ACO REACH – Basics and Strategy

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Presentation Notes

- 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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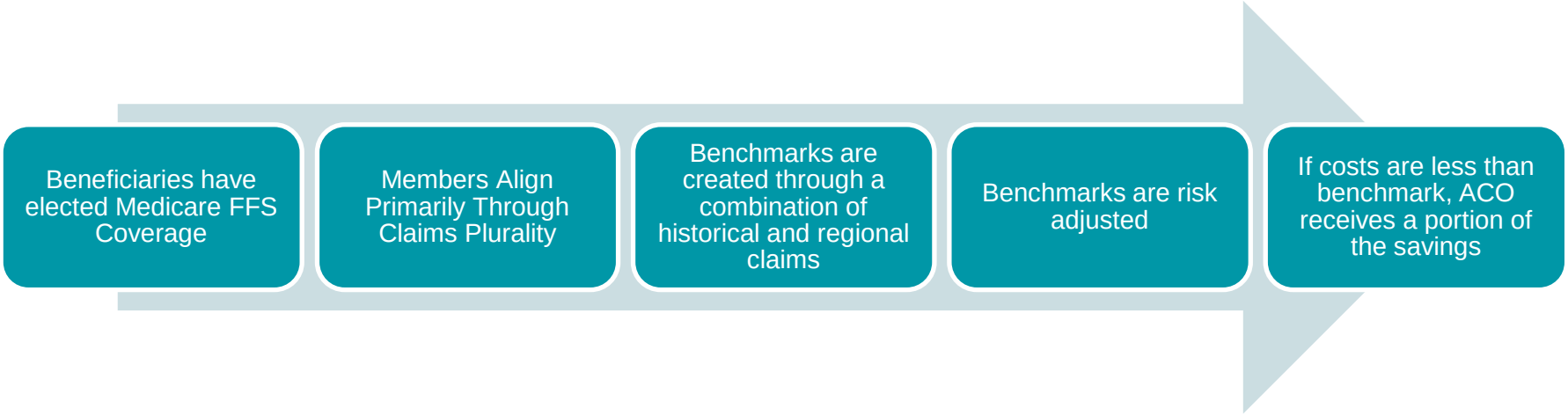
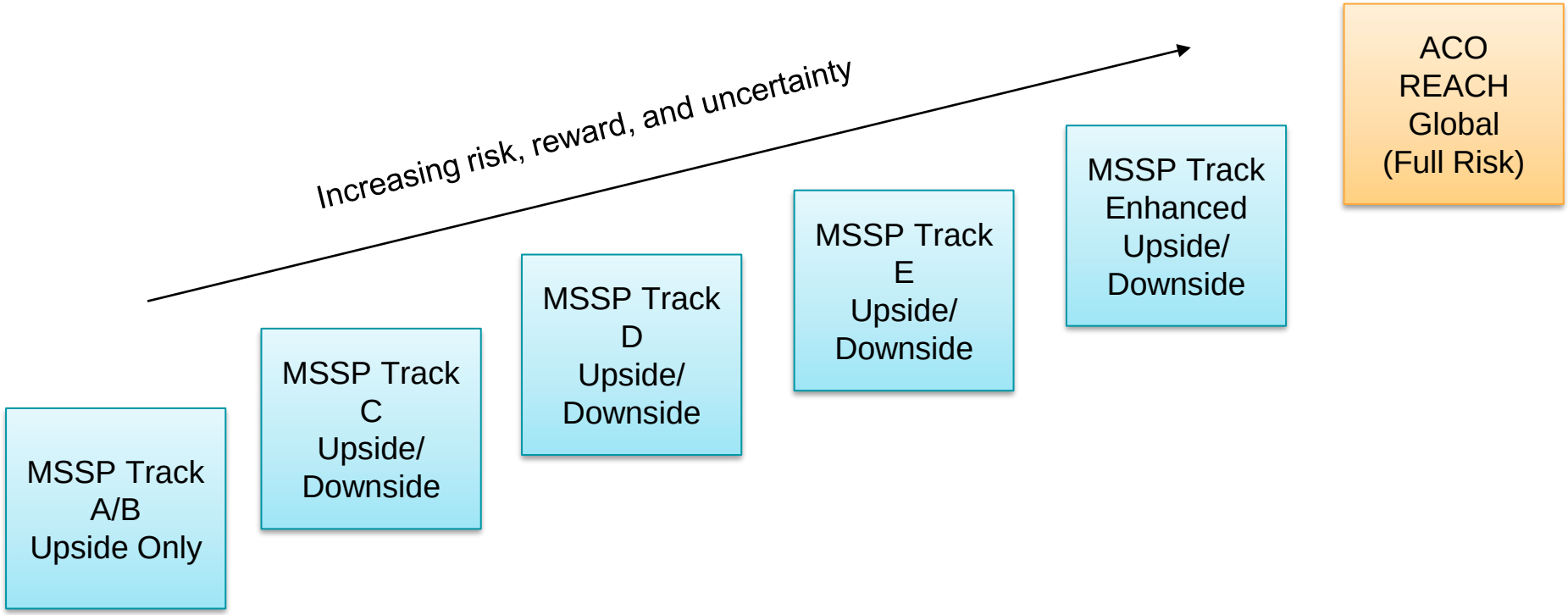
ACO REACH – Basics

Overview of Medicare FFS ACO Programs



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

Overview of Medicare FFS ACO Programs



Detailed Comparison - MSSP VS ACO REACH

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

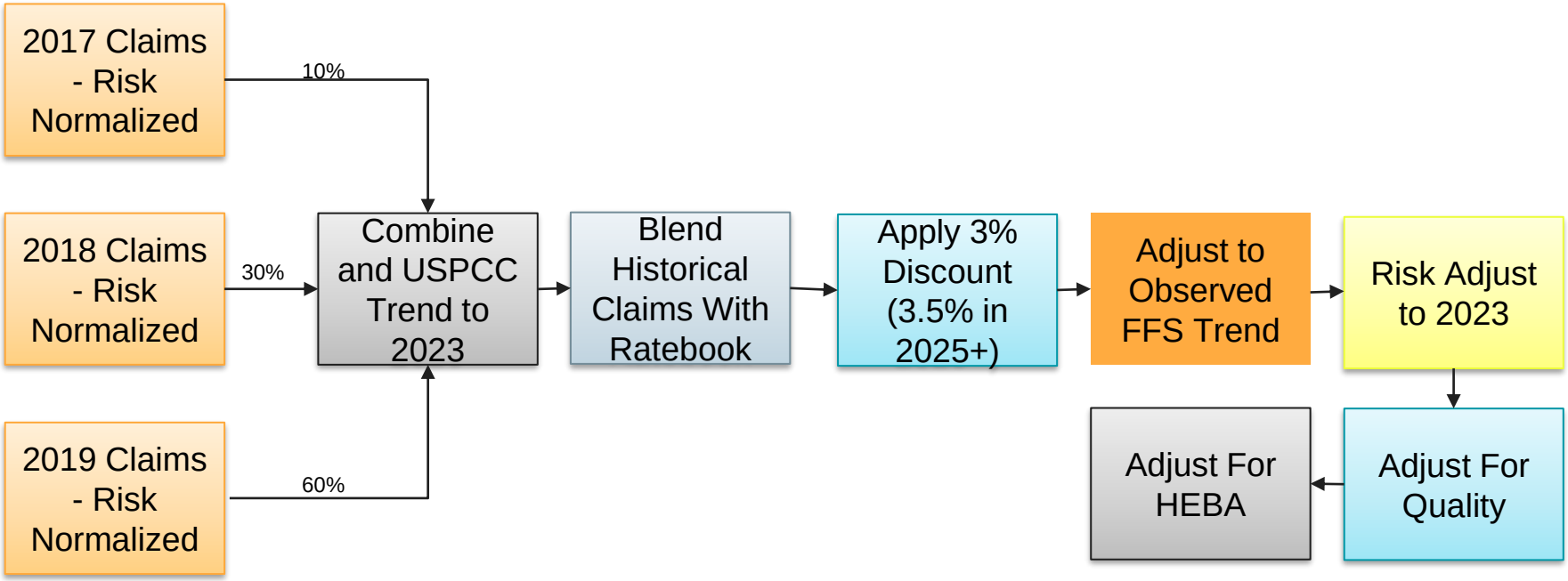
- 3% to 3.5% benchmark discount
- Symmetrical upside/downside risk
- CMS does not garnish savings beyond the discount
- Prospective alignment only, with a much longer lookback period
- Quality adjusts the benchmark instead of savings
- National benchmark trend

Claims Alignment Periods

Claims Plurality Explained

- **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

ACO REACH – 2023 Example Benchmark Calculation



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

ACO REACH – Health Equity Benchmark Adjustment

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[1]:

Area Deprivation Index	Dual Medicaid Status
*Area-level measure of **local socioeconomic factors** correlated with medical disparities and underservice*	*Beneficiary-level measure of economic challenges affecting individuals' ability to access high quality care*
Percentile Score from 1-100	**+ 25 Point Adjustment for Full or Partial Dual Eligibility**

91st – 100th Percentile (Top Decile)	***+$30 PBPM Adjustment***
51st – 90th Percentile (Middle 4 Deciles)	*No Adjustment*
1st – 50th Percentile (Bottom 5 Deciles)	*-$6 PBPM Adjustment*

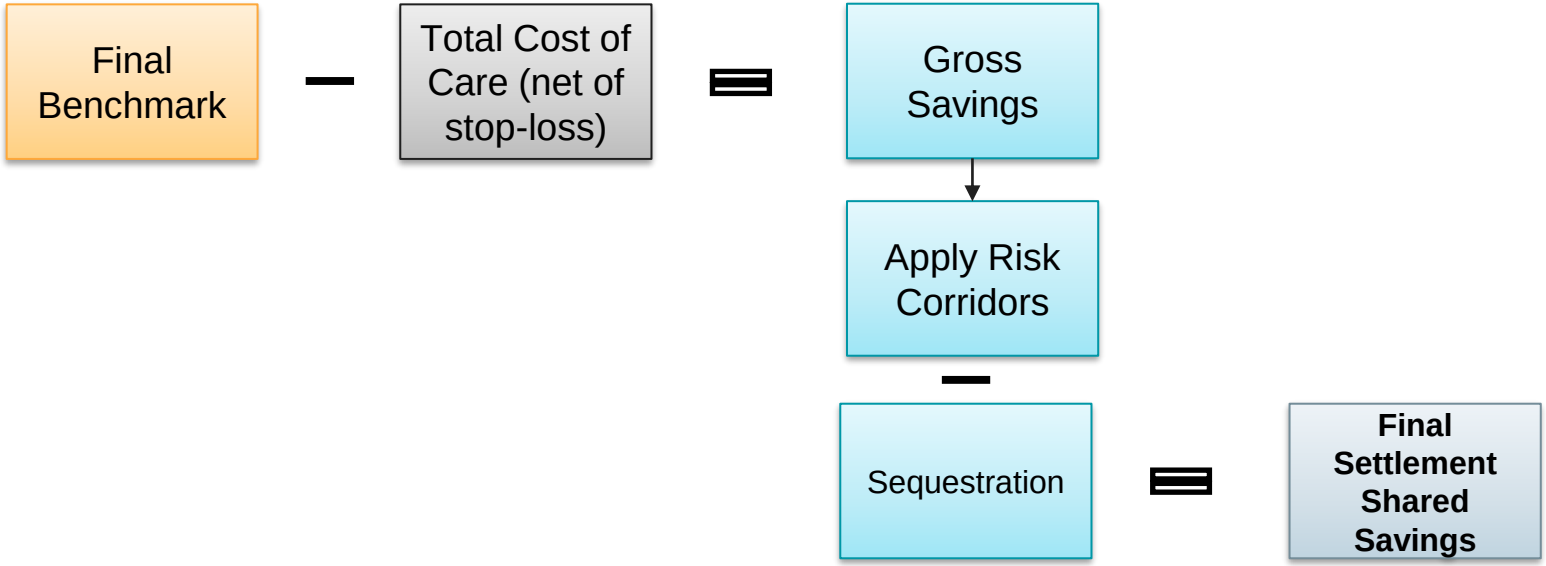
Source: https://www.cms.gov/priorities/innovation/media/document/aco-reach-fin-meth-webinar-slides

ACO REACH – Risk Score Considerations

- 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%

	Claims Aligned	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

ACO REACH – Settlement Calculation

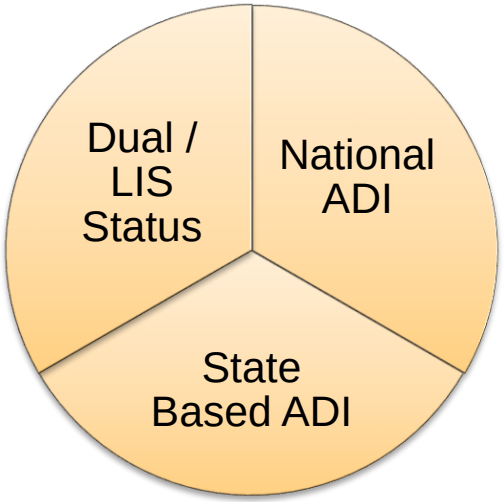


ACO REACH – 2024 Significant Model Changes

- 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

2024 HEBA Change Details

HEBA Score Calculation

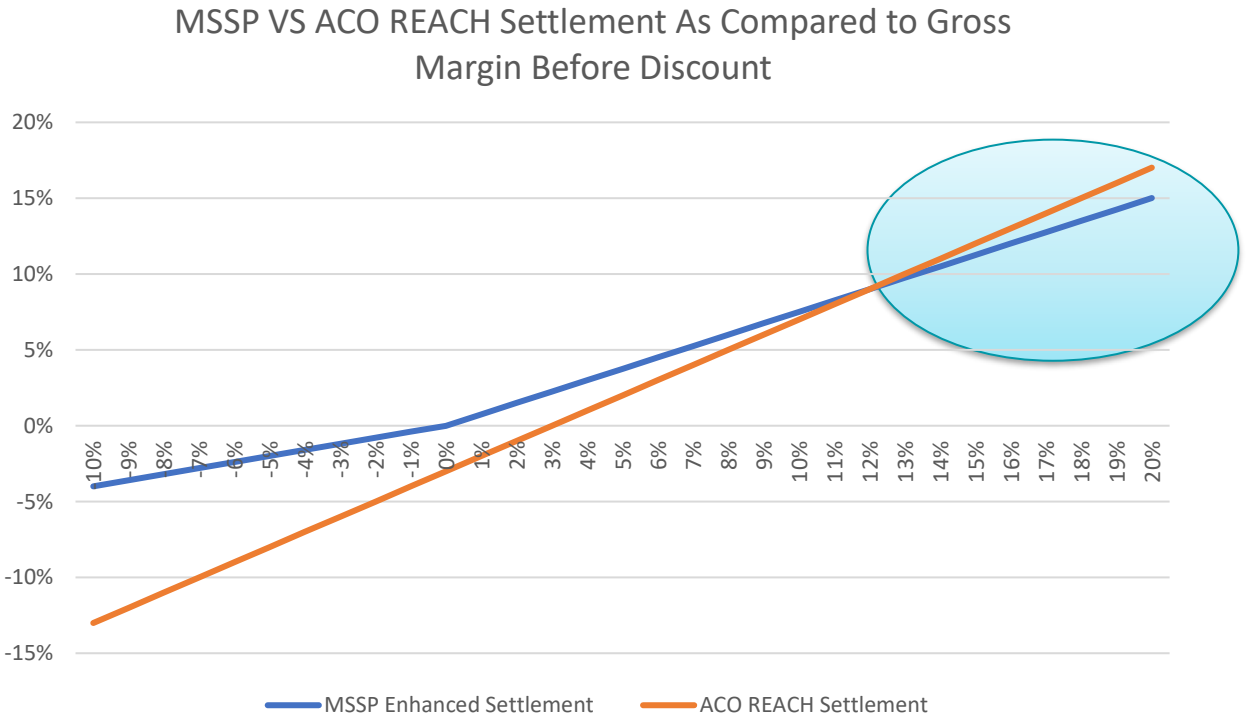


HEBA Benchmark Adjustment

$30 Top Decile
$20 Second Decile
$10 Third Decile
$0 4th-7th Deciles
($10) 3 Bottom deciles

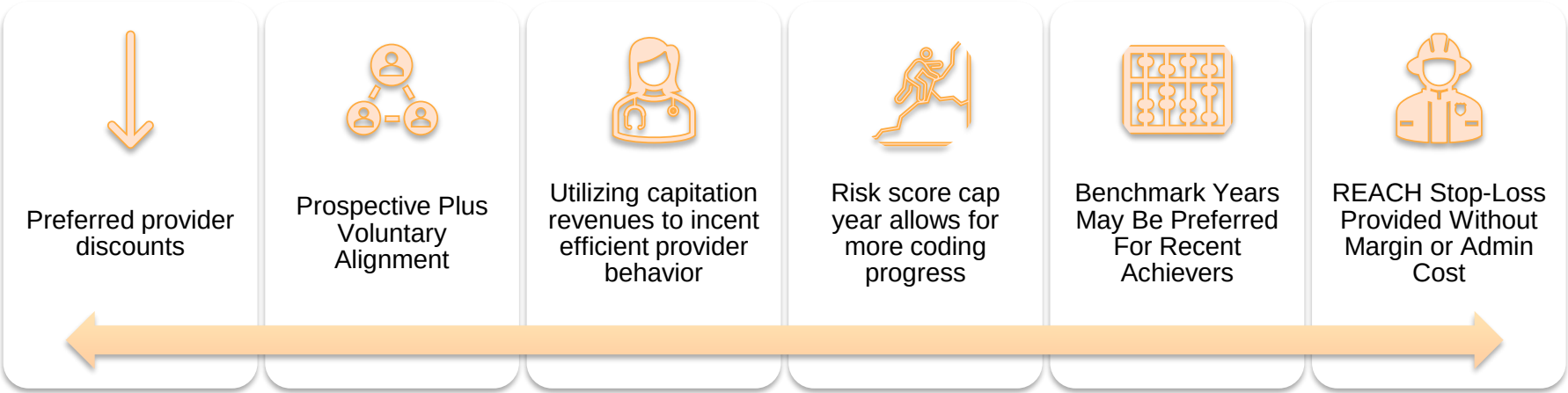
ACO REACH Strategy

Pick Your Poison – Discount or % Of Savings



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

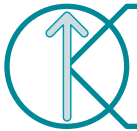
REACH Only Financial Advantages



Preferred Provider Discounts

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

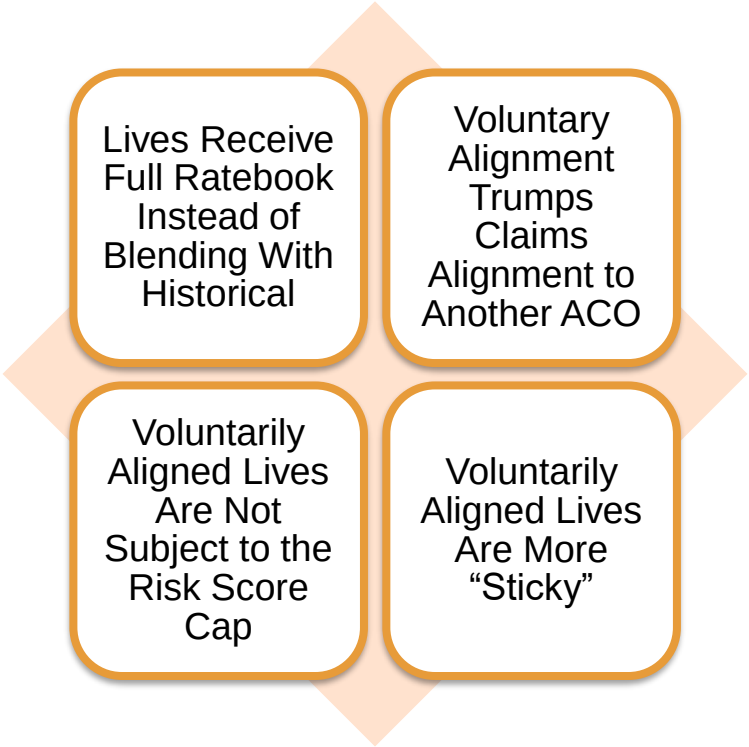
Discounts are measured as a percent reduction to Medicare FFS



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

REACH Voluntary Aligned Advantages



Capitation Revenues

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

REACH Stop-Loss

Cost is calculated to be break-even for the ACO → No margin or administrative cost charges → Often Elected Because Priced Better Than Private Options

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

Options For Forecasting

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

Takeaways On REACH

- 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**