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

PY2024 Participant and Preferred Provider Management Guide

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Acronyms

4i	4Innovation
A&D	Aged & Disabled
ACO	Accountable Care Organization
APO	Advanced Payment Option
BE	Benefit Enhancement
BHI	Behavioral Health Integration
BY	Base Year
CAH2	Critical Access Hospital Method 2
CEC	Comprehensive ESRD Care
CCM	Chronic Care Management
CCN	CMS Certification Number
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus
CPI	Center for Program Integrity
DCE	Direct Contracting Entity
ESRD	End Stage Renal Disease
FQHC	Federally Qualified Health Center
GAF	Geographic Adjustment Factor
GPDC	Global and Professional Direct Contracting
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System (HCPCS)
MA	Medicare Advantage
NGACO	Next Generation ACO
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
NPO	No Payment Option
OACT	Office of the Actuary
PBPM	Per-Beneficiary-Per-Month
PCC	Primary Care Capitation
PECOS	Provider Enrollment, Chain, and Ownership System
PM	Payment Mechanism
PQEM	Primary Care Qualified Evaluation and Management
PTAN	Provider Transaction Access Number
PY	Performance Year
REACH	Realizing Equity, Access, and Community Health
REH	Rural Emergency Hospital
RHC	Rural Health Clinic
SSN	Social Security Number
TCC	Total Care Capitation
TIN	Taxpayer Identification Number

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Section 1: Introduction

This document is intended to help Realizing Equity, Access, and Community Health (REACH) Accountable Care Organizations (ACOs) better understand the process of adding providers and suppliers to their ACO REACH Participant Provider List or Preferred Provider List in the 4Innovation (4i) tool as well as indicating in 4i which Participant Providers or Preferred Providers are participating in Payment Mechanisms (PMs): Capitation or Advanced Payment Option (i.e., have agreed to take Medicare fee-for-service (FFS) claims reductions for eligible services provided to aligned beneficiaries) and which have elected to provide Benefit Enhancements (BEs) or Beneficiary Engagement Incentives (BEIs). This document is intended to help answer questions such as:

- What should I consider before adding a given provider or supplier as a Participant Provider or Preferred Provider?
- Under which of the four Participant Types available in 4i should I enter each Participant Provider or Preferred Provider?
- Once I have selected a Participant Type, which required data identifiers should I enter in 4i?

Section 2 describes the differences between the two ACO REACH provider classes: Participant Providers and Preferred Providers.

Section 3 describes the provider types REACH ACOs may include as Participant Providers and/or Preferred Providers. These provider types are: Individual Practitioners; Facilities or Institutional Practitioners; and Organizational Providers. This section also details how the identifiers associated with these provider types are utilized in claims-based alignment and capitation.

Section 4 describes the Participant Management and Screening procedures each provider record must pass in order to participate in the model.

Section 5 describes the Benefit Enhancements (BEs) and Payment Mechanisms (PMs) providers may participate in as part of their REACH ACO.

Section 2: ACO REACH Provider Classes: Participant Providers versus Preferred Providers

In the ACO REACH Model, Medicare-enrolled providers or suppliers can participate directly in a REACH ACO in two ways: (1) by serving as a Participant Provider or (2) by serving as a Preferred Provider. Each provider type is subject to different requirements and has different model features available to them.

Only Participant Providers are considered for beneficiary alignment and are used for quality measure scoring. Therefore, all REACH ACOs must include Participant Providers. In addition, the Capitation Payment Mechanism chosen by the REACH ACO applies to all Participant Providers, and Participant Providers are eligible to qualify for Qualifying Alternative Payment Model Participant (QP) status under the Quality Payment Program (QPP) if they meet the QPP thresholds. For QPP-related questions, please email inquiries to QPP@cms.hhs.gov. Participant Providers may optionally participate in the Advanced Payment Options (APO) (if the REACH ACO selects Primary Care Capitation (PCC) and APO as its Capitation Payment Mechanism) and Benefit Enhancements (BEs) and Beneficiary Engagement Incentives (BEIs).

Including Preferred Providers is optional. Preferred Providers may participate in certain Benefit Enhancements, Capitation, and the APO (if the REACH ACO has selected PCC and APO), but are not considered in beneficiary alignment, are not used for quality measure scoring, and are not eligible for QP status.

Table 2.0 summarizes the differences between ACO REACH Participant Providers and Preferred Providers:

Is the provider…	**Participant Provider**	**Preferred Provider**
Included in REACH ACO?	Mandatory	Optional
Used for beneficiary alignment?	Yes	No
Eligible to participate in capitation?	Mandatory	Optional
Eligible to participate in APO[1]?	Optional	Optional
Used for Quality Measure scoring?	Yes	No
Eligible to participate in BEs/BEIs[2]?	Optional	Optional
Required to have a contract with the REACH ACO?	Yes	Yes
Required to have a signed Fee Reduction Agreement?	Yes	Only if participating in Capitation / APO
Eligible to receive shared savings?	Yes	Yes
Eligible to be a QP in the QPP[3]?	Yes	No

[1] Only applicable if the REACH ACO selects PCC.
[2] Further detail on BE and BEI eligibility included in Section 5.
[3] Subject to meeting QPP thresholds.
APO = Advanced Payment Option; BE = Benefit Enhancement; BEI = Beneficiary Engagement Incentive

Most Medicare-enrolled providers or suppliers may serve as a Participant Provider or Preferred Provider, including (but not limited to):

- Physicians or other practitioners in group practice arrangements;
- Networks of individual practices of physicians or other practitioners;
- Hospitals;

- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs); and
- Critical Access Hospitals (CAHs), Methods I and II (‘CAH2’[1]).

The following Medicare-enrolled providers and suppliers, however, are not eligible to serve as a Participant Provider or Preferred Provider:

- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers;
- Ambulance suppliers;
- Drug or device manufacturers; and/or
- Providers excluded or otherwise prohibited from participation in Medicare or Medicaid.

[1] CAH facilities are distinguished by two types of reimbursement for Outpatient Part B services: the Standard Payment Method (Method I) and the Optional Payment Method (Method II, which is also referred to as ‘CAH2’). Under the Standard Payment Method, CAH Method I facilities receive reimbursement from their Medicare Administrative Contractor (MAC) for CAH-furnished professional medical services under the Medicare Professional Fee Schedule (MPFS) that are rendered through a hospital outpatient department. Under the Optional Payment Method, physicians or practitioners may reassign billing rights to the CAH, thereby opting not to bill the MAC for professional outpatient services directly and instead receive their professional payment from the CAH. For more information, please review this Medicare Learning Network booklet: https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsht.pdf

Section 3: ACO REACH Participant Types: Three Types of Providers ACOs Can Add in 4i

In order to be included on a REACH ACO's Participant Provider List or Preferred Provider List for a given Performance Year (PY), REACH ACOs must first add the provider in the REACH ACO's 4Innovation (4i) portal during the window designated by CMS. There are three Participant Types[2] from which REACH ACOs can choose when adding a Participant Provider or Preferred Provider: (1) Individual Practitioner; (2) Facility or Institutional Provider; and (3) Organizational Provider. Each Participant Provider or Preferred Provider record must be entered into 4i as one of these three Participant Types and each requires different data elements as described in **Table 3.0**. Please note that the same person (e.g., Dr. Jones) may be entered multiple times with different identifiers which the ACO REACH Model considers unique provider records (please see the sections below on each Participant Type for details).

Table 3.0. Participant Type Identifiers and Medicare Enrollment Forms

Participant Type	Individual NPI[1]	Taxpayer ID Number[2]	Organization NPI[3]	CMS Certification Number[4]	Medicare Enrollment Form[5]
Individual Practitioner[6]	Required	Required	Prohibited	Prohibited	855i[7]
Facility or Institutional Provider	Prohibited[8]	Required	Required	Required	855A
Organizational Provider[9]	Prohibited	Required	Required	Prohibited	855B

[1] The NPI for practitioner records.
[2] Either the Employer Identification Number or the Social Security Number.
[3] The Organization NPI to which the physician assigns billing. This is required for Group Practices, Facilities, and Institutional Providers.
[4] Only Facilities and Institutional Providers will have a CMS Certification Number.
[5] Certain types of providers/suppliers are prohibited from participating in the ACO REACH model: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers, enrolled in Medicare as Institutional Providers submit Form CMS-855S. Ambulance Service Suppliers and Party B Drug Vendors – technically termed by Medicare Enrollment purposes as "Suppliers:" submits an 855B
[6] An Individual Practitioner can include a practitioner at a solo practice or sole proprietor that bills for their own services through a corporate entity of which the physician or non-physician practitioner is the sole owner.
[7] See Section 3.1 for additional detail regarding reassignment.
[8] See Section 3.1.2.1 for additional detail regarding practitioners at FQHC/RHC/CAH facilities.
[9] Organizational Providers are non-practitioner clinics and group practice records that submit a Form CMS-855B and are not Institutional Providers. These providers typically have a Provider Transaction Access Number (PTAN) that is not submitted for the model.

Note that all three Participant Types are available to both Participant Providers and Preferred Providers. However, it is important to carefully consider (1) how each provider or supplier that the REACH ACO wishes to add (as a Participant Provider or Preferred Provider) submits claims to Medicare and (2) how such billed claims are used in ACO REACH Model features such as claims-based alignment and claims reductions associated with Capitation and APO (see Section 3.1 for further details).

3.0.1 Using the 4Innovation System

The 4Innovation (4i) System will be used for managing the ACO's operations with CMS. Starting in PY2024, in addition to allowing ACOs to add and drop providers prior to the final add deadline for PY2024, 4i will allow ACOs

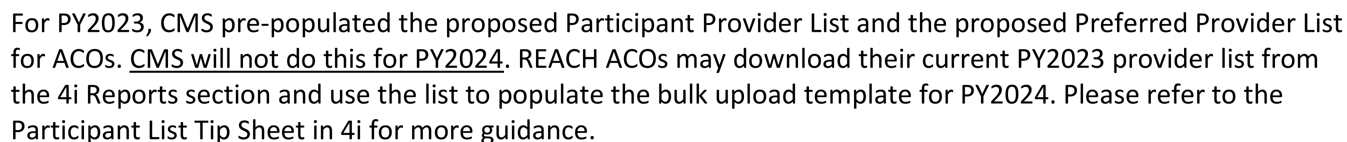
[2] For GPDC PY2021-PY2022, there were four participant types including the three in PY2024 and Practitioners at FQHC/RHC/CAH. Starting in PY2023, the Practitioners at FQHC/RHC/CAH type was removed as alignment and capitation activities are performed at the facility level and apply for all practitioners at these facilities (with the exception of voluntary alignment). For voluntary alignment, Individual NPIs for practitioners at these facilities can be added under an existing FQHC/RHC/CAH facility record.

to drop any providers that will not be participating in ACO REACH for PY2024 between the final add deadline and final drop deadline. ACOs will drop any providers prior to the final drop deadline directly in 4i and should not submit providers you intend to drop through 4i's File Exchange.

For technical guidance on how to complete the processes described here in 4i, please refer to the 4i Tip Sheets available in the 4i Knowledge Library (note: this resource is only available to active REACH ACOs). The most up to date Tip Sheets will be in the Data and IT Resources Category of the 4i Knowledge Library. CMS will notify the REACH ACOs of any updates to the Tip Sheets via the weekly newsletter.

3.0.2 Maintaining Participant Lists across Performance Years

Please note that it is the responsibility of the REACH ACO to maintain the accuracy of the Participant Provider Lists and Preferred Provider Lists for all PYs in which they are participating. In the event of a change to a provider's status, Benefit Enhancements (BEs), or Payment Mechanisms (PMs) that impacts more than one participant list, the ACO must separately update the lists for both periods**. For example, if a provider terminated their relationship with a PY2023 REACH ACO, the REACH ACO should terminate the provider in their PY2023 list and separately drop the provider from their PY2024 list (dropping the provider from the PY2023 list does not automatically drop the provider from the PY2024 list).**



For PY2023, CMS pre-populated the proposed Participant Provider List and the proposed Preferred Provider List for ACOs. CMS will not do this for PY2024. REACH ACOs may download their current PY2023 provider list from the 4i Reports section and use the list to populate the bulk upload template for PY2024. Please refer to the Participant List Tip Sheet in 4i for more guidance.

3.0.3 Adding Records to the Participant List

While submitting a provider record into 4i is the first step in adding a provider or supplier to the REACH ACO's approved ACO REACH Participant Provider List or Preferred Provider List, only records that pass validation in the 4i tool will be approved (see Section 4 for more details).

A Participant Provider may include one or more legacy TINs in the 4i submission if that TIN was previously used by the provider but is no longer in use by that provider[3]. A Participant Provider may include a single legacy CCN if the provider is practicing at a Rural Emergency Hospital (REH) that was previously a Critical Access Hospital (CAH) or qualifying Rural Health Clinics (RHCs). Submitted legacy TINs and legacy CCNs for Participant Providers will be used in claims-based alignment and are subject to model overlap checks (see Section 3.1.1.2 for additional details on legacy TIN overlap checks).

Participant Providers may be eligible to be added to a REACH ACO's provider list during an Ad Hoc window after the start of the Performance Year. Providers added during the Performance Year must pass the same processes and procedures applied to providers added before the start of the Performance year, and Participant Providers added during the Performance Year must also meet one of the following four conditions:

1. If the provider in question (1) bills (at the time of the addition) for items and services they furnish under a TIN that is used by an active Participant Provider in the same

[3] See the 4i tool guidance for how to submit multiple legacy TINs as applicable.

REACH ACO (TINs used by *only* Preferred Providers do not qualify), and (2) was not able to bill under that TIN when the ACO submitted its provider list prior to the start of the PY;

2. If the Participant Provider bills under a TIN that has been acquired by or merged with an existing TIN on your ACO REACH Participant Provider list since the ACO submitted its provider list prior to the start of the PY; or
3. If (1) the Participant Provider was dropped by CMS from the ACO's final ACO REACH Participant Provider list prior to the start of the PY due to overlaps with another CMMI model or shared savings initiative (e.g., Medicare Shared Savings Program) and (2) that overlap has since been resolved.
4. If the (1) Participant Provider was dropped by CMS from the ACO's final ACO REACH Participant Provider list prior to the start of the PY due to failing PECOS and (2) the Participant Provider is now passing PECOS.

Providers not present on the REACH ACO's Provider List submitted by the final drop deadline prior to the beginning of the Performance Year are not eligible to be added under the third and fourth conditions listed above, as CMS requires a record that these providers were initially submitted by the REACH ACO and initially failed the PECOS and/or overlap check in order to validate eligibility. **NOTE**: If you receive a PECOS check error or an overlap error when entering your proposed Participants for PY2024, do not delete or drop the Participant entry. Leave the entry in 4i so that CMMI has an audit trail to verify resolved PECOS and overlap ad hoc additions during PY2024.

Further details on adding providers during the Performance Year are provided in the PY2024 Ad Hoc Provider Guidance available in 4i's Knowledge Library.

3.0.4 Dropping Records from the Participant List

ACOs may drop providers that have not yet been approved prior to the close of the initial 4i window (prior to the Performance Year) or respective Ad Hoc window (during the Performance Year). Providers that are dropped from the Participant List *before* the respective 4i window closes are not submitted for CMS review for participation in the model (see Section 4 for approval criteria). Note if you may submit a provider as a Participant Provider during an Ad Hoc window during the Performance Year that you expect will meet condition 3 or 4 described in Section 3.0.3 and in the PY2024 Ad Hoc Provider Guidance, the provider must be included on your REACH ACO's Participant List as a Participant Provider at the close of the initial 4i window. Therefore, REACH ACOs are advised not to drop such Participant Providers who do not pass the initial PECOS and/or overlap check on their initial proposed Participant List in order to qualify for those conditions during the Performance Year.

3.1 ACO REACH Participant Types: Use in Claims-Based Alignment and Capitation

Identifiers submitted as part of a provider record are utilized in beneficiary alignment and financial calculations. REACH ACOs should ensure identifiers submitted in the 4i tool align with the identifiers submitted on billed services.

3.1.1 Individual Practitioner

An *Individual Practitioner* is a physician or a non-physician practitioner (NPP) who is enrolled with Medicare and defined as a *supplier* by Medicare regulations[4]. A non-physician practitioner may include, but is not limited to, a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, clinical psychologist, physical therapist, occupational therapist, and clinical social worker.

A physician or other professional supplier enrolled in Medicare using the CMS 855I form who bills for services using the professional claim form (the CMS-1500) or the ANSI ASC X12 Health Care Claim (837-P) transaction set for electronic submission of professional claims may be added in 4i as an Individual Practitioner.

Some Medicare-enrolled physicians or NPPs may practice independently, in a group practice setting, or at multiple practice locations. (A group practice is not an FQHC, RHC or CAH2.) For example:

1. Solo Practitioner: An individual practitioner as the sole proprietor, by either having a private practice or a professional corporation, professional association, etc. in which he/she is the sole owner.
2. Group Practitioner: An individual practitioner in a physician group practice that is not an FQHC/RHC/CAH2.

An Individual Practitioner can include a practitioner at a solo practice or sole proprietor that bills for their own services using a Taxpayer Identification Number (TIN) where the physician or non-physician practitioner is the sole owner. The TIN is either the Employer Identification Number (EIN) or the Social Security Number (SSN) and should be included on the Participant Provider List or Preferred Provider List.

For practitioners, the Individual NPI must be enrolled in Medicare, and in most cases, the billing must be reassigned to the submitted TIN (which would be separately enrolled through an 855B). For Physician Assistants (PAs), the PA must be employed at the TIN since there is often no reassignment relationship for PAs. See Section 3.1.1.1 for details on sole proprietors.

As noted in Section 3.1, an Individual Practitioner is identified in 4i by the unique combination of TIN and Individual NPI. The Individual NPI is the only NPI required for practitioner records. Typically, the Individual NPI is the rendering NPI on the claim line for professional claims and the rendering NPI on the claim header for institutional claims. For both claims-based alignment and for capitation or advanced payment, Medicare covered services (that count for claims-based alignment or are subject to FFS claims reductions) are identified as follows:

- The Individual NPI. This NPI is used to identify services on professional claims at the claim line level ('rendering physician'); and
- The Billing TIN. This TIN may be submitted on professional claims but is not a required field. If the Billing TIN is not submitted on the claim, the Billing NPI[5] appearing at the claim header level for

[4] Medicare regulations (42 CFR §400.202) define a *supplier* as: "A physician or other practitioner, or an entity *other than a provider*, that furnishes health care services under Medicare." (Emphasis added.) Suppliers are most often health care professionals, but a durable medical equipment company that is not a provider is also considered a supplier. Therefore, all health care professionals are suppliers, in the sense used by Medicare regulations, but a supplier is not necessarily a professional (for example: DMEPOS suppliers and ambulance suppliers are not professionals)

[5] The Billing NPI is either the Organizational NPI if the rendering NPI is part of a group practice or the Individual NPI if the provider has not assigned benefits to a group practice. Further details available in the **Medicare Claims Processing Manual, Chapter 26**.

professional claims is used to lookup its associated TIN in PECOS.

In all cases, the TIN and Individual NPI identifiers submitted in 4i must be the same as those used for Medicare billing by the practitioner. The Individual NPI submitted to 4i should match the rendering NPI at the claim line level on the professional claim format for services the REACH ACO wishes to identify, and the TIN submitted should be associated with the NPI that appears at the claim header level (billing NPI) on professional claims for services that the REACH ACO wishes to identify for the model. If the practitioner has reassigned billing rights to a group practice, the relevant TIN may be the group practice's TIN. If the practitioner practices in multiple settings billing professional claims that would be identified by different TIN-NPI combinations, then the REACH ACO must create separate Individual Practitioner records multiple times (as many times as required) if the REACH ACO intends to capture all of the services billed by the practitioner.

For example, a practitioner with NPI=1234567890 that practices in their solo practice billing under TIN=111111111 on Mondays but practices in a Group Practice billing under TIN=222222222 the rest of the week, the practitioner would need to be entered as two different Individual Practitioners, one identified by the TIN and Individual NPI combination of 111111111-1234567890 and the other by the TIN and Individual NPI combination of 222222222-1234567890, in order for all claims the practitioner renders (at the claim line level) and bills to count for claims-based alignment.

Importantly, adding an Individual Practitioner will only result in Medicare covered services on Professional claims at the claim line level, identified as described above (i.e., by the rendering NPI and Billing TIN), to be used for claims-based alignment or to be subject to FFS claims reductions associated with capitation or advanced payment. If the same practitioner also practices at a setting that bills institutional claims, such as rounds in an inpatient hospital setting or practices at an FQHC or RHC, adding this supplier as an Individual Practitioner identified by their TIN and Individual NPI will only impact the professional claims billed. In order to capture the Facility or Institutional provider claims, the supplier must also be entered as another Participant Type in 4i (Sections 3.1.2 and 3.1.3 for details).

Also, the TIN and Individual NPI will be used for voluntary alignment. For both Medicare.gov Voluntary Alignment (MVA) and Signed Attestation-based Voluntary Alignment (SVA), attestations must be associated with an active Individual Practitioner who is a Participant Provider. Any voluntary alignment attestations not associated with an active Individual Practitioner who is a Participant Provider will be rejected.

3.1.1.1 Sole Proprietors

If the Individual Practitioner is a sole proprietor, the relevant TIN to enter in 4i may be the practitioner's Social Security Number (SSN) or a TIN operated by the practitioner's solo practice (i.e., EIN). For sole proprietors, the Individual NPI must map to the Sole Proprietor's Billing TIN since there is no reassignment relationship in these cases. It is imperative that the Billing TIN, not the Enrollment TIN, is submitted for sole proprietors. In most cases, if the Enrollment TIN and Individual NPI are submitted for a sole proprietor, these identifiers will not map to claims. Only the Billing TIN and Individual NPI will map to claims. As such, if a REACH ACO does submit the Enrollment TIN and Individual NPI for a Sole Proprietor record, when the PECOS check is run, the Enrollment TIN will automatically be updated to the

Billing TIN, which will be displayed in 4i. The Billing and Enrollment TINs (EIN and SSN) will be used for claims-alignment purposes, and only the Billing (EIN) TIN will be used for capitation purposes. (Note: Sole Proprietor records will be identified as such in 4i once the PECOS check is complete.)

REACH ACOs should not submit the SSN associated with the sole proprietor's EIN as a legacy TIN on the sole proprietor record as it is already accounted for as part of the sole proprietor record.

3.1.1.2 Legacy Record

A *Legacy Record* identifies the Taxpayer Identification Number (TIN) or CMS Certification Number (CCN) that was used by a health care professional who is a Participant Provider in a given Performance Year when billing for primary care services during the 24-month *Alignment Period* associated with that Performance Year, but that will not be used by the professional bill for primary care services during the Performance Year itself. There are two types of legacy records:

1. A "Sunsetted" legacy record includes provider identifiers (and more specifically the Billing TIN or CCN) that will not appear on any claim record for services provided to any Medicare beneficiary in the Performance Year; and
2. An "Active" legacy record includes a Billing TIN that will appear on claim records for services provided to Medicare beneficiaries but will not on any claim record for services where the rendering NPI is the individual NPI of the REACH ACO practitioner.

Only Individual Practitioners that are Participant Providers or Preferred Providers are eligible to submit legacy TINs in 4i. Only Individual Practitioners at the new CMS provider type, Rural Emergency Hospitals (REHs), that were previously Critical Access Hospitals (CAHs) or Rural Health Clinics (RHCs) may submit a single legacy CCN to ensure that claims incurred when the REH was previously a CAH or RHC are considered in alignment processes. Facilities and Institutional Providers are not eligible to submit legacy TINs because the TIN is not used for alignment purposes. For these provider types, the CCN is present on the claim and used for alignment purposes. Preferred Providers are eligible to submit legacy TINs (or legacy CCNs, if applicable) for capitation calculation purposes; however, legacy TINs (or any other identifiers) for Preferred Providers are not used for alignment purposes.

As noted above, submitted legacy TINs and legacy CCNs for Participant Providers will be used in claims-based alignment and are subject to model overlap checks. If, for example, a submitted legacy TIN by a Participant Provider is an 'active' TIN that is used by a Medicare Shared Savings Program ACO, the legacy TIN submission will be rejected due to overlaps (since the Medicare Shared Savings Program defines its participants at the TIN level).

CMS is not requiring REACH ACOs to secure a completed 'Legacy TIN Acknowledgement Form' prior to submitting 'active' legacy TINs i.e., the TIN owner of an 'active' legacy TIN does not need to consent in writing to a REACH ACO's usage of the 'active' legacy TIN on its Participant Provider List or Preferred Provider List for PY2024 or any subsequent performance years. Instead, the REACH ACO should simply notify the 'active' legacy TIN of its usage.

3.1.2 Facility or Institutional Provider

A *Facility or Institutional Provider* is a facility (institutional provider) that is enrolled in Medicare and is part of a REACH ACO. A participating facility (institutional provider) is uniquely identified by the combination of:

1. A TIN
2. An organization NPI; and
3. A CMS Certification Number.

A facility (institutional provider) is a *provider* as defined in Medicare regulations. For purposes of the operating policies and procedures, a Facility or *Institutional Provider* is an organizational entity that has in effect an agreement to participate in Medicare. Facilities (institutional providers) enroll in Medicare using the CMS 855a form and submit claims using the institutional claim form (the CMS-1450) or the ANSI ASC X12 Health Care Claim (837-I) transaction set for electronic submission of institutional claims.

Examples of institutional providers or facilities include but are not limited to:

1. Acute care hospitals;
2. Skilled Nursing Facilities (and skilled nursing units of acute hospitals including swing-beds);
3. Home Health Agencies;
4. Hospices;
5. Rural Emergency Hospitals;
6. Federally Qualified Health Centers;
7. Rural Health Clinics;
8. Critical Access Hospitals;
9. Inpatient Rehabilitation Facilities;
10. Comprehensive Outpatient Rehabilitation Facilities and Outpatient Rehabilitation Facilities;
11. Long-Term Care Hospitals;
12. Psychiatric hospitals (and units of acute hospitals); and
13. Renal Dialysis Facilities (both free-standing and hospital-based).

An Institutional Provider does <u>not</u> include an individual physician, non-physician practitioner or physician group practice.

The Organizational NPI is the NPI to which the physician assigns billing and is required for Organizational Providers, Facilities, and Institutional Providers. Typically, the Organizational NPI is the Billing NPI on the claim header based on the corresponding TIN for professional claims. As noted in Section 3.1, only Facilities and Institutional Providers will have a CMS Certification Number (CCN).

Facilities (institutional providers) that are Federally Qualified Health Centers (FQHC), Rural Health Clinic (RHC), or Critical Access Hospital Method 2 (CAH2) are used for claims-based alignment; all services billed under the CCN provided will count towards claims-based alignment, regardless of rendering provider. Facilities (institutional providers) that are not FQHCs, RHCs, or CAH2s are not used for claims-based alignment. The CCN and Organizational NPI present on institutional claims is the only identifier used for these records for financial calculation purposes. If a Facility or Institutional Provider agrees to receive FFS claims reductions associated with capitation or APO, the claims reduction entered in 4i will apply to all claims billed under the CCN submitted with the provider record.

Adding a Facility or Institutional Provider does not add all practitioners who practice at or are employed by that Facility or Institutional Provider. For example, adding a hospital does not also add all employed physicians who work at that hospital (though it will cover any institutional claims they submit under the hospital's CCN, per above). If hospital-employed physicians also practice elsewhere and/or bill

professional claims, they must be added as Individual Practitioners (see above) for those claims to be identified for claims-based alignment and capitation purposes.

3.1.2.1 Practitioners at FQHC, RHC, or CAH2

For Federally Qualified Health Centers (FQHC), Rural Health Clinic (RHC), or Critical Access Hospital Method 2 (CAH2), REACH ACOs may also add the Individual NPIs that identify the practitioners that practice in the FQHC/RHC/CAH2 under the FQHC/RHC/CAH2 Facility or Institutional Provider record for *Participant Providers only*. The Individual NPI is typically the rendering NPI on the claim header for institutional claims and must be enrolled to bill Medicare in order to be valid. Like Individual Practitioner records (see Section 3.1.1), Individual NPIs[6] added under a FQHC/RHC/CAH2 Facility or Institutional Provider record where the FQHC/RHC/CAH2 Facility or Institutional Provider record is a Participant Provider will count towards voluntary alignment only and be used to determine which attestations are valid.

If a provider practices both in a practice setting and in an FQHC/RHC/CAH2, they must be added both as an Individual Practitioner, and the FQHC, RHC, or CAH2 Facility or Institutional Provider must be added (i.e., two separate provider records) in order to capture services billed at both in the practice setting and at the FQHC/RHC/CAH2.The Individual NPI associated with the provider may also be added to the FQHC/RHC/CAH2 record for voluntary alignment purposes, and adding the Individual NPI will not impact claims-based alignment or capitation for that facility.

3.1.3 Organizational Provider

For purposes of the REACH ACO operating policies and procedures, an *Organizational Provider* is an organizational entity that has in effect an agreement to participate in Medicare. Organizational providers enroll in Medicare using the CMS 855b form.

Examples of organizational providers include but are not limited to:

1. Mammography Centers;
2. Ambulatory Surgical Centers;
3. Clinic/Group Practices; and
4. Independent Clinical Laboratories.

Organizational Providers are non-practitioner clinics and group practice records that submit a Form CMS-855B and are not Institutional Providers. These providers typically have a PTAN that is not submitted for the ACO REACH Model. Importantly, adding an Organizational Provider does not add all practitioners within that practice. In order to add the practice and all practitioners at that practice, REACH ACOs should submit the TIN and Organizational NPI of the practice as an Organizational Provider and all practitioners at that practice separately using the TIN and their Individual NPIs as Individual Practitioners (see Section 3.1.1 for details on Individual Practitioners).

Typically, the Organizational NPI is the billing NPI on the claim header based on the corresponding TIN for professional claims. Organizational Providers are not used for claims-based alignment (i.e., adding a

[6] The combination of FQHC/RHC/CAH TIN and Individual NPI would be used for voluntary alignment purposes only.

Participant Provider as an Organizational Provider Participant Type will not affect the REACH ACO's claims- based alignment, even if the provider record in question is a primary care practice). Organizational Providers can contribute to capitation or Advanced Payment Option calculations if the provider in question agrees to receive FFS claims reductions associated with capitation or APO.

Note: Certain types of providers/suppliers are prohibited from participating in the ACO REACH Model: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers, enrolled in Medicare as Institutional Providers submit Form CMS-855S. Ambulance Service Suppliers and Part B Drug Vendors –technically termed by Medicare Enrollment purposes as "Suppliers"– submit an 855B.

Section 4: Participant Management and Screening Procedures

Before a provider can enter “Approved” status in 4i and become active in the ACO REACH Model, additional processes and procedures must be completed. A provider that does not pass all processes will not be approved to participate in the Model.

Please note that processes are completed both within and outside of the 4i System, each of which is discussed in this section. Note additional checks may performed at the discretion of CMS.

The following checks are completed automatically within 4i. For these checks, REACH ACOs can see the results in 4i as soon as the provider information is entered in the system:

- PECOS Check for Medicare Enrollment
- ACO REACH Duplicates Check
- 4i Provider Attestation Check
- Preliminary Program Overlaps Check[7]

The following checks are completed outside the system after the close of the 4i Provider list window. The results of these checks will become available to the REACH ACOs at a date specified by CMS:

- Program Integrity Screening
- Final Provider Overlaps Check

4.1 PECOS Check for Medicare Enrollment

Submitted proposed Participant Providers and Preferred Providers must be enrolled Medicare providers by the deadline set by CMS for each Performance Year. The 4i tool utilizes the Provider Enrollment, Chain, and Ownership System (PECOS) database to confirm Medicare enrollment at the time of submission. PECOS is also the source-of-record for verifying if a provider or supplier is considered a primary care specialist based on their specialty code for the purposes of Primary Care Capitation (PCC) eligibility. The PECOS check is automatically run when a proposed provider is added in 4i. If a provider is in the process of enrolling in PECOS, the record may fail the PECOS check when initially submitted; you may re-submit the provider in 4i to run the PECOS check again.

Note: passing the PECOS check for Medicare enrollment does not necessarily mean there are claims billed under those identifiers. Medicare enrollment only demonstrates there is an active billing potential. If the provider bills under a different combination of TIN and Individual NPI, for example, but that combination is not included on the provider list, no claims will be found for that provider for the purposes of claims-based alignment and capitation.

If a provider fails the PECOS check prior to the beginning of the Performance Year (as of the September 5, 2023 deadline for PY2024), the provider may still be eligible to be added at a later date during the Performance Year as part of an ad hoc window. In order to be eligible to be added during the Performance Year as a Participant Provider, the provider must then pass the PECOS check as well as meet all eligibility criteria for Participant Provider additions during the PY. Note: REACH ACOs that may decide to re-submit these records during the Performance Year should still attempt to add these records to their Provider List

[7] Results of overlaps check in 4i are subject to change as overlaps may be created or resolved before the close of a submission window.

prior to the beginning of the Performance Year, as CMS requires a record that these providers were initially submitted by the REACH ACO and initially failed the PECOS check in order to validate eligibility. Providers that are not submitted prior to the beginning of the Performance Year may be eligible to be added as Preferred Providers. More details will be included in the PY2024 Ad-Hoc Provider Guidance.

4.2 ACO REACH Duplicates Check

A provider, defined by its unique identifiers described in Section 3.1, may be included once and only once on a REACH ACO's Participant Provider List or Preferred Provider List. That is, a Participant Provider may not be identified as a Preferred Provider by the same REACH ACO using the same identifiers.

A Participant Provider may be identified as a Participant Provider by one and only one REACH ACO. A Preferred Provider may be identified as a Preferred Provider or a Participant Provider by another REACH ACO, or as a provider/supplier in another Medicare ACO or other shared savings model/demonstration.

The ACO REACH Duplicates Check automatically checks for duplicates within a REACH ACO's own list and for overlaps within the ACO REACH Model. In the event that two or more REACH ACOs add the same provider as a Participant Provider, both ACOs will receive a notification asking them to contact the provider to clarify the provider's intent. If a REACH ACO attempts to add the same provider to their own list again, 4i will not permit the second addition.

4.3 4i Provider Attestation

You will be required to attest in 4i to the language below. Please note that this language does not substitute for a provider agreement as described in the relevant sections of the ACO REACH Participation Agreement. Your provider cannot move to Approved status unless you attest to the language below.

"If this addition is a request to add an individual or entity to the Participant Provider List or Preferred Provider List effective on the first day of the next Performance Year or Implementation Period, by checking this box, I acknowledge that my REACH ACO is aware of and has complied or plans to comply with all requirements in Sections 3.04.G and 4.05 of the Performance Period Participation Agreement or Sections 3.04.G, 4.05.C-D, and 4.05.G of the Implementation Period Participation Agreement, as applicable.

If this addition is a request to add an individual or entity to the Participant Provider List or Preferred Provider List effective on a date other than the first day of a Performance Year ("During a Performance Year") by checking this this box, I certify that my REACH ACO has met the requirements listed in Section 4.03.A.4 of the Performance Period Participation Agreement."

4.4 Program Integrity Screening

A Participant Provider or Preferred Provider may be rejected if one or more of its identifiers (e.g., its TIN, its NPI) is excluded or otherwise prohibited from participation in Medicare, Medicaid, or Children's Health Insurance Program (CHIP); has a history of exclusion or other sanctions imposed with respect to participation in Medicare, Medicaid, or CHIP; history of failure to pay Medicare debts in a timely manner; current or prior law enforcement investigations or administrative actions; affiliations with individuals or entities that have a history of program integrity issues; and other information pertaining to the trustworthiness of the individual or entity.

4.5 Provider Overlap Check

Overlap checks will be performed for Participant Providers between REACH ACOs and with other initiatives for which overlap is prohibited as outlined in **Table 4.3**. This check is performed prior to the start of a Performance Year and on a monthly basis for providers added as part of the monthly provider addition process during the Performance Year. Unlike the Duplicates Check, this check includes all initiatives for which overlaps are prohibited. The results of the final overlap check will be communicated to REACH ACOs after the close of the window at a time identified by CMS. Note that providers who fail the overlap check after the final drop deadline prior to the Performance Year may be eligible to be added during the Performance Year, provided that the overlap is resolved and they are added under a TIN that is already on the REACH ACO's provider list. Note: REACH ACOs that expect an overlap to be resolved during the Performance Year in order for the provider to join ACO REACH should still attempt to add the provider to their Provider List prior to the beginning of the Performance Year, as CMS requires a record that these providers were initially submitted by the REACH ACO and initially failed the overlap check in order to validate eligibility.

Table 4.3. Initiatives for which Provider Overlap is Prohibited for PY2024

Initiative	Participant Provider Overlap	Preferred Provider Overlap
Another REACH ACO	Prohibited	Allowed
Medicare Shared Savings Program	Prohibited	Allowed
Vermont All-Payer ACO Model	Prohibited	Allowed
Primary Care First Model	Prohibited	Allowed
Maryland Total Cost of Care Model	Prohibited	Prohibited
Kidney Care Choices Model	Prohibited	Allowed

Section 5: Benefit Enhancements, Beneficiary Engagement Incentives, and Payment Mechanisms

REACH ACOs must first decide which Benefit Enhancements (BEs), Beneficiary Engagement Incentives (BEIs), and Payment Mechanisms (PMs) they will offer their aligned Participant Providers and Preferred Providers through 4i. Then, REACH ACOs must assign BEs, BEIs, and PMs to their aligned Participant and Preferred Providers with whom they have established financial arrangements (as applicable) through 4i. Only records that pass validation in the 4i tool will be accepted for further processing. **To reiterate, REACH ACOs must make elections BEs, BEIs, and PMs for Participant Providers and Preferred Providers submitted and approved for the final Participant Provider and Preferred Provider list**. The timeline for submitting BEs, BEIs, and PMs for each Performance Year will be shared by CMS. Any elections submitted for providers that were not approved for participation in the model will be rejected. Only REACH ACOs that have signed agreements with CMS, their Participant Providers, and their Preferred Providers may participate in BEs, BEIs, and PMs.

5.1 Payment Mechanism Elections

Participant Providers for REACH ACOs participating in Total Care Capitation (TCC) or Primary Care Capitation (PCC) are required to participate in their REACH ACO's selected Capitation Payment Mechanism. In PY2024, Participant Providers will be required to accept at least a 20% PCC claims reduction. REACH ACOs that elect PCC will have the additional flexibility to contract with Participant Providers and Preferred Providers under the Advanced Payment Option (APO). Preferred Providers may elect to participate in their REACH ACO's selected Capitation Payment Mechanism or participate in the Advanced Payment Option. A REACH ACO in the Professional Risk Sharing Option may not select the Total Care Capitation Payment Mechanism.

REACH ACOs may only add PM elections to Participant Provider or Preferred Provider records prior to the start of a Performance Year concurrent with the submission of the Participant Provider and Preferred Provider lists in 4i. REACH ACOs may, however, add BE/BEI elections for Participant Providers and Preferred Providers prior to the start and during a Performance Year. REACH ACOs cannot terminate their PM participation for Participant Provider or Preferred Providers active in the model during a Performance Year. These elections are only terminated if the provider is terminated.

Preferred Providers in a REACH ACO participating in PCC may elect reductions in integers greater than or equal to 1% but less than or equal to 100% for all Performance Years. Participant Providers and Preferred Providers electing PCC should have a Provider Specialty as noted in the Primary Care Specialist Table in Table B.6.4 of the ACO REACH Financial Operating Guide: Overview[8]. Participant Providers and Preferred Providers in a REACH ACO that elected PCC and are participating in the APO for non-primary care claims payments may elect reductions greater than or equal to 1% but less than or equal to 100% for all PYs. FQHCs and RHCs that are Participant Providers or Preferred Providers in a REACH ACO that elected PCC are not eligible to elect the APO as all claims from these providers are considered primary care services, regardless of rendering provider specialty or service provided.[9] Other institutional providers (non-FQHC/RHC) are not eligible to elect PCC but may elect the APO on an optional basis.

[8] An updated version for PY2024 of the ACO REACH Model will become available summer of 2023.
[9] See Table 3 here for more details: https://innovation.cms.gov/media/document/gpdc-py2022-cap-adv-pay-mech

Participant Providers in a REACH ACO that elected TCC must elect reductions of 100% for all Performance Years. Preferred Providers participating in TCC may elect reductions greater than or equal to 1% but less than or equal to 100% for all PYs. Participant Providers and Preferred Providers in a REACH ACO that elected TCC are not eligible to elect the APO. In PY2024, Participant Providers must have some portion of their eligible claims reduced via PCC, with a floor of at least 20% claims reduction. Preferred Providers still have the option to elect PCC or not.

PCC reductions on FQHCs and RHCs will be applied at the facility/institutional level. TCC reductions on FQHCs, RHCs, and CAH2s will also be applied at the facility/institutional level.

Participant and Preferred Providers who are enrolled in Periodic Interim Payment (PIP) are not required to forgo PIP in order to participate in ACO REACH. They may participate in ACO REACH and/or a capitation PM; however, providers enrolled in PIP will not have their claims reduced through TCC, PCC, or APO. If the provider (TIN-oNPI-CCN) unenrolls from PIP during the PY, they will begin to have their claims reduced per TCC, PCC, or APO effective the following business day.

Table 5.1 summarizes the ACO REACH PM election requirements by Performance Year.

Table 5.1. ACO REACH PM and Claims Reduction Requirements by Provider Class

Payment Mechanism Elected by the REACH ACO	Participant Providers	Preferred Providers
TCC	Must Participate 100% Claims Reduction, all PY’s	Optional for all PY’s If selected, 1-100% Claims Reduction, all PY’s
PCC	Must Participate PY2024: Primary Care Claims Reduction 20-100% PY2025: Primary Care Claims Reduction 100% PY2026: Primary Care Claims Reduction 100%	Optional for all PY’s If selected, 1-100% Claims Reduction, all PY’s
APO (Option only available if PCC is also elected)	Optional If selected, 1-100% for all PYs	Optional If selected, 1-100% for all PYs

5.2 Benefit Enhancements and Beneficiary Engagement Incentives

Participant Providers and Preferred Providers in REACH ACOs participating in BEs/BEIs may be eligible for BEs/BEIs as outlined in **Table 5.2**.

Table 5.2. ACO REACH BE/BEI Eligibility Criteria by Model Option and Participant Type

Benefit Enhancement Type	**Risk Option**	**Participant Type**
Telehealth Expansion Waiver	Professional and Global	All
Post Discharge Home Visit	Professional and Global	Individual Practitioners only[1]
SNF 3-Day Stay Waiver[2]	Professional and Global	Facilities with eligible CCN ranges[3]
Care Management Home Visit	Professional and Global	Individual Practitioners only[1]
Concurrent Care for Hospice Beneficiaries	Global only	All
Home Health Homebound Waiver	Professional and Global	Home Health Agencies only[4]
Nurse Practitioner and Physician Assistant Services	Professional and Global	Individual Practitioners only[1]
Beneficiary Engagement Incentive Type	**Risk Option**	**Participant Type**
Part B Cost Sharing Support	Professional and Global	All
Chronic Disease Management Reward	Professional and Global	All

[1] Practitioners only refers to Individual Practitioners Provider Record Type. Non-practitioner providers, including Organizational Providers, Facilities and Institutional Providers are prohibited from the electing the respective BE

[2] Participants and Preferred Providers that are SNF facilities are eligible for the SNF waiver if their Nursing Home Star Rating is three or more stars under the CMS 5-Star Quality Rating System in at least seven of the previous twelve months, if at least ten months of data are available), as reported on the Nursing Home Compare website. SNF facilities with only eight or nine months of data are eligible if their Nursing Home Star Rating is three or more stars in at least six of those months. SNF facilities with seven or less months of data are eligible if their Nursing Home Star Rating is three or more stars in at least five of those months.

[3] Applicable ranges for CCNs for the SNF 3-Day Stay Waiver are the following: SNFS = 5000-6499, and CAHs with swing bed approval = third CCN character is Z.

[4] In order to be eligible to submit claims for services furnished under this BE, the individual or entity must be a home health agency that is a Participant Provider or Preferred Provider. Applicable ranges for CCNs for the Home Health Homebound Waiver are the following: HHAs = 3100-3199, 7000-8499, 9000-9799, the third character is Q.

Note: Provider Class, ACO Type, and ACO Payment Mechanism do not determine BE eligibility.

Participant Providers and Preferred Providers that are SNF facilities are eligible for the SNF waiver if their Nursing Home Star Rating is three or more stars under the CMS 5-Star Quality Rating System in at least:

- 5 of the previous 6 months for SNFs with 6 months of data
- 5 of the previous 7 months for SNFs with 6 months of data
- 6 of the previous 8 months for SNFs with 6 months of data
- 6 of the previous 9 months for SNFs with 6 months of data
- 7 of the previous 10 months for SNFs with 6 months of data
- 7 of the previous 11 months for SNFs with 6 months of data
- 7 of the previous 12 months for SNFs with 6 months of data

The SNF Star Rating policy subject to change and any further updates to the policy will be communicated to REACH ACOs.

A Participant Provider or Preferred Provider that is a practitioner may participate in the telehealth waiver. In order for a distant site practitioner to participate in the waiver, REACH ACOs should identify the distant site practitioner (by submitting a telehealth BE indicator on behalf of the provider record).

A Participant Provider or Preferred Provider that is a practitioner may also participate in the post-discharge home visit waiver or care management home visit waiver. Institutional providers (facilities) cannot participate in either of these two waivers.

5.3 4i Benefit Enhancement Report

You can review the BEs and PMs applied to your Participant Providers and Preferred Providers as anExcel file or csv. This extract is called the Benefit Enhancement Report where each row represents a record corresponding to a provider's alignment to the REACH ACO (Value Code 0) or the Provider's BE or PM enrollment (Value Codes 1-9, B). This report serves as a valuable reference of a Provider's period of alignment to the REACH ACO and the effective start and termination dates of each BE and PM applied to that Provider. REACH ACO review of this report is **strongly advised** prior to certifying the PY Participant and Provider Lists, in addition to certifying BE, BEI, and PM elections. Records in this file represent the last status of each record ever attributable to the REACH ACO during a given PY. To download the extract, please follow the below steps:

Step 1: Click '**Reports**' on the left navigation pane. The page displays different extract types you can download.

Step 2: Use the year drop-down to select the correct PY.

Step 3: Click on '**Benefit Enhancement Report**' and the csv or Excel file is downloaded on your computer.

Pro tip: Use the radio button in the '**Data Extracts'** bar to choose if you would like the file to be downloaded as a csv or Excel file.

Step 4: Open the downloaded file to view all the BEs/PMs and respective statuses applied to your Entity's Participants.