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

Overview Webinar

CMS/CMMI
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Speakers

- Meghan Elrington-Clayton, Director, Division of Financial Risk
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Agenda

1. Model Design and Goals
2. Participation and Eligibility
3. REACH Accountable Care Organization (ACO) Types
4. Beneficiary Alignment
5. Payment and Quality
6. Benefit Enhancements and Beneficiary Engagement Incentives
7. Model Timeline
8. Upcoming Webinars and Questions

CMS ACO Vision and Strategy

CMS Innovation Center Statute

"The purpose of the [CMS Innovation Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

Three scenarios under which the duration and scope of an initial CMS Innovation Center model test may be expanded:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.

CMMI Strategy Refresh | Vision & Strategic Objectives

ACO REACH incorporates several of these strategic objectives.

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Alignment with Strategic Objectives

Increase the number of people in a care relationship with accountability for quality and total cost of care. **Goal: All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.**

Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

Leverage a range of supports that enable integrated, person-centered care such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

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CMS' Vision for Accountable Care

- In October of 2021, CMS outlined a renewed vision and strategy for how the Innovation Center will drive health system transformation to achieve equitable outcomes through high-quality, affordable, person-centered care for all beneficiaries. https://innovation.cms.gov/strategic-direction-whitepaper
- CMS' ACO models and programs are an important component of achieving this vision.
- CMS wants to work with partners who share its vision and values for improving patient care, guided by three key principles:
    1. Any model that CMS tests within traditional Medicare **must ensure that beneficiaries retain all rights** that are afforded to them, including freedom of choice of all Medicare-enrolled providers and suppliers.
    2. CMS must have confidence that any model it tests works to **promote greater equity** in the delivery of high-quality services.
    3. CMS expects models to **extend their reach into underserved communities** to improve access to services and quality outcomes.

Model Redesign and Goals

What is ACO REACH?

- **ACO REACH redesigns the Global and Professional Direct Contracting (GPDC) Model to advance Administration priorities**, including our commitment to advancing health equity, and in response to stakeholder feedback and participant experience.
- **ACO REACH will enable CMS to test an ACO model that can inform the Medicare Shared Savings Program** and future models with a greater focus on health equity, health care provider leadership and beneficiary voice in model participant decisions, and robust participant screening, monitoring, and transparency.
- The ACO REACH Model's **performance period will begin on January 1, 2023**.
- **Current GPDC Model participants must have a strong compliance record** and agree to meet all the ACO REACH Model requirements by January 1, 2023 to continue participating in the ACO REACH Model.
- The **application period will open March 7, 2022** and close April 22, 2022.

“Reaching” Beyond GPDC: ACO REACH Model Goals

GPDC

Empower beneficiaries to personally engage in their own care delivery.

Transform risk-sharing arrangements in Medicare fee-for-service (FFS).

Reduce provider burden to meet health care needs effectively.

ACO REACH

Promote health equity and address healthcare disparities for underserved communities

Continue the momentum of provider-led organizations participating in risk-based models

Protect beneficiaries and the model with more participant vetting and monitoring and greater transparency

New Focus on Health Equity

To promote Health Equity and expand the availability of accountable care to underserved communities, ACO REACH includes the following provisions:

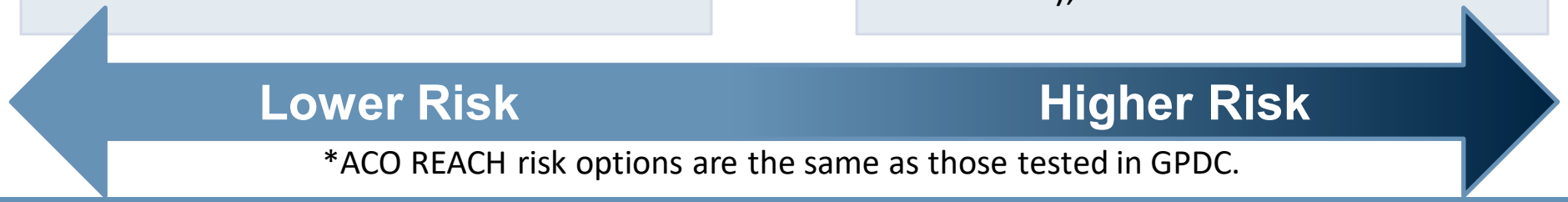
Health Equity Provision	Description
Health Equity Plan	REACH ACOs will be required to develop and implement a Health Equity Plan starting in 2023 to identify underserved patients within their beneficiary population and implement initiatives to measurably reduce health disparities
Health Equity Benchmark Adjustment	A beneficiary-level adjustment will be applied to increase the benchmark for those REACH ACOs serving higher proportions of underserved beneficiaries in order to mitigate the disincentive for ACOs to serve underserved patients by accounting for historically suppressed spending levels for these populations

New Focus on Health Equity (Continued)

Health Equity Provision	Description
Health Equity Data Collection Requirement	REACH ACOs will be require to collect and report certain beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries for purposes of Model monitoring and evaluation
Nurse Practitioner Services Benefit Enhancement	A new Benefit Enhancement will be offered to help reduce barriers to care access, particularly for beneficiaries in areas with limited access to physicians. Under this Benefit Enhancement, Nurse Practitioners will be able to assume certain responsibilities or furnish certain services without physician supervision such as certifying the need for diabetic shoes or hospice care
Health Equity in Application Scoring	To encourage participation by provider groups with demonstrated direct patient care experience and/or demonstrated successful experience furnishing high quality care to underserved communities, discrete points will be attached to application questions related to these categories of experience

ACO REACH Model Risk Options*

Professional	Global
• ACO structure with Participant Providers and Preferred Providers defined at the TIN/NPI level • 50% shared savings/shared losses with CMS • **Primary Care Capitation (PCC)** equal to 7% of the PY Benchmark for enhanced primary care services	• ACO structure with Participant Providers and Preferred Providers defined at the TIN/NPI level • 100% risk • Choice between **Total Care Capitation (TCC)** equal to 100% of total cost of care provided by Participant Providers (and participating Preferred Providers), and **PCC**



*ACO REACH risk options are the same as those tested in GPDC.

How else does ACO REACH differ from GPDC?

Design Element	Original Global and Professional Direct Contracting (GPDC) Model (PY2021 – PY2022)	ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023-PY2026)
Timeline	The GPDC Model originally consisted of 6 performance years (PYs), PY2021 through PY2026	The policy changes and new name (ACO REACH Model) will take effect at the start of **PY2023 and continue through PY2026**
Participants	Model participants are called Direct Contracting Entities (DCEs), but are equivalent to ACOs	Model participants referred to as 'REACH ACOs'
Governance	• **Participating providers generally must hold at least 25% of the governing board voting rights** • Each DCE's governing board must include **a beneficiary representative and a consumer advocate**, though these representatives may be the same person and neither is required to hold voting rights	• **Participating providers generally must hold at least 75% of the governing board voting rights** • Each REACH ACO governing board must include a beneficiary representative and a consumer advocate, **who must hold governing board voting rights and must be different people**

Design Element	Original Global and Professional Direct Contracting (GPDC) Model (PY2021 – PY2022)	ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023-PY2026)
Application	• **Participants began** in PY2021 or deferred to PY2022 due to the Public Health Emergency • Next Generation ACOs were able to apply for PY2022 • Application scoring criteria focused on the following five domains: (1) organizational structure; (2) leadership and management; (3) financial plan and risk-sharing experience; (4) patient centeredness and beneficiary engagement; and (5) clinical care	• **Application period opening in Spring of 2022** for participation beginning in PY2023 • New ACO REACH **application scoring criteria consider**, in addition to the five GPDC domains: ✓ Demonstrated **strong track record of direct patient care** ✓ Demonstrated record of **serving historically underserved patients** with positive quality outcomes ✓ Program integrity **risks posed by REACH ACO ownership/parent companies** • GPDC participants **must agree to meet all the ACO REACH requirements** by January 1, 2023 in order to continue participating in ACO REACH.
Quality Withhold	The quality withhold applied to the benchmarks of both Professional DCEs and Global DCEs is 5%	Quality withhold for both Professional ACOs and Global ACOs is reduced to 2%

<table>
<tr><th>Design Element</th><th>Original Global and Professional Direct Contracting (GPDC) Model (PY2021 – PY2022)</th><th>ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023-PY2026)</th></tr>
<tr><td>Discount for Global</td><td>• Global DCEs receive 100% of gross savings / losses. A discount is applied to the benchmark before gross savings / losses are calculated, which helps guarantee shared savings for CMS
• There is no discount for Professional DCEs
• Original discount levels originally planned for the benchmarks of Global DCEs:
<table><tr><th></th><th>PY2021</th><th>PY2022</th><th>PY2023</th><th>PY2024</th><th>PY2025</th><th>PY2026</th></tr><tr><td>Professional</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr><tr><td>Global</td><td>2%</td><td>2%</td><td>3%</td><td>4%</td><td>5%</td><td>5%</td></tr></table></td><td>• Reduced discount rate for Global ACOs to 3-3.5% beginning in PY2023 will further CMS's goal of increasing participation in full risk FFS initiatives.
<table><tr><th></th><th>PY2021</th><th>PY2022</th><th>PY2023</th><th>PY2024</th><th>PY2025</th><th>PY2026</th></tr><tr><td>Professional</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr><tr><td>Global</td><td>2%</td><td>2%</td><td>3%</td><td>3%</td><td>3.5%</td><td>3.5%</td></tr></table></td></tr>
<tr><td>Risk Adjustment</td><td>Two policies protect against risk coding growth:
• The 'Coding Intensity Factor' (CIF) limits risk score growth across the entire model. The CIF applies to all DCEs to limit risk score growth to the average prior to the start of the model
• A 'Risk Score Growth Cap' limits a DCE's risk score growth to +/- 3% over a 2-year period. The DCE-specific caps on over-coding ensure DCEs are coding appropriately and limit gaming</td><td>Two changes to the 'Risk Score Growth Cap' further mitigate potential inappropriate risk score gains beginning PY2024:
• Adopt a static reference year population for the remainder of the model performance period
• Cap the REACH ACO's risk score growth relative to the DCE's demographic risk score growth, so the +/- 3% cap is appropriately adjusted based on demographic changes in the underlying population over time (currently risk score cap is based on HCC growth; this would cap HCC growth relative to demographic growth)</td></tr>
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Participation and Eligibility

Model Participants

A REACH Accountable Care Organization (ACO) is generally comprised of health care providers and suppliers, operating under a common legal structure, which enter into an arrangement with CMS and accept financial accountability for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the entity.

Standard ACOs	ACOs that have experience serving beneficiaries in traditional Medicare program.
New Entrant ACOs	ACOs that have not traditionally provided services to a traditional Medicare FFS population and / or have not participated in FFS Medicare value-based arrangements. Beneficiaries may be aligned primarily based on voluntary alignment.
High Needs Population ACOs	ACOs that serve Medicare FFS beneficiaries with complex needs employing care delivery strategies similar to those used by Program of All-Inclusive Care for the Elderly (PACE) organizations.

What is a REACH ACO?

- Legal entity identified by a tax identification number (TIN) that contracts with CMS for participation in the ACO REACH Model
- Must meet all requirements outlined in the ACO REACH Model RFA (e.g., governing body requirements)
- **Particular interest in organizations with direct patient care experience and a strong track record serving underserved communities**
- Minimum of at least 5,000 traditional Medicare beneficiaries for Standard ACOs, with glide path for New Entrant and High Needs ACOs
- Responsible for receiving shared savings and paying shared losses to CMS
- **Must be capable of administering payments to Participant Providers, and if applicable, Preferred Providers**
- Beneficiaries aligned to an ACO retain full access to Medicare-enrolled providers and suppliers and traditional Medicare benefits. There are no provider networks, prior authorizations, or other constraints on access to traditional Medicare coverage and benefits.

Provider Relationships

REACH Accountable Care Organization (ACO)

- REACH ACOs must have arrangements with Medicare-enrolled providers or suppliers who agree to participate in the Model and contribute to the ACO's goals pursuant to a written agreement with the ACO.
- REACH ACOs may form relationships with two types of providers or suppliers:

Participant Providers (Required)

- Used to align beneficiaries to the ACO
- Required to accept payment from the ACO through their negotiated payment arrangement with the ACO, continue to submit claims to Medicare, and accept claims reduction
- Included in quality calculations
- Eligible to receive shared savings
- May participate in benefit enhancements or beneficiary engagement incentives

Preferred Providers (Optional)

- Not used to align beneficiaries to the ACO
- Can elect to accept payment from the ACO through a negotiated payment arrangement with the ACO, continue to submit claims to Medicare, and accept claims reduction
- Eligible to receive shared savings
- May participate in benefit enhancements and beneficiary engagement incentives

Eligible Providers and Suppliers

- Participant Providers and Preferred Providers **must be Medicare-enrolled providers or suppliers and identified on the ACO's Participant Provider list or Preferred Provider list.** Providers must be identified by name, National Physician Identifier (NPI), TIN, CMS Certification Number (CCN), and Legacy TIN or CCN (if applicable).
- Participant Providers and Preferred Providers may include but are not limited to:
  - Physicians or other Practitioners in group practice arrangements
  - Network 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)

Prohibited Participants

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

ACO Service Area

- The ACO Service Area, used for beneficiary alignment, consists of a Core Service Area and an Extended Service Area. ACOs can operate in multiple, non-contiguous service areas including in the same state or in multiple states.
  - **Core Service Area** includes all counties in which Participant Providers have office locations.
  - **Extended Service Area** includes all counties contiguous to the Core Service Area.
- Service area is distinct from an ACO's region, which is used to determine the ACO's Performance Year benchmark; an ACO's region includes all counties where ACO - aligned beneficiaries reside.

Beneficiary Eligibility

Beneficiaries will be eligible for alignment to a REACH ACO if they meet the following criteria:

- Are enrolled in both Medicare Parts A and B;
- Are not enrolled in a Medicare Advantage plan, Medicare Cost Plan under section 1876, PACE organization, or other Medicare health plan;
- Have Medicare as their primary payer; and
- Reside in a county included in the ACO's Service Area.

Beneficiary Eligibility (Continued)

For High Needs Population ACOs, beneficiaries must also meet at least one of the following criteria:

- Have one or more developmental or inherited conditions or congenital neurological anomalies that impair the Beneficiary's mobility or the Beneficiary's neurological condition[1]; **OR**
- Have at least one significant chronic or other serious illness (defined as having a risk score of 3.0 or greater for Aged & Disabled (A&D) Beneficiaries or a risk score of 0.35 or greater for ESRD Beneficiaries); **OR**
- Have a risk score between 2.0 and 3.0 for A&D Beneficiaries, or a risk score between 0.24 and 0.35 for ESRD Beneficiaries, and two or more unplanned hospital admissions in the previous 12 months; **OR**
- Exhibit signs of frailty, as evidenced by a claim submitted by a provider or supplier for a hospital bed (e.g., specialized pressure-reducing mattresses and some bed safety equipment), or transfer equipment (e.g., patient lift mechanisms, safety equipment, and standing systems) for use in the home[1]

(1) The list of codes that meet this criterion will be published in a methodology paper prior to PY2023. For reference, the codes used for this criterion in PY2022 of the GPDC Model are available in Appendix B of the Financial Operating Guide: Overview paper available at: https://innovation.cms.gov/innovation-models/gpdc-model

REACH Accountable Care Organization (ACO) Types

Standard ACOs

- REACH ACOs with substantial historical experience serving Medicare FFS beneficiaries.
- Use both voluntary and claims-based beneficiary alignment.
- Minimum of 5,000 aligned beneficiaries is required prior to the start of each performance year.
- Performance Year Benchmark is a blend of regional expenditures (ACO REACH/KCC Rate Book) with aligned beneficiary historical expenditures.

New Entrant ACOs

- REACH ACOs with limited historical experience delivering care to Medicare FFS beneficiaries and / or have not participated in FFS Medicare value-based arrangements. Beneficiaries may be aligned primarily based on voluntary alignment.
- Not more than 50% of the Participant Providers may have prior experience in the Medicare Shared Savings Program, the Next Generation ACO Model, the Vermont All-Payer ACO Model, the Comprehensive ESRD Care Model, the Kidney Care Choices Model, the Comprehensive Primary Care Plus Model, the Primary Care First Model, the Maryland Primary Care Program, or the Pioneer ACO Model.
- Use both voluntary and claims-based beneficiary alignment; some ACOs may rely primarily on voluntary alignment.
- During PY2023-PY2024, if a New Entrant ACO exceeds 3,000 claims-aligned beneficiaries in any base year* (2017-2019), they will become a Standard ACO .
- For PY2025-2026, ACOs will be expected to align 3,000 or more beneficiaries via claims.
- Performance Year Benchmark is based on regional expenditures (not historical expenditures) for PY2023 and PY2024.

**The base years are used to establish the historical baseline expenditures. While the base years will remain fixed throughout the model (2017-2019), the historical baseline expenditures will be updated using the ACO's most recent list of Participant Providers.*

New Entrant ACOs (Continued)

Glide path for minimum number of aligned beneficiaries required:

Performance Year	Number of Beneficiaries
PY2023	2,000
PY2024	3,000
PY2025	5,000
PY2026	5,000

High Needs Population ACOs

- REACH ACOs that focus on small populations of beneficiaries with complex health needs and meet additional eligibility criteria (see slide 27)
- Expected to employ care delivery strategies such as those used by PACE organizations.
- Use both voluntary and claims-based beneficiary alignment.
- Performance Year Benchmark is based on regional expenditures (not historical expenditures) in PY2023 – PY2024.

High Needs Population ACOs (Continued)

Glide path for minimum number of aligned beneficiaries required:

Performance Year	Number of Beneficiaries
PY2023	500
PY2024	750
PY2025	1,200
PY2026	1,400

Beneficiary Alignment

Beneficiary Alignment

CMS will align beneficiaries to a REACH ACO in two ways:

1. **Voluntary alignment:** Beneficiaries choose to align to a ACO by designating a Participant Provider affiliated with the ACO as their primary clinician or main source of care
2. **Claims-based alignment:** CMS aligns a beneficiary based on where the beneficiary receives the plurality of their primary care services, as evidenced in claims utilization data.

Voluntary alignment takes precedence over claims-based alignment.

Voluntary Alignment

A beneficiary can voluntarily align to a REACH ACO by one of two means:

1. **Electronic voluntary alignment:** Beneficiary selects a “primary clinician” on Medicare.gov.
2. **Paper-based voluntary alignment:** Beneficiary identifies a primary clinician by completing a paper-based form using the “Voluntary Alignment Form” template developed by CMS.

If a beneficiary seeks voluntary alignment through both electronic and paper-based means, the most recent valid attestation will take precedence.

Frequency of Voluntary Alignment

- **Prospective Alignment**
  - Annual alignment process with all voluntary alignment and claims-based alignment completed prior to each performance year.
- **Prospective Plus Alignment *(optional)***
  - Annual claims-based alignment process completed prior to each performance year.
  - Quarterly voluntary alignment process in which voluntarily aligned beneficiaries are added to the ACO's aligned beneficiary population throughout the performance year.
  - Prospective Plus alignment will be used for two purposes: (1) calculating the Performance Year Benchmark, and (2) determining aligned beneficiaries for the purpose of making monthly capitated payments.

Schedule for Prospective Plus

Alignment Date	Months ACO Alignment Recognized*
January 1	12 months (January through December)
April 1	9 months (April through December)
July 1	6 months (July through December)
October 1	3 months (October through December)

*Assumes continuous alignment to the ACO through the end of the performance year. Beneficiaries may contribute fewer months due to loss of alignment eligibility or due to mortality.

Claims-based Alignment

- **Claims-based Alignment will occur prior to the start of each performance year (PY).**
- Beneficiaries will be aligned based on historical claims for certain primary care services furnished by Participant Providers, identified by TIN/NPI combination or CCN.
- A two-year look back period, the “Alignment Period,” will be used to identify Primary Care Qualified Evaluation and Management (PQEM) claims furnished by a Participant Provider (either a primary care practitioner or select non-primary care specialists).
  - Consists of two consecutive 12-month periods, with the second period ending six months prior to the start of the relevant performance year.
- CMS will align a beneficiary to a REACH ACO if the beneficiary has historically received the plurality of their PQEM services from the ACO's Participant Providers.

Claims-based Alignment Algorithm

Alignment of a beneficiary for a performance year and each base year is determined by comparing:

1. Weighted allowable charge for all PQEM services received from Participant Providers in the ACO; and
2. Weighted allowable charge for all PQEM services received from each TIN not participating in the ACO.

Allowable Charges Billed by Primary Care Specialties	Basis for Alignment
Greater than or Equal to 10%	• Allowable charges for PQEM services provided by primary care specialists
Less than 10%	• Allowable charges for PQEM services provided by physicians and practitioners with certain non-primary specialties

Legacy TINs or CCNs

A Legacy TIN or CCN is a TIN or CCN that was used by a proposed Participant Provider when billing for primary care services during the Alignment Period but will not be used during the performance year.

- Submission of Legacy TINs and CCNs can help ensure that services furnished during the Alignment Period are accurately reflected during beneficiary alignment.
- Legacy TINs or CCNs are only submitted once a year, prior to the start of the performance year, on the Proposed Participant Provider List.
- Submission of Legacy TINs or CCNs are required for New Entrant ACOs and optional for Standard ACOs and High Needs Population ACOs.

Payment and Quality

Financial Goals and Opportunities

The ACO REACH Model includes features from the GPDC Model, and introduces a new health equity adjustment to better support services for underserved communities

- **Performance year benchmark methodologies** focused on increasing benchmark stability, simplicity, accuracy, and prospectivity;
- **Capitation and other advanced payment alternatives** for model participants; and
- Financial model that **supports broader participation** by entities new to Medicare FFS and/or focused on delivering care for high needs populations.
- ***New* health equity benchmark adjustment** to better support ACOs providing care to underserved communities.

Payment Mechanisms

The Thesis

Having control of the flow of funds with their downstream providers and suppliers will enable REACH ACOs to improve care coordination and delivery, and to better manage the health needs of their aligned population, resulting in reduced costs and better outcomes.

The ACO REACH Model offers ACOs several mechanisms to receive stable monthly payments.

Capitation Payment Mechanisms

REACH ACOs receive a capitation payment covering total cost of care or cost of primary care services.

MANDATORY

Payment amount is **NOT RECONCILED** against actual claims expenditures.

Advanced Payment

REACH ACOs that select Primary Care Capitation may receive an advanced payment of their FFS non-primary care claims.

VOLUNTARY

Payment amount is **RECONCILED** against actual claims expenditures

Capitation Payments

REACH ACOs with Participant Providers and/or Preferred Providers must select one of the two Capitation Payment Mechanisms. The Capitation Payment Mechanisms available vary based on the Risk Option selected.

1	**Primary Care Capitation (PCC)**	Monthly capitation payments for primary care services furnished to aligned beneficiaries.	*Available for Global and Professional*
2	**Total Care Capitation (TCC)**	Monthly capitation payments for all services furnished to aligned beneficiaries.	*Available for Global Only*

Reconciliation

- **Shared Savings or Shared Losses** will be determined by CMS after comparing actual Medicare expenditures against a Final Performance Year Benchmark.
  - Medicare expenditures include capitated payments, Advanced Payments, and FFS claim amounts paid by CMS directly.
  - A discount is applied to the Performance Year Benchmark for Global as primary mechanism for CMS to obtain savings.
  - 2% quality withhold is applied to Performance Year Benchmark to incentivize quality performance.
- **Final Financial Reconciliation:** Conducted for all REACH ACOs after the end of the performance year and sufficient time has passed for claims processing.
- **Provisional Financial Reconciliation *(optional)*:** Conducted shortly after the end of the performance year based on six months of expenditures.

Quality Performance

- The ACO REACH Quality strategy is designed to:
  - Reduce reporting burden;
  - Focus on relevant, actionable measures; and
  - Provide incentives for continuous improvement and sustained exceptional performance.
- Measure tools include:
  - Claims-based measures; and
  - Patient experience measures

Quality Measure Set

Claims-based Measures

- Risk-Standardized, All Condition Readmission
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- Days at home for Patients with Complex, chronic Patients (High Needs ACOs only)
- Timely Follow-up after Acute Exacerbations of Chronic Conditions (Standards and New Entrants ACOs only)

Patient Experience Survey

- CAHPS®* Survey

*CAHPS®, which stands for Consumer Assessment of Healthcare Providers and Systems, is a registered trademark of the Agency for Healthcare Research and Quality

Quality Withhold

- In each PY, 2% of the ACO's financial benchmark (the Quality Withhold) will be held "at risk" and is tied to the ACO's performance on the Quality Measures
- The quality measures are Pay-for-Performance and the entire 2% quality withhold will be tied to performance
- In PY2023, CMS will reward ACOs for successful reporting of required beneficiary-reported demographic data (slides #12 and #13) 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 and ACO Total Quality Scores will not be permitted to exceed 100%
- More details will be forthcoming

Continuous Improvement and Sustained Exceptional Performance (CI/SEP)

- 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
  - CMS will publish the CI/SEP methodology in late summer 2022
  - 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%

High Performers Pool (HPP)

- 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)
  - CMS will publish the HPP methodology in late summer 2022
- The highest performing ACOs that meet or exceed the CI/SEP criteria may also earn a bonus payment from the High Performers Pool (HPP)
  - Because PY2023 starter ACOs will not be subject to the CI/SEP in PY2023, they will not be eligible to earn payments from the HPP in PY2023
- 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

Benefit Enhancements and Beneficiary Engagement Incentives

Benefit Enhancements and Beneficiary Engagement Incentives

CMS is seeking to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries through benefit enhancements and beneficiary engagement incentives.

- We propose to use the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain requirements.
- REACH ACOs may choose which, if any, of these benefit enhancements and beneficiary engagement incentives to implement.
- Applicants must provide information regarding the proposed implementation of selected benefit enhancements and beneficiary engagement incentives in their applications.

Benefit Enhancements

- Benefit Enhancements are conditional waivers of Medicare FFS payment policies that create flexibilities and new care opportunities for Model participants.
- Benefit Enhancements are paid through the Medicare Trust Fund, by way of the FFS claims processing system.

Benefit Enhancements for PY2023

ACO REACH will continue to offer the same benefit enhancements as available in PY2022 under the GPDC Model:

- 3-Day SNF Rule Waiver Benefit Enhancement
- Telehealth Benefit Enhancement
- Post-Discharge Home Visits Rule Benefit Enhancement
- Care Management Home Visits Benefit Enhancement
- Home Health Homebound Waiver Benefit Enhancement*
- Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit

In addition, ACO REACH will offer one new benefit enhancement starting in PY2023:

- Nurse Practitioner Services Benefit Enhancement (New for 2023)

Beneficiary Engagement Incentives

ACO REACH will continue to offer the same Beneficiary Engagement Incentives as available in PY2022 under the GPDC Model:

- Beneficiary Engagement Incentives provide model participants with another set of tools to encourage beneficiaries to engage in coordinated care.
- Beneficiary Engagement Incentives are optional and are paid for by the ACO directly.
- Available Beneficiary Engagement Incentives for PY2023:
  - Chronic Disease Management Reward Program
  - Cost Sharing Support for Part B Services
  - In-Kind Items or Services

Model Timeline

Model Timeline

Events	Dates for Performance Period (PY) 2023
Application Period	March 7, 2022 – April 22, 2022
REACH ACO Selection	June 2022
Optional Implementation Period 3 (IP3)	August 1, 2022 – December 31, 2022 Note: Voluntary Attestations that count towards meeting beneficiary alignment for PY2023 will be due by Early – Mid November
Start of Performance Year 2023 (PY2023)	January 1, 2023

This timeline may be subject to change. Please check the ACO REACH webpage for updated timelines.

Upcoming Webinars and Questions

Upcoming Webinars

Webinar	Date
ACO REACH Financial Methodology Webinar	Monday, March 28, 4:00 – 5:00 PM ET Register here.
ACO REACH Application Office Hours	Tuesday, March 29, 4:00 – 5:00 PM ET Register here.
ACO REACH Health Equity Webinar	Tuesday, April 5, 4:00 – 5:00 PM ET Register here.
ACO REACH General Office Hours	Tuesday, April 12, 3:00 – 4:00 PM ET Register here.

Questions

Contact Information and References

ACO REACH Webpage:

https://innovation.cms.gov/innovation-models/aco-reach

ACO REACH Request for Applications:

https://innovation.cms.gov/media/document/aco-reach-rfa

ACO REACH/GPDC Comparison Table:

https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison

ACO REACH Summary Graphic:

https://innovation.cms.gov/media/document/aco-reach-graphic

Email: ACOREACH@cms.hhs.gov