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

Frequently Asked Questions

Version 1

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Contents

General Questions

1. Q: What is the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, which will transition from the Global and Professional Direct Contracting (GPDC) Model as of January 1, 2023?

The ACO REACH Model is the redesigned version of the Global and Professional Direct Contracting (GPDC) Model (collectively "the Model") and focuses on promoting health equity and addressing healthcare disparities for underserved communities, continuing the momentum of provider-led organizations participating in risk-based models, and protecting beneficiaries and the model with more applicant vetting, participant monitoring, and public transparency. The Model provides tools and resources to empower doctors and other health care providers to better coordinate and improve the quality of care they provide for patients in traditional Medicare. This approach affords patients greater individualized attention to their specific health care needs while preserving all services and flexibilities beneficiaries enjoy in traditional Medicare. The goal of the Model is to provide beneficiaries with access to enhanced benefits and to increase the availability of high quality, coordinated care, including for people in underserved populations.

The Model takes all the important lessons learned thus far from the CMS Center for Medicare and Medicaid Innovation's (Innovation Center) previous model tests and brings accountable care to Medicare beneficiaries who have previously lacked access to healthcare providers that participate in value-based initiatives in new and exciting ways. Please refer to the table for a comparison of ACO REACH and GPDC at https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison.

2. Q: What risk-sharing options are offered under the Model?

The CMS Innovation Center is testing two voluntary risk-sharing options under the Model:

1. Professional, a lower-risk option (50 percent Shared Savings/Shared Losses, subject to risk corridors) and

2. Global, a full risk option (100 percent Shared Savings/Shared Losses, subject to risk corridors)

3. Q: What are the benefits of participating in the Model?

The Model is intended to test whether the risk-based payment strategies available under the model align financial incentives across health care providers, and offer model participants (called ACOs, known as Direct Contracting Entities (DCEs) through December 31, 2022) flexibility to engage health care providers and patients in care delivery that preserves or enhances quality of care while at the same time reducing the total cost of care. Specifically, ACO REACH offers:

- Multiple risk-sharing arrangements,
- Flexible beneficiary alignment options, including enhancements to voluntary alignment relative to existing Medicare FFS initiatives,
- Capitation payment options that vary by risk-sharing arrangement,
- Benefit enhancements, which involve conditional waivers of Medicare payment rules, and other payment rule waivers to improve care coordination and service delivery,

- A focus on complex chronic and seriously ill beneficiaries,
- Options for organizations that have not participated in Medicare FFS previously, and
- Incentives to improve the quality of care for all aligned Medicare beneficiaries through financial mechanisms and, beginning in performance year (PY) 2023, health equity plans that encourage and support model participants and providers in addressing health inequities.

4. Q: What is the model timeline?

The first Performance Year of the Model began on April 1, 2021. The redesign of the Model, and its new name, the ACO REACH Model, starts on January 1, 2023 and will span four additional Performance Years, ending on December 31, 2026. On February 24, 2022, CMS issued a (Request for Applications (RFA) with an application deadline of April 22, for interested provider-led organizations to apply and begin participation in performance year 2023 (PY2023) with an optional Implementation Period (IP) to run from August 1, 2022 through December 31, 2022.

Since a number of model design features vary by year, we have summarized the policies here (note that the parameters listed in the table below apply to all REACH ACOs (called Direct Contracting Entities (DCEs) through December 31, 2022) whether they began model participation in PY2021, PY2022 or PY2023).

Revised model timeline and 'time-dependent model parameters':

Calendar year / PY	Benchmark discount for Global ACOs	New Entrant / High Needs Population ACOs beneficiary alignment minimum	New Entrant & High Needs Population ACOs Benchmarking	Quality Withhold	Earn back for quality withhold
PY2021*	2%	1,000 / 250	Rate book-driven	5%	1% performance, 4% reporting
PY2022	2%	1,000 / 250	Rate book-driven	5%	1% performance, 4% reporting
PY2023	3%	2,000 / 500	Rate book-driven	2%	2% performance
PY2024	3%	3,000 / 750	Rate book-driven	2%	2% performance
PY2025	3.5%	5,000 / 1,200	Baseline-driven	2%	2% performance
PY2026	3.5%	5,000 / 1,400	Baseline-driven	2%	2% performance

* April 1 – December 31, 2021

5. Q: What is the purpose of the Implementation Period (IP) and when will it begin?

To help organizations newer to Medicare FFS and/or Innovation Center models build an aligned Medicare FFS population, the Model provides enhanced opportunities for voluntary alignment relative to existing Medicare FFS initiatives. In line with the opportunities made available to model participants that began participation in PY2021 and PY2022, the Innovation Center will allow all applicants accepted

under the February 24, 2022 RFA to participate in an Implementation Period leading up to PY2023 (herein referred to as 'IP3,' since it will be the third such Implementation Period). The IP3 will begin August 1, 2022 and run through December 31, 2022 and is intended to provide REACH ACOs joining the model beginning in PY2023 an opportunity to conduct voluntary alignment activities in preparation for meeting the applicable beneficiary alignment minimum at the start of PY2023. Participation in the IP3 does not commit a REACH ACO to participate in the model performance period beginning in PY2023.

6. Q: How can a REACH ACO assess if it meets the requirements to be a Standard ACO, New Entrant ACO, or High Needs Population ACO, for example, if it has its sufficient level of experience with Medicare FFS to be a Standard ACO?

A REACH ACO is a legal entity that participates in ACO REACH pursuant to a Participation Agreement with CMS. In addition to organizations that have traditionally provided services to a Medicare FFS population, the Model provides new opportunities for provider-led organizations without significant experience in FFS alternative payment models but with strong track records of taking risk and improving quality of care for seniors and vulnerable populations outside of FFS Medicare. There are three types of participating REACH ACOs with different characteristics and operational parameters.

Key criteria are outlined below. The complete details of each of the three ACO types are available in the RFA.

<u>Standard ACOs</u>

- Organizations with substantial experience serving Medicare FFS beneficiaries, including Medicare-only and dually eligible beneficiaries, who are aligned to an ACO through voluntary alignment or claims-based alignment. These may be organizations that previously participated in section 1115A shared savings models (e.g., Next Generation ACO (NGACO) Model and Pioneer ACO Model) and/or the Medicare Shared Savings Program (Shared Savings Program), , or new organizations, composed of existing Medicare FFS providers and suppliers created in order to participate in ACO REACH. Alternatively, new organizations, composed of existing Medicare FFS providers and suppliers, may be created in order to apply to participate as this ACO type. In either case, CMS expects that providers and suppliers participating within these organizations would have substantial experience serving Medicare FFS beneficiaries.
- Required to have a minimum of 5,000 aligned beneficiaries prior to the start of each PY from PY2023 through PY2026.
- Required to have at least 3,000 beneficiaries that would have been aligned via claims in at least one base year (2017-2019).

<u>New Entrant ACOs</u>

- Organizations with less experience serving a Medicare FFS population and/or taking risk for FFS Medicare beneficiaries.
- May not have more than 50% of Participant Providers* with prior experience in the Shared Savings Program, the NGACO Model, Vermont All Payer ACO Model, the Comprehensive ESRD Care (CEC) Model, the Kidney Care Choices Model, Comprehensive Primary Care Plus

(CPC+) Model, the Primary Care First Model, the Maryland Primary Care Program or the Pioneer ACO Model.**

- Must meet an increasing minimum number of aligned beneficiaries, starting with 2,000 prior to the start of PY2023, 3,000 prior to the start of PY2024, and 5,000 prior to the start of PY2025 and PY2026.
- For PY2023 through PY2024, may not have more than 3,000 beneficiaries that are "alignable" through claims-based alignment in any base year (2017, 2018 and 2019). CMS will assess this by determining the volume of services provided by the ACO's proposed Participant Providers to Medicare FFS beneficiaries. Any FFS beneficiaries with a plurality of Primary Care Qualified Evaluation & Management (PQEM) claims billed by an ACO's proposed Participant Providers during the alignment period who also meet beneficiary eligibility requirements as of January 1 of a given year will be considered "alignable" in that year.**

*See definition in the ACO REACH Model RFA: https://innovation.cms.gov/media/document/aco-reach-rfa
**Organizations found ineligible to participate as a New Entrant ACO based on this criterion will be offered the opportunity to participate as a Standard ACO, provided all other model eligibility requirements are met.

High Needs Population ACOs

- ACOs that serve FFS Medicare beneficiaries with complex needs, including dually eligible beneficiaries, who are aligned to the ACO through voluntary alignment or claims-based alignment. These ACOs are expected to use a model of care designed to serve individuals with complex needs, like the one employed by the Programs of All-Inclusive Care for the Elderly (PACE), to coordinate care for their aligned beneficiaries. Entities applying as a Standard ACO or a New Entrant ACO will not be allowed to also apply as a High Needs Population ACO in the same service area.
- Where applicable, CMS will also assess an organization's experience providing a range of Medicaid-covered services and demonstrated ability to coordinate services across Medicare and Medicaid for dually eligible beneficiaries and prevent unnecessary utilization of higher cost institutional care.
- Required to have demonstrated capabilities in coordination of services that emphasize person-centered care, such as an interdisciplinary care team that includes primary care, behavioral health, and Long-Term Services and Supports (LTSS) providers and that manages care across a range of settings.
- Must meet an increasing minimum number of aligned beneficiaries, with a minimum of at least 500 prior to the start of PY2023, 750 prior to the start of PY2024, 1,200 prior to the start of PY2025, and 1,400 prior to the start of PY2026. In addition to the beneficiary eligibility requirements that apply for purposes of aligning beneficiaries to other types of ACOs in ACO REACH, beneficiaries must meet additional eligibility requirements to be aligned to a High Needs Population ACO – see Appendix B of the Financial Operating Guide Overview paper available on our website for details.

7. Q: Can an ACO move between the Global and Professional options?

ACOs may not simultaneously participate in more than one ACO REACH Model risk-sharing option (Professional or Global) during the model test. Before signing the ACO REACH Model Performance Period (MPP) Participation Agreement, the ACO may switch from Global to Professional, and vice versa. The ACO cannot move from the Global risk-sharing option to the Professional risk-sharing option after signing the MPP Participation Agreement. If the ACO wants to move from Professional to Global, it can select to change its risk-sharing option only at the following times:

- During PY2023 (specific deadline to be set by CMS), to take effect PY2024
- During PY2024 (specific deadline to be set by CMS), to take effect PY2025
- During PY2025 (specific deadline to be set by CMS), to take effect PY2026.

8. Q: Is ACO REACH an Advanced Alternative Payment Model (APM)?

Both the Global and Professional risk-sharing options under the Model meet the criteria to be Advanced Alternative Payment Models (APMs) (42 C.F.R. 414.1410) in PY2021 and PY2022, and we anticipate they will continue to meet such criteria for all subsequent performance years, subject to annual Advanced APM determinations. Eligible clinicians who are included on the Participation List, as defined in 42 C.F.R. 414.1305, of an ACO participating under either Global or Professional will be eligible for Qualifying APM Participant (QP) determinations.

9. Q: How does the Model impact Medicare beneficiaries?

Beneficiaries with Traditional Medicare retain all of their rights, coverage, and benefits, including the freedom to see any Medicare provider. Like previous ACO models, the Model requires participants to make medically necessary covered services available to beneficiaries in accordance with applicable law and prohibits restricting a beneficiary's freedom to choose where he or she receives care. Even if a beneficiary is aligned to a REACH ACO, they always have the freedom to see any Medicare-enrolled provider or supplier. CMS expects that beneficiaries whose primary care provider is part of a REACH ACO will see and feel improvements in the quality and experience of care they are getting because of the ACO REACH Model. For example, they may receive increased access to telehealth, home visits after leaving the hospital, cost sharing support to help with certain co-pays, or other enhanced services and beneficiary engagement incentives. Moreover, the new Health Equity provisions are expected to provide greater access for underserved communities, reaching beneficiaries who have not previously received coordinated care.

Starting in PY2023, CMS is requiring each REACH ACO to have both a Medicare beneficiary and consumer advocate serving on the REACH ACO's governing body who will hold voting rights (the same person is no longer permitted to fill both roles) to ensure beneficiary representation in the REACH ACO's governance.

If at any time a Medicare beneficiary or their caregiver has concerns about the ACO REACH Model, the Innovation Center has a model liaison that is part of the Medicare Beneficiary Ombudsman team in the Offices of Hearings and Inquiries. The model liaison can be reached through 1-800 Medicare and will assist in facilitating communications with the Medicare Quality Improvement Organizations (QIOs), the CMS regional offices, and ACO REACH Model team to ensure the beneficiary's concerns are heard.

10. Q: Can beneficiaries opt-out of CMS data sharing with ACOs?

Yes. Beneficiaries can opt out of having CMS share their claims data with a REACH ACO for care coordination and quality improvement purposes at any time by contacting 1-800-MEDICARE and indicating their preference that CMS does not share such with the ACO.

11. Q: How does ACO REACH differ from Medicare Advantage (MA)?

Beneficiaries with Traditional Medicare are able the freedom to see any Medicare enrolled provider or supplier while beneficiaries who enroll in most MA plans are usually required to see a provider in the MA plan's network for services that are not an emergency or urgently needed, with some plans permitting out-of-network coverage only with increased cost sharing. Like previous ACO models, the Model requires participants to make medically necessary covered services available to beneficiaries in accordance with applicable law and prohibits restricting a beneficiary's freedom to choose where he or she receives care. Even if a beneficiary is aligned to a REACH ACO, he or she always has the freedom to see any Medicare-enrolled provider or supplier they choose.

12. Q: Do beneficiaries retain freedom of choice in this model? Can beneficiaries switch primary care providers?

Beneficiaries aligned to a participant in the Model are in traditional Medicare and retain all of their rights, coverage, and benefits, including the freedom to see any Medicare-enrolled provider or supplier. They may switch healthcare providers at any time.

13. Q: Why is CMS making the change from GPDC to ACO REACH?

CMS redesigned and renamed the GPDC Model as the ACO REACH Model to better reflect the priorities of the Biden-Harris Administration, due to feedback received from participants and stakeholders, and to affirm our commitment to health equity as central to improving the quality of care for all beneficiaries. CMS is committed to making sure our nation's health care system works for everyone and eliminates health disparities. The ACO REACH Model is designed to advance this goal through the following important policies:

- Requiring all participants to have a robust health equity plan describing how they will identify and address health disparities in underserved communities; and

- Applying an adjustment to increase the benchmark for ACOs serving higher proportions of underserved beneficiaries, which will be identified using a composite measure that incorporates a combination of the Area Deprivation Index* and Dual Eligible Status to ensure the benefits of ACOs are available to all Medicare beneficiaries.

The ACO REACH Model takes all the important lessons learned thus far from the Innovation Center's previous model tests to bring accountable care to Medicare beneficiaries who have previously lacked access in new ways. Please refer to the table for a comparison of ACO REACH and GPDC at https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison.

* The University of Wisconsin Neighborhood Atlas website (https://www.neighborhoodatlas.medicine.wisc.edu/), Area Deprivation Index, was developed by researchers at the University of Wisconsin based on a measure developed by the Health Resources and Services Administration (HRSA) over three decades ago. It has been adapted to the Census Block Group level and includes factors measuring income, education, employment, and housing quality, which have

been linked to a number of healthcare outcomes, to rank neighborhoods by socioeconomic disadvantage

14. Q: How does the Model differ from the Next Generation ACO (NGACO) Model?

The Model builds on the experience of prior ACO initiatives including the NGACO Model and incorporates innovative approaches. The Model incorporates opportunities for greater financial risk than the NGACO Model and the Medicare Shared Saving Program supported by enhanced flexibilities and additional benefit enhancements (BEs). The Model also builds on the cash flow mechanisms of the NGACO Model by introducing capitation, requiring ACOs to receive upfront, at-risk, capitated payments and to pay their downstream providers and suppliers that participate in such capitated payment arrangements for services, allowing the ACO to better coordinate care delivery.

Additionally, the Model has a new financial methodology that features a benchmark developed based on the ACO REACH/KCC Rate Book (formerly called the GPDC/KCC Rate Book) and a new risk adjustment strategy that mitigates coding intensity and improves the accuracy of risk adjustment for complex, high-risk patients. In order to support this new methodology, the Model also offers an enhanced voluntary alignment methodology relative to existing Medicare initiatives, Prospective Plus Alignment, which allows ACOs to incorporate new beneficiaries into their aligned beneficiary population on a quarterly basis. The Model's benchmarking methodology and risk-sharing and beneficiary alignment options support the participation of organizations without significant experience in FFS alternative payment models but with a strong track record of taking risk and improving quality of care for seniors and vulnerable populations outside of FFS Medicare.

15. Q: Will there be any change in the file formats for claims data and other data elements that participants receive today beginning in PY2023?

CMS expects the data and reports, including the specific file formats and data elements, shared in the GPDC Model to remain largely the same when the model transitions to the redesigned and renamed ACO REACH Model. Some Model policies will require minor revisions to reporting templates, for example the inclusion of the Health Equity Benchmark Adjustment in the Quarterly Benchmark Reports. Additionally, CMS is always looking to improve and streamline the way data and reports are shared. As such, minor updates and improvements may be made independent of the Model policy updates. CMS expects to publish an updated version of the Reporting and Data Sharing Overview in the summer of 2022 that outlines the specifications of all data and reports to be shared in PY2023.

Application Process

16. Q: If our organization a current participant in GPDC, do we need to reapply for ACO REACH?

Current Model participants must maintain a strong compliance record and agree to meet all the ACO REACH Model requirements by January 1, 2023 to continue participating in the Model. All other entities that would like to begin participation on January 1, 2023 must submit an application in response to February 24, 2022 RFA.

17. Q: How does an organization apply to participate in the model?

The application portal opened on March 7, 2022 and will close at 11:59 PM Eastern Time (E.T.) on April 22, 2022. Applications are due by 11:59 PM E.T. on April 22, 2022. CMS is not soliciting Letters of Intent

(LOIs) for PY2023 starters, therefore submitting an LOI is not required to submit an application in response to this RFA. All ACOs accepted under this RFA for participation beginning in PY2023 will also have the opportunity (but not the obligation) to participate in the IP3. Please continue to check the website for updated timelines: https://innovation.cms.gov/innovation-models/aco-reach. Applicants may access the application portal using this link: https://cms.gov1.qualtrics.com/jfe/form/SV_3ObYIoSMcM621My

18. Q: If we apply for ACO REACH, is the application binding on our organization?

An application does not obligate your organization to join the ACO REACH Model. If your organization's application is accepted, you will be offered a Model Performance Period (MPP) Participation Agreement (PA) to sign in late December 2022. Only if you sign the PA are you able to participate in ACO REACH for PY2023. Organizations can apply and subsequently withdraw their applications. The instructions for withdrawing an application are in section IV.B. of the RFA.

19. Q: Will there be another Model cohort in 2024?

CMS does not anticipate reopening applications after this year.

20. Q: Is there a cap on the number of applicants that CMS will accept?

Although there is no cap currently established, as stated in the RFA, depending on the volume of applications received, CMS may choose to limit the total number of accepted applications.

21. Q: How will CMS select participants for the model?

CMS will assess applications in accordance with specific criteria in multiple domains: organizational readiness (15 points); financial plan and risk-sharing experience (35 points); clinical care model (35 points), and data and health IT capabilities (15 points). These domains and associated point scores are detailed in Appendix D of the RFA. In addition, new application scoring criteria will consider a demonstrated strong track record of direct patient care, a demonstrated record of serving historically underserved populations with positive quality outcomes as well as program integrity risks posed by Applicant ACOs.

22. Q: How does the Participant Provider and Preferred Provider list submission process work?

Prior to each performance year (PY), REACH ACOs will have the opportunity to add Participant Providers and Preferred Providers to their Participant Provider List and Preferred Provider List effective on the 1st day of that PY. For example, for PY2023, we expect the dates to add / remove Participant Providers and Preferred Providers to their respective lists will be in mid to late summer of 2022 (CMS will publish specific deadlines for adding and removing providers and suppliers from these lists in the near future). The specific list submission process occurs through 4innovation (4i), the user interface for participation in the ACO REACH Model. Access to 4i and details for adding providers and suppliers via 4i will be made available to applicants selected for participation in the Model beginning in PY2023. The PY2022 Participant Provider List and Preferred Provider List will be carried over as a starting place for those REACH ACOs that were participating in the Model Performance Period of the Model during PY2022.

This initial, pre-Performance Year window to add Participant Providers and Preferred Providers is important, as only Participant Providers added in this window count for claims-based alignment and for

prospective voluntary alignment (i.e., voluntary alignment effective the first day of the year) for the PY. Additionally, only Participant Providers and Preferred Providers added in the pre-PY window are eligible to participate in the ACO's selected Capitation Payment Mechanism (Total Care Capitation, Primary Care Capitation) or Advanced Payment in the PY.

Participant Providers and Preferred Providers can also be added mid-PY, effective at the start of each month, as part of an ad-hoc process; however, Participant Providers that are added mid-PY will not contribute to claims-based alignment for that PY and neither Participant Providers nor Preferred Providers added mid-year will be eligible to participate in the ACO's selected Capitation Payment Mechanism (Total Care Capitation, Primary Care Capitation) or Advanced Payment. Further, physicians and non-physician practitioners may be added to the Participant Providers List only under one of three conditions (Preferred Providers are not subject to the same restrictions):

1. If the individual (1) bills (at the time of the proposed addition) for items and services he or she furnishes under a Medicare billing number assigned to the TIN of an entity that is a Participant Provider in the same ACO (at the time of the proposed addition), and (2) did not bill for such items and services under that TIN when the ACO submitted its Proposed Participant Provider List prior to the start of the PY;

2. The individual (1) bills for items and services under a billing number assigned to a TIN that is under the control of the ACO or a current Participant Provider in the ACO (at the time of the proposed addition) as the result of a merger or acquisition by the ACO or Participant Provider, and (2) the individual's billing number was not assigned to a TIN that was under the control of the ACO or Participant Provider when the ACO submitted its Proposed Participant Provider List prior to the start of the PY; or

3. The individual was dropped from the ACO's final Participant Provider List prior to the start of the PY due to overlaps with another Innovation Center model or Medicare initiative (e.g., Medicare Shared Savings Program), and that overlap has since been resolved.

23. Q: When will REACH ACOs be required to submit their Participant Provider Lists and Preferred Provider Lists?

Organizations applying to participate in the ACO REACH model do not need to submit their proposed Participant Provider List or proposed Preferred Provider Lists with their application. CMS will ask for such lists beginning in July and ending in early September. Applicants that are selected for participation in the Model will receive a detailed timeline of list submission activities and due dates in early Spring 2022.

24. Q: What are the processes, deadlines and consequences for withdrawing early from the Model should an ACO choose to do so?

ACOs may participate in the IP3 and choose not to sign the Participation Agreement for the Model Performance Period ("MPP Participation Agreement"), which would signal a withdrawal from the Model, without any financial consequences.

To withdraw from the Model once a PY begins, ACOs generally must give notice of termination of their MPP Participation Agreement prior to February 28th of a PY or such other date specified in the MPP Participation Agreement (the "Termination Withhold Liability Date") to avoid liability for shared losses

for that PY (note: Regardless of the PY in which an ACO begins participation in the Model, there is no "Termination Without Liability Date" for an ACO's first PY in the model. Thus, ACOs that early terminate their participation in the Model during their first PY will be liable for any shared losses for that PY regardless of the date on which the ACO provides notice of termination). To incentivize ACOs to participate in the model for a minimum of two PYs, ACOs will also face financial consequences for not participating in at least two PYs and have two options for securing a Participation Commitment Mechanism:

1. ACOs may choose a 2% "retention withhold," which is an additional 2% withhold applied to the ACO's PY Benchmark. If the ACO has not provided notice of termination by the Termination Without Liability Date of their second PY, the 2% retention withhold will be refunded to the ACO during financial settlement for the ACO's first PY. If, on the other hand, the ACO voluntarily terminates its participation in the model prior to the Termination Withhold Liability Date for its second Performance Year, the ACO will not receive the 2% withhold as part of financial settlement for its first PY.
2. Alternatively, the ACO may choose to secure a "Retention Guarantee Amount," calculated to be an amount equivalent to the retention withhold (i.e., 2% of the ACO's PY Benchmark), either by increasing the amount of the financial guarantee the ACO will be required to secure to ensure its ability to repay CMS Shared Losses and Other Monies Owed, or through a separate financial guarantee. In the event that the ACO voluntarily terminates its participation in the model prior to the Termination Without Liability Date of its second PY, the ACO will be required to pay CMS the retention guarantee amount. If the ACO does not pay the retention guarantee amount to CMS, CMS would collect the retention amount under the terms of the ACO's financial guarantee.

Note: If a PY2022 starter decides against continuing participation in the Model into PY2023, CMMI will terminate the entity's Model Performance Period Participation Agreement effective 12/31/22. Under these circumstances, CMS will refund the retention withhold or will decline to seek the retention guarantee amount, as applicable.

25. Q: How may I receive more information?

For more information regarding the ACO REACH Model, CMS recommends that you:

- Visit the ACO REACH website,
- Read the ACO REACH Request for Applications, and
- Subscribe to the ACO REACH Model listserv.

Questions may be submitted to ACOREACH@cms.hhs.gov. Questions about the application should be directed to the same address with the Subject Line "Application Question."

Eligibility

26. Q: What types of organizations can apply for the ACO REACH model?

In the ACO REACH Model, providers are incentivized to provide high quality, well-coordinated health care to Medicare beneficiaries, including those in underserved communities. CMS encourages health care providers with a strong track record of direct patient care and experience providing care in underserved communities to apply to be part of this transformative model. ACO REACH places a strong

emphasis on provider-led organizations participating in the model, including a requirement that participating providers generally hold at least 75 percent of governing board voting rights beginning in PY2023. Additionally, a key objective of the Model is to provide organizations that have not traditionally provided services to a Medicare FFS population or have not previously participated in Innovation Center models but have innovative care delivery approaches with an opportunity to join a risk-based total cost of care model for the Medicare FFS population. Therefore, a wide variety of organizations may be eligible to apply. The following are examples of organization types that may be eligible:

- ACOs or ACO-like organizations
- Network of individual practices (e.g., IPA)
- Hospital system(s)
- Integrated delivery system
- Partnership of hospital system(s) and medical practices
- Skilled Nursing Facilities (SNFs)

27. Q: What eligibility criteria do potential ACOs need to meet to be accepted into the model?

An ACO must be a legal entity identified by a Federal taxpayer identification number (TIN) formed under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates.

Each ACO's TIN must be unique from all other TINs used by another ACO (i.e., two REACH ACOs cannot share a TIN). An ACO formed by two or more Participant Providers, each of which is identified by a unique TIN, must be a legal entity separate from the legal entity of any of its Participant Providers or Preferred Providers. If the ACO is formed by a single Participant Provider (such as a group practice), the ACO's legal entity and governing body may be the same as that of the Participant Provider.

All applicants must provide a copy of a certificate of incorporation or other documentation demonstrating that they are recognized as a legal entity in the state in which they are located prior to participating in the model. If the entity has not yet been incorporated by the application submission deadline, the entity can either submit your application to incorporate or a statement identifying the proposed corporation. Please note when the entity intends to incorporate in the application.

The ACO must also comply with all applicable laws and regulations, as well as all Model requirements.

ACOs must have an identifiable governing body with sole and exclusive authority to execute the functions and make final decisions on behalf of the ACO. The ACO governing body must be separate and unique to the ACO and must not be the same as the governing body of an entity participating in the ACO (unless the ACO is formed by a single Participant Provider, in which case the ACO's governing body may be the same as that of the Participant Provider).

28. Q: Can an ACO become a REACH ACO if it is currently participating in the Shared Savings Program, or in another Innovation Center model? Can ACOs, Participant Providers and Preferred Providers also participate in the Shared Savings Program or in other Innovation Center models?

During each PY, simultaneous participation by ACOs and their Participant Providers in ACO REACH and certain other risk-based initiatives is prohibited. Specifically, simultaneous participation in ACO REACH

and the Shared Savings Program, the Vermont All-Payer ACO Model, the Kidney Care Choices Model, any other Medicare initiative that involves shared savings, the Primary Care First Model, the Maryland Total Cost of Care Model, or the Independence at Home Demonstration is prohibited unless otherwise instructed by CMS. Simultaneous participation in ACO REACH and the Maryland Total Cost of Care Model is also prohibited for Preferred Providers.

Related to overlaps, beneficiaries aligned to REACH ACOs during the model performance period will not be eligible to initiate episodes under the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model.

29. Q: Does ACO REACH have any regional eligibility requirements? How many ACOs are selected in each region?

Generally, there are no regional eligibility requirements. Participation in ACO REACH is open to organizations across the country. CMS will select ACOs based on the quality of their application and the criteria listed in the RFA.

30. Q: What eligibility criteria do providers need to meet to participate as part of an ACO?

Each Standard ACO, New Entrant ACO, or High Needs Population ACO must contract with one or more Participant Providers. At least 75 percent control of the ACO's governing body must be held by Participant Providers or their designated representatives.

ACOs may also elect to enter into arrangements with Preferred Providers. Participant Providers and Preferred Providers may include, but are not limited to:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Hospitals employing physicians or other practitioners
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs)

While an ACO is not required to be a Medicare-enrolled provider or supplier in order to participate in the ACO REACH Model, each Participant Provider and Preferred Provider under the ACO must be a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202) at the time when they are added to the Participant Provider list or Preferred Provider list. ACOs will be able to update their list of Participant Providers and Preferred Providers annually to add Participant Providers or Preferred Providers that satisfy the requirements of the model.

31. Q: Must all downstream providers, including all Participant Providers and Preferred Providers, meet CEHRT Requirements?

Under the Model, ACOs are required to ensure that the percentage of Participant Providers that are eligible clinicians and that use certified electronic health record technology (CEHRT) to document and communicate clinical care to their patients or other health care providers meets or exceeds the CEHRT use criterion established under 42 C.F.R. 414.1415(a)(1)(i), currently 75%. If palliative care, hospice or home health providers are Participant Providers then they would be subject to this requirement and

included in the denominator of the 75% requirement. Preferred Providers are not subject to the CEHRT use requirement under the Model.

32. Q: What is the difference between Participant Providers and Preferred Providers?

Participant Providers are the core health care providers and suppliers in the Professional and Global risk-sharing Options. Beneficiaries are aligned to the ACO through the Participant Providers and these providers and suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Unlike Preferred Providers, all Participant Providers are required to be subject to the Capitation Payment Mechanism selected by the ACO, which involves Medicare Fee-For-Service claims reductions and the requirement that the ACO and the Participant Provider enter into a written payment arrangement. Participant Providers may participate in benefit enhancements and beneficiary engagement incentives.

Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, Preferred Providers may participate in benefit enhancements and beneficiary engagement incentives and have the option to participate in the ACO's selected Capitation Payment Mechanism. Services furnished by Preferred Providers will not be considered in beneficiary alignment and Preferred Providers are not responsible for reporting quality through the ACO. Preferred Providers are optional for all ACOs.

There are no restrictive provider networks in ACO REACH. Beneficiaries aligned to an ACO are not required to receive services from Participant Providers or Preferred Providers. Beneficiaries, including those aligned to an ACO, may choose to receive services from Medicare FFS providers and suppliers that are not associated with the ACO.

33. Q: Explain how CMS will determine that at least 75 percent of the governing body consists of Participant Providers.

CMS will review the members of the governing body consistent with section V.C. of the February 24, 2022 Request for Applications. Starting in PY2023, at least 75 percent control of each ACO's governing body must be held by Participant Providers or their designated representatives. Please see the ACO REACH Model RFA (https://innovation.cms.gov/media/document/aco-reach-rfa) for a definition of Participant Providers and description of their role in ACO activities. Early in 2023, CMS will check each REACH ACO's governing body against the finalized list of Participant Providers to ensure this requirement is met.

As noted in the RFA, the ACO may seek an exception from the 75 percent control requirement, for example if state law prohibits health care providers from serving on the governing body, by submitting a proposal to CMS describing the current composition of the ACO's governing body and how the ACO will involve Participant Providers in innovative ways in ACO governance. Any exception to the 75 percent control requirement will be at the sole discretion of CMS.

34. Q: If the ACO's TIN is associated with another program, for example a Shared Savings Program ACO, does it need to create a new TIN in order to apply to ACO REACH as an ACO?

During a given Performance Year, the same TIN cannot be associated with both a REACH ACO and a Shared Savings Program ACO. An entity that intends to operate both a REACH ACO and a Shared Savings Program ACO would have to create a unique TIN for each ACO (and would be subject to restrictions on

provider/supplier and beneficiary overlaps as described in the RFA). An entity currently participating in the Shared Saving Program would not need to create a new TIN in order to participate in the ACO REACH Model provided its participation in the Shared Savings Program will terminate before the start of PY2023.

35. Q: Can a TIN choose which of its associated National Provider Identifiers (NPIs) participate in ACO REACH and which do not? Can a TIN have some NPIs in the Shared Savings Program and some NPIs in ACO REACH?

ACO REACH is a split TIN model, meaning that not all providers and suppliers billing under a TIN participating in the Model have to participate in ACO REACH. Participant Providers and Preferred Providers are identified based on the TIN-NPI combination. Only providers and suppliers that are included on the Participant Provider and Preferred Provider List submitted by the ACO and approved by CMS will be included in the ACO (and identified by the TIN-NPI combination).

During each PY of the ACO REACH Model, ACOs and their Participant Providers may not simultaneously participate in the Shared Savings Program and ACO REACH because the Shared Savings Program defines its participants at the TIN level (i.e., it is not a split TIN initiative). This restriction is not applicable to Preferred Providers, meaning that Preferred Providers can simultaneously participate in the Shared Savings Program and ACO REACH.

36. Q: How many beneficiaries does each ACO need to begin each PY?

ACOs are required to meet beneficiary alignment thresholds prior to the start of each PY. The IP3 provides additional time for ACOs concerned about meeting the minimum beneficiary thresholds to align beneficiaries prior to the start of PY2023. In both the Professional and Global risk-sharing options, ACOs will be expected to meet the minimum number of aligned beneficiaries outlined in the list below prior to the start of the applicable PY.

Performance Year (PY)	High-Needs-Population	New Entrant	Standard
PY2023	500	2,000	5,000
PY2024	750	3,000	5,000
PY2025	1,200	5,000	5,000
PY2026	1,400	5,000	5,000

New Entrant ACOs must not exceed 3,000 beneficiaries aligned via claims in any baseline year (2017, 2018 or 2019). If the 3,000 threshold is exceeded, the ACO will have the opportunity to participate as a Standard ACO, provided the applicable requirements are met. Additionally, of the 5,000 aligned beneficiaries a New Entrant ACO is required to have by PY2025, 3,000 or more must have been aligned via claims to show progress in establishing patient-provider relationships.

37. Q: Can a Standard ACO or New Entrant ACO split to form a separate High Needs Population ACO?

Per the ACO REACH Model RFA, High Needs Population ACOs and Standard or New Entrant ACOs with common ownership will not be permitted to operate in the same geography. For example, this means that Standard ACOs or New Entrant ACOs would not be allowed to split and form two separate ACOs –

one High Needs Population ACO for their High Needs-eligible beneficiaries and one Standard ACO / New Entrant ACO for their remaining beneficiaries.

38. Q: What happens if a High Needs Population ACO has high numbers of beneficiaries that can be used to construct a credible benchmark?

High Needs Population ACOs that reach 3,000 claim-based aligned beneficiaries in at least one base year (2017, 2018 or 2019) will convert to a Standard ACO methodology for purposes of their benchmark, similar to New Entrant ACOs. These High Needs Population ACOs will still have the flexibility to focus only on High Needs-eligible beneficiaries and will still use the concurrent risk adjustment methodology, but their benchmark will incorporate a historical baseline component for claims-aligned beneficiaries.

39. Q: Can an organization that primarily provides care for a specific population of Medicare FFS patients participate in ACO REACH?

The ACO REACH Model is intended only for organizations that serve a general, heterogenous population of FFS Medicare beneficiaries or that serve a sub-population of FFS Medicare beneficiaries for which a targeted total cost of care initiative does not exist. For example, the Kidney Care Choices (KCC) Model is a total cost of care initiative focused on Medicare beneficiaries with renal disease. Accordingly, organizations (or their Participant Providers, as appropriate) that serve primarily beneficiaries with Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD) should not submit an application for the ACO REACH Model and are instead encouraged to apply for KCC.

To help ensure that ACO REACH participants are not focused primarily on sub-populations of Medicare beneficiaries for which CMS already has a total cost of care initiative, to be selected for participation in the ACO REACH Model beginning in PY2023, an applicant must demonstrate an appropriate focus and / or diversity, as determined by CMS, among the individuals and entities the Applicant ACO expects will be Participant Providers. Specifically, an applicant comprised primarily of renal disease providers would not be selected to participate in the ACO REACH Model beginning in PY2023.

In addition, beginning in PY2023, no greater than 50% of each REACH ACO's aligned population may have a given medical condition or belong to a specialized subpopulation for which a targeted total cost of care initiative exists; ACOs that fail to satisfy this requirement will be subject to remedial action, potentially including termination. This requirement will apply to both existing ACOs and those organizations starting January 1, 2023. Organizations that serve a sub-population of FFS Medicare beneficiaries for which a targeted total cost of care initiative does not exist should further consider whether it is appropriate to apply to the ACO REACH Model as a High Needs Population ACO.

Beneficiary Alignment

40. Q: What eligibility criteria do beneficiaries need to meet to be aligned?

Beneficiaries will be considered alignment-eligible in a given month across all options for ACO alignment if they meet the following criteria:

- Are enrolled in both Medicare Parts A and B;
- Are not enrolled in an MA plan, Medicare Cost Plan under section 1876, Programs of All-Inclusive Care for the Elderly (PACE) organization, or other Medicare health plan;

- Have Medicare as the primary payer;
- Are a resident of the United States; and
- Reside in a county included in the ACO's service area (defined below).

For individuals to be eligible to be aligned to a High Needs Population ACO, they must also meet one or both of the following conditions: (1) have conditions that impair their mobility; and/or (2) meet the high needs special conditions for eligibility described in the RFA. Beneficiaries meeting one or both conditions are eligible for alignment to High Needs Population ACOs.

41. Q: How will ACO REACH alignment interact with Medicare managed care enrollment processes, including auto-assignment and Duals -Special Needs Plans (D-SNPs) default enrollment for newly eligible Medicare beneficiaries?

There is no impact on Medicare managed care enrollment. Only beneficiaries in traditional Medicare are eligible to be prospectively aligned to an ACO. If a beneficiary is aligned to an ACO and becomes ineligible for ACO alignment due to Medicare managed care enrollment, the beneficiary would become de-aligned from the ACO effective starting the first day of the month they lost eligibility (i.e. the date their Medicare managed care became effective.)

ACOs will not be permitted to undertake communication or marketing activities directed at influencing beneficiary insurance coverage choices (e.g., ACOs are prohibited from marketing Medicare Advantage to traditional Medicare beneficiaries).

42. Q: How does beneficiary alignment affect their Part D coverage?

Alignment has no effect on Part D enrollment or coverage. CMS expects that ACOs will help with beneficiary medication management as part of effective care management plans.

43. Q: How does CMS align beneficiaries to ACOs?

Beneficiaries may be aligned to a Standard ACO, New Entrant ACO, or High Needs Population ACO in two ways:

1. Claims-based alignment where beneficiaries are aligned based on the plurality of primary care services furnished by Participant Providers, as evidenced in historical claims data.

2. Voluntary alignment where a beneficiary designates a Participant Provider as his or her primary clinician or main source of care.

In order to be aligned to an ACO, the beneficiary must also meet the beneficiary eligibility criteria (described above). For more information on beneficiary alignment, please refer to Appendix B of the Financial Operating Guide Overview paper available on our website.

44. Q: Will the Model retain voluntary alignment features such as paper-based voluntary alignment, electronic voluntary alignment, and prospective plus alignment in PY2023 and beyond?

Yes. These features will remain part of the Model after it transitions to the redesigned and renamed ACO REACH Model.

45. Q: What is voluntary alignment?

Voluntary alignment is a process whereby CMS aligns to an ACO those beneficiaries who have designated a Participant Provider as their primary clinician or main source of care. A beneficiary who indicates that a Participant Provider is their primary clinician or main source of care generally will be aligned to the ACO, even if the beneficiary would not otherwise be aligned to the ACO based on claims-based alignment. In most cases, voluntary alignment will override claims-based alignment to another organization.

46. Q: How does voluntary alignment work?

CMS will permit ACOs to proactively communicate with beneficiaries regarding voluntary alignment, provided such communications comply with all applicable laws, regulations, guidance, and with the requirements of the Participation Agreement. Beneficiaries may voluntarily align with an ACO by designating a Participant Provider as their primary clinician or main source of care by either selecting a "primary clinician" on Medicare.gov (referred to as electronic voluntary alignment) or completing a paper-based voluntary alignment form. In the event a beneficiary has selected more than one Participant Provider as his or her primary clinician or main source of care, the most recent valid attestation will take precedence. The paper-based voluntary alignment will make use of a standardized template developed by CMS specific for the Model. Electronic platforms such as DocuSign or a patient portal may be used to accept "paper-based" voluntary alignment forms.

47. Q: Will paper-based voluntary alignment from the first two Performance Years of the Model be valid in PY2023 and beyond?

Paper-based voluntary alignment attestations previously accepted for the first two Performance Years of the Model will be considered valid in PY2023 and subsequent Performance Years if either the attestation was made within 2 calendar years prior to the start of the performance year (e.g., for a 1/1/2023 start in PY2023, the attestation was made no earlier than 1/1/2021) or the attestation was made more than 2 years prior to the start of the performance year, but the Participant Provider designated by the beneficiary has submitted a claim for a primary care qualified evaluation and management (PQEM) service furnished to the beneficiary within the last two calendar years.

Note that to ensure that ACOs are serving beneficiaries aligned via voluntarily alignment, if at Final Financial Settlement for a Performance Year CMS determines that a beneficiary did not have a single claim (of any type) during the performance year submitted by a Participant Provider or Preferred Provider in the ACO the beneficiary was aligned to via voluntary alignment AND the beneficiary had at least one claim for PQEM services during the performance year in the ACO's service area with a provider or supplier not in the ACO, the beneficiary will be retroactively removed from alignment to the ACO.

48. Q: How will CMS identify and align beneficiaries to High Needs Population ACOs?

CMS will align individuals to a High Needs Population ACO if they meet the high needs criteria prior to initial alignment and are otherwise eligible for alignment to an ACO via voluntary alignment or claims-based alignment. For individuals to be eligible to be aligned to a High Needs Population ACO, they must meet at least one of the criteria listed at the bottom of page 63 in the ACO REACH Model RFA. Medicare FFS beneficiaries, including dually eligible beneficiaries, meeting at least one of these conditions are eligible for alignment to a High Needs Population ACO.

In recognition of how the health of High Needs beneficiaries can deteriorate quickly and that eligibility determinations must be made in a timely manner to provide the necessary support to at-risk beneficiaries when they need it most, we will be checking High Needs eligibility quarterly. Beneficiaries who do not currently meet the High Needs Population ACO-specific beneficiary eligibility criteria, but who would otherwise be aligned to a High Needs Population ACO either through claims or voluntary alignment, will have up to four chances to become eligible for alignment to the High Needs Population ACO each PY. Once a beneficiary is determined to be eligible they will be aligned starting in the next quarter for the remaining months of the PY, for example January 1, April 1, July 1, or October 1 as applicable (unless the beneficiary does not meet general eligibility requirements, dies, or is otherwise retrospectively removed from alignment).

Starting in PY2021, once a beneficiary is determined to be High Needs-eligible and is aligned to an ACO, that beneficiary will be considered High Needs-eligible for the duration of the model performance period as long as the beneficiary remains aligned to the same High Needs Population ACO. For example, if a beneficiary meets High Needs eligibility criteria and is aligned to ACO X in PY2023, the beneficiary will not be de-aligned in PY2024 even if he/she ceases to meet High Needs eligibility in PY2024, provided that he/she continues to be aligned to ACO X in PY2024 (through claims or voluntary alignment) and meets the general model eligibility requirements (enrolled in both Part A and B, Medicare primary payer, etc.). This is to ensure continuity of care for High Needs beneficiaries and to avoid disadvantaging High Needs Population ACOs for providing effective care.

49. Q: How will CMS determine an ACO's Core Service Area and Extended Service Areas?

For Standard ACOs, New Entrant ACOs, and High Needs Population ACOs, CMS will identify an ACO's service area for purposes of beneficiary alignment based on the list of the Participant Providers submitted by the ACO. An ACO's Core Service Area includes all counties in which the ACO's Participant Providers have physical office locations. The Extended Service Area includes all counties adjacent to the Core Service Area. Beginning in PY2022, ACOs will be permitted to update their Core Service Area on a quarterly basis to add counties in the event that a Participant Provider with a physical office location in a new county is added during the PY.

The ACO's service area is distinct from the ACO's region, which includes all counties where ACO-aligned beneficiaries reside. For ACOs whose clinical model does not rely on a physical practice location (e.g., through delivery of services in locations other than a provider's office, such as beneficiaries' homes), ACOs may propose for CMS' consideration an alternative to the county-by-county physical practice location standard. To receive an exception, ACOs will be required to document their capability to operate in the proposed service area including the provision of face-to-face care and interaction with beneficiaries.

50. Q: Will ACOs be permitted to impose additional eligibility criteria in order to align only a subset of their otherwise alignment-eligible population, e.g., those with only certain diagnoses or living in certain subsets of the ACO's service area?

No, ACOs are not able to impose additional eligibility criteria beyond those listed in the ACO REACH Model RFA. ACOs will be responsible for all beneficiaries that are eligible and aligned according to the process CMS has established.

51. Q: Can an ACO operate in multiple regions that are geographically separate?

Yes, an ACO will be permitted to operate in multiple, non-contiguous regions.

52. Q: What is an ACO's region?

The ACO's region includes all counties where ACO-aligned beneficiaries reside. An ACO's region is used to determine which counties' regional expenditures should be incorporated into the PY Benchmark for an ACO. More details on the benchmark methodology can be found in the Financial Operating Guide Overview document available on our website. The ACO's region is distinct from its service area.

53. Q: Will the beneficiary alignment processes differ for New Entrant ACOs given they may have no experience with FFS beneficiaries?

In an effort to encourage participation in ACO REACH by organizations new to providing services to traditional Medicare beneficiaries, CMS will provide an alignment "glide path" to allow these New Entrant ACOs an adequate time to grow their population of aligned beneficiaries. Fundamentally, the mechanics of alignment will not change; voluntary alignment and claims-based alignment will serve as the sources of beneficiary alignment for these ACOs.

New Entrant ACOs may participate in ACO REACH during the IP3 and engage in activities related to voluntary alignment to meet the minimum of 2,000 aligned beneficiaries prior to the start of PY2023. New Entrant ACOs will be required to increase their population of aligned beneficiaries to a minimum of 3,000 prior to the start of PY2024 and 5,000 prior to the start of PY2025 and PY2026. Further, prior to the start of both PY2025 and PY2026, the New Entrant ACO must have more than 3,000 beneficiaries aligned using claims-based alignment. If the ACO does not meet this requirement, the ACO will not be permitted to continue participating in the model.

54. Q: What is the difference between Prospective Alignment and Prospective Plus Alignment? If a beneficiary voluntarily changes their alignment, does the selection of Prospective Alignment or Prospective Plus Alignment affect when the beneficiary is voluntarily aligned to an ACO?

Both of these alignment options rely on establishing the ACO's aligned beneficiary population prospectively; however, they differ in the frequency with which CMS aligns beneficiaries through voluntary alignment.

- **Prospective Alignment** will function similarly to the prospective alignment methodology used in the NGACO Model. All claims-based alignment and voluntary alignment will be completed prior to the start of each PY. If an ACO selects Prospective Alignment and a beneficiary who is not otherwise aligned to any other entity voluntarily aligns to that ACO after the annual alignment process is run for a PY, the beneficiary will not be aligned to the ACO until the following PY.

- **Prospective Plus Alignment** will allow ACOs to have beneficiaries aligned to the ACO via voluntary alignment (either electronic or paper-based) on a quarterly basis throughout the PY. Only those beneficiaries who were not already aligned to another ACO or an organization participating in another initiative for the PY will be aligned to the ACO mid-PY under Prospective Plus Alignment.

Benefit Enhancements (BEs) and Beneficiary Engagement Incentives (BEIs)

55. Q: What are some examples of benefit enhancements (BEs) and beneficiary engagement incentives (BEIs) that will be offered in the Model?

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS has designed certain benefit enhancements using the authority under section 1115A of the Social Security Act to conditionally waive certain Medicare payment requirements as part of testing the Model. In addition, CMS permits ACOs to furnish certain Beneficiary Engagement Incentives in the Model, which are designed to enhance beneficiary engagement and care coordination. While we will include the BEs and BEIs previously permitted in the GPDC Model, we are also including a new benefit enhancement in ACO REACH. The BEs and BEIs for implementation in ACO REACH are highlighted in the following table.

BEs and BEIs Available for PY2021 & PY2022[1]	New Benefit Enhancements for PY2023
• 3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement • Telehealth Benefit Enhancement • Post-Discharge Home Visits Benefit Enhancement • Care Management Home Visits Benefit Enhancement • Home Health Homebound Waiver Benefit Enhancement • Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement • Chronic Disease Management Reward Benefit Engagement Incentive • Cost Sharing Support for Part B Sharing Benefit Engagement Incentive	• Nurse Practitioner Services Benefit Enhancement

(1) Please note, the previously proposed benefit enhancement "Home Health Services Certified by Nurse Practitioners" was made permanent as authorized by section 3708 of the CARES Act.

56. Q: Can CMS provide a comprehensive list of BEs and BEIs that are currently available in the Model and expected to be available in the Model when it transitions to ACO REACH?

The Model currently includes the following BEs and BEIs, which CMS will continue to make available in PY2023 and subsequent Performance Years:

- **3-Day SNF rule waiver:** Conditionally waives the requirement for the three-day inpatient stay prior to admission to a qualified SNF or Swing Bed Hospital that is a Participant Provider or Preferred Provider.

- **Telehealth:** Conditionally waives the rural geographic requirement for an originating site and allows the beneficiary's place of residence to serve as an originating site when telehealth services are furnished by Preferred Providers, and also permits coverage of certain teledermatology and teleophthalmology services furnished by Participant Providers and Preferred Providers through asynchronous (i.e., store and forward) technologies.

- **Post-discharge home visits:** Allows auxiliary personnel (e.g., licensed clinicians) to perform "incident to" post-discharge home visit services to non-homebound aligned beneficiaries under the general supervision of a Participant Provider or Preferred Provider for up to nine visits in a 90-day period.

- **Nurse Practitioner Services:** This BE is expected to be available starting PY2023 and will allow ACOs to provide a streamlined approach for certifying and ordering care, avoiding duplicative work. ACOs that elect this BE will be able to have Nurse Practitioners who are Participant Providers or Preferred Providers and in accordance with state practice laws certify hospice care, need for diabetic shoes, and care plans for cardiac rehabilitation and home infusion therapy, and refer patients for medical nutrition therapy.

- **Care management home visits:** Allows auxiliary personnel (e.g., licensed clinicians) to perform "incident to" care-management home visit services to non-homebound aligned beneficiaries under the general supervision of a Participant Provider or Preferred Provider up to twenty times within a PY, unlike the NGACO Model, which allowed only 2 visits per 90-day period.

- **Part B Cost-Sharing Support:** This BEI allows ACOs to enter into arrangements with Participant Providers and Preferred Providers, under which they will reduce or eliminate beneficiary cost sharing for certain categories of Part B services and aligned beneficiaries identified by the ACO.

- **Chronic Disease Management Reward Program:** This BEI allows ACOs to provide a gift card reward to eligible beneficiaries for the purpose of incentivizing participation in a qualifying chronic disease management program. Among other requirements, the annual aggregate value of any and all gift cards provided to a beneficiary as a chronic disease management reward cannot exceed $75, cannot be offered in the form of cash or monetary discounts or rebates, including reduced cost-sharing or reduced premiums, and cannot be redeemable for cash.

57. Q: Are ACOs required to offer these BEs and BEIs?

BEs and BEIs are optional for all ACO types. An ACO may choose to implement some or all BEs and BEIs available under ACO REACH. ACOs will be asked to provide information, via an Implementation Plan, regarding their proposed execution of any BEs or BEIs they select to offer, but acceptance into ACO REACH is not contingent upon the ACO agreeing to implement any particular BE or BEI.

58. Q: If our ACO previously selected to offer a BE or BEI in PY2021 or PY2022, are we required to submit another implementation plan when the model transitions to ACO REACH in PY2023?

A new implementation plan is only required if the ACO has never utilized that BE or BEI. If an ACO is currently participating in the Model and submitted an implementation plan that CMS approved, a new implementation plan is not required, except as specified in the Participation Agreement.

Health Equity

59. Q: What is the purpose of the Health Equity Plan?

The purpose of a Health Equity Plan is for each REACH ACO to identify underserved communities within its aligned beneficiary population and implement initiatives to measure and reduce health disparities for such populations over the course of the model performance period. CMS will provide REACH ACOs a

template for their health equity plans that will be based on the CMS Disparities Impact Statement. REACH ACOs will use the template to identify health disparities, define their health equity goals, describe their health equity strategy, their plan for implementing their health equity strategy, and their approach for monitoring and evaluating progress in improving health equity within their aligned beneficiary population.

60. Q: Will CMS provide a template for the Health Equity plan?

Yes. CMS expects to provide a Health Equity plan template in late Fall 2022 for model participants to complete.

61. Q: Must REACH ACOs include their plans for using model payments to advance health equity in their Health Equity Plan?

As part of the Health Equity Plan, the template will prompt REACH ACOs to provide information on how they will use model-specific payments to provide more equitable healthcare to the underserved community(ies) they have chosen to prioritize.

62. Q: What is considered an underserved community?

Underserved communities are defined in the RFA as populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life. We derive this definition from the definition of "underserved communities" provided in Executive Order 13895. Executive Order 13895 provides a list of communities who exemplify its definition of "underserved communities" by referencing, within such definition, the definition it provides for "equity." When considering your aligned beneficiary population, REACH ACOs should consider populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life.

Financial Model

Note: Please refer to the finance-focused FAQ document available on our website under the Financial Methodology header.

Quality and Reporting

63. Q: What quality measures will be included in the proposed core set?

To ensure that ACOs meet the model goals of improved quality of care and health outcomes for Medicare beneficiaries, the Model includes the assessment of quality performance during each of the PYs. The quality strategy is designed to provide achievable performance criteria that incent the care delivery transformations necessary to reduce unnecessary utilization while maintaining and improving quality of care. CMS expects the core quality measures for PY2023 will be:

1. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (Claims Based)
2. Risk-Standardized All Condition Readmission (Claims Based)
3. Days at Home for Patients with Complex, Chronic Conditions (Claims Based). The measure will be utilized only by High Needs Population ACOs.

4. Timely Follow-up After Acute Exacerbation of Chronic Conditions (Claims Based). The measure will be utilized only by Standard ACOs and New Entrant ACOs.
5. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for Accountable Care Organizations (ACOs) surveys.[1]

64. Q: How does quality, including the quality measures, the CI/SEP, and the HPP, fit into the Performance Year Benchmark?

CMS will use a quality "withhold," in which a portion of an ACO's Performance Year Benchmark is held "at-risk," contingent upon the ACO's quality score. The quality withhold for PY2023-PY2026 will be set at two percent. The ACOs' performance on quality measures will determine how much of the quality withhold they will earn back at financial settlement. Assessment of all quality measures will be Pay-for-Performance for PY2023-PY2026 and will result in a quality score (0-100%) based on performance across all quality measures compared to the benchmark for each quality measure.

Starting in PY2024 for REACH ACOs that begin participation in PY2023 under this RFA (and starting in PY2023 for all other REACH ACOs), CMS is introducing a Continuous Improvement and Sustained Exceptional Performance (CI/SEP) factor. Because the methodology will factor in quality improvement over time, PY2023 starter REACH ACOs will be exempt / not assessed in their first performance year. ACOs that meet or exceed the CI/SEP criteria will have their quality score applied to the full quality withhold when calculating the earn back. ACOs that do not meet or exceed the CI/SEP criteria will have their quality score applied to half of the quality withhold when calculating the earn back. For example, an ACO with a quality score of 75% that meets the CI/SEP criteria will earn back 75% x 2% = 1.50%, whereas an ACO with a quality score of 75% that does not meet the CI/SEP criteria will earn back 75% x 1% = 0.75%.

Starting in PY2024 for REACH ACOs that begin participation in PY2023 under this RFA (and starting in PY2023 for all other REACH ACOs), CMS is introducing a High Performers Pool (HPP). The highest performing ACOs that meet or exceed the CI/SEP criteria may also earn a bonus payment from the HPP. The HPP will be funded by the portion of the quality withhold that is not earned back by ACOs that pass the CI/SEP criteria. For example, an ACO with a quality score of 75% that meets the CI/SEP criteria will contribute (1 - 75%) x 2% = 0.50% of its quality withhold to the HPP.

In PY2023, CMS will also reward ACOs for successful reporting of required beneficiary-reported demographic data to CMS by providing a bonus to the ACO's Total Quality Score of up to 10 percentage points. There will be no downward adjustment for non-submission in PY2023 and ACO Total Quality Scores will not be permitted to exceed 100%.

More details on this methodology will be included in the Quality Measurement Methodology paper made available on the ACO REACH website in the summer of 2022.

65. Q. Will an ACO's Participant Providers and Preferred Providers be eligible for Qualifying APM Participant (QP) status under the Quality Payment Program (QPP)?

Both the Global and Professional risk-sharing options under the Model met the criteria to be Advanced Alternative Payment Models (APMs) (42 C.F.R. 414.1410) in PY2021 and PY2022, and we anticipate they

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

will continue to meet such criteria for all subsequent performance years of the Model, subject to annual Advanced APM determinations. Eligible clinicians who are included on the Participation List, as defined in 42 C.F.R. 414.1305, of an ACO participating under either Global or Professional will be eligible for Qualifying APM Participant (QP) determinations. **Preferred Providers are not eligible for QP status under the ACO REACH Model**. Any Participant Providers who are eligible clinicians and who do not attain QP status for a performance year are eligible to be scored as participants in a MIPS APM for that performance year.

For the 2023 Performance Year/2025 payment year, QPs will continue to be excluded from MIPS scoring and payment adjustments, but will not receive an incentive payment. In the 2024 Performance Year/ 2026 payment year, and future years, QPs will receive an enhanced Conversion Factor update of 0.75% (as opposed to the 0.25% update for non-QPs), which will compound annually. For additional questions related to MIPS and the APM Incentive Payment, you can see the qpp.cms.gov website for more details or contact the Quality Payment Program help desk at qpp@cms.hhs.gov.

66. Q: Is the APM Incentive Payment considered an expenditure when calculating shared savings or shared losses?

The APM Incentive Payment will not be included in the Performance Year Benchmark or counted as part of the total cost of care for an ACO's aligned population used in calculating shared savings or shared losses.