



# ACO REACH – Basics and Strategy

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- This presentation describes the ACO REACH, Standard Entrant, Global Risk option, which is the track most ACOs have selected
- When the term “ACO REACH” is used for the remainder of the presentation, it refers to this track specifically
- For those interested in discussing New Entrant, High-Needs, or Professional tracks of ACO REACH, please contact me after the presentation

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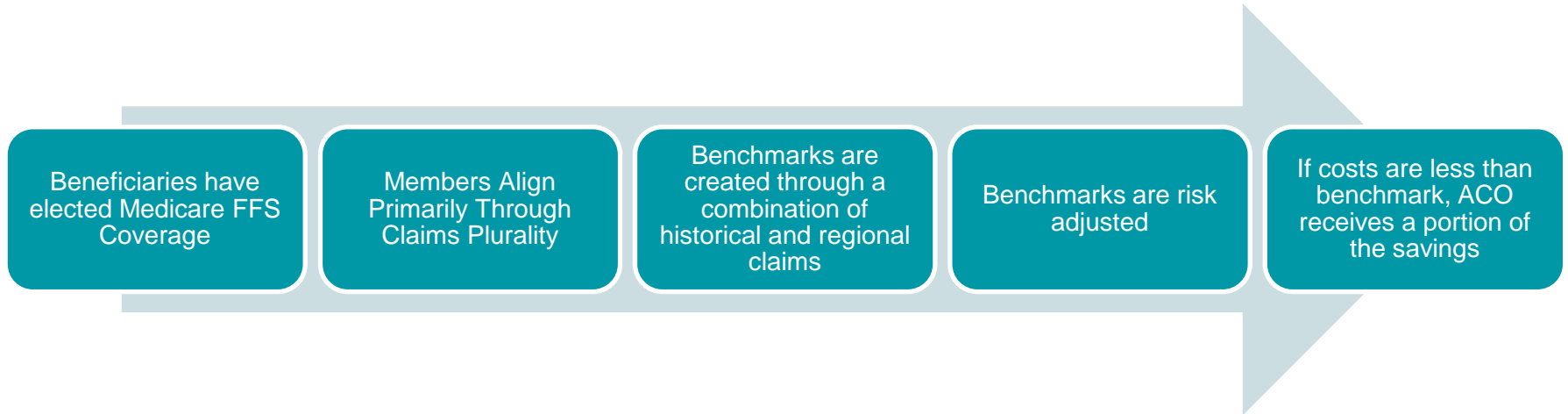


## Where should we begin?

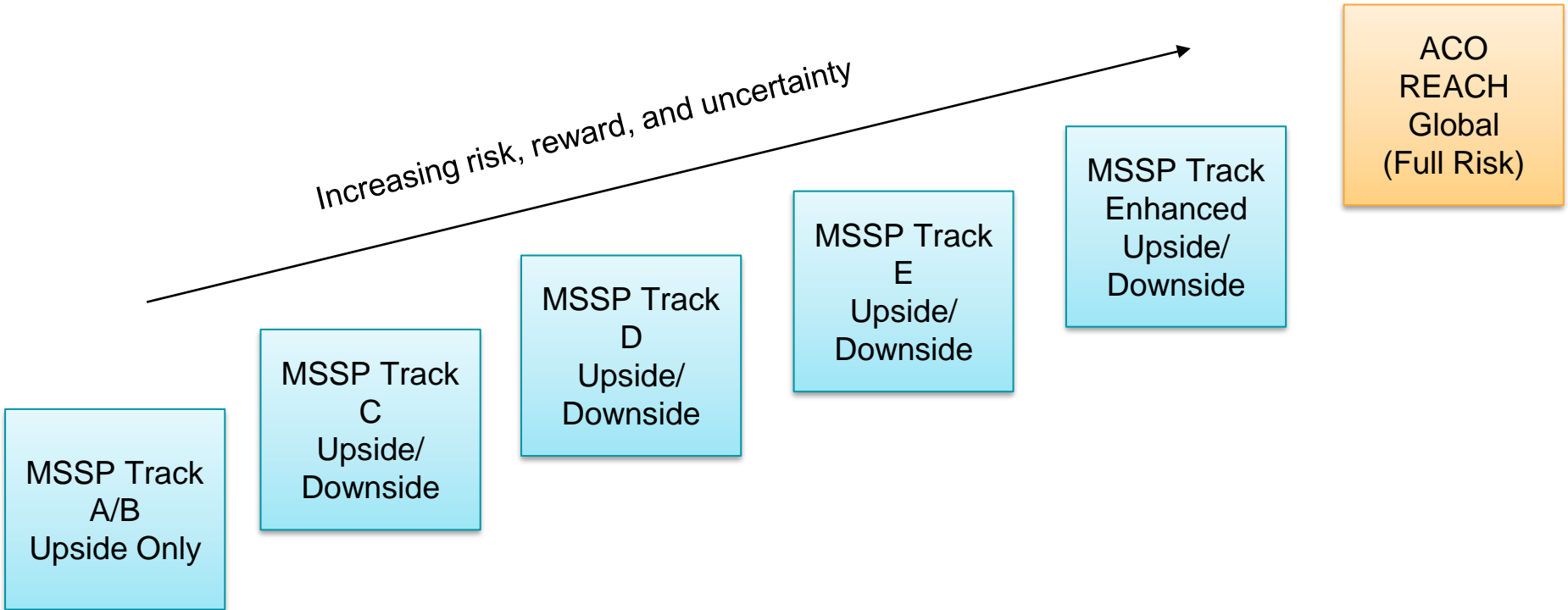
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## ACO REACH – Basics



Calculations vary materially between programs, but intent is to calculate a “fair” status quo cost of care benchmark, and ACOs attempt to keep costs below that benchmark



## MSSP

- No benchmark discount (benchmarks are often higher)
- Asymmetrical upside/downside risk to protect the ACO from losses
- CMS garnishes savings by 25%-60%
- Prospective or retrospective member alignment
- Quality adjusts the ACO's retained savings
- Primarily regional benchmark trend

## ACO REACH

- 3% to 3.5% benchmark discount
- Symmetrical upside/downside risk
- CMS does not garnish savings beyond the discount
- Prospective alignment only, with a much longer lookback period
- Quality adjusts the benchmark instead of savings
- National benchmark trend



2020

2021

2022

2023

Performance Year

ACO REACH Alignment (1/3 weight)

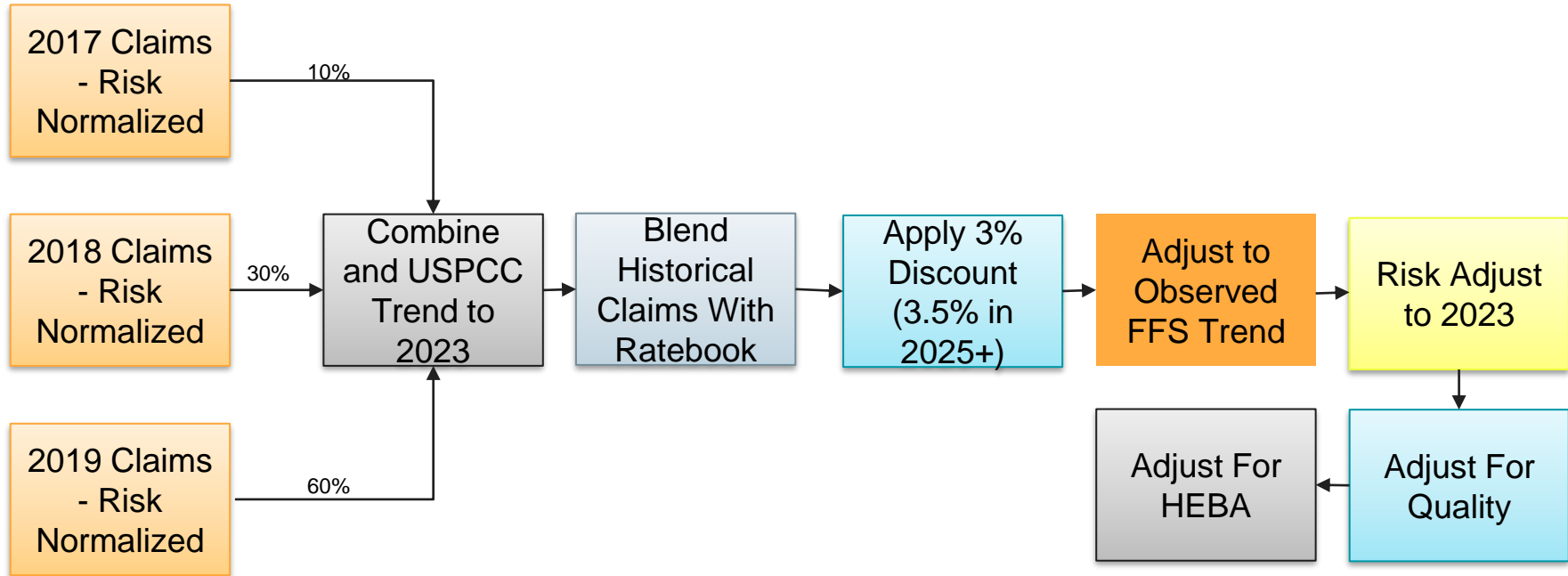
ACO REACH Alignment (2/3 weight)

MSSP - Retrospective Alignment

MSSP - Prospective Alignment

- **Basic Rule: Highest Allowable dollars wins**
- CMS compares allowed claims incurred by REACH Participating providers, and non-aligned providers
- Highest ACO spend, which must also be higher than non-aligned spend aligns a life
- Only PCP specialty codes and Primary Care procedures are considered
- If PCP specialty codes only account for <10% of E&M codes, same exercise is performed on specialist claims





\*Subject to 3% risk score cap (next slide)

**ACO REACH includes a benchmark adjustment that increases benchmarks for ACOs serving higher proportions of underserved beneficiaries**

CMS will stratify all beneficiaries aligned to ACO REACH using a composite measure of underservice that incorporates a combination of<sup>1</sup>:

### Area Deprivation Index

*Area-level measure of local socioeconomic factors correlated with medical disparities and underservice*

Percentile Score from 1-100

### Dual Medicaid Status

*Beneficiary-level measure of economic challenges affecting individuals' ability to access high quality care*

25 Point Adjustment for Full or Partial Dual Eligibility



91<sup>st</sup> – 100<sup>th</sup> Percentile  
(Top Decile)

**+\$30 PBPM  
Adjustment**

51<sup>st</sup> – 90<sup>th</sup> Percentile  
(Middle 4 Deciles)

*No Adjustment*

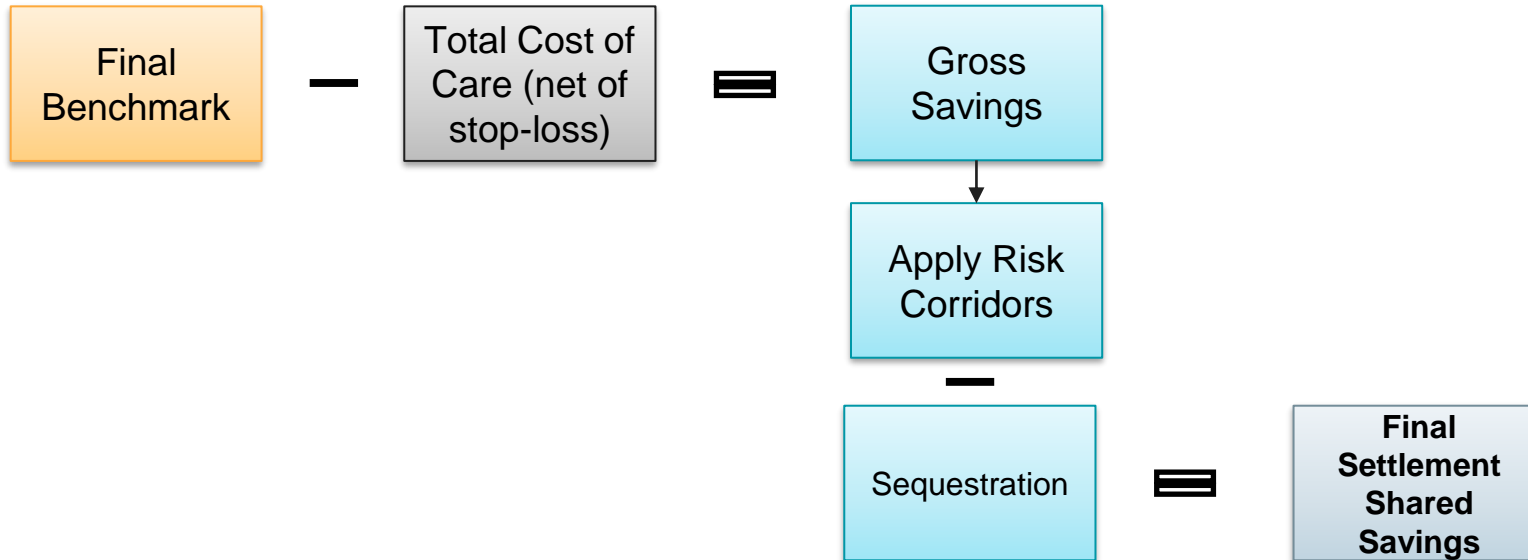
1<sup>st</sup> – 50<sup>th</sup> Percentile  
(Bottom 5 Deciles)

**-\$6 PBPM Adjustment**

Source: <https://www.cms.gov/priorities/innovation/media/document/aco-reach-fin-meth-webinar-slides>

- Risk Scores may only increase (or decrease) by 3% between the reference year and the performance year
- The reference risk score will be adjusted for observed demographic changes between the reference and performance year
- 2022 will be the reference year for the remainder of the REACH program (2026)
- A coding intensity factor (CIF) is applied after the risk score cap
- CIF ensures budget neutrality by ensuring the 2019 – Performance Year trend is 0%

	<b>Claims Aligned</b>	2022	2024
1.	Raw Risk Score	1.350	1.741
2.	Normalization Factor	1.089	1.176
3.	Normalized Risk Score	1.239	1.480
5.	PY Risk Score Floor (0.97 X RY normalized risk score)		1.202
6.	PY Risk Score Ceiling (1.03 X RY normalized risk score)		1.276
7.	PY Capped Risk Score for Claims Aligned		1.276
8.	CIF		1.020
9.	PY Benchmark Risk Score for Claims Aligned		1.251





No Overlapping Financial Guarantees\*



Retro Trend Adjustment Corridors to limit the impact of the factor



HCC Model Mirrors MAPD 33%/67% V28/V24



Reference Risk Score Incorporates Changes To Demographics



Coding Intensity Factor capped at 1% in 2024

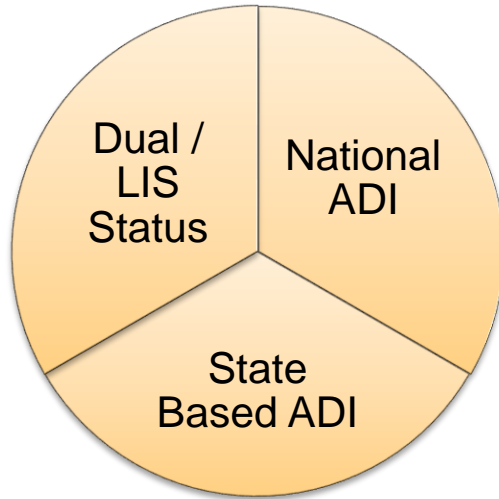


HEBA Based on ADI, Dual and LIS



Expanded HEBA Access To More Lives

## HEBA Score Calculation



## HEBA Benchmark Adjustment

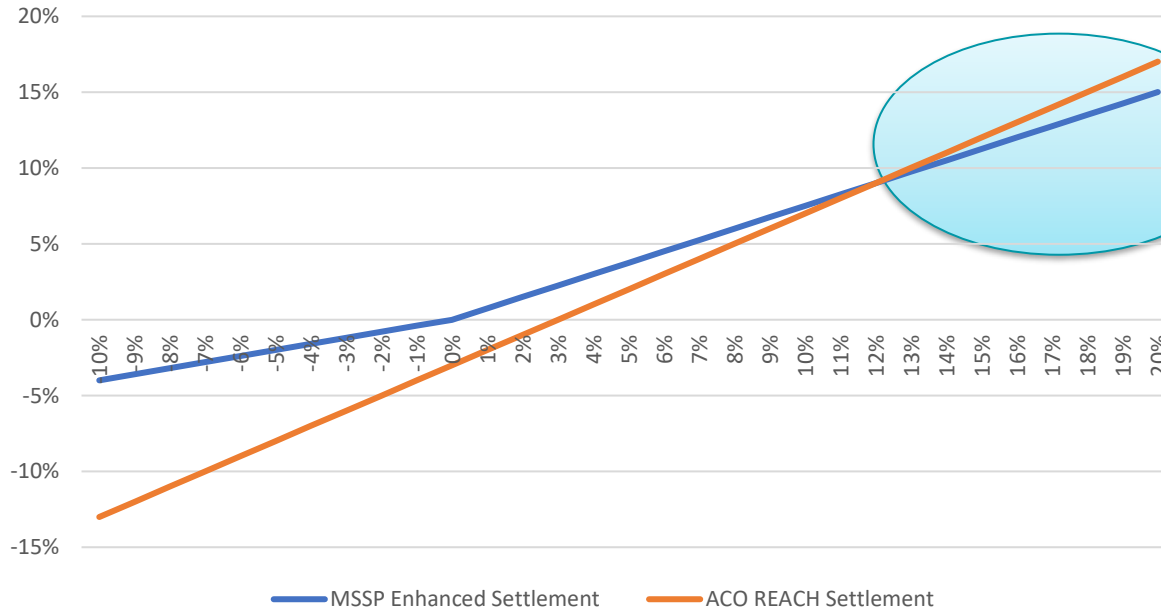
\$30 Top Decile
\$20 Second Decile
\$10 Third Decile
\$0 4 <sup>th</sup> -7 <sup>th</sup> Deciles
(\$10) 3 Bottom deciles





## ACO REACH Strategy

MSSP VS ACO REACH Settlement As Compared to Gross Margin Before Discount



Conclusion:  
All else being equal, top performing ACOs do better in REACH, but lower performing ACOs often do better in MSSP

# REACH Only Financial Advantages



Preferred provider discounts



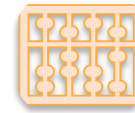
Prospective Plus  
Voluntary  
Alignment



Utilizing capitation  
revenues to incent  
efficient provider  
behavior



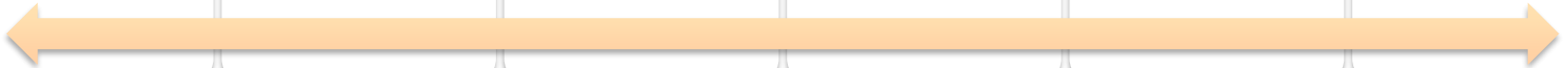
Risk score cap  
year allows for  
more coding  
progress



Benchmark Years  
May Be Preferred  
For Recent  
Achievers



REACH Stop-Loss  
Provided Without  
Margin or Admin  
Cost

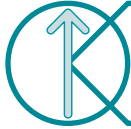




ACOs use market leverage to negotiate discounts from non-participating providers in the area



Discounts are measured as a percent reduction to Medicare FFS



Providers typically agree to refer more to Preferred Providers, increasing their volume



**Preferred Providers must be reviewed for efficiency, to ensure overall costs will be reduced by sending patients there**

Lives Receive Full Ratebook Instead of Blending With Historical

Voluntary Alignment Trumps Claims Alignment to Another ACO

Voluntarily Aligned Lives Are Not Subject to the Risk Score Cap

Voluntarily Aligned Lives Are More “Sticky”

## Enhanced Cap

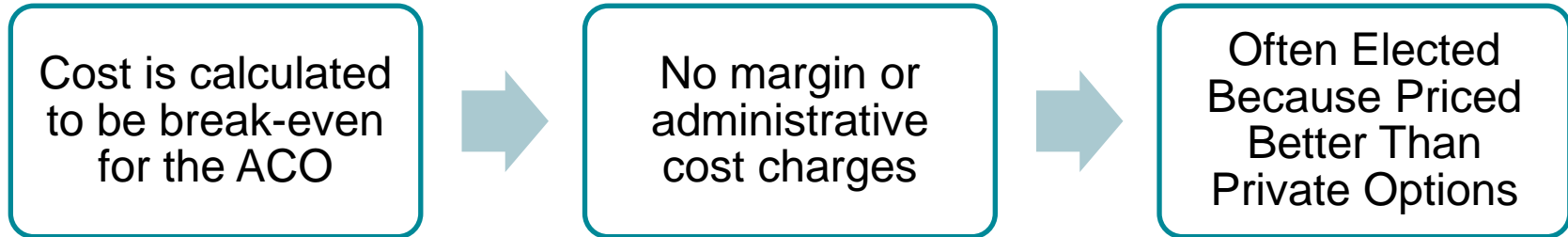
- Interest Free “Payday Loan” on settlement
- Utilized as working capital
- Often ~4% of benchmark

## Base Primary Care Capitation

- Replaces PCP FFS revenue with a capitated revenue
- Participants elect a discount to FFS claims, which determines the size of the cap
- Capitated revenues are trued-up to FFS claims at settlement

## Total Cost of Care Capitation

- Replaces Part A and Part B services rendered by Participant Provider and Preferred Providers that have elected a cap
- The next step up from converting revenues from FFS to capitation
- Capitated revenues are trued-up to FFS claims at settlement



- Coverage acts like specific stop-loss with multiple coverage tiers
- Applied entirely at the claims level, so no money is changing hands

## Brute Force

- Hire a team and process VRDC or QE data (100% of Medicare claims)
- Develop a claims attribution logic
- Hire a knowledgeable actuarial team to develop a model
- Actuaries also create a risk score accrual process

## Consultant

- Purchase off the shelf models for REACH and MSSP
- In-house actuaries should run these models
- Consultants will also typically run a forecast for you



- Overcoming the **benchmark discount** is typically the paramount concern in REACH via some combination of:
  - Having such high margin that the ACO prefers the discount to the % of settlement in MSSP
  - Utilizing REACH financial advantages to overcome the benchmark discount
- Another sticking point for providers is the **hesitancy to go full downside** risk
- CMMI programs are less stable than MSSP, creating additional uncertainty
- **For savvy and efficient groups however, ACO REACH could be the perfect fit**