCC model?

CMS-HCC prospective risk adjustment model software is available for everyone to use. The 2020 Model Software/ICD-10 Mappings can be found at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2020>. CMMI is looking into making the CMMI-HCC concurrent risk adjustment model software also available for stakeholders to use. We expect to have this software available in the near future.

41. Q: How will the symmetric 3% cap and CIF be applied relative to voluntarily aligned beneficiaries?

Risk scores for beneficiaries who are aligned solely on the basis of voluntary alignment (i.e., voluntarily aligned, and not eligible for claims-based alignment) to Standard and New Entrant ACOs will be excluded from the application of the symmetric 3% cap and CIF in their first PY of alignment. However, voluntarily aligned beneficiaries in their second or later PY of alignment will be included in the application of the symmetric 3% cap and CIF even if they have not yet been eligible for claims-based alignment. The reference populations for both the symmetric 3% cap and the CIF are based on the beneficiaries that would have been aligned to the ACO through claims-based alignment in the relevant reference year (as voluntary alignment for ACO REACH does not exist before the model starts). In a voluntarily aligned beneficiary's initial year of alignment, the ACO has not had a chance to engage with the beneficiary; however, once the beneficiary reaches their second year of voluntary alignment to the ACO, it is anticipated that the ACO will have engaged with the beneficiary, such that the beneficiary's risk scores can be compared to beneficiaries who would have been aligned to the ACO via claims-based alignment during the historical reference year.

42. Q: Will CMMI allow for the submission of diagnoses for risk adjustment pulled from retrospective medical record chart review linked to claims?

Diagnoses for risk adjustment will be collected directly from FFS claims data and MA encounter data that meet the risk adjustment filtering requirements. A separate data stream of diagnoses pulled from medical record reviews will not be used for ACO REACH risk adjustment.

43. Q: How will risk score accruals and updates work under monthly payments? Will there be a true-up at the end of the PY?

Beneficiary risk scores will be updated during the course of each PY as diagnoses, which are submitted on beneficiaries' FFS claims, become available. Initial risk scores will be based on lagged data to start with; however, this data will be replaced with diagnoses from the formal data collection period over the course of each PY. As the PY progresses, more current and more accurate beneficiary data will be submitted on FFS claims and the risk scores will be recalculated. ACOs will be provided with multiple risk score updates for each beneficiary throughout each PY, and after the end of the PY, the risk score for each beneficiary will be finalized. This final risk score will be used in the Final Reconciliation process for determining shared savings or losses.

44. Q: How do the risk adjustment calculations and coding intensity policies compare between ACO REACH and the GPDC Model?

For PY2023, CMS will generally apply the same risk adjustment and coding intensity policies in ACO REACH as were applied in the GPDC Model. The CMS-HCC prospective model will be used for Aged & Disabled (A&D) beneficiaries in Standard and New Entrant ACOs. The CMMI-HCC concurrent model will be used for A&D beneficiaries in High Needs Population ACOs. The CMS-HCC ESRD model will be used for End Stage Renal Disease (ESRD) beneficiaries in all ACO types. CMS will continue to apply the symmetric 3% risk score growth cap and coding intensity factor (CIF) to ACO risk scores.

Beginning in PY2024, CMS will adjust the application of the symmetric 3% risk score growth cap in two ways: (1) the cap will be adjusted to account for changes in an ACO's demographic risk score, and (2) the cap will use a fixed reference year beginning in PY2024.

45. Q: How will the adjustment to the 3% symmetric risk score growth cap, used to account for demographic risk score changes, be applied to ACO risk scores?

Beginning in PY2024, the ACO REACH model will calculate the symmetric 3% risk score growth cap relative to the measured demographic risk score changes for the ACO's aligned beneficiaries, using the demographic model used in the Medicare Shared Savings Program. Any demographic risk score growth changes identified will be applied to adjust ACO risk scores before applying the 3% risk score cap.

For example, if an ACO's demographic risk score growth from the reference year to the performance year is +1%, then the symmetric 3% risk score cap for the ACO's average CMS-HCC prospective risk adjustment model or the CMMI-HCC concurrent risk adjustment model risk score growth will constrain growth between -2% to +4%.

46. Q: What year will be used as the static reference year for the symmetric 3% risk score growth cap beginning in PY2024? How will the cap apply relative to this fixed reference year?

For PY2023, CMS will use a reference year for the symmetric 3% cap of CY2021, two years prior to the performance year. Beginning in PY2024, CMS will apply a static reference year for the symmetric 3% risk score growth cap using CY2022 as the static reference year. This CY2022 reference year will continue to apply for the risk score cap in PY2025 and PY2026. Note however, that CMS is continuing to monitor the potential impact of COVID-19 on reference years for applying the symmetric cap. For example, CMS may determine that 2021 is not appropriate to use as a reference year for PY2023 and instead use PY2020 to avoid biases introduced by claims with CY2020 dates of service.

Reconciliation

47. Q: How are the PCC, TCC and Advanced Payments considered in final shared savings/losses calculations?

The TCC and Base PCC payments will be treated as an expenditure in shared savings/shared losses calculations. That is, when CMS calculates the total cost of care at the end of the PY, we will incorporate these payments, as well as additional FFS Medicare expenditures made on behalf of aligned beneficiaries for claims and services not covered by the capitation payments, and determine whether together these expenditures exceed the PY Benchmark. If so, the ACO must repay CMS shared losses in an amount calculated according to its risk sharing arrangement. If not, CMS will pay the ACO shared savings in an amount calculated according to its risk sharing arrangement. CMS will not reconcile payments made through the PCC and TCC against actual services rendered to make ACOs whole—the ACO is at risk for expenditures that exceed what CMS pays through the PCC and TCC.

Advanced Payments, however, are treated differently than the PCC and TCC payments. The full amount of Advanced Payments will be reconciled against the actual amount of FFS claims dollars reduced under the Advanced Payment Option (APO). For example, if CMS paid the ACO fewer dollars than it reduced during the PY, CMS would make up the difference. CMS will monitor claims submission and Advanced Payments to adjust payments as needed to protect against significant over or under payments. A final reconciliation for Advanced Payments will be conducted as part of the calculations of Medicare expenditures for a PY and shared savings/shared losses determination.

48. Q: Do all Medicare services count toward Shared Savings/Shared Losses?

Yes, all Parts A and B services for aligned beneficiaries will count toward shared savings/shared losses. Under the ACO REACH Model, Professional ACOs will bear risk for 50% of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for their aligned beneficiaries. Global ACOs will bear risk for 100% of shared savings/shared losses on the total cost of care for aligned beneficiaries.

For both TCC and PCC, shared savings/losses are based off total cost of care and are calculated by comparing the ACO's benchmark with all Medicare expenditures for services delivered to aligned beneficiaries. Medicare expenditures are defined as capitation payments, Advanced Payments, and FFS claims billed for aligned beneficiaries. Under TCC, capitation includes payments made for claim reductions for all Participant Providers and Preferred Providers that opt into capitation; there is no Advanced Payment for TCC. Under PCC, capitation is the 'Base PCC amount,' defined as the percent of historical spending represented by primary care billing by all Participant Providers and Preferred Providers that opt into capitation; 'Enhanced PCC amount,' which is the difference between the Base PCC amount and 7% of the benchmark. The Enhanced PCC amount is recouped fully by CMS separately from the reconciliation process, and so is not included in our definition of 'Medicare expenditures' in this context.

49. Q: How do the risk corridors apply when calculating shared savings? For example, if a Professional ACO achieved gross savings equal to 7.5% of the benchmark, how much would that ACO earn in shared savings?

The ACO would earn 3.375% of the benchmark as shared savings. For Professional ACOs, the following risk corridors apply:

| Corridor | Savings in corridor | ACO responsibility | ACO savings |
|----------|---------------------|--------------------|---------------|
| 0-5% | 5% | 50% | 2.500% |
| 5-10% | 2.5% | 35% | 0.875% |
| Total | | | 3.375% |

For the first 5% of gross savings achieved, a Professional ACO earns 50% shared savings. For the next 5% of gross savings (5-10%), a Professional ACO earns 35% shared savings. Thus, for an ACO that achieves 7.5% gross savings, of the first 5% the ACO earns 50% as shared savings (2.5%) plus 35% of the next 2.5% (0.875%), for a total of 3.375%.

50. Q: What risk mitigation strategies will be available in ACO REACH?

ACO REACH employs several risk mitigation strategies. Risk corridors are applied to all ACO types and vary based on risk option (Professional or Global). Risk corridors mitigate extreme shared savings or shared losses for ACOs if their actual PY expenditures are far lower or higher than the benchmark. ACOs also have the option of electing a stop-loss arrangement prior to the start of each PY. Stop loss is intended to reduce financial uncertainty associated with infrequent, but high-cost, expenditures for aligned ACO beneficiaries. It is calculated at the beneficiary level and the benchmark is adjusted to account for an ACO opting to have stop loss.

51. Q: When is final reconciliation conducted?

Starting in PY2022, CMS will conduct final reconciliation approximately six months after the PY ends. To provide more timely distribution of shared savings/shared losses, CMS will also provide the option for ACOs to select a provisional reconciliation option (this option must be selected at the start of the PY). Under provisional reconciliation, CMS will distribute interim-shared savings and collect interim-shared losses shortly after the end of the PY reflecting cost experience through the first six months of the PY, with a final reconciliation-taking place once complete data are available for the full PY (approximately seven months after the PY ends).

Since PY2021 lasts only 9 months, it will function differently. Provisional reconciliation will occur approximately six months after the PY ends, while final reconciliation will occur 12 months after provisional reconciliation (at the same time as final reconciliation for PY2022). While provisional reconciliation starting in PY2022 is optional, it will be required in PY2021. This change is a result of the shortened duration of PY2021 and more details is available in the financial specification papers.

52. Q: Will ACOs know the stop-loss attachment points specific to their ACO prior to their decision to purchase or not purchase stop-loss from CMS for any given PY?

Yes, full details about stop loss attachments points and details about each ACO’s stop-loss charge will be made available prior to the deadline to make stop-loss participation decisions for a given PY. The final details of the stop loss methodology are included in the Participation Agreement, while a summary is available in the Financial Reconciliation Overview paper.

53. Q: What changes are being made to the stop-loss methodology for PY2023 and subsequent PYs?

Beginning with PY2023, the ACO REACH Model will make an adjustment to the calculation of the optional stop-loss arrangement to incorporate a given beneficiary's predicted expenditures into the determination of their attachment point. Rather than protecting against exposure for high cost beneficiaries, this approach will consider the difference between predicted and observed expenditures for each beneficiary to determine stop-loss payouts. This approach, known as 'residual based reinsurance,' more accurately channels stop loss payouts to REACH ACOs whose aligned beneficiaries' predicted spending exceeds expected spending.

54. Q: Are ACOs required to secure a financial guarantee?

Each ACO must secure a financial guarantee for each PY to ensure it can repay all shared losses and any other amounts owed under ACO REACH. If CMS does not receive payment for shared losses and other amounts owed by the date the payment is due, CMS will pursue payment under the financial guarantee and may withhold payments otherwise owed to the ACO under this model or any other CMS program or initiative.