ACO REACH PY2025 UPDATES – COULD THIS BE THE LAST STRAW FOR ACOS?

Brad Heywood, ASA, MAAA
720.221.9601 • brad.heywood@wakely.com

Zach Davis, FSA, MAAA
404.282.4780 • zach.davis@wakely.com

ACO REACH PY2025 Benchmarking Updates

The long-awaited methodology changes for Performance Year (PY) 2025 ACO REACH benchmarking were finally released in late July. While the more detailed methodology papers have yet to be released as of the time of writing this paper, the quick reference guide on the key changes was released on Friday, July 26th[1]. The methodology changes, while some being favorable and some unfavorable, have been met with disappointment and further uncertainty surrounding the future of the model.

As stated by The CMS Innovation Center (CMMI), the recommendations contained within the release were influenced by the Global and Professional Direct Contracting Model PY2022 Evaluation Report released by CMMI earlier in July[2]. The study found that Standard DCEs (Direct Contracting Entities, AKA an ACO) increased Medicare spending by 0.8% ($193 Million) through increasing professional, specialty, and acute care spending. New Entrant DCEs reduced Medicare spending by -1.4% (-$14 Million), and High Needs ACOs reduced Medicare spending by -3.8% ($8 Million). The net result was an increase to overall Medicare spending which likely influenced the unfavorable changes outlined in the PY2025 benchmarking updates.

The following sections outline some of the expectations ACOs were hoping to see in the updates, along with a summary of all of the key changes included within the actual release.

Expected Changes / Advocacy for PY2025 and PY2026

Prior to the release of the PY2025 benchmarking updates, there were many program updates groups were advocating to see within the updated methodology documentation. The following are some of those updates. These do not reflect an exhaustive list of the advocacy efforts, but rather some of the key changes seen for the financial benchmarking.

- **Lower Discount**

[1] https://www.cms.gov/aco-reach-model-performance-year-2025-model-update-quick-reference
[2] https://www.cms.gov/priorities/innovation/data-and-reports/2024/gpdc-2nd-ann-report

   - The prior regulation was increasing the discount from 3.0% in PY2024 to 3.5% in PY2025. Given the recent struggles with utilization increases seen across all Medicare programs, the increase to 3.5% was seen as too high of an impediment to realize savings.

- **Regional Retrospective Trend Adjustment**
   - The current methodology to calculate a Retrospective Trend Adjustment (RTA) is based off a national trend. Many regions experience higher trend than seen nationally putting them in an unfair disadvantage within the program.

- **RTA Additional Protection**
   - CMMI recently released an update adding in risk corridors to the RTA[3]. However, these risk corridors are particularly wide and only provide protection in outlier scenarios.

- **Regional Baseline Adjustment for High Needs & New Entrant ACOs**
   - Prior methodology for PY2025 would have used actual PY2021 – PY2023 experience to establish this adjustment. This would have caused disconnects from the actual PY2025 provider lists and their experience, to what the PY2021 – PY2024 actual experience was. Advocates wanted a change to use population based upon the PY2025 provider list.
   - Additionally, High Needs ACOs advocated for a change to the USPCC cap placed on the regional adjustment made as part of the regional baseline adjustment calculation. Advocates argued the 5% cap to the adjustment was not reflective of their population and therefore needed to be increased.

- **Risk Score Capping & Reference Year**
   - ACOs were looking for CMMI to further review the ACO risk capping methodology starting in PY2024. In particular, High Needs ACOs were going to be capped on their risk score from 2022 as well. Continued advocacy persists in this area.

- **Additional Data Transparency**
   - ACOs argued for additional data transparency into national / regional trends, substance abuse experience, and experience of non-data sharers within their organization, just to name a few.

As stated earlier, the above advocacy efforts are not an exhaustive list, but do reflect known advocacy efforts to help improve the ACO REACH program. Groups such as NAACOS[4] have released their advocacy efforts if the reader is interested in what other advocacy efforts are underway.

[3] https://www.cms.gov/priorities/innovation/innovation-models/reach-py24-model-perf
[4] National Association of ACOs

While some of the items listed above were part of the methodology changes, many were not, and some were in the opposite direction creating shock and concern across the industry. The following are the changes found within the methodology release.

PY2025 Methodology Changes

Maintain Current Benchmark Blend of Historical/Regional Expenditures for Standard ACOs

Summary of Update

In the development of the regional baseline adjustment that uses a lookback period of 2017 – 2019, a blend of 55% historical and 45% regional is applied before calculating the regional to historical comparison. This comparison adjustment is applied to the PY benchmark in the first few steps of its development. The prior regulation would have moved this to 50/50 creating an equal blend of regional and historical experience.

Potential Implications

This regional baseline adjustment is a factor (1.000 being no adjustment) applied to the county rate. In theory, the larger the factor, the higher the benchmark, and vice versa. This update will have a different impact depending on how the ACO compares to their region as follows:

- *ACO is **more** efficient than the region:* When an ACO is more efficient than the region, their factor is below 1.000. CMS allows a blend with the region to help adjust that factor slightly closer to 1.000. In essence, the more regional blend, the better the adjustment. This change will therefore lower the regional adjustment factor resulting in an unfavorable benchmark adjustment compared to what it would have been at a 50/50 blend.
- *ACO is **less** efficient than the region:* The opposite is true when an ACO is less efficient than the region. Under this scenario, the ACO would hold a higher adjustment when having a smaller regional blend resulting in a favorable benchmark adjustment compared to what it would have been at a 50/50 blend.

Reduce Ceiling for Regional Blend Adjustment to Benchmark for Standard ACOs

Summary of Update

Building upon the prior update above, CMMI is further adjusting the regional baseline rate by limiting the amount of increase the regional blend can have on the historical experience. Prior to 2025, an ACO could increase their historical experience by 5% (5% of USPCC) leading to an approximate5% “regional adjustment” that many saw as a potential arbitrage in benchmark savings in the performance year. The updated regulation is going to reduce that 5% to 3% which will limit that benefit many looked for to support potential savings in the future.

Potential Implications

The potential impact to an ACO falls into two categories:

- *ACO is **more than 6%** efficient than the region:* In simple terms, if an ACO is more than 6% lower cost (on a risk-adjusted basis) than the region, the ACO could have had an increase to their adjustment between 6% and 10% as well. Now, the adjustment will stop near the 6% mark. This change will therefore lower the add-on to the regional adjustment, lowering the factor resulting in an unfavorable benchmark adjustment.
- *ACO is **less than 6%** efficient than the region:* No impact will come from this program element update as the only change is to the max adjustment an ACO can achieve.

Increase Benchmark Discount for ACOs in Global Risk Sharing Option

Summary of Update

Arguably the *most discussed and controversial adjustment* to the benchmark is the discount. The discount is implemented to *guarantee* savings to the program since each ACO in the Global track has 100% upside and downside exposure. Without a discount applied to the program, savings to Medicare would not be realized for Global ACOs.

The discount has increased since the beginning of the model. When the program was first announced back in 2019, the discount was intended to start at 2% in 2021 and increase to 5% by 2025. When ACO REACH started in 2023, the glide path changed to 2% in 2021, increasing to 3.5% by 2025, and holding at 3.5% into 2026. This change will be another update to this glide path with the 2026 discount increasing to 4%.

Potential Implications

The discount only applies to Global ACOs which does represent the majority of the ACOs in ACO REACH. The impact will be a 0.5% reduction to their prior estimated PY2026 benchmark. No change will come to Professional ACOs.

A 0.5% impact to the benchmark has a much higher impact to the shared savings % earned by ACOs. For example, if an ACO earned 3% shared savings in 2025, that savings would be reduced by 17% (2.5% / 3.0% - 1) in 2026.

Update Risk Adjustment Model

Summary of Update

As part of the 2024 Medicare Advantage Advanced Notice[5], CMS announced a new risk adjustment model starting in 2024. It was later announced that this new model would be blended in with the old

[5] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/announcements-and-documents/2024-advance-notice

model by 1/3 every year until 2026 when it would be fully implemented. Both the MSSP and ACO REACH programs announced they would follow Medicare Advantage and blend in the new risk adjustment model as well. This update is simply a confirmation of the continual implementation of the new model (v28) blend into PY2025 at 2/3 weight and a full transition to v28 for PY2026.

Potential Implications

This update does not reflect an unexpected change to PY2025 and PY2026 methodology. Therefore, no potential impact due to an updated methodology is expected.

However, the new model, v28, does pose a potential impact to an ACO's overall benchmark. As seen in a previous white paper written by Wakely Consulting[6], **groups can experience large variations in the realm of +10% to -25% to their risk scores** due to the new risk adjustment model. If this is an area that your ACO has not reviewed as part of your future planning, contact a Wakely consultant to help you estimate what kind of impact you could potentially expect.

Ensure Budget Neutrality of Stop-Loss Reinsurance

Summary of Update

ACO REACH since its inception has included an optional stop-loss coverage to protect against members with excessive spending. This coverage was updated as part of the PY2024 updates and protects the ACO when a member exceeds costs around $150k (highly variable by ACO and member).

Given this is an optional coverage, CMS provided the estimated cost of the coverage to each ACO as part of the interim benchmark reporting package. This estimate was based off a CMS algorithm looking at prior years of experience and projecting a similar experience for the performance year. Depending on the level of high-cost members in the ACO's prior experience, the cost estimate had high variation ACO to ACO.

CMMI is now proposing to create this program as budget neutral by applying an adjustment to the payout (money given back to the ACO), to ensure budget neutrality. No consideration was given to overall, program-wide experience prior to this update.

Potential Implications

CMS has not publicly disclosed if the stop-loss program has historically generated a net benefit or net loss to ACOs on average. This update could imply that the program has historically generated a net benefit for ACOs, and CMS is looking to reconcile this. As such, it might be expected that this would be an unfavorable adjustment leading to increased expenditures. ACOs evaluating the CMS stop loss option for 2025 and 2026 should keep this in mind when evaluating against external stop-loss coverage.

Increase Ceiling for Regional Blend Adjustment to Benchmark for High Needs Population ACOs

[6] https://www.wakely.com/blog/proposed-ma-risk-adjustment-model-good-news-some-detrimental-others/

Summary of Update

This update is built of two different components that apply to the High Needs ACOs only:

1) Adjustment to the 5% cap on the regional blend when developing the regional baseline adjustment rate.

2) Change in the population developing the historical experience underneath the regional baseline adjustment calculation.

Adjustment to the 5% Cap – Contrast to the change above that dropped the 5% adjustment to 3%, High Needs ACOs will see the 5% cap, which was set to be implemented for the first time in PY2025, increase to 9%. This represents a win for High Needs ACOs that were expecting to see their benchmark drop significantly starting in PY2025 due to the incorporation of the regional baseline adjustment. While the 9% may not be the level the High Needs ACOs were hoping to see, it is an improvement above the prior level.

Attributed Population Adjustment – The prior regulation was written saying the *actual* experience of the ACO in PY2021 – PY2024 (2021 – 2023 for PY2025, and 2022 – 2024 for PY2026) would be included as the historical experience underlying the baseline regional adjustment. This created concerns for High Needs ACOs who had significant changes to their provider lists over the years creating a disconnect in their actual PY2021 – PY2024 experience and the potential of the new PY2025 provider list experience. CMS agreed to this concern and is now reverting to the Standard ACO methodology that takes the PY provider list, and then reviews the historical experience of *who would have been attributed* for each year.

Baseline Periods - Lastly, the regional baseline adjustment is going to be held constant at 2021 – 2023. Prior to this, PY2026 was going to rely on 2022 – 2024 for the adjustment factor. This was going to result in potential decreased savings moving into PY2026 as well.

Potential Implications

Adjustment to the 5% Cap – This will be an improvement to a High Needs ACO benchmark if they have more than a 5% regional efficiency. The 4% increase (5% -> 9%) will be seen as a 4% increase to their otherwise expected PY2025 and PY2026 benchmark if their regional efficiency is greater than that 9%.

Attributed Population Adjustment – This adjustment will better align with the methodology for the Standard ACOs and even the MSSP ACOs. However, this change could be favorable, or unfavorable. This adjustment will be favorable if the ACO had significant savings in *actual* PY2021 – PY2024, but their PY2025 provider list wasn't as efficient as the providers included back in those PYs. The adjustment will be unfavorable if the opposite is true and the new PY2025 provider list is more efficient than the PY2021 – PY2024 actual experience.

Baseline Periods – This update will be highly variable by ACO with some ACOs seeing it as favorable, and others as unfavorable. The overall impact will vary depending on the PY2025 provider's experience between 2021 – 2024.

High Needs ACOs may be at a disadvantage to understand their true adjustment due to this update if they have providers in their PY2025 that are new to their ACO. Contact your Wakely consultant if you want insights into these providers and how this adjustment might compare to the prior methodology.

Apply Standardized Area Deprivation Index (ADI) for Health Equity Benchmark Adjustment

Summary of Update

The Health Equity Benchmark Adjustment was first introduced as part of the ACO REACH revamp from Direct Contracting in PY2023. Since then, this adjustment was updated in PY2024 to include additional data to calculate it along with the actual adjustment made by decile. This represents the third iteration of this benchmark adjustment in CMMI's attempt to find the most appropriate approach to adjust the benchmark to account for health equity within the program.

The update in PY2024 was a change from the national level Area Deprivation Index to a blend of the national and a state-based Area Deprivation Index. This is now going to be removed and replaced with an area-level socioeconomic deprivation measure that uses standardized variables. CMS states the following on this change:

"This will ensure the ADI accurately captures deprivation in areas with high housing values. More information on the methodology will be forthcoming."

Potential Implications

This change will be highly specific to each ACO, but overall, the financial implications are unknown at this time until CMMI releases further information.

Reconcile Total Monies Owed (TMO) in Provisional Settlement

Summary of Update

The Provisional Settlement has long been one of the biggest benefits of ACO REACH in that it provides an earlier distribution of the prior year's shared savings to ACOs that opted into the settlement. This is another component that has continually been updated. It started as a reconciliation of solely the first six months of the prior year's shared savings to a provisional settlement of the full year's shared savings with placeholder values such as the Coding Intensity Factor (CIF), Quality earn back, and others.

In prior years, the placeholder values have led to provisional settlement distributions that resulted in an overpayment of savings. Under this scenario, ACOs needed to pay back the overpayment during final reconciliation. This is especially true for High Needs ACOs that didn't have final risk scores until much later after the provisional settlement.

Potential Implications

The financial implications of this adjustment is more reflective of the actual cash flow timing. As described above, some ACOs historically had received provisional settlements above what they were actually due. This resulted in repayments to CMS during the final reconciliation.

This adjustment will help mitigate this issue by including final adjustment factors for the PY, hopefully preventing the same repayment scenario from happening again.

Please note, this adjustment **does not change the actual PY settlement** overall. It only impacts the cash flow.

Improve Statistical Reliability of Benchmark for Voluntarily Aligned Beneficiaries

Summary of Update

In prior methodology, voluntary aligned beneficiaries were going to implement a regional baseline adjustment similar to the High Needs methodology described above. That is, using *actual* experience from PY2021 – PY2024 to adjust this population's benchmark. Through PY2024, only the county rate had been used with no adjustment for historical experience.

CMS is holding this methodology steady for voluntary aligned members by adjusting their regional baseline by using the *actual* 2021 – 2023 experience from voluntary aligned members in those years. CMS within this update clarifies that this applies only to Standard and New Entrant ACOs with more than 500 voluntarily aligned members, and High Needs ACOs with more than 250 members. If the thresholds aren't met, the voluntarily aligned members will continue using the ratebook only methodology with no baseline adjustment.

Please note, at the time of writing this paper, there is confusion in the industry around these thresholds and how they apply. In a recent webinar, CMMI stated the membership thresholds would be implemented during the performance year and not necessarily during the benchmark years. This comes as a change from what's seen in the Standard model that looks at membership thresholds in the benchmark years. More details are forthcoming from CMMI on this update.

Potential Implications

The prior methodology was going to adjust the PY benchmark depending on the *actual* experience from the ACO overall in the benchmark period. Now, the claims-aligned beneficiaries will have a new adjustment as described above, and the voluntary aligned members will be adjusted based upon the voluntary member's experience from 2021 – 2023.

This update has the potential for a favorable or unfavorable change depending on the experience of the voluntary aligned members in the ACO from 2021 – 2023. If the voluntary aligned members had more favorable experience 2021 – 2023, it will be an unfavorable adjustment. If the voluntary aligned members were less favorable in 2021 – 2023, this update will be favorable for ACOs.

Adjust PY 2023 Expenditures for Significant, Anomalous, and Highly Suspect (SAHS) Billing

Summary of Update

In PY2023, ACOs noticed significant billing to DME (Durable Medical Equipment). After further investigation, it was found that two CPT codes (A4352 and A4353) were the cause of this dramatic increase to DME expenditures. CMS investigated these two codes and found them to be fraudulent. From there, guidance has been released saying that those two codes would be removed from both the benchmark and expenditures.

This update follows on the heels of this issue with the following:

- The two codes described above will be removed from PY2023 expenditures when calculating the regional baseline adjustment.
- Additional guidance on any other anomalous billing will be forthcoming

Potential Implications

This update is set to mitigate any benchmark or expenditure concerns with regards to the DME fraud in PY2023. For those ACOs not impacted, or minimally impacted by the fraud, a very minimal impact is expected to be seen from this update. For ACOs significantly impacted by the fraud, this will result in the following:

- PY2023 expenditures will reduce significantly due to the DME fraud removal. This initially would result in higher savings in PY2023 which has already been seen.
    - Please note, DME fraud in PY2023 is estimate somewhere around 0.8% - 1.0% of total expenditures nationwide.
- PY2025 benchmark, which includes PY2023 experience, would result in a lower regional baseline adjustment, resulting in a slightly lower benchmark for PY2025. However, one could argue it's a more accurate benchmark that would have been overly-inflated if the DME fraud was included.
- PY2025 expenditures would vary depending on level of potential DME fraud. Given the recent investigations, this should be minimal in PY2025.

One important implication here is understanding how your own ACO would differ from the nation. For example, for High Needs ACOs, a 1% drop in benchmark due to removing the DME fraud CPTs could be a much heavier drop in benchmark than they might see in their expenditures.

Update Policy to Accommodate Guiding an Improved Dementia Experience (GUIDE) Model Overlaps

Summary of Update

GUIDE is a new CMMI model designed to provide enhanced funding to improve care for beneficiaries in Medicare suffering from Dementia. Prior to this change, the additional funding / payments made to beneficiaries aligned to both the GUIDE model and to ACO REACH was not included as an ACO REACH

expenditure. In contrast, the MSSP did include those payments in their settlements thus creating a disconnect between MSSP and ACO REACH.

This update now includes those additional payments as part of ACO REACH expenditures aligning with the MSSP.

Potential Implications

Overall, if an ACO has providers involved with the GUIDE model, this is an unfavorable update from PY2025 prior expectations given these payments were not going to be included prior to this update.

However, GUIDE is a new program designed to support beneficiaries with Dementia. While more payments are made under the model that will be included in the ACO REACH expenditures, *it could lead to reductions in other expenditures through the potentially improved care coordination for these beneficiaries*. While not guaranteed, this could offset the added costs.

Conclusion

While a few of the updates will lead to improvements to the model, the increased downward pressure placed on the benchmark via the discount increase, USPCC regional adjustment decrease, and others, could lead to ACOs deciding to leave ACO REACH and join the MSSP (Medicare Shared Savings Program) which has seen favorable adjustments in it's benchmarking methodology over the past few years (including the introduction of the new, PC Flex model[7]).

The concern of the authors here is the use of the Global and Professional Direct Contracting Model PY2022 Evaluation Report as the basis for making these updates to the ACO REACH model in PY2025. The model was in a very early stage of its existence which was also arguably impacted by outside forces such as COVID, an increased Q4 utilization, and a couple DCEs with significant losses driving the majority of the results[8]. Additionally, PY2023 & PY2024 saw a large increase in ACOs and overall membership joining the ACO REACH program that may not be reflective of the PY2022 results. Could CMMI have jumped the gun on relying too much on the PY2022 results? Could relying on these results so heavily be the last straw for the ACO REACH program overall?

Please contact Brad Heywood at brad.heywood@wakely.com or Zach Davis at zach.davis@wakely.com with any questions or to follow up on any of the concepts presented here.

[7] https://www.wakely.com/blog/pc-flex-right-your-aco/
[8] https://www.wakely.com/blog/direct-contracting-aco-reach-observations-py2022-financial-results/