



ACO Realizing Equity, Access, and Community  
Health (REACH) Model<sup>1</sup>  
Request for Applications  
**02/24/2022**

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<sup>1</sup> The Global and Professional Direct Contracting (GPDC) Model has been redesigned and renamed the ACO REACH Model.

Table of Contents

- I. Background and Introduction..... 4
- II. Statutory Authority..... 4
  - A. General Authority to Test Model..... 4
  - B. Financial and Payment Model Authorities ..... 4
  - C. Waiver and Safe Harbor Authority..... 5
- III. Scope and General Approach ..... 6
  - A. Model Performance Period..... 6
  - B. Implementation Period ..... 8
- IV. Application Process ..... 8
  - A. Application ..... 8
  - B. Withdrawal of Application ..... 8
- V. Applicant Eligibility and Participation Requirements..... 9
  - A. Eligible Providers and Suppliers ..... 10
  - B. Screening..... 11
  - C. ACO Organization Types, Legal Entity Status, Governance Structure, and Leadership..... 12
  - D. Participant Providers and Preferred Providers..... 15
  - E. ACO Service Area..... 15
  - F. State Licensure ..... 15
  - G. Use of Certified EHR Technology ..... 16
  - H. Program Overlap..... 16
  - I. Advanced APM Determination ..... 18
  - J. MIPS APM Scoring..... 18
  - K. Focus on Health Equity ..... 18
  - L. Additional updates from prior Request for Applications ..... 21
- VI. Model Design Elements..... 23
  - A. Beneficiary Eligibility ..... 23
  - B. Beneficiary Alignment ..... 23
  - C. Beneficiary Engagement and Marketing ..... 28
  - D. Financial Methodology: Risk Sharing Options, Risk Mitigation, and Financial Settlement .. 32
  - E. Financial Methodology: ACO REACH Model Payment Mechanisms ..... 38

- F. Financial Methodology: Beneficiary Alignment and the Performance Year Benchmark for Each of the Three ACO Types ..... 46
- G. Medicare Part D..... 70
- H. Benefit Enhancements ..... 70
- I. Health Equity Plan..... 77
- VII. Quality and Performance ..... 78
  - A. Quality Monitoring..... 78
  - B. Quality in Calculating the Performance Year Benchmark ..... 78
  - C. Demographic Data Collection and Reporting ..... 79
- VIII. ACO Monitoring and Oversight..... 80
- IX. CMS Monitoring..... 81
- X. Remedial Actions ..... 81
- XI. Data Sharing and Reports..... 83
  - A. Data Sharing ..... 83
  - B. Data Suppression and Beneficiary Data Sharing Opt Out..... 84
- XII. Evaluation..... 85
- XIII. Information Resources for Beneficiaries and Providers..... 85
- XIV. Application Scoring and Selection ..... 85
- XV. Duration of the ACO REACH Model ..... 86
- XVI. Learning and Diffusion Resources ..... 86
- XVII. Public Reporting ..... 86
- XVIII. Termination ..... 87
- XIX. Amendment ..... 87
- Appendices ..... 89
  - Appendix A: Glossary of Key Definitions ..... 89
  - Appendix B: Summary Table of ACO Types by Design Elements..... 94
  - Appendix C: Global and Professional Quality Measures for PY2023 ..... 99
  - Appendix D: Application Template ..... 100

## I. Background and Introduction

**NOTE: This Request for Applications (RFA) is for the ACO Realizing Equity, Access, and Community Health (REACH) Model, which is the redesigned and renamed Global and Professional Direct Contracting (GPDC) Model. Per the Center for Medicare and Medicaid Innovation (Innovation Center) announcement dated 2/24/22 (see the ACO REACH Model website: <https://innovation.cms.gov/innovation-models/aco-reach>), all Model-related documents (including this RFA) specific to 2023 and beyond will use the revised Model name. Model participants, formerly referred to as Direct Contracting Entities (DCEs), will be referred to as Accountable Care Organizations.**

The ACO Realizing Equity, Access, and Community Health (REACH) Model provides an opportunity for the Centers for Medicare & Medicaid Services (CMS) to test an array of financial risk sharing options, leveraging lessons learned from other Medicare Accountable Care Organization (ACO) initiatives, such as the Medicare Shared Savings Program (Shared Savings Program) and the Next Generation ACO (NGACO) Model, as well as innovative approaches from Medicare Advantage (MA) and private sector risk sharing arrangements. The ACO REACH Model seeks to improve quality of care and health outcomes for Medicare beneficiaries through the alignment of financial incentives, emphasis on patient choice, strong monitoring to ensure that beneficiaries maintain access to care, and an emphasis on care delivery. This model is part of a strategy by the CMS Center for Medicare and Medicaid Innovation (Innovation Center) to use the redesign of primary care as a platform to drive broader health care delivery system reform. The ACO REACH Model creates a variety of pathways for taking on financial risk supported by enhanced flexibilities. Because the model reduces administrative burden, supports a focus on complex, chronically ill patients, and aims to encourage organizations to participate that have not typically participated in Medicare fee-for-service (FFS), Innovation Center models, or both (for example, provider-led organizations with a strong track record of taking risk in Medicare Advantage or Managed Medicaid), we anticipate that this model will appeal to a broad range of provider-led organizations. The ACO REACH Model provides an opportunity for health care providers that have not previously been eligible for the Shared Savings Program, the NGACO Model, or both due to an insufficient number of aligned Medicare FFS beneficiaries.

Under the ACO REACH Model, CMS is testing two voluntary risk sharing options, which are described in this Request for Applications (RFA): (1) Professional Option (hereinafter referred to as Professional), a lower-risk option with 50 percent Shared Savings/Shared Losses and Primary Care Capitation generally equal to seven percent of the Performance Year Benchmark for enhanced primary care services; and (2) Global Option (hereinafter referred to as Global), a full risk option with 100 percent Shared Savings/Shared Losses and either Primary Care Capitation or Total Care Capitation.

## II. Statutory Authority

### A. General Authority to Test Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Innovation Center to test innovative payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

### B. Financial and Payment Model Authorities

Section 1115A(b)(2) of the Act requires the Secretary to select models to be tested where the Secretary

determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute also provides a non-exhaustive list of examples of models that the Secretary may select to test.

The ACO REACH Model seeks to improve quality of care and health outcomes for Medicare beneficiaries through alignment of financial incentives to promote effective and appropriate care, the promotion of health equity among all Model participants, emphasis on patient choice, strong monitoring to ensure that beneficiaries maintain access to care, and emphasis on care delivery for the complex, chronically and seriously ill population. The two risk sharing options available under the ACO REACH Model, combined with other Model flexibilities, like the ability to offer Benefit Enhancements which broaden the set of covered services available to aligned beneficiaries, are expected to increase beneficiaries' access to innovative, affordable care while maintaining all original Medicare benefits. The ACO REACH Model also places a greater emphasis on voluntary alignment, empowering beneficiaries to choose the health care providers with whom they want to have a care relationship, and enabling stability through stronger patient and provider relationships.

The ACO REACH Model advances risk sharing options and builds upon lessons from CMS' ACO portfolio. It addresses stakeholders' concerns that there is no common approach to benchmarking, that the financial methodology in other CMS risk-based initiatives offered under Medicare FFS, such as the Shared Savings Program and NGACO Model, has not borrowed sufficiently from private sector approaches, and that they lack access to a true population-based payment structure to drive broad transformation. Further, we are designing financial incentives to attract organizations that responsibly manage complex, chronically and seriously ill patients, through refinements in our benchmarking methodology and risk adjustment. Through accountability for the total cost of care and the option for population-based payments, participating providers and suppliers will shift from FFS billing and gain the flexibility to adapt clinical delivery to meet beneficiaries' needs, such as longer visits for high-risk patients or continued care beyond a standard office visit. ACOs may also benefit from risk stratification of patients and tailoring care management strategies to match their patient population.

Building on the lessons learned from and experiences of the previous initiatives, the ACO REACH Model is expected to reduce administrative burdens and empower primary care providers to spend more time caring for patients while reducing overall health care costs. For many patients, the primary care clinician is the first point of contact with the health care delivery system. Empirical evidence shows that strengthening primary care is associated with high quality of care, better outcomes, and lower costs within and across major population subgroups. Despite this evidence, primary care spending accounts for a small portion of the total cost of care, and is even lower for patients with complex, chronic conditions. CMS' experience with innovative models, programs and demonstrations to date has shown that when incentives for primary care clinicians are aligned to reward the provision of high-value care, the quality and cost effectiveness of patient care improves.

### **C. Waiver and Safe Harbor Authority**

The authority for the ACO REACH Model is section 1115A of the Act. Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). Please refer to the Benefit Enhancements section for a list of programmatic

waivers offered under the ACO REACH Model starting in Performance Year 2021 (PY2021).

Consistent with the authority under section 1115A(d)(1), the Secretary issued a waiver of 1877(a) of the Act (relating to the Federal physician self-referral law) and sections 1128B(b)(1) and (2) of the Act (relating to the Federal anti-kickback statute) with respect to any startup arrangement between a DCE and one or more DC Participant Providers or Preferred Providers or both (as such terms were defined in the Participation Agreements for the first and second Implementation Periods of the model).<sup>2</sup> For startup arrangements entered into for any future Implementation Period, CMS is considering whether to seek an amendment to the current fraud and abuse waiver (e.g., to reflect the revised terminology of the ACO REACH Model) or, in lieu of a fraud and abuse waiver, to determine that the anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR § 1001.952(ii)(1)) is available. No fraud or abuse waivers are being issued in this document. A new or revised fraud and abuse waiver, if any, would be set forth in separately issued documentation. Any such waiver would apply solely to the ACO REACH Model and could differ in scope or design from waivers granted for other programs or models.

In addition to the fraud and abuse waiver issued for certain startup arrangements, CMS determined that, beginning April 1, 2021, the anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR § 1001.952(ii)(1)) is available to protect certain DCE financial arrangements between or among the DCE, one or more DC Participant Providers, one or more Preferred Providers, or a combination thereof, provided that such arrangements comply with the applicable requirements set forth in the Participation Agreement for the Model Performance Period (“MPP Participation Agreement”). Further, CMS determined that, beginning April 1, 2021, the anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)(2)) is available to protect certain in-kind patient incentives and Beneficiary Engagement Incentives furnished to a DC Beneficiary by a DCE, a DC Participant Provider, or a Preferred Provider, as applicable, provided that such incentives (as defined in the MPP Participation Agreement) are furnished in a manner that complies with the relevant requirements set forth in the MPP Participation Agreement. For future performance years under the ACO REACH Model, CMS intends that ACOs, Participant Providers, and Preferred Providers will receive the same scope of protection currently available for this model under the CMS-sponsored model safe harbor at 42 CFR 1001.952(ii).

Notwithstanding any provision of this RFA, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided for the ACO REACH Model in a separately documented waiver issued pursuant to section 1115A(d)(1). We note that the applicable law includes the CMS-sponsored model safe harbor to the extent CMS has determined that it is applicable for this model.

### **III. Scope and General Approach**

#### **A. Model Performance Period**

The model will be implemented over six performance years, from PY2021-PY2026 (collectively, the Model Performance Period or MPP). PY2021 occurred from April 2021 through December 2021, and PY2022, PY2023, PY2024, PY2025 and PY2026 will occur in calendar years 2022, 2023, 2024, 2025, and 2026

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<sup>2</sup> The waiver document can be found at <https://www.cms.gov/files/document/notice-waiver-certain-fraud-and-abuse-laws-connection-global-and-professional-options-direct.pdf>.

respectively<sup>3</sup>. This RFA is for applications to begin participation in PY2023. Throughout this RFA and all other ACO REACH Model materials, CMS has chosen to use performance year-specific terminology (PY2021 – PY2026) rather than participant-specific terminology (e.g., a given participant's first performance year (PY1), second performance year (PY2), etc.) because **all model policies apply equally to all model participants within a given year, regardless of when each participant began participation** (unless otherwise specified<sup>4</sup>). As such, all tables and other descriptions of policies that vary throughout the life of the model will be described in performance year-specific terms. **While the policies for PY2021 and PY2022 may be shown for completeness and as a reference, organizations that submit applications in response to this RFA and that are selected to begin participation in PY2023 would be subject to only those policies described for PY2023 and subsequent Performance Years.**

The risk sharing options available under the ACO REACH Model aim to reduce expenditures while preserving or enhancing quality of care for beneficiaries. By aligning financial incentives, providing a prospectively determined and predictable revenue stream for participants, and putting a greater emphasis on beneficiary choice, the ACO REACH Model aims to:

- **Transform risk sharing options in Medicare FFS** by offering both capitated and partially capitated population-based payments that move away from traditional FFS;
- **Broaden participation in CMS Innovation Center models** by allowing model participation by organizations new to Medicare FFS, such as physician managed organizations currently operating exclusively in the MA program and organizations too small to meet the beneficiary minimum requirements of prior ACO initiatives;
- **Empower beneficiaries** to engage in their care delivery through voluntary alignment and potential Benefit Enhancements;
- **Reduce health care provider burden** to meet health care needs effectively through, for example, a smaller set of core quality measures (than used in the Pioneer ACO Model, NGACO Model, and Shared Savings Program), and waivers to facilitate care delivery; and
- **Improve the quality of care for all aligned Medicare beneficiaries** through financial mechanisms and health equity plans that encourage and support model participants and providers in addressing health inequities beginning in PY2023.

The risk sharing options available under the ACO REACH Model are expected to increase beneficiaries' access to innovative, affordable care while maintaining all original Medicare benefits. While an ACO that has selected either of the risk sharing options available under the ACO REACH Model may offer Benefit Enhancements to eligible beneficiaries, these beneficiaries may still choose whether to receive enhanced benefits. Relative to other CMS initiatives, the ACO REACH Model places an emphasis on voluntary alignment, empowering beneficiaries to choose the health care providers with whom they want to have a care relationship. The ACO REACH Model also aims to improve beneficiaries' experience of care by reducing administrative burden on practitioners, so that they can focus on what is most important: caring for patients.

CMS is committed to improving care for beneficiaries and thereby may modify or terminate the ACO REACH Model if the model is not achieving its established goals and aims or as may be required under

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<sup>3</sup> Please note that the shortened PY2021 (9 months) and the addition of PY2026 is a policy change from the PY2021 RFA due to the challenges posed by coronavirus disease 2019.

<sup>4</sup> For example, the participation retention policy described in Section XVIII.

section 1115A.

## **B. Implementation Period**

In line with the opportunities made available to ACOs that began participation in PY2021 and PY2022, the Innovation Center will allow all applicants accepted under this 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 over the life of the ACO REACH Model). The IP3 will begin August 1, 2022 and run through December 31, 2022 and is intended to provide ACOs joining the model beginning in PY2023 an opportunity to conduct voluntary alignment activities (described in Section VI.B) in preparation for meeting the applicable beneficiary alignment minimum at the start of PY2023 (also described in Section VI.B). While lists of Participant Providers (described in Section V.A) will be established for IP3 for purposes of documenting which providers and suppliers will be conducting voluntary alignment activities during the IP3, no beneficiaries will be aligned to the ACO for the IP3 itself, either through claims-based alignment or voluntary alignment (described in section VI.B); all beneficiaries aligned to the ACO via voluntary alignment activities conducted during the IP3 will have an effective date of alignment at the beginning of PY2023. Moreover, ACOs participating in the ACO REACH Model during IP3 do not take financial risk for their performance during IP3 and no beneficiary-identifiable data will be shared with these ACOs for purposes of participation in IP3 (described in Section XI).

All accepted applicants under this RFA will have the opportunity, but not the obligation, to participate in the IP3. Accepted applicants choosing to participate in the IP3 must sign an IP3-specific Participation Agreement governing their participation in the IP3. Signing the IP3 Participation Agreement does not obligate an accepted applicant to participate in the model performance period beginning in PY2023 and choosing not to sign the IP3 Participation Agreement does not prevent an accepted applicant from participating in the model performance period beginning in PY2023. Regardless of whether they participate in the IP3, all accepted applicants must sign an MPP Participation Agreement in order to participate in the model performance period beginning in PY2023.

## **IV. Application Process**

All entities that want to participate in the ACO REACH Model are required to submit an application.

### **A. Application**

The application portal will be available beginning 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>.

**Any questions that arise during the application process may be directed to the ACO REACH Model mailbox: [ACOREACH@cms.hhs.gov](mailto:ACOREACH@cms.hhs.gov) with the subject "Application Question."**

### **B. Withdrawal of Application**

Applicants seeking to withdraw a completed application must submit an electronic withdrawal request to CMS via email to the ACO REACH Model mailbox: [ACOREACH@cms.hhs.gov](mailto:ACOREACH@cms.hhs.gov), prior to signing either the



participation agreement for IP3 (if applicable) or the MPP Participation Agreement. The request must be submitted as a PDF on the organization's letterhead and signed by an official authorized to act on behalf of the organization. It should include the applicant organization's legal name; the organization's primary point of contact; the full address of the organization; and a description of the reason for the withdrawal.

#### **V. Applicant Eligibility and Participation Requirements**

The following sections describe the requirements an entity must meet to be eligible to participate in the ACO REACH Model. The ACO REACH Model is designed to attract a range of providers and suppliers operating under a common legal structure, with attention given to advancing primary care as a means to better managing health care overall. We believe this model is well-suited to various types of provider-led organizations, including those with prior experience participating in the NGACO Model or the Shared Savings Program that are interested in continuing and deepening their participation in Medicare shared risk arrangements.

In addition to attracting participants from the NGACO Model, one of the goals of the ACO REACH Model is to add innovative organizations to CMS risk sharing arrangements that have not been eligible for the Shared Savings Program and/or the NGACO Model due to an insufficient number of aligned Medicare FFS beneficiaries or other reasons. These innovative organizations may include provider-led organizations that have strong track records in taking on risk and improving quality of care for seniors and other vulnerable populations outside of FFS Medicare. Enhanced opportunities for voluntary alignment, along with an alignment "glide path," provide opportunities for organizations new to Medicare FFS and/or Innovation Center models to build an aligned Medicare FFS population through means other than claims-based alignment.

Depending on the volume of applications received, CMS may choose to limit the total number of accepted applications. Please note that this RFA is intended only for applicants that serve a general, heterogeneous 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 sub-population 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 accepted under this RFA.

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. Please refer to Section VI.F.3 for additional details on the High

Needs Population ACO Type.

#### **A. Eligible Providers and Suppliers**

The ACO must be a legal entity. All ACOs must contract with Participant Providers (defined in the Glossary at Appendix A). Participant 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)

All ACOs participating in the ACO REACH Model also have the option of entering into arrangements with Preferred Providers (defined in the Glossary at Appendix A). While an ACO will not be 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 C.F.R. § 400.202) or supplier (as defined at 42 C.F.R. § 400.202) when they are added to the Participant Provider list or Preferred Provider list and must remain Medicare-enrolled as long as they remain on either list<sup>5</sup>. Participant Providers who are included on the Participant Provider list for PY2023 in advance of PY2023 will be eligible to contribute to claims-based alignment, if applicable (see Section VI.B for details). Participant Providers and Preferred Providers who are included on the Participant Provider list or Preferred Provider list for PY2023 at the start of PY2023 will be able (and in some cases required) to participate in the ACO's selected Capitation Payment Mechanism. For subsequent performance years of the model, 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 and are not Prohibited Participants (defined in the Glossary at Appendix A) or to remove Participant Providers or Preferred Providers that no longer meet model requirements.

During each performance year, an ACO can add Participant Providers and Preferred Providers under certain circumstances, as specified in the MPP Participation Agreement. Participant Providers that are added during a performance year cannot contribute to claims-based alignment for that performance year. Neither Participant Providers nor Preferred Providers that are added during a performance year will be eligible to participate in the ACO's selected Capitation Payment Mechanism in that performance year (they can begin participation in the next performance year).

All Participant Providers and Preferred Providers, regardless of when they are added to the Participant Provider list or Preferred Provider list, can participate in the ACO's selected Benefit Enhancements and the Cost-Sharing Support for Part B Services Beneficiary Engagement Incentive and may receive a distribution from the ACO of any shared savings payment received by the ACO for a performance year in which the Participant Provider or Preferred Provider participated in the ACO REACH Model. A beneficiary may designate any Participant Provider, regardless of when that provider or supplier was added to the Participant Provider list for a given performance year, as his or her main source of care for purposes of

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<sup>5</sup> For additional information on Medicare provider and supplier enrollment, see CMS website: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.

voluntary alignment. See Program Overlap at Section V.I below for an explanation of the restrictions on ACOs, Participant Providers, and Preferred Providers participating in multiple Medicare initiatives during the IP3, PY2023, and subsequent performance years of the model.

## **B. Screening**

Applications will be screened to determine eligibility for further review. Screening will include the criteria for ACOs detailed in this RFA and applicable law and regulations, including 2 C.F.R Parts 180 and 376. In addition, CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity (PI) review of the applicant or any other relevant individuals or entities associated with the applicant. The PI review may include the following, without limitation, with respect to the Applicant ACO, persons with an ownership or control interest (as that term is defined in Appendix A) in the Applicant ACO, Key Executives (as that term is defined in Appendix A), equity partners (e.g., private equity or venture capital) , and individuals and entities that the Applicant ACO expects will be Participant Providers or Preferred Providers:

- Confirmation of current Medicare enrollment status and history of adverse enrollment actions;
- Identification of delinquent Medicare and Medicaid debt;
- Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- Review of compliance with Medicare and Medicaid program requirements;
- Review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any administrative, civil, or criminal actions related to integrity or other factors relevant to participation in an initiative involving Federal funds;
- Confirmation that the Applicant ACO has not engaged in anti-competitive practices.

To support the PI review, Applicant ACOs will be required to disclose the following with respect to the Applicant ACO, persons with an ownership or control interest in the Applicant ACO, Key Executives, equity partners, and individuals and entities the Applicant ACO expects to be Participant Providers and Preferred Providers: (i) any sanctions or corrective action plans imposed under Medicare, Medicaid, or state licensure authorities within the last three years (including corporate integrity agreements); (ii) any fraud investigations initiated, conducted, or resolved within the last three years; (iii) any outstanding debts owed to Federal healthcare programs, including any debts owed under an Innovation Center model or to any agency of the federal government; (iv) any awards of a CMS contract in the past five years, and, if applicable, the contract number and period of performance for such award; (v) whether any such individuals or entities are on a government suspension, debarment, or exclusion list relating to procurement and non-procurements; (vi) any instances of criminal conduct; and (vii) any bankruptcy filings.

The Applicant ACO's application must include each Key Executive's Curricula Vitae, which must include, at a minimum, professional history and identification of any organizations on whose governing body the Key Executive is a member. The experience of the Applicant ACO's Key Executives will be reviewed to ensure alignment with the ACO REACH Model goals and requirements. Applicant ACOs will additionally be required to disclose whether individuals and entities on their governing body or leadership team have any ownership or control interest in the Applicant ACO.

While CMS will not be collecting lists of Participant Providers or Preferred Providers for PY2023 as part of

the application, if an Applicant ACO is selected for participation in the Model, CMS will require the ACO to submit a list of the ACO's proposed Participant Providers and proposed Preferred Providers. CMS will conduct a program integrity (PI) screening of the ACO's proposed Participant Providers and proposed Preferred Providers and may deny their participation in the Model based on the results of a program integrity (PI) screening or other information obtained regarding an individual's or entity's history of program integrity issues.

### C. ACO Organization Types, Legal Entity Status, Governance Structure, and Leadership

#### ACO Organization Types

A key aspect of the ACO REACH Model is providing new opportunities for a variety of different organizations to participate in value-based care arrangements in Medicare FFS. In addition to organizations that have traditionally provided services to a Medicare FFS population, the ACO REACH Model provides new opportunities for provider-led organizations without significant experience in FFS but with strong track records of taking risk and improving quality of care for seniors and other vulnerable populations outside FFS Medicare to enter into value-based care arrangements.

There are three types of ACOs under the ACO REACH Model with different characteristics and operational parameters. These three types of ACOs are:

- 1. Standard ACOs** – ACOs comprised of organizations that generally have experience serving Medicare FFS beneficiaries, including dually eligible beneficiaries. These organizations may have previously participated in section 1115A models involving shared savings (e.g., NGACO and Pioneer ACO Model) and/or the Shared Savings Program. Alternatively, new organizations, composed of existing Medicare FFS providers and suppliers, may be created in order to participate as this ACO type. In either case, providers and suppliers participating within these organizations would have substantial experience serving Medicare FFS beneficiaries. Beneficiaries will be aligned to Standard ACOs through voluntary alignment and claims-based alignment.
- 2. New Entrant ACOs** – ACOs comprised of organizations that have not traditionally provided services to a Medicare FFS population and that may primarily rely on voluntary alignment, at least in the first few performance years of the model. Claims-based alignment will also be utilized.
- 3. High Needs Population ACOs** – ACOs that serve Medicare FFS 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, similar to the one employed by the Programs of All-Inclusive Care for the Elderly (PACE), to coordinate care for their aligned beneficiaries. (Please see Section VI.F.3 for the specific criteria defining this complex population.)

All ACOs must meet certain requirements to be eligible to participate in the ACO REACH Model (for example, see Minimum Beneficiary Threshold section below). Please note that High Needs Population ACOs and Standard or New Entrant ACOs with common ownership will not be permitted to operate in the same geography.

Given that applicant organizations will be distinct in their composition of providers and suppliers, as well as in their experience in value-based care arrangements in Medicare FFS, certain model features, including beneficiary alignment, benchmarking methodology, and alternative payment mechanisms, may vary based on ACO type. Design parameters and model requirements will be described separately for each ACO type later in this RFA. A summary table comparing the different elements for each of the three ACO types has been provided in Appendix B.

### **Legal Entity**

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. 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 one or more Participant Providers that bill under a single TIN (such as a group practice), the ACO's legal entity and governing body may be the same as that of the Participant Provider(s). The ACO must also comply with all applicable laws and regulations, as well as all ACO REACH Model participation requirements.

### **Structure of the Governing Body**

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 all of the Participant Providers that comprise the ACO bill under a single TIN, in which case the ACO's governing body may be the same as that of the Participant Provider(s)).

### **Responsibilities of the Governing Body**

- The governing body must have responsibility for oversight and strategic direction of the ACO and will be responsible for holding ACO management accountable for the ACO's activities.
- The governing body must have a transparent governing process.
- The ACO governing body's incorporating documents shall require that, when acting as a member of the governing body of the ACO, each governing body member shall have a fiduciary duty to the ACO, including the duty of loyalty, and shall act consistent with that fiduciary duty.
- The governing body must receive reports periodically from the designated compliance official of the ACO, who cannot serve as legal counsel to the ACO, and who must report directly to the governing body.

### **Composition and Control of the Governing Body**

- The ACO governing body must include at least one Medicare beneficiary served by the ACO: (1) who does not have a conflict of interest with the ACO; (2) who has no immediate family member with a conflict of interest with the ACO; (3) who is not a Participant Provider or Preferred Provider; and (4) who does not have a direct or indirect financial relationship with the ACO, a Participant Provider, or a Preferred Provider, except that such individual may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO. Please note that this requirement is the minimum; CMS strongly encourages greater beneficiary participation in advising and informing ACO activities. In cases where beneficiary representation on the ACO governing body is prohibited by state

law, the ACO shall provide for an alternative mechanism, subject to CMS approval, to ensure that its policies and procedures reflect patient perspectives.

- The ACO governing body must include at least one consumer advocate who is a different individual as the Medicare beneficiary. The consumer advocate must be an individual with training or professional experience in advocating for the rights of consumers and who: (1) does not have a conflict of interest with the ACO; (2) has no immediate family member with a conflict of interest with the ACO; (3) is not a Participant Provider or Preferred Provider; and (4) does not have a direct or indirect financial relationship with the ACO, a Participant Provider, or a Preferred Provider, except that such individual may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO. In cases where consumer advocate representation on the ACO governing body is prohibited by state law, the ACO shall provide for an alternative mechanism, subject to CMS approval, to ensure that its policies and procedures reflect consumer perspectives.
- At least two of the individuals serving on the governing body as a Medicare beneficiary or consumer advocate must hold voting rights. In cases where beneficiary and consumer advocate representation on the ACO governing body is prohibited by state law, the ACO shall provide for an alternative mechanism, subject to CMS approval, to ensure that its policies and procedures reflect beneficiary and / or consumer perspectives.
- At least 75 percent control of the ACO's governing body shall be held by Participant Providers or their designated representatives (this is an increase from the 25 percent control requirement for PY2021 and PY2022). The ACO may seek an exception from the 75 percent control requirement 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.
- The ACO governing body shall not include a Prohibited Participant (as defined in the Glossary at Appendix A), or an owner, employee or agent of a Prohibited Participant.
- The governing body members may serve in similar or complementary roles or positions for a Participant Provider or Preferred Provider as the role or position that they serve for the ACO.

### **Conflict of Interest**

The ACO governing body must have a conflict of interest policy that applies to members of the governing body. The conflict of interest policy must:

- Require each member of the governing body to disclose relevant interests that may present a potential conflict of interest;
- Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and
- Address remedial actions for members of the governing body who fail to comply with the policy.

### **ACO Leadership and Management**

ACOs must have a leadership and management structure that meets the following criteria:

- The ACO's operations must be managed by an executive, officer, manager, general partner, or similar individual whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve the efficiency of processes and outcomes.

- Clinical management and oversight must be managed by a senior-level medical director who is: (1) a Participant Provider; (2) physically present on a regular basis at any clinic, office, or other location participating in the ACO; and (3) a board-certified physician and licensed in a state in which the ACO operates.

#### **D. Participant Providers and Preferred Providers**

The ACO REACH Model defines categories of Medicare providers and suppliers based on their respective relationships to the ACO. The two primary categories are Participant Providers and Preferred Providers. Participant Providers are the core providers and suppliers in the ACO REACH Model. Beneficiaries are aligned to the ACO through the Participant Providers and these providers and suppliers are responsible for, among other things, committing to beneficiary care improvement. Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, Preferred Providers may participate in available Benefit Enhancements and Capitation Payment Mechanisms with the ACO. Beneficiaries will not be aligned to an ACO through its Preferred Providers. Beneficiaries aligned to an ACO may also choose to receive services from Medicare FFS providers and suppliers that are not associated with that ACO.

#### **E. ACO Service Area**

To be aligned to an ACO, a beneficiary must reside in a county in the ACO's service area. The service area also determines where the ACO can engage in Marketing Activities. For all ACO types, an ACO's service area consists of the Core Service Area and the Extended Service Area. For this purpose, the Core Service Area includes the counties in which the ACO's Participant Providers have physical office locations. The Extended Service Area includes the counties adjacent to the Core Service Area. Based on the list of the Participant Providers submitted by the ACO during the application process and on an ongoing basis during the model performance period, CMS will identify the ACO's service area. 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 performance year. This updated service area will be used for the purposes of Prospective Plus Alignment (see Section VI.B) and the ACO's future marketing activities. ACOs are permitted to operate in multiple, non-contiguous service areas. For example, an ACO could operate in service areas in the same state or more than one state. If CMS determines that an ACO's clinical care model does not rely on physical practice locations (e.g., through delivery of services in locations other than a provider's office, such as beneficiaries' homes), such as if the ACO is located in a Rural Area (see Appendix A for the definition of Rural Area) or is a High Needs Population ACO, and the ACO proposes an alternative to the county-by-county physical practice location standard which CMS approves, the ACO's service area will be the alternative service area approved by CMS.

The service area is distinct from the ACO's region, which includes all counties where ACO-aligned beneficiaries reside. An ACO's region is used to determine which counties' regional expenditures are incorporated into the Performance Year Benchmark for an ACO. More details on the benchmark methodology can be found in Section VI.F.

#### **F. State Licensure**

In order to participate in the ACO REACH Model, an ACO must demonstrate compliance with all applicable

state licensure requirements regarding risk-bearing entities. Each state has unique regulatory systems for health care delivery, the practice of medicine, fraud and abuse, and insurance, but CMS understands that states may not have laws that specifically address provider organizations bearing substantial financial risk or distributing savings. Therefore, depending on the particular state laws and the discretion of state authorities, ACOs may be subject to insurer or third-party administrator (TPA) licensure requirements. It is an ACO's responsibility to determine and meet all applicable licensure requirements. The ACO REACH Model does not alter state law requirements, but CMS intends to engage with relevant state agencies to promote an understanding of the ACO REACH Model's features and requirements. A model overview for State Insurance Regulators can be found on the ACO REACH Model website.

### **G. Use of Certified EHR Technology**

ACOs shall 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%. For purposes of the previous sentence, the terms "eligible clinician" and "CEHRT" are defined at 42 C.F.R. 415.1305.

Under the terms of the IP3 Participation Agreement and the MPP Participation Agreement, if an arrangement between an ACO and a Participant Provider or Preferred Provider involves the provision of electronic health records software to one or more Participant Providers or Preferred Providers, such software must be interoperable (as defined in 42 C.F.R. § 411.351) or must satisfy 42 C.F.R. § 411.357(w)(2) regarding interoperability at the time the software is provided to the recipient. Under § 411.357(w)(2), electronic health records software is deemed to be interoperable if, on the date it is provided to a physician, it is certified by a certifying body authorized by the National Coordinator for Health Information Technology to certification criteria identified in the then-applicable version of 45 CFR part 170.

### **H. Program Overlap**

#### **Internal Model Overlaps**

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 MPP Participation Agreement, the ACO may switch from Global to Professional, and vice versa. The ACO cannot move from the Global to 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, to take effect PY2024
- During PY2024, to take effect PY2025
- During PY2025, to take effect PY2026.

#### **Medicare Shared Savings Program**

During each performance year from PY2021 (April-December 2021) through PY2026 (CY2026), ACOs and their Participant Providers may not simultaneously participate in the Shared Savings Program. The determination of whether such an overlap exists during PY2021 – PY2026 will be made at the TIN level. During the IP3, ACOs and their Participant Providers may participate in both the ACO REACH Model IP3



and the Shared Savings Program.

### **Other Medicare Initiatives Involving Shared Savings, Primary Care First, and other Innovation Center Models**

During the model's performance years (PY2021 – PY2026), Participant Providers may not simultaneously participate in the ACO REACH Model and another model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings unless otherwise permitted by CMS. For example, Participant Providers may not participate in the Kidney Care Choices model or the Vermont All-Payer ACO Model. In addition, for the Primary Care First model, Independence at Home demonstration, and the Maryland Primary Care Program, which have similar payment structures to the ACO REACH Model, overlap is prohibited despite the fact that they are not shared savings initiatives. For each of these initiatives, overlap is determined based on the TIN/NPI combination of the participating clinicians.

Participant Provider overlap with these initiatives is permitted, however, during the IP3. In addition, ACOs and their Participant Providers may participate in other Medicare demonstrations or Innovation Center models that do not involve shared savings, with the exception of those specified above, during IP3 and the model's performance years if they meet all applicable eligibility criteria under the applicable demonstration or model.

CMS may issue guidance that assists ACOs and their Participant Providers in determining how participation in certain demonstrations or models can be combined with participation in the ACO REACH Model, and whether a beneficiary may be aligned to more than one initiative and, in such cases, whether there is any adjustment made to account for the potential overlap at Financial Settlement.

### **Participant Providers**

Participant Providers will be identified by a combination of their TIN and NPI. However, splitting the TIN will be permitted, which will allow Participant Providers with separate NPIs who bill through the same TIN to join separate models. In addition, a Participant Provider may participate in another model using another TIN that is not being used for the ACO REACH Model. ACOs should note that if an ACO includes an NPI who will be billing through a new TIN on its list of Participant Providers, the NPI will not be able to contribute claims history to the beneficiary alignment process, unless the NPI's former TIN, known as a "Legacy TIN" is also included on the ACO's Participant Provider list and the Legacy TIN is not being used by a participant in another CMS initiative. Legacy TINs are subject to similar overlap rules as Participant Providers.

### **Preferred Providers**

The overlap requirements described above generally do not apply to an ACO's Preferred Providers. Specifically, a Preferred Provider may serve in the following roles during both IP3 and the model performance period provided all other applicable requirements are met: (1) Preferred Provider for one or more other ACOs participating in the ACO REACH Model; (2) Participant Provider in another ACO participating in the ACO REACH Model; (3) ACO participant, ACO provider or supplier and/or ACO professional in an ACO in the Shared Savings Program (note: CMS intends to waive the non-duplication requirements under section 1899(b)(4)(A) of the Act and 42 C.F.R. § 425.114(a) and (b) as they apply to Preferred Providers as necessary solely for purposes of testing the ACO REACH Model); and/or (4) a role

similar in function to a Participant Provider in another Medicare initiative that involves shared savings.

#### **I. Advanced APM Determination**

Both the Global and Professional risk sharing options under the ACO REACH 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 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.

#### **J. MIPS APM Scoring**

The Global and Professional risk sharing options of the model are both considered Merit-based Incentive Payment System (MIPS) APMs under the definition at 42 C.F.R. 414.1305. 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 according to 42 C.F.R. §§ 414.1317 or 414.1367.

#### **K. Focus on Health Equity**

The ACO REACH Model seeks to improve quality of care and health outcomes for all aligned Medicare FFS beneficiaries. Research shows that certain underserved communities experience worse health outcomes and lower quality of care than the general population<sup>6, 7, 8</sup>. To improve the quality of care and outcomes for all aligned beneficiaries, the ACO REACH Model will test ways to address these health inequities.

The Innovation Center believes that equitable care is a key component necessary to achieve high-quality care for Medicare beneficiaries and is therefore critical to the ACO REACH Model's success. The ACO REACH Model is defining the term "equity" as it was defined in the Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985): "the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American individuals, Asian Americans and Pacific Islanders and other individuals of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals; individuals with disabilities; individuals who live in rural areas; and individuals otherwise adversely affected by persistent poverty or inequality." The term "underserved communities" refers to 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, as exemplified by the list in the definition of "equity."

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<sup>6</sup> Fredriksen-Goldsen KI, Hoy-Ellis CP, Muraco A, Goldsen J, Kim H-J. The health and well-being of LGBT older adults: Disparities, risks, and resilience across the life course. *The lives of LGBT older adults: Understanding challenges and resilience*. Washington, DC, US: American Psychological Association; 2015:25-53.

<sup>7</sup>Krahn GL, Walker DK, Correa-De-Araujo R. Persons with disabilities as an unrecognized health disparity population. *Am J Public Health*. 2015;105 Suppl 2(Suppl 2):S198-S206. doi:10.2105/AJPH.2014.302182

<sup>8</sup> Douthit N, Kiv S, Dwolatzky T, Biswas S. Exposing some important barriers to health care access in the rural USA. *Public Health*. 2015;129(6):611-620. doi:10.1016/j.puhe.2015.04.001

Equitable care is one of the six domains of health care quality developed by the Institute of Medicine (IOM) and promoted by the Agency for Healthcare Research and Quality (AHRQ), defined as providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status. As such, the ACO REACH Model is introducing five new policies to promote Health Equity starting in PY2023:

1. Health Equity Plan Requirement
2. Health Equity Benchmark Adjustment
3. Health Equity Data Collection Requirement
4. Nurse Practitioner Services Benefit Enhancement
5. Health Equity Questions in Application and Scoring for Health Equity Experience

These updates are expected to reduce disparities in health such that those with the greatest needs and least resources receive the care they need. Each of these new policies is discussed in greater detail below and, with the exception of the application questions and scoring, will apply to all ACOs (including PY2021 and PY2022 starters).

### **Health Equity Plan Requirement**

Consistent with the ACO REACH Model's goal to increase quality of care for all aligned Medicare beneficiaries by promoting health equity, beginning for PY2023, the Innovation Center is requiring all ACOs to develop and implement a Health Equity Plan based on the CMS Disparities Impact Statement<sup>9</sup>. The purpose of a Health Equity Plan is for each 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. More information on the specific requirements related to the Health Equity Plan are available in Section VI.I of this RFA.

### **Health Equity Benchmark Adjustment**

Historically, participants in CMS's ACO initiatives have had aligned populations that are relatively less underserved than the population of Medicare FFS beneficiaries eligible for alignment<sup>10</sup>. To help address this historical inequity, the Innovation Center will apply a beneficiary-level adjustment in the ACO REACH Model that will increase the benchmark for those ACOs serving higher proportions of underserved beneficiaries in order to mitigate the disincentive for ACOs to serve historically underserved communities by accounting for historically suppressed spending levels for these populations. Specifically, a benchmark adjustment is needed to eliminate the existing negative incentive for ACOs to offer value-based care and care coordination to underserved communities in order to improve quality of care for these beneficiaries.

Research indicates that underserved communities have lower health care spending overall relative to their health care needs.<sup>11</sup> A variety of factors contribute to this underuse or under-provision of care,

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<sup>9</sup> [Disparities Impact Statement \(cms.gov\)](https://www.cms.gov/Disparities/ImpactStatement)

<sup>10</sup> Yasaitis LC, Pajerowski W, Polsky D, et al. Physicians' Participation In ACOs Is Lower In Places With Vulnerable Populations Than In More Affluent Communities. *Health Affairs*. 2016;35(8):1382-1390. doi:10.1377/hlthaff.2015.1635.

<sup>11</sup> <https://jamanetwork.com/journals/jama/fullarticle/2783068>;  
<https://www.science.org/doi/abs/10.1126/science.aax2342>

including inequities related to geographic and socioeconomic variation<sup>12</sup>. These findings indicate that, because benchmarks in the ACO REACH Model are set in part on historical spending (both specific to the ACO and specific to the county in which a given beneficiary resides), benchmarks for ACOs that serve higher proportions of underserved communities may be set below levels of beneficiary needs, creating a disincentive for ACOs to serve these populations or to allocate the resources necessary to address their unmet needs in order to support more equitable care and outcomes.

This new upward adjustment to the benchmark is a necessary step towards removing the disincentive for ACOs to serve underserved communities in a manner that reflects their health needs. Please see Section VI.F of this RFA for additional details on the mechanics of how the Health Equity Financial Incentive will function.

### **Health Equity Data Collection Requirement**

Under 42 CFR 403.1110(b), any entity participating in the testing of an Innovation Center model is required to collect and report such information, including “protected health information” as that term is defined at 45 CFR 160.103, determined necessary to monitor and evaluate the model. For the purpose of monitoring the ACO REACH Model, starting in PY2023, CMS is requiring all ACOs to collect and report certain beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries to enable CMS to monitor the model to ensure that ACOs and their Participant Providers and Preferred Providers are not causing harm to REACH Beneficiaries in general, or to any groups of REACH Beneficiaries connected by one or more demographic characteristics or social needs, including not discriminating against beneficiaries in conducting marketing activities or in providing healthcare to beneficiaries in a manner prohibited under the ACO REACH Model IP3 Participation Agreement and MPP Participation Agreement. In addition, CMS is requiring all ACOs to collect and report this information to enable CMS to determine whether quality is improving for all beneficiaries aligned to ACOs, including underserved subpopulations, as part of the Model evaluation. In PY2023, completing the requirement to collect and report beneficiary-reported demographic information will result in a bonus to the ACO’s quality score, but there will be no downward adjustment for the failure to report this information. In PY2024 and beyond, CMS may impose a requirement on ACOs to collect and report demographic and social determinants of health data on their aligned beneficiaries that results in a downward adjustment to the ACO’s quality score if not completed. However, beneficiary submission of demographic information is voluntary and ACOs should not impose on the beneficiaries they serve any requirement to report such information or impose on its Participant Providers and Preferred Providers any requirement to collect such information from beneficiaries who choose not to report it. ACOs that document a beneficiary’s choice not to disclose demographic data (e.g., answering ‘Prefer not to say’ on a survey) will receive credit for reporting that data. Please see Section VII.C for more information on how CMS will expect ACOs to collect and report data and how this requirement will factor into ACO quality scores.

### **Nurse Practitioner Services Benefit Enhancement**

Beginning in PY2023, the ACO REACH Model plans to make available a new Benefit Enhancement to model participants to help reduce barriers to care access, particularly for beneficiaries in areas with limited access to physicians: The Nurse Practitioner (NP) Services Benefit Enhancement. This Benefit

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<sup>12</sup> Williams DR, Jackson PB. Social sources of racial disparities in health. *Health Affairs*. 2005 Mar-Apr;24(2):325-34. doi: 10.1377/hlthaff.24.2.325. <https://www.healthaffairs.org/doi/10.1377/hlthaff.24.2.325>

Enhancement, which was developed in response to feedback from current model participants and stakeholders, and experience from other Innovation Center models, is intended to allow ACOs to increase flexibility in care delivery and improve care coordination for their aligned beneficiary populations. Under this Benefit Enhancement, Nurse Practitioners will be able to assume certain responsibilities or furnish certain services without physician supervision that they typically could not under current Medicare law, to the extent permitted under applicable state law.

Specifically, CMS intends to issue waivers as necessary to test the ACO REACH Model to allow Nurse Practitioners:

- To certify a REACH Beneficiary's need for hospice care;
- To certify a REACH Beneficiary's need for diabetic shoes;
- To order and supervise cardiac rehabilitation for a REACH Beneficiary;
- To establish, review, sign, and date a REACH Beneficiary's home infusion therapy plan of care; and
- To refer a REACH Beneficiary for medical nutrition therapy.

Please review Section VI.H of this RFA for additional details.

#### **Health Equity Questions in Application and Scoring for Health Equity Experience**

CMS has designed the application for the ACO REACH Model with the intent of encouraging participation by applicants with direct patient care experience and / or experience furnishing high quality care to underserved communities. Research suggests that, historically, access to clinicians participating in ACOs has not been equally shared across patients of differing backgrounds, with ACOs tending to be more likely present in non-rural communities with higher socioeconomic status,<sup>13</sup> and with ACOs serving high proportions of racial and ethnic minorities tending to perform worse on quality metrics as compared to other ACOs.<sup>14</sup> While this particular research concerns rurality, socioeconomic status, race, and ethnicity, it is important to note that these characteristics are not the only ones that could be considered under the ACO REACH definition of "underserved communities."

In light of this research, we believe that it is critical that we take steps to identify applicants with demonstrated successful historical experience (1) providing direct patient care and / or (2) furnishing high-quality care to underserved communities. While CMS will not determine whether a given Applicant ACO is selected for participation in the ACO REACH Model based solely these two criteria, by updating the application questions, and by attaching discrete points separately to questions relating to each category of experience, we hope to best ensure that selected ACOs are well positioned to improve quality outcomes for all aligned beneficiaries, including those in underserved communities, while also achieving savings.

#### **L. Additional Updates from Prior Request for Applications**

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<sup>13</sup> Yasaitis LC, Pajeroski W, Polsky D, et al. Physicians' Participation In ACOs Is Lower In Places With Vulnerable Populations Than In More Affluent Communities. *Health Affairs*. 2016;35(8):1382-1390. doi:10.1377/hlthaff.2015.1635.

<sup>14</sup> Lewis VA, Frazee T, Fisher ES, et al. Accountable Care Organizations Serving High Proportions of Racial and Ethnic Minorities Lag in Quality Performance. *Health Affairs*. 2017;36(1):57-66. doi:10.1377/hlthaff.2016.0626.

In addition to the five Health Equity-related policies described above, the Innovation Center is updating several policies that first appeared in the RFA released in November, 2019. These policy updates will take effect in PY2023 and will apply to all ACOs, including PY2021 and PY2022 starters. The Innovation Center is making the following policy updates, each of which is described in greater detail in its respective section of the RFA:

- In response to stakeholder concerns that the discount applied to ACOs selecting the Global risk-sharing option is too large relative to prior ACO models, CMS will reduce the discount to 3% for PY2023 and PY2024 and 3.5% for PY2025 and PY2026. This change represents a downward revision from the prior policy of the discount being 4% for PY2024 and 5% for PY2025 and PY2026. The discount remains at 2% for PY2021 and PY2022. Please see section VI.F for discussion of the discount within the financial benchmarking calculations.
- In response to stakeholder concerns regarding the magnitude of the quality withhold, and in light of the rigorous, outcomes-driven quality measures used in the model, the quality withhold will be reduced to 2% for PY2023 through PY2026. (Note: see Section VII for further discussion of the quality approach.) This change represents a downward revision from the prior policy of a 5% quality withhold for PY2023 through PY2026. The quality withhold remains at 5% for PY2021 and PY2022. Please see section VI.F for discussion of the quality withhold within the financial benchmarking calculations.
- To ensure that participating ACOs operate as health care provider-led organizations, starting in PY2023, at least 75 percent control of each ACO's governing body must be held by Participant Providers or their designated representatives. This change represents an upward revision from the prior policy of requiring Participant Providers to have at least 25% control of the ACO's governing body. Additionally, starting in PY2023, the Medicare beneficiary and the consumer advocate serving on the ACO's governing body are not permitted to be the same individual and both must hold voting rights. Please see section V.C for discussion of this requirement among other ACO governance requirements.
- Starting with PY2023, the ACO REACH Model will make an adjustment to the optional stop-loss arrangement: rather than protecting against exposure for high cost beneficiaries whose healthcare spending exceeds a *fixed* attachment point, the attachment points will be risk-adjusted to reflect beneficiary risk scores and benchmarks. The optional stop-loss arrangement will instead protect against exposure for high cost beneficiaries whose healthcare spending exceeds their *predicted spending* by a certain amount (attachment point). This approach, known as 'residual based reinsurance,' more accurately channels stop loss payouts to ACOs whose aligned beneficiaries' predicted spending exceeds expected spending and is described in greater detail in Section VI.D.
- The ACO REACH Model employs several approaches for deterring coding intensity, including the ACO-specific symmetric 3% risk score cap (see Section VI.F for details). To further deter coding intensity, starting in PY2024, the application of the symmetric 3% risk score cap will be modified to: 1) adopt a static reference year population for the remainder of the model performance period (as a substitute for the rolling reference year population), and 2) cap the ACO's risk score growth relative to the ACO's demographic risk score growth in determining the ACO-specific 3% risk score

cap thresholds. See Section VI.F for additional details.

## **VI. Model Design Elements**

The ACO REACH Model includes a number of key design elements that will test new features in payment and care delivery in Medicare FFS. This section describes beneficiary eligibility, alignment, engagement and marketing requirements, financial risk sharing options, risk mitigation, Capitation Payment Mechanisms, and an Advanced Payment Option. It also includes a detailed discussion of the benchmark methodology, which addresses each of the ACO types individually. In addition, this section describes the Benefit Enhancements and patient incentives that participating ACOs may choose to implement to support their ability to manage the care of their aligned beneficiaries.

### **A. Beneficiary Eligibility**

In order for a beneficiary to be aligned to a specific ACO, the beneficiary must meet certain eligibility criteria. Once the beneficiary has met the eligibility criteria, they must also meet the ACO alignment criteria, which varies by ACO type (see below). Beneficiaries will be considered alignment-eligible in a given month 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, PACE organization, or other Medicare health plan;
- Have Medicare as the primary payer;
- Are a resident of the United States;
- Reside in a county included in the ACO's service area (defined above); and
- For individuals to be eligible to be aligned to a High Needs Population ACO, they must also meet at least one of the following conditions: (1) have conditions that impair their mobility; and/or (2) meet the high needs special conditions for eligibility (see Section VI.F.3 for details). Medicare FFS beneficiaries, including dually eligible beneficiaries, meeting at least one of these conditions are eligible for alignment to a High Needs Population ACO.

### **B. Beneficiary Alignment**

Beneficiary alignment is used for two purposes in the ACO REACH Model. First, CMS prospectively aligns beneficiaries to an ACO for each performance year. ACOs assume accountability for the total cost of care of beneficiaries aligned to their organization for the performance year, according to the risk sharing option selected by their organization (see Section VI.D). Second, CMS uses beneficiary alignment to determine an organization's historical baseline expenditure for purposes of calculating the Performance Year Benchmark. ACOs will be required to maintain a minimum number of aligned beneficiaries for each Performance Year; however, lower minimum numbers of aligned beneficiaries are required for New Entrant ACOs (through PY2024) and High Needs Population ACOs. This section of the RFA describes the beneficiary alignment options, alignment hierarchies, alignment for beneficiaries with partial-year experience, and lastly, minimum threshold alignment requirements by ACO type.

#### **Beneficiary Alignment Methodologies**

For the purpose of assigning accountability for risk-sharing and the total cost of care, beneficiaries may be aligned to an ACO in two ways. The two beneficiary alignment methodologies are as follows:

1. Claims-based alignment where beneficiaries are aligned based on the plurality of primary care services received from a Participant Provider, as evidenced in claims utilization data; and
2. Voluntary alignment where beneficiaries designate a Participant Provider as their main source of care.

In order to be aligned to an ACO, the beneficiary must also meet the applicable beneficiary eligibility criteria (described above). Further, since beneficiaries may be aligned through more than one alignment methodology, a hierarchy of alignment precedence will be applied.

In instances in which a beneficiary meets the eligibility criteria and can be aligned to more than one ACO (e.g., a beneficiary voluntarily aligns to an ACO, but would be aligned to a different ACO on the basis of claims-based alignment), Voluntary Alignment will take precedence over Claims-Based Alignment. In addition, a beneficiary, who has designated a provider or supplier that is not a Participant Provider as her or his primary clinician through Electronic Voluntary Alignment will not be aligned to an ACO if the designation is the most recent valid designation made by the beneficiary.

In addition to developing within-model alignment hierarchies, CMS also employs a formal (cross-agency) governance structure to execute hierarchical decision-making to prevent the alignment of beneficiaries to multiple initiatives that prohibit such overlapping alignment and resolve conflicts when they occur. CMS will specify the initiatives that take alignment precedence over the ACO REACH Model prior to each performance year.

### **Claims-Based Alignment**

Claims-based alignment is used in the ACO REACH Model to align beneficiaries to Standard, New Entrant and High Needs Population ACOs. Claims-based alignment will occur for each performance year prospectively, prior to the start of the performance year, based on historical claims for certain primary care services furnished by the ACO's Participant Providers, as identified by a TIN and NPI combination. Specifically, CMS will align a beneficiary to an ACO if the beneficiary has historically (i.e., within the two-year alignment "look back" period) received the plurality of their Primary Care Qualified Evaluation and Management (PQEM) services from Participant Providers in the ACO that are either primary care practitioners or select non-primary care specialists. For the lists of PQEM services, primary care practitioners, and select non-primary care specialists for PY2022, see [the PY2022 Financial Operating Guide Overview](#). If an ACO includes an NPI who will be billing through a new TIN on its list of Participant Providers, the NPI will not be able to contribute claims history to the beneficiary alignment process, unless the old TIN ("Legacy TIN") for the NPI is also included on the Participant Provider list. The alignment "look back" period is a 2-year period that includes two consecutive 12-month periods, with the second period ending six months prior to the start of the relevant performance year.

Similarly, CMS aligns beneficiaries to an ACO for each base year for the purpose of calculating the baseline expenditure (for the Performance Year Benchmark calculation) on the basis of each beneficiary's receipt of PQEM services from Participant Providers during the 2-year alignment "look back" period ending six months prior to the start of each of the three base years.

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

- a. The weighted allowable charge for all PQEM services that the beneficiary received from Participant Providers in the ACO; and



- b. The weighted allowable charge for all PQEM services that the beneficiary received from each physician practice (including institutional practices) whose members are not participating in the ACO and is identified by a Medicare-enrolled billing TIN.

The allowable charges will be weighted one-third for the first alignment year and two-thirds for the second (more recent) alignment year so that beneficiaries are more likely aligned to primary care clinicians they visited more recently. Generally, a beneficiary is aligned to an ACO if its Participant Providers furnished the plurality of PQEM services to the beneficiary during the 2-year alignment period. Alignment for a base year or performance year uses a two-stage alignment algorithm.

- **Alignment based on primary care services provided by primary care specialists.** If 10% or more of the allowable charges incurred for PQEM services received by a beneficiary during the 2-year alignment period are billed by physicians and practitioners with a primary care specialty, then alignment is based on the allowable charges incurred for PQEM services provided by primary care specialists.
- **Alignment based on primary care services provided by selected non-primary care specialties.** If less than 10% of the allowable charges for PQEM services received by a beneficiary during the 2-year alignment period is billed by primary care specialists, then alignment is based on the allowable charges incurred for PQEM services provided by physicians and practitioners with certain non-primary specialties. (See the Financial Operating Guide: Overview paper for additional information on the specialties that are included in the primary care specialist and selected non-primary care specialist lists for PY2022; this list is subject to change in revisions of the Operating Guides listed below for PY2023 and subsequent performance years:  
<https://innovation.cms.gov/media/document/gpdc-py2022-fin-op-guide-ovw.>)

Provider specialty is determined by the specialty code that is assigned to the claim during claims processing, in the case of physician claims, or by the specialty associated with the NPI of the physician or Non-Physician Practitioner in the Medicare provider enrollment database in the case of certain Method II CAH claims. For Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), all services are treated as services provided by primary care specialists for purposes of our alignment algorithm.

#### **Alignment for Beneficiaries with Partial-year Experience**

If a beneficiary does not meet all of the beneficiary eligibility criteria (described above in the beneficiary eligibility section) in a given month of a base year or performance year, the beneficiary will be excluded from expenditure calculations for that month and all subsequent months of the base year or performance year, as applicable. Beneficiaries initially aligned to an ACO, who subsequently lose alignment eligibility (e.g., after a beneficiary enrolls in MA) will contribute partial-year experience for purposes of calculating the Performance Year Benchmark and for purposes of Financial Settlement, up to the month prior to the month in which the beneficiary loses his or her alignment eligibility. For example, a beneficiary who loses Medicare as a primary payer in August of a performance year will contribute a total of seven months of experience to the performance year (January through July).

#### **Voluntary Alignment and Options for Frequency of Prospective Alignment**

CMS will align beneficiaries based on voluntary alignment to Standard ACOs, New Entrant ACOs, and High Needs Population ACOs. Beneficiaries will be able to choose to align to an ACO voluntarily by designating

a Participant Provider affiliated with the ACO as their primary clinician or main source of care through voluntary alignment. Voluntary alignment can be completed by a beneficiary either by selecting a “primary clinician” on Medicare.gov or, if the ACO has selected to participate in paper-based voluntary alignment, completing a paper-based form using a template developed by CMS (the “Voluntary Alignment Form”). In recognition that some care previously provided in-person has moved to telehealth, CMS will accept ‘paper-based’ voluntary alignment forms that were e-signed (e.g., signed by beneficiaries or their appointed representatives through patient portals), provided that ACOs fulfill the required auditing and monitoring requirements described later in Section IX of this RFA and the IP3 Participation Agreement and MPP Participation Agreement.

If a beneficiary seeks voluntary alignment through both electronic and paper-based means, the most recent valid attestation will take precedence, as determined by the date of the attestation. An attestation is considered valid 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 PQEM service furnished to the beneficiary within the last two calendar years. To ensure that ACOs are serving beneficiaries aligned via voluntarily alignment, if at Final Financial Settlement 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.

Starting in the IP3, for IP3-participating ACOs, or starting in PY2023 for all other ACOs that submit applications in response to this RFA and are selected to participate in the ACO REACH Model, ACOs may take steps, within certain parameters, to affirmatively ask beneficiaries to confirm their care relationships with the ACO. Alignment for beneficiaries who select a Participant Provider as their primary clinician or main source of care during a year will take effect at the start of the subsequent performance year, unless the ACO chooses Prospective Plus Alignment, in which case such alignment may take effect sooner (see the discussion of Prospective Alignment with a Quarterly Update Option below). A beneficiary who completes a Voluntary Alignment Form will have the option to reverse that decision or change the identified care relationship, and beneficiaries may update their selection in Medicare.gov at any time.

Standard ACOs, New Entrant ACOs, and High Needs Population ACOs will have two choices for the frequency of prospective alignment of beneficiaries through voluntary alignment. These options were developed in response to the following feedback from organizations that have participated in shared savings initiatives, including the NGACO Model: (1) a prospectively set benchmark is highly important in that it provides a stable goal; and (2) an interest in better engaging beneficiaries through voluntary alignment, including more “real time” alignment for those beneficiaries who choose to voluntarily align. To meet both of these goals, ACOs will have a choice of: (1) Prospective Alignment; or (2) Prospective Plus Alignment. Both of these policies rely on establishing the ACO’s aligned population prospectively; however, for those ACOs that select Prospective Plus Alignment, beneficiaries who designate a Participant Provider as their main source of care during the performance year will be added to the ACO’s aligned beneficiary population on a quarterly basis prior to the start of the second, third, and fourth quarters of the performance year. Providing ACOs with this choice allows them to make a business decision regarding which goal they value more.

- 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 performance year.
- Prospective Plus Alignment will allow ACOs to have beneficiaries who have selected a Participant Provider as their main source of care added to their aligned beneficiary population on a quarterly basis throughout the performance year. Prospective Plus alignment will be used for two purposes: (1) calculating the performance year benchmark, and (2) determining which beneficiaries are aligned to the ACO for the purpose of making monthly capitated payments and the subsequent Financial Settlement (see section VI.E for details). Prior to the start of each quarter, CMS will compile a list of beneficiaries who have designated a Participant Provider as their main source of care through Medicare.gov and a list of beneficiaries who have completed a paper-based voluntary alignment form and meet all other beneficiary eligibility criteria. For ACOs that have opted into both paper-based voluntary alignment and prospective plus alignment that submit to CMS updated paper-based voluntary alignment information prior to the start of a quarter, CMS will align beneficiaries via paper-based voluntary alignment effective at the start of the next calendar quarter. Only those beneficiaries who were not already aligned to another ACO or an organization participating in another initiative with which beneficiary overlap is prohibited will be aligned to the ACO mid-year under Prospective Plus Alignment.

**Table 6.1: Voluntary Alignment Dates under Prospective Plus Alignment**

Alignment Date	Months ACO Alignment Recognized <sup>1</sup>
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)

<sup>1</sup>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.

CMS will incorporate safeguards into the IP3 Participation Agreement and MPP Participation Agreement to ensure that voluntary alignment is used appropriately and that beneficiaries who are voluntarily aligned to an ACO maintain a meaningful primary care relationship with the ACO. For example, ACOs will be able to conduct activities related to voluntary alignment only within the ACO’s service area (described above).

#### **Minimum Beneficiary Alignment Threshold**

To be eligible for participation in the ACO REACH Model, ACOs will be required to have a minimum number of aligned beneficiaries prior to the start of each performance year. (As noted above, since no beneficiaries will be aligned to IP3-participating ACOs for the IP3, there are no minimum beneficiary requirements for the IP3.) The minimum number of aligned beneficiaries varies by ACO type, as described in Table 6.2 below. For benchmarking purposes, Standard ACOs will also be required to have had a minimum number of beneficiaries who would have been alignment-eligible during at least one base year (CY2017, CY2018, CY 2019).

Standard ACOs will be required to have a minimum of 5,000 aligned beneficiaries prior to the start of each Performance Year from PY2021 through PY2026, as well as at least 3,000 beneficiaries that would have been aligned during at least one base year (CY2017, CY2018, or CY2019).

New Entrant ACOs will be provided with flexibilities with regard to the minimum aligned beneficiary requirement during the glide path under which the minimum number of aligned beneficiaries will increase incrementally from 1,000 at the start of PY2021 and PY2022 to 2,000 and 3,000 prior to the start of PY2023 and PY2024, respectively before moving to 5,000 prior to the start of PY2025 (as shown in Table 6.2).

High Needs Population ACOs will also have a different minimum number of aligned beneficiaries, which will increase from at least 250 beneficiaries prior to the start of PY2021 and PY2022 to 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.

Table 6.2 summarizes the minimum beneficiary alignment requirements by ACO type, **which apply to all ACOs regardless of whether they began model participation in PY2021, PY2022, or PY2023.**

**Table 6.2: Minimum Number of Aligned Beneficiaries by ACO Organization Type**

ACO Organization Type	Minimum Number of Aligned Beneficiaries Required at the Start of Each Performance Year
Standard ACO	Minimum of 5,000 aligned beneficiaries prior to the start of each performance year. Minimum of 3,000 beneficiaries that would have been aligned during at least one base year (CY2017, CY2018, or CY2019).
New Entrant ACO	Minimum number of aligned beneficiaries prior to the start of each performance year under the “glide path”: <ul style="list-style-type: none"> <li>• PY2021 (April-December 2021): 1,000 beneficiaries</li> <li>• PY2022: 1,000 beneficiaries</li> <li>• PY2023: 2,000 beneficiaries</li> <li>• PY2024: 3,000 beneficiaries</li> <li>• PY2025: 5,000 beneficiaries</li> <li>• PY2026: 5,000 beneficiaries</li> </ul>
High Needs Population ACO	Minimum number of aligned beneficiaries prior to the start of each performance year under the “glide path”: <ul style="list-style-type: none"> <li>• PY2021 (April-December 2021): 250 beneficiaries</li> <li>• PY2022: 250 beneficiaries</li> <li>• PY2023: 500 beneficiaries</li> <li>• PY2024: 750 beneficiaries</li> <li>• PY2025: 1,200 beneficiaries</li> <li>• PY2026: 1,400 beneficiaries</li> </ul>

### C. Beneficiary Engagement and Marketing

ACOs will be required to adhere to a number of beneficiary protections, including but not limited to the following:

- The ACO shall require its Participant Providers and Preferred Providers to make Medically Necessary Covered Services available to beneficiaries in accordance with applicable laws and regulations.

- The ACO must permit its aligned beneficiaries to maintain the freedom to choose their providers and suppliers, including the ability to select a primary clinician on Medicare.gov, even if the provider or supplier is not a Participant Provider or Preferred Provider with an arrangement with the ACO. The ACO is further required to notify its aligned beneficiaries on an annual basis that they have the freedom to select their own primary clinician and to receive services from the providers and suppliers of their choice according to traditional Medicare rules. Additionally, all Participant Providers will be required to prominently display informational materials in settings where beneficiaries receive primary care services notifying aligned beneficiaries that the Participant Provider is participating in the ACO REACH Model and that beneficiaries retain all FFS Medicare benefits and rights. CMS will make available a template for such informational materials that the ACO and its Participant Providers will be required to use.
- ACOs must inform beneficiaries who have been aligned to the ACO what that means for the beneficiary in terms of the care that they will receive and how to opt-out of CMS sharing certain data about them with the ACO.
- ACOs must communicate the details of their Benefit Enhancements (where applicable) to all of their aligned beneficiaries, and CMS must approve such written materials prior to use.

ACOs are required to submit any marketing materials and marketing activities to CMS for review to ensure that the materials comply with the requirements of the ACO REACH Model, including that they are not inaccurate or misleading, are not discriminatory or used in a manner that is discriminatory, and make clear that alignment to an ACO does not remove or otherwise affect a beneficiary's freedom to choose a provider or supplier. Additional requirements concerning this review process will be provided in the IP3 Participation Agreement and MPP Participation Agreement. ACOs are prohibited from conducting communication or marketing activities targeted to individuals aligned to their ACOs for the purpose of recruitment into Medicare managed care products. Similarly, ACOs are prohibited from conducting communication or marketing activities targeted to individuals enrolled in Medicare managed care.

In order to allow for more robust outreach to beneficiaries regarding the ACO, CMS will permit ACOs to proactively communicate with beneficiaries regarding voluntary alignment, provided such communications comply with all applicable laws and regulations and with the requirements of the IP3 Participation Agreement and MPP Participation Agreement, as applicable. For example, ACOs will be able to provide marketing materials and hold outreach events to the extent permitted by law. However, the IP3 Participation Agreement and MPP Participation Agreement prohibit ACOs from engaging in marketing activities that are misleading to beneficiaries (e.g., stating that beneficiaries will receive benefits that are not available under either Medicare FFS or the ACO REACH Model) and from expressly stating or implying that alignment to the ACO removes or otherwise affects their freedom to choose a provider or supplier. ACOs will not be allowed to engage in certain activities that may be intrusive to beneficiaries or to discriminate against beneficiaries (such as based on the anticipated costs of a beneficiary's care).

### **Patient Incentives**

During the Implementation Period, ACOs will be prohibited from furnishing gifts or other remuneration to beneficiaries, except as permitted by applicable law. Except as will be set forth in the MPP Participation Agreement for the ACO REACH Model, ACOs, Participant Providers, Preferred Providers, and other individuals or entities performing functions and services related to ACO activities are prohibited from

providing gifts or other remuneration to beneficiaries to induce them to receive items or services from the ACO, Participant Providers, or Preferred Providers, or to induce them to receive or to continue to receive items or services from the ACO, Participant Providers, or Preferred Providers. During a Performance Year, ACOs, Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO activities will be permitted to furnish certain in-kind incentives described below. In addition, ACOs may elect to offer the Cost-Sharing Support for Part B Services Beneficiary Engagement Incentive, the Chronic Disease Management Reward Program Beneficiary Engagement Incentive, or both (each, a “Beneficiary Engagement Incentive”).

### **In-kind Incentives**

We believe that beneficiary engagement is an important part of encouraging more active participation by beneficiaries in their health care. Beneficiary engagement and coordination of care could be enhanced by providing certain in-kind incentives to beneficiaries that would potentially encourage beneficiaries to become actively involved in their care. Subject to compliance with all applicable laws and regulations and the terms of the MPP Participation Agreement, ACOs, Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO activities will be permitted to provide in-kind items or services to beneficiaries, if the following conditions are satisfied:

1. There is a reasonable connection between the items or services and the medical care of the beneficiary;
2. The items or services are preventive care items and services or advance a clinical goal for the beneficiary, including adherence to a treatment regime (including prescribed medication), adherence to a follow-up care plan, or management of a chronic disease or condition;
3. The in-kind item or service is not a Medicare-covered item or service for the beneficiary on the date the in-kind item or service is furnished to that beneficiary (for purposes of this exception, an item or service that could be covered pursuant to a Benefit Enhancement is considered a Medicare-covered item or service, regardless of whether the ACO selects to participate in such Benefit Enhancement for a given performance year);
4. The in-kind item or service is not furnished in whole or in part to reward the beneficiary for designating, or agreeing to designate, a Participant Provider as his or her primary clinician, main doctor, main provider, or the main place where the beneficiary receives care through Voluntary Alignment; and
5. The in-kind item or service is furnished to a Beneficiary directly by the ACO, a Participant Provider, or a Preferred Provider.

For example, under the terms of this model, an ACO, Participant Provider or Preferred Provider could provide blood pressure monitors to patients with hypertension in order to encourage regular blood pressure monitoring thus educating beneficiaries and engaging them to be more proactive in their disease management.

Additional examples of in-kind incentives that ACOs could consider offering might include but are not limited to:

- Vouchers for over-the-counter medications recommended by a health care provider;

- Prepaid, non-transferable vouchers that are redeemable for transportation services solely to and from an appointment with a health care provider;
- Items and services to support management of a chronic disease or condition, such as home air-filtering systems or bedroom air-conditioning for asthmatic patients, and home improvements such as railing installation or other home modifications to prevent re-injury;
- Wellness program memberships, seminars, and classes;
- Electronic systems that alert family caregivers when a family member with dementia wanders away from home or gets up from a chair or bed;
- Vouchers for those with chronic diseases to access chronic disease self-management, pain management and falls prevention programs;
- Vouchers for those with malnutrition to access meal programs;
- Phone applications, calendars, or other methods for reminding patients to take their medications and promote patient adherence to treatment regimens; and
- Vouchers for dental care services, for example, prior to jaw surgery to reduce the risk of infection.

These items and services would be funded by the ACO and therefore, calculation of the ACO's benchmark and performance year expenditures will not account for any of these items or services.

#### **Cost Sharing Support for Part B Services**

Subject to compliance with all applicable laws and regulations, the terms of the MPP Participation Agreement, and CMS approval, an ACO may select to participate in the Cost-Sharing Support for Part B Services Beneficiary Engagement Incentive. Under the terms of the MPP Participation Agreement, an ACO that selects this option must enter into a cost sharing support arrangement with its Participant Providers and Preferred Providers, pursuant to which the Participant Providers and Preferred Providers would not collect beneficiary cost sharing amounts (in whole or in part) from categories of aligned beneficiaries and for categories of Part B services (excluding prescription drugs and durable medical equipment, prosthetics, orthotics, and supplies) identified by the ACO. ACOs would then make payments to those Participant Providers and Preferred Providers to cover some or all of the amount of beneficiary cost sharing not collected. The principal aim of allowing ACOs to offer this cost sharing support is to reduce financial barriers so that certain beneficiaries may obtain needed care and better comply with treatment plans, thereby improving their own health outcomes. In addition, permitting ACOs this flexibility will provide a critical tool to engage aligned beneficiaries, promote the utilization of high-value services, and incentivize aligned beneficiaries to continue receiving their care from Participant Providers and Preferred Providers.

ACOs that select to offer cost sharing support for Part B Services will be required to enter into a cost sharing support arrangement with those Participant Providers and Preferred Providers who will participate in this Beneficiary Engagement Incentive. The ACO will also be required to identify the categories (e.g., subset) of beneficiaries, types of Part B services, or both, for which cost sharing support will be provided in an Implementation Plan that the ACO submits to CMS. ACOs will be permitted to specify both primary care and specialty care services for this cost sharing support so that beneficiaries with specialty needs may also be incented to obtain the care they need. To the extent the ACO will not be

paying the cost of the cost sharing support entirely, the ACO will also be required to specify in its Implementation Plan how it will determine the relative contributions of the ACO and the Participant Providers and Preferred Providers. Cost sharing support payments must come only from the ACO and, if applicable, its Participant Providers and Preferred Providers. Participating ACOs will be subject to monitoring and compliance activities in connection with the use of cost sharing support. To minimize possible abuse of this Beneficiary Engagement Incentive, CMS will incorporate certain beneficiary protections and other safeguards into the MPP Participation Agreement.

### **Chronic Disease Management Reward Program**

Subject to compliance with all applicable laws and regulations, the terms of the MPP Participation Agreement, and CMS approval, an ACO may select to participate in the Chronic Disease Management Reward Program Beneficiary Engagement Incentive. Under this option, an ACO may provide gift cards to eligible aligned beneficiaries, up to an annual limit of \$75, for the purpose of incentivizing participation in a chronic disease management program. Use of modest beneficiary incentives and rewards – such as gift cards – has been widely adopted by a variety of payers to influence healthy behaviors. ACOs will pay for the gift cards out of their own funds and at their discretion, subject to certain conditions. We believe that allowing ACOs to incentivize beneficiary participation in a chronic disease management program will promote beneficiary self-management, and ultimately improve quality and reduce costs.

ACOs that elect to offer a Chronic Disease Management Reward Program will be required to submit an Implementation Plan detailing how they will structure their program. ACOs will be permitted to offer programs that focus on aligned beneficiaries with a specific disease or chronic condition, as long as the program does not discriminate against any aligned beneficiary who would otherwise qualify for participation. ACOs that elect to offer a Chronic Disease Management Reward Program will be required to maintain records of their reward program, including documentation of the amount and type of each gift card awarded and the basis for beneficiary eligibility. Participating ACOs will be subject to monitoring and compliance activities in connection with their reward program. To minimize possible abuse of this Beneficiary Engagement Incentive, we will incorporate certain beneficiary protections and other safeguards into the MPP Participation Agreement.

### **D. Financial Methodology: Risk Sharing Options, Risk Mitigation, and Financial Settlement**

The financial methodology for the ACO REACH Model includes the Performance Year Benchmark, risk-sharing options, risk mitigation strategies, Capitation Payment Mechanisms, the Advanced Payment Option, and Financial Settlement. The Performance Year Benchmark represents the average Medicare beneficiary total cost of care for aligned beneficiaries and refers to the target expenditure amount that will be compared to Medicare expenditures for items and services furnished to aligned beneficiaries (REACH Beneficiaries) during a performance year. This comparison will be used to calculate Shared Savings and Shared Losses. The Performance Year Benchmark will be addressed in a later section (see section VI.F) and will be discussed relative to each ACO type because there are variations in the way the Performance Year Benchmark will be calculated across the different ACO types. First, however, this section of the RFA will address the risk sharing options, risk mitigation strategies, and Financial Settlement, which will generally be applicable to all of the ACO types.

The risk sharing options are a key driver in determining the percent of savings/losses (either 50% or 100%) that ACOs are eligible to receive as Shared Savings or may be required to repay as Shared Losses. The risk



mitigation mechanisms include risk corridors and stop-loss arrangements. During Financial Settlement, Medicare expenditures for Part A and Part B items and services furnished to aligned beneficiaries during the performance year (inclusive of capitated and Advanced Payment Option payments paid by CMS to the ACO as well as FFS claims paid by CMS directly to the Medicare providers and suppliers) will be reconciled against the Performance Year Benchmark after the performance year has ended. Additionally, an optional Provisional Financial Settlement will be offered to provide a timelier distribution of provisional Shared Savings/repayment of provisional Shared Losses.

**Table 6.3: Risk Sharing Options, Risk Mitigation, and Financial Settlement for Professional and Global**

	<b>Policy</b>	<b>Professional</b>	<b>Global</b>
<b>1</b>	Risk Sharing Option	50% of savings/losses.	100% of savings/losses.
<b>2</b>	Risk Corridors	Apply at the aggregate savings/losses level.  Risk corridors for Professional have lower cutoffs than Global’s risk corridors with ACOs being responsible for a lower proportion of savings or losses in every corridor.	Apply at the aggregate savings/losses level.  Risk corridors for Global have higher cutoffs than Professional’s risk corridors with ACOs being responsible for a higher proportion of savings or losses in every corridor.
<b>3</b>	Stop-Loss Arrangement (Optional)	Addresses random, high cost expenditures.	Addresses random, high cost expenditures.
<b>4</b>	Provisional Financial Settlement (Optional)	Provides timely distribution of provisional Shared Savings/repayment of provisional Shared Losses following the end of the performance year (January 31 <sup>st</sup> target). <sup>15</sup>	Provides timely distribution of provisional Shared Savings/repayment of provisional Shared Losses following the end of the performance year (January 31 <sup>st</sup> target).
<b>5</b>	Final Financial Settlement	Conducted approximately seven months after the performance year ends.	Conducted approximately seven months after the performance year ends.

### **Risk Sharing Option**

The ACO REACH Model will offer two risk sharing options, which determine the portion of the savings or losses in relation to the Performance Year Benchmark that will accrue to the ACO as Shared Savings or Shared Losses. The applicable risk sharing option will depend on whether the ACO is participating in the Professional or the Global option:

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<sup>15</sup> Since this RFA is for applications to participate in the model beginning in PY2023, it generally focuses on the policies for PY2023 and subsequent performance years. The approach and timing for Provisional Financial Settlement and Final Financial Settlement for PY2021 was different - for more information please see the Financial Settlement Overview paper (<https://innovation.cms.gov/media/document/dc-model-financial-reconcil-guidance>)

- **Professional:** offers a partial risk sharing option of 50% of savings/losses, with risk corridors and optional stop-loss protection risk mitigation strategies.
- **Global:** offers a full risk sharing option of 100% of savings/losses, with broader risk corridors and optional stop-loss protection risk mitigation strategies.

No Minimum Saving Rate or Minimum Loss Rate will apply to aggregate savings/losses for either Global or Professional. As such, all ACOs will retain “first dollar” savings or be responsible for “first dollar” losses.

### Risk Corridors

The aggregate amount of savings or losses that ACOs in Global or Professional will be eligible to receive as Shared Savings or be required to repay as Shared Losses will be constrained by a series of risk corridors. ACOs will receive a portion of Shared Savings, or be liable for a portion of Shared Losses, above each risk band, with the portion of gross savings/losses decreasing with each risk band. To illustrate using Professional as an example, for all savings or losses up to, and including, 5% of the Performance Year Benchmark (Risk Band 1), the ACO is responsible for 50% of savings or losses and CMS is responsible for the remaining 50%. ACOs will be responsible for a progressively smaller portion of additional savings or losses as their savings or losses reach Risk Bands 2, 3, and 4. Should an ACO’s savings or losses be above 5% of the Performance Year Benchmark but below 10% (Risk Band 2), the ACO will be responsible for 35% of savings or losses that fall between 5% and 10% of the Performance Year Benchmark (in addition to the 50% of savings or losses in Risk Band 1). Meanwhile, CMS would be responsible for 65% of savings or losses in Risk Band 2. Should an ACO’s savings or losses be above 10% of the Performance Year Benchmark but below 15% (Risk Band 3), the ACO will be responsible for 15% of savings or losses that fall between 10% and 15% of the Performance Year Benchmark (in addition to the 50% of savings or losses in Risk Band 1 and 35% of savings or losses in Risk Band 2). Meanwhile CMS would be responsible for 85% of savings or losses in Risk Band 3. Finally, for the portion of ACO savings or losses that exceeds 15% of the Performance Year Benchmark (Risk Band 4), the ACO will be responsible for 5% of savings or losses, and CMS will be responsible for 95%. Risk Corridors for Global operate in an analogous manner, but with different cutoff points for each Risk Band. Global ACOs also will be responsible for a higher portion of savings or losses in each Risk Band compared to ACOs in Professional. The series of Shared Savings/Shared Losses caps are outlined below for the Professional (Table 6.4) and Global (Table 6.5) risk sharing options:

**Table 6.4: Series of Shared Savings/Shared Losses Caps under Professional**

Gross Savings/Losses as a percent (%) of the Final PY Benchmark	ACO Shared Savings/ Shared Losses cap	CMS Shared Savings/ Shared Losses cap
Risk Band 1: Gross Savings/Losses Less than 5%	50% of savings/losses	50% of savings/losses
Risk Band 2: Gross Savings/Losses Between 5% and 10%	35% of savings/losses	65% of savings/losses
Risk Band 3: Gross Savings/Losses Between 10% and 15%	15% of savings/losses	85% of savings/losses

Gross Savings/Losses as a percent (%) of the Final PY Benchmark	ACO Shared Savings/ Shared Losses cap	CMS Shared Savings/ Shared Losses cap
Risk Band 4: Gross Savings/Losses Greater than 15%	5% of savings/losses	95% of savings/losses

**Table 6.5: Series of Shared Savings/Shared Losses Caps under Global**

Gross savings/losses as a percent (%) of the Final PY Benchmark	ACO Shared Savings/ Shared Losses cap	CMS Shared Savings/ Shared Losses cap
Risk Band 1: Gross Savings/Losses Less than 25%	100% of savings/losses	0% of savings/losses
Risk Band 2: Gross Savings/Losses Between 25% and 35%	50% of savings/losses	50% of savings/losses
Risk Band 3: Gross Savings/Losses Between 35% and 50%	25% of savings/losses	75% of savings/losses
Risk Band 4: Gross Savings/Losses Greater than 50%	10% of savings/losses	90% of savings/losses

### Stop-Loss

The purpose of the stop-loss arrangement is to reduce the financial uncertainty associated with infrequent, but high-cost, expenditures for aligned beneficiaries. Stop-loss protects ACOs from financial liability for individual beneficiary expenditures that are above the stop-loss “attachment points” (i.e., dollar thresholds at which stop-loss protection begins). The stop-loss arrangement will be an optional feature of both Global and Professional, and must be selected prior to the start of the Performance Year for ACOs choosing to opt-in. ACOs may choose to change their stop-loss preference prior to the start of each Performance Year.

Starting with PY2023, rather than protecting against exposure for high cost beneficiaries whose healthcare spending exceeds a *fixed* attachment point (as was the case of PY2021-PY2022), the optional stop-loss arrangement will instead protect against exposure for high cost beneficiaries whose healthcare spending exceeds their *predicted spending* by a certain amount (attachment point). This approach is known as “residual based reinsurance”. Predicted spending for a beneficiary will be determined by the ACO’s benchmark and the beneficiary’s risk score, using either the CMS-HCC prospective risk adjustment model for Standard ACOs and New Entrant ACOs or the CMMI-HCC concurrent risk adjustment model for High Need Population ACOs.

CMS will calculate the model-wide stop-loss attachment points prospectively, prior to the start of each Performance Year, based on expenditure data derived from a national reference population of Medicare FFS beneficiaries. These model-wide attachment points will be adjusted to the beneficiary level (generating an attachment point for each beneficiary) using beneficiary risk scores and the ACO’s regionally based benchmarks.

Under the stop-loss arrangement, if selected, ACOs will continue to retain liability for a portion of expenditures above each beneficiary's attachment point. Requiring organizations to retain a percentage of liability for the beneficiary expenditures above the attachment point provides a direct economic incentive for the organization to continue to manage costs even after a beneficiary's annual expenditures exceed the attachment point. This approach continues to build on the voluntary stop-loss methodology utilized in the first two performance years of the ACO REACH Model, which includes the use of multiple attachment points with decreasing levels of liability for spending above each attachment point.

ACOs that elect the stop loss arrangement are charged for this protection. CMS will apply a per-beneficiary per-month stop loss "charge" to the ACO's Performance Year Benchmark. This charge will be based upon the percent of expenditures in excess of *predicted spend* above the applicable attachment point for each beneficiary in the ACO's baseline period. As such, CMS believes it will more appropriately channel stop loss payouts to ACOs whose aligned beneficiaries unexpectedly incur high expenditures. Please see the Financial Settlement Overview paper for more detail on stop-loss:

(<https://innovation.cms.gov/media/document/dc-model-financial-reconcil-guidance>).

### **Optional Provisional Financial Settlement and Final Financial Settlement**

Financial Settlement is the process by which CMS determines Shared Savings or Shared Losses by comparing actual Medicare expenditures (inclusive of Total Care Capitation Payment, Primary Care Capitation Payment, and Advanced Payment Option payment, as applicable, paid by CMS to the ACO, as well as FFS claims paid by CMS directly to Medicare providers and suppliers) for Medicare Part A and Part B items and services furnished to REACH Beneficiaries against the Performance Year Benchmark. Final Financial Settlement will be conducted after the Performance Year has ended and sufficient time has passed to allow for claims processing. Final Financial Settlement will be conducted for all ACOs; however, starting for PY2022, ACOs will also have the option to select Provisional Financial Settlement, which will be conducted shortly after the end of the Performance Year. This Provisional Financial Settlement will allow for more timely distributions of provisional shared savings or repayment of provisional shared losses, but it will not account for full claims run out due to the immediacy of this Settlement shortly after the close of the Performance Year. Since this RFA is for applications to participate in the model beginning in PY2023, it focuses only on the Provisional Financial Settlement approach for PY2023 and subsequent performance years. For information on the approach for Provisional Financial Settlement for PY2021 (which is different), please see the Financial Settlement Overview paper:

(<https://innovation.cms.gov/media/document/dc-model-financial-reconcil-guidance>).

The Final Financial Settlement process will be conducted on/or about July 31<sup>st</sup> of the calendar year following the close of the Performance Year. This Final Financial Settlement will include claims run out through the end of Q1 of the calendar year following the Performance Year for expenditures incurred in the Performance Year. Final Financial Settlement will be based on risk adjusting the Performance Year Benchmark using the final risk scores for the Performance Year and then comparing the Performance Year Benchmark against Performance Year expenditures for aligned beneficiaries to determine Shared Savings or Shared Losses. For more details on the calculation of the Performance Year Benchmark, refer to the financial methodology for the applicable ACO type in the following sections of this RFA as well as the Financial Operating Guide Overview paper and Financial Settlement Overview paper available on our website (<https://innovation.cms.gov/innovation-models/direct-contracting-model-options>).

Prior to the start of PY2022 and each subsequent Performance Year, CMS will provide ACOs participating

in either Global or Professional with the option of the Provisional Financial Settlement, including the disbursement of provisional Shared Savings or the requirement to repay provisional Shared Losses, which will occur shortly following the end of the Performance Year, with a target date of January 31<sup>st</sup> of the calendar year following the Performance Year. The purpose of the Provisional Financial Settlement is to provide ACOs with a timelier disbursement of provisional Shared Savings and to require ACOs to more promptly repay provisional Shared Losses to CMS. This Provisional Financial Settlement will include ACO expenditures for the first six months of the Performance Year (through June 30) with six months of claims run-out. The parameters of the Provisional Financial Settlement are described below.

All ACOs, including those that opt for the Provisional Financial Settlement, will also be subject to the Final Financial Settlement. Final Financial Settlement will occur on or about July 31<sup>st</sup> of the calendar year following the performance year for both ACOs that opt into Provisional Financial Settlement and those that elect not to do Provisional Financial Settlement.

**Table 6.6: Provisional Financial Settlement and Final Financial Settlement, PY2022- PY2026**

	<b>Provisional Financial Settlement</b>	<b>Final Financial Settlement</b>
<b>Target Date for Financial Settlement</b>	January 31 <sup>st</sup> of calendar year following the Performance Year	July 31 <sup>st</sup> of calendar year following the Performance Year
<b>Claims Included in Financial Settlement</b>	Performance year expenditures incurred through June 30 <sup>th</sup> of the Performance Year	Performance year expenditures incurred through December 31 <sup>st</sup> of the Performance Year
<b>Claims Run-out</b>	Through December 31 <sup>st</sup> of the Performance Year	Through March 31 <sup>st</sup> of the calendar year following Performance Year
<b>Risk Scores</b>	Preliminary risk scores	Final risk scores

For purposes of calculating Shared Savings or Shared Losses as part of the Provisional Financial Settlement, CMS may make adjustments to the ACO’s performance year expenditures included in the Provisional Financial Settlement to account for anticipated differences between the ACO’s expenditures included in the Provisional Financial Settlement and those that will be included in the Final Financial Settlement, including the use of an Incurred But Not Reported (IBNR) estimate of Performance Year expenditures, and a seasonal adjustment to account for anticipated seasonal fluctuations in expenditures throughout the Performance Year. These expenditures are then compared to a *Provisional* Performance Year Benchmark; provisional insofar as several elements of the Performance Year Benchmark are not finalized until well after the end of the Performance Year. For example, the ACO’s quality performance and final risk scores are components of the benchmark, which will not be available when CMS performs Provisional Financial Settlement. Consequently, CMS may use a default quality score (e.g., the average quality score from a prior year) to account for quality performance in the calculation of the Provisional Performance Year Benchmark for purposes of the Provisional Financial Settlement. Furthermore, the Provisional Financial Settlement will need to be performed using preliminary risk scores. Final risk scores and the ACO’s actual quality performance will be incorporated into the Performance Year Benchmark for the Final Financial Settlement.

### **Financial Guarantee**

The ACO must have the ability to repay all Shared Losses and Other Monies Owed for which it may be liable under this model, and shall secure a financial guarantee to ensure CMS is able to recoup any Shared Losses and Other Monies Owed. ACOs who select higher risk features within the model will be required

to maintain a larger financial guarantee. Table 6.7 shows the required financial guarantee as a percent of the ACO’s total performance year benchmark based on its risk sharing option and capitation payment mechanism elections.

**Table 6.7: Financial Guarantee Requirement by Risk Sharing Option and Capitation Payment Mechanism Election**

	<b>ACOs Participating in Primary Care Capitation Payment</b>	<b>ACOs Participating in Primary Care Capitation Payment + Advanced Payment Option</b>	<b>ACOs Participating in Total Care Capitation Payment</b>
<b>Professional</b>	2.5% of Performance Year Benchmark	2.5% of Performance Year Benchmark	N/A
<b>Global</b>	3.0% of Performance Year Benchmark	3.0% of Performance Year Benchmark	4.0% of Performance Year Benchmark

This financial guarantee must be in the form of funds placed in escrow, a line of credit, or a surety bond. CMS will annually notify the ACO of the amount that must be funded by its financial guarantee for the relevant performance year. The ACO must submit documentation of its compliance with the financial guarantee requirements by a deadline specified by CMS. If the ACO fails to submit such documentation, CMS will withhold monthly payments to the ACO under the ACO’s selected capitation payment mechanism until the ACO has submitted the required documentation.

If CMS does not receive payment for Shared Losses and Other Monies Owed by the date the payment is due, CMS shall pursue payment under the financial guarantee and may withhold payments otherwise owed to the ACO under this model or any other CMS program or initiative.

**E. Financial Methodology: ACO REACH Model Payment Mechanisms**

In the ACO REACH Model, Medicare Parts A and B expenditures for aligned beneficiaries will be compared to the ACO’s Performance Year Benchmark, a target dollar amount representing the total cost of Medicare Parts A and B services provided to the ACO’s aligned beneficiaries, to determine the ACO’s savings or losses. The ACO REACH Model will offer Capitation Payment Mechanisms including Total Care Capitation Payment (TCC) and Primary Care Capitation Payment (PCC), as well as the Advanced Payment Option (APO). The Capitation Payment Mechanisms and Advanced Payment Option will allow for prospectively determined and more predictable revenue streams paid on a monthly basis to ACOs. ACOs are required to select a Capitation Payment Mechanism; ACOs that select the Primary Care Capitation Payment may optionally elect the Advanced Payment Option as well.

The Capitation Payment Mechanisms offered in the ACO REACH Model build on the NGACO Model’s test of the Population Based Payment (PBP) and All-Inclusive Population Based Payment (AIPBP) policies. PBP and AIPBP were prospective payments, based on historical spending estimates, made to ACOs that elected to participate in PBP or AIPBP; in return, CMS applied corresponding fee reductions to claims-based payments for PBP- and AIPBP-participating providers and suppliers. Such fee reductions were 100% for AIPBP and ranged from 1-100% for PBP. At the end of each performance year in NGACO, the amount of PBP or AIPBP paid to ACOs participating in these population-based payments was reconciled against the reductions actually made to claim payments to PBP and AIPBP-participating providers and suppliers. While PBP and AIPBP enhanced the ability of organizations to contract with providers and suppliers in innovative

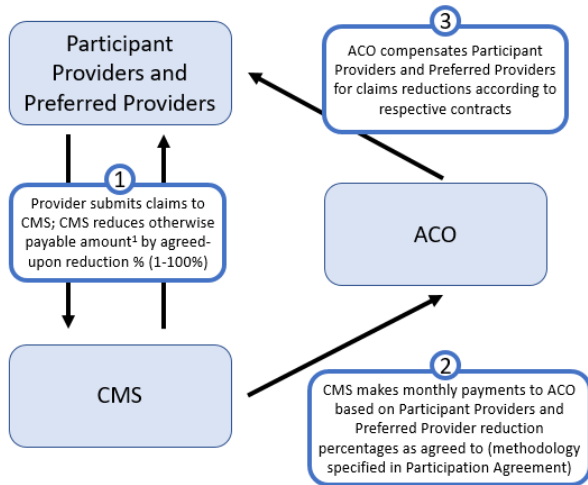
payment arrangements, PBP and AIPBP remained directly linked to Medicare FFS payment and utilization through the annual reconciliation process. In contrast, the ACO REACH Model's Capitation Payment Mechanisms are not reconciled against actual claims expenditures.

The ACO REACH Model's Capitation Payment Mechanisms and Advanced Payment Option are tools designed to support population health management. For example, these tools may allow the ACO to enter into value-based payment arrangements with downstream providers or to invest in health information technology. Predictable cash flows may offer a stronger incentive for healthcare providers to work together and coordinate care for a defined population of aligned beneficiaries, with the potential to shape better outcomes and lower costs.

The amount of payment made by CMS to the ACO will depend on the Capitation Payment Mechanism selected by the ACO, and, if the ACO selected PCC Payment, whether the ACO also selected the Advanced Payment Option and the amount of the ACO's selected Enhanced PCC. With the exception of the Enhanced PCC (which is recouped in its entirety by CMS), all expenses incurred for Parts A and B items and services furnished to aligned beneficiaries, including the monthly cash flow received by the ACO through its selected Capitation Payment Mechanism and, if applicable, the Advanced Payment Option, will be compared against the ACO's Performance Year Benchmark to determine savings and losses.

**Figure 6.1: Capitation Payment Mechanisms**

**Flow of funds and provider-facing economics**



(1) The amount that Medicare would have paid for the claim in the absence of Capitation or Advanced Payment Option

**Capitation Payment Mechanism:**

The ACO has the flexibility to use these payments to support population health including investments in:

- Technology
- Resources
- Delivery of Care
- Innovative Value based payment arrangements with their provider

**Value Proposition**

- Smoothed revenues for the ACO
- Increased capitalization to invest in value based infrastructure
- Increased flexibility to pursue tailored value based payment arrangements with providers

**Simplified Example**

Value of what FFS would have paid	\$90
Value of what FFS reduced	\$10
Value of what FFS paid on the claim	\$80
Value of monthly payments to Model Participant (Capitation / APO)	\$10

All ACOs participating in the ACO REACH Model must select a Capitation Payment Mechanism. The two Capitation Payment Mechanisms available to ACOs are:

1. **Total Care Capitation Payment:** A per-beneficiary, per-month (PBPM) capitated payment for all services provided to aligned beneficiaries by all Participant Providers and those Preferred Providers who have opted to participate in TCC Payment. This Total Care Capitation Payment amount will reflect the estimated total cost of care for the ACO’s aligned population (i.e. the risk adjusted, trended, and regionally blended benchmark). This Capitation Payment Mechanism is only available to ACOs participating in Global.
2. **Primary Care Capitation Payment:** A PBPM capitated payment for primary care services provided to aligned beneficiaries by all Participant Providers and those Preferred Providers who have opted to participate in PCC Payment. This Primary Care Capitation Payment amount will generally be equal to seven percent of the estimated total cost of care for the ACO’s aligned population (i.e. the risk adjusted, trended, and regionally blended benchmark).

ACOs participating in the Professional risk-sharing option must select the Primary Care Capitation Payment. ACOs participating in the Global risk-sharing option may choose between Primary Care Capitation Payment and Total Care Capitation Payment as described in more detail below. ACOs who elect Primary Care Capitation Payment may also elect the Advanced Payment Option.

The Capitation Payment Mechanisms that are available in each risk sharing option are highlighted in Table 6.8 and detailed further below.



**Table 6.8: Capitation Payment Mechanisms by Global and Professional**

	Professional	Global
<b>Total Care Capitation Payment</b>	No – not available.	Optional – must select one of the two Capitation Payment Mechanisms.
<b>Primary Care Capitation Payment</b>	Mandatory – only Capitation Payment Mechanism available.	Optional – must select one of the two Capitation Payment Mechanisms.

Under the model, Participant Providers and those Preferred Providers that have elected to participate in the ACO’s selected Capitation Payment Mechanism will continue to submit claims to CMS for services provided to aligned beneficiaries. The CMS FFS claims processing system will then reduce claims payment amounts according to the specifications detailed below for a select set of services furnished to aligned beneficiaries by Participant Providers and participating Preferred Providers. The set of services subject to such reductions will be determined by the ACO’s selection of either Total Care Capitation Payment or Primary Care Capitation Payment, each of which is described in greater detail below.

#### **Total Care Capitation Payment**

Total Care Capitation Payment represents all Medicare Part A and Part B services furnished to aligned REACH Beneficiaries by Participant Providers and TCC Payment-participating Preferred Providers. Under the Total Care Capitation Payment, Participant Providers will be required to take a 100% fee reduction to their claims-based payment, and those Preferred Providers who have agreed to participate in TCC Payment may choose a fee reduction between 1-100% (as shown in the Table 6.9 below).

**Table 6.9. Total Care Capitation Payment**

Type	Requirements	Fee Reduction
Participant Providers	Required	100%
Preferred Providers	Optional	1-100%

The monthly Total Care Capitation Payment amount paid to the ACO will equal one-twelfth of the Performance Year Benchmark, adjusted by the Total Care Capitation Withhold. CMS expects that a portion of the total cost of care for aligned beneficiaries will be for services provided by providers and suppliers who are not participating in Total Care Capitation Payment, therefore, CMS will “withhold” a portion of the monthly Total Care Capitation Payment amount to offset the expected payments that will be made by CMS to these providers and suppliers. This withhold will be referred to in this RFA as the “Total Care Capitation Withhold.” This withhold is intended to avoid the need for significant year end recoupments from ACOs to account for the claims payments that have been made by CMS to providers and suppliers not participating in Total Care Capitation Payment. CMS will estimate the Total Care Capitation Withhold for each ACO, prior to the start of the performance year, based on aligned Beneficiaries’ historical utilization of services furnished by Participant Providers and Preferred Providers that have agreed to participate in Total Care Capitation Payment, and by all other providers and suppliers. Following the conclusion of the performance year, CMS will reconcile the Total Care Capitation Withhold against actual expenditures incurred by aligned beneficiaries for services provided by providers and suppliers not participating in Total Care Capitation Payment. Please refer to the Capitation and Advanced Payment Mechanisms paper and Companion guide available on our website for example calculations:

(<https://innovation.cms.gov/innovation-models/direct-contracting-model-options>).

### Primary Care Capitation Payment

The Primary Care Capitation Payment is the payment for primary care services provided to aligned REACH beneficiaries by all Participant Providers and those PCC Payment-participating Preferred Providers. This Capitation Payment Mechanism will provide participating ACOs a monthly payment, which includes two components, Base Primary Care Capitation and Enhanced Primary Care Capitation. The Base Primary Care Capitation Amount is intended to cover primary care services furnished to aligned beneficiaries by Participant Providers and those Preferred Providers who have agreed to participate in Primary Care Capitation Payment that are thus subject to fee reductions under Primary Care Capitation Payment. The Enhanced Primary Care Capitation Amount, which will be recouped by CMS in full during Final Financial Settlement (see below for details), is intended to enable ACOs to make upfront investments in infrastructure, technology, tools, and resources to support increased access to primary care, provision of care, and care coordination. Primary Care Capitation Payment is expected to encourage greater flexibility in payment and innovative primary care service delivery as a means of improving the quality and cost effectiveness of care overall.

For PY2022, CMS is defining services subject to Primary Care Capitation as follows (note: this list is subject to change in revisions of the Operating Guides listed below for PY2023 and subsequent performance years):

- Services billed on a professional claim format: claims for certain Evaluation and Management (E/M) office visits for both new and established patients using the current procedural terminology (CPT®)<sup>16</sup> and Healthcare Common Procedure Coding System (HCPCS) codes described in Appendix B of [the PY2022 Financial Operating Guide Overview](#) and billed by Primary Care Specialists, defined as health care providers with specialty codes found in [the PY2022 Financial Operating Guide Overview](#) as well.
- Services billed on an institutional claim format: all services billed by Federally Qualified Health Centers (FQHCs, Type of Bill = 77x) and Rural Health Clinics (RHCs, Type of Bill 71x, respectively)

All services not subject to Primary Care Capitation will be subject to the Advanced Payment Option, if selected by the ACO, as shown in Table 6.10.

**Table 6.10: Services subject to Primary Care Capitation and Advanced Payment Option**

	Professional claims		Institutional claims	
	Primary Care Specialists	Non-Primary Care Specialists	FQHCs and RHCs	All other institutional providers
<b>Primary Care Services</b>	Primary Care Capitation-eligible	Advanced Payment Option-eligible	Primary Care Capitation-eligible	Advanced Payment Option-eligible

<sup>16</sup> CPT codes, descriptions and other data only are copyright 2022 American Medical Association. All Rights Reserved. Applicable FARS/HHSAR apply. CPT is a registered trademark of the American Medical Association.

	Professional claims		Institutional claims	
	Primary Care Specialists	Non-Primary Care Specialists	FQHCs and RHCs	All other institutional providers
<b>Non-Primary Care Services</b>	Advanced Payment Option-eligible	Advanced Payment Option-eligible	Primary Care Capitation-eligible	Advanced Payment Option-eligible

For the majority of ACOs, the Primary Care Capitation Payment for a performance year will equal seven percent of the ACO’s Performance Year Benchmark, paid in monthly installments equal to one-twelfth of the annual Primary Care Capitation Payment. Under Primary Care Capitation Payment, CMS pays the ACO the capitated payments for Primary Care Capitation Payment-eligible services and the ACO is responsible for entering into payment arrangements with its Participant Providers. Participant Providers will continue to submit claims for all services furnished to aligned beneficiaries, including Primary Care Capitation Payment-eligible services. CMS will reduce FFS claim payments for Primary Care Capitation-eligible services furnished to aligned beneficiaries in accordance with each Participant Provider’s selected fee reduction percentage.

In PY2021, fee reductions were optional for Participant Providers in ACOs that selected Primary Care Capitation Payment. Those Participant Providers that opted in could choose a claims reduction between 1-100%. In PY2022, all Participant Providers in ACOs that select Primary Care Capitation Payment must choose a 5-100% claims reduction, followed by a 10-100% reduction in PY2023, and a 20-100% reduction in PY2024. 100% claims reduction for Primary Care Capitation Payment-eligible services furnished to aligned beneficiaries will be required in PY2025-PY2026. Participant Providers that participate in Primary Care Capitation Payment will continue to be fully reimbursed under FFS for the services not subject for Primary Care Capitation Payment that they provide (unless they opt into the Advanced Payment Option).

Preferred Providers may also choose to participate in Primary Care Capitation Payment. Preferred Providers who participate will have additional flexibility regarding the amount by which their Primary Care Capitation Payment-eligible FFS claims will be reduced; they may choose a claims reduction percentage between 1% and 100% for all performance years. CMS will pay Preferred Providers the remaining FFS claim amounts for Primary Care Capitation Payment-eligible services and fully reimburse them under FFS for services they provide that are not subject to Primary Care Capitation Payment (unless they opt into the Advanced Payment Option).

**Table 6.11. Primary Care Capitation**

Type	Requirements	Claims Reduction Flexibility
Participant Providers	PY2021: Participation in Primary Care Capitation is optional PY2022-2026: Participation in Primary Care Capitation is mandatory	PY2021: 1-100% PY2022: 5-100% PY2023: 10-100% PY2024: 20-100% PY2025: 100% PY2026: 100%
Preferred Providers	PY2021-2026: Participation in Primary Care Capitation is optional	PY2021-2026: 1-100%

As outlined above, the Primary Care Capitation Payment amount includes an estimated base amount to

cover Primary Care Capitation Payment-eligible services (Base Primary Care Capitation Amount) and an optional additional amount for providing enhanced primary care services (Enhanced Primary Care Capitation Amount). The Base Primary Care Capitation Amount will be included as a performance year expenditure in the calculation of Shared Savings/Shared Losses for the performance year. CMS will calculate the estimated Base Primary Care Capitation Amount using claims data submitted for Primary Care Capitation Payment-eligible services provided to aligned beneficiaries by Participant Providers and Primary Care Capitation Payment-participating Preferred Providers during a lookback period. The maximum Enhanced Primary Care Capitation Amount that an ACO is eligible to receive will be either the difference between seven percent of the Performance Year Benchmark and the estimated Base Primary Care Capitation Amount, or two percent of the Performance Year Benchmark, whichever is larger. ACOs that have selected to receive the Enhanced Primary Care Capitation Amount will be able to choose an Enhanced Primary Care Capitation Amount up to the maximum amount they are eligible to receive. CMS will recoup the Enhanced Primary Care Capitation Amount in full at the close of the relevant performance year.

For example, an ACO selecting Primary Care Capitation Payment with a Base Primary Care Capitation Amount equal to three percent of the ACO's Performance Year Benchmark will be eligible to receive a maximum Enhanced Primary Care Capitation Amount equal to four percent of the Performance Year Benchmark [7% - 3% = 4%]. If that ACO elects to receive the maximum Enhanced Primary Care Capitation Amount it is eligible to receive, it will receive a Primary Care Capitation Amount equal to seven percent of the Performance Year Benchmark [3% Base Primary Care Capitation + 4% Enhanced Primary Care Capitation]. When conducting Final Financial Settlement following a performance year, CMS would first recoup the full Enhanced Primary Care Capitation Amount before calculating the ACO's performance year expenditures for the performance year. The Base Primary Care Capitation Amount would then be included as a performance year expenditure in the calculation of Shared Savings/Shared Losses for the performance year.

When calculating the Base Primary Care Capitation Amount, CMS will factor in the fee reduction amounts agreed to by each Participant Provider (which can be 10-100% in PY2023) and those Preferred Providers that have agreed to participate in Primary Care Capitation Payment (which can be 1-100%). However, when calculating the maximum Enhanced Primary Care Capitation amount an ACO is eligible to receive, CMS will assume a 100% fee reduction amount for all Participant Providers (for Preferred Providers, CMS will continue to use the agreed upon fee reduction amounts). This ensures that an ACO's Enhanced Primary Care Capitation payment is not artificially increased due to lower fee reduction amount elections by Participant Providers. In the example cited above where three percent of the ACO's historical claims expenditures are determined to be for Primary Care Capitation Payment-eligible services, if that ACO's Participant Providers all elect 100% fee reduction, the ACO's Base Primary Care Capitation Amount will be three percent and its Enhanced Primary Care Capitation Amount will be four percent. However, if that ACO's Participant Providers elect (on average) only 50% fee reduction, the Base Primary Care Capitation Amount will be 1.5% and the Enhanced Primary Care Capitation Amount will remain four percent.

CMS will not constrain the Base Primary Care Capitation Amount calculated for an ACO, even if it exceeds seven percent of the Performance Year Benchmark. Per the description above, ACOs will be guaranteed the option to have an Enhanced Primary Care Capitation Amount equal to at least two percent of the Performance Year Benchmark, even if their Base Primary Care Capitation Amount exceeds five percent of the Performance Year Benchmark (i.e., even if 7% - the Base Primary Care Capitation Amount is <2% of

the Performance Year Benchmark).

The Primary Care Capitation Payment amount will not be impacted by the amount of the actual primary care claims submitted by Participant Providers and Primary Care Capitation Payment-participating Preferred Providers. Using the example illustrated above, if an ACO with a Base Primary Care Capitation Amount equal to three percent of the Performance Year Benchmark experiences actual primary care expenditures above three percent of the Performance Year Benchmark, CMS would still recoup the Enhanced Primary Care Capitation Amount at Final Financial Settlement and count the Base Primary Care Capitation Amount as performance year expenditures.

### **Optional Advanced Payment Option for ACOs Electing Primary Care Capitation Payment**

ACOs that select Primary Care Capitation Payment will have additional flexibility to contract with Participant Providers and Preferred Providers under a claims reduction mechanism, which builds upon the Alternative Payment Mechanism in the NGACO Model referred to as “Population Based Payments.” The Advanced Payment Option is the converse of Primary Care Capitation Payment, and only applies to non-Primary Care Capitation Payment-eligible services (defined in Table 6.10 above), also known as Advanced Payment Option-eligible services.

Under the Advanced Payment Option, ACOs can enter into arrangements with Participant Providers and Preferred Providers whereby CMS would reduce the claims payment amount for Advanced Payment Option-eligible services furnished by these Advanced Payment Option-participating Participant Providers and Preferred Providers, between 1% and 100% of the value of the FFS claims payment amount, as agreed to by the Participant Providers and Preferred Providers. In exchange, CMS would make a monthly Advanced Payment Option payment to the ACO equivalent to the estimated value of the FFS claims reductions for Advanced Payment Option-eligible services furnished to aligned beneficiaries by Participant Providers and Preferred Providers who have agreed to participate in the Advanced Payment Option and receive the Advanced Payment Option fee reduction. The amount of the Advanced Payment Option payment is estimated by CMS based on historical utilization by aligned beneficiaries and the amount of the fee reduction agreed to by the Advanced Payment Option-participating Participant Providers and Preferred Providers. These Advanced Payment Option payments will be reconciled against actual FFS claims at Final Financial Settlement. The Advanced Payment Option payment will be paid by CMS to the ACO, and the ACO is then responsible for paying the Advanced Payment Option-participating Participant Providers and Preferred Providers based on the terms negotiated between the ACO and the Advanced Payment Option-participating providers and suppliers (subject to applicable laws).

### **Claims Payments Excluded from TCC Payment, PCC Payment, and the APO**

There are additional FFS payment categories that are not subject to the Capitation Payment Mechanisms or APO. These claim categories include:

- Claims payments where Medicare is not the primary payer
- Claims payments for providers enrolled in the Periodic Interim Payments (PiP) program or other Medicare programs or initiatives specified by CMS prior to the start of the Performance year or relevant subsequent quarter
- Claims payments that are subject to the Medicare Health Professional Shortage Area (HPSA) Physician Bonus Program
- Claims payments to a home health agency for an episode period for which the home health

agency has submitted a Request for Anticipated Payment (RAP)

- Claims payments for beneficiaries who elect to decline data sharing or for services related to the diagnosis and treatment of substance use disorder (SUD)

### **Quarterly Updates to Capitation and Advanced Payment Mechanisms**

CMS may adjust the amount of any monthly payment (Total Care Capitation Payment, Primary Care Capitation Payment, and Advanced Payment Option payments) in subsequent quarters of the Performance Year. Such adjustments will help to reduce under- or over-estimates of the amount of the monthly payments, potentially resulting in cash flow issues for the ACO or necessitating significant payment recoupments in the Final Financial Settlement. Additional payment adjustments will be made at quarterly intervals during the Performance Year. These adjustments vary by payment type:

- **Primary Care Capitation Payment:** Adjustments will be made to account for differences between expected beneficiary-months and actual beneficiary-months in each quarter. Since payments are made prospectively and the number of beneficiary months is not known for certain in advance (due to exclusions, loss of eligibility, and death), the number of beneficiary months is estimated each quarter, assuming a beneficiary attrition rate based on historical ACO-specific data. Adjustments will also be made for updates to the Performance Year Benchmark (e.g., as more updated risk scores become available), since PCC payments are calculated in part as a percentage of the Performance Year Benchmark.
- **Total Care Capitation Payment:** As in Primary Care Capitation Payment, adjustments will be made to account for differences between expected beneficiary-months and actual beneficiary-months in each quarter. Similarly, adjustments will also be made for updates to the Performance Year Benchmark, since TCC payments are calculated in part as a percentage of the Performance Year Benchmark. Additionally, the TCC Withhold, which is estimated based on historical utilization patterns, will be updated in the Performance Year to reflect changing patterns of care.
- **Advanced Payment Option:** As in Primary Care Capitation Payment, adjustments will be made to account for differences between expected beneficiary-months and actual beneficiary-months in each quarter. Additionally, as in PBP and AIPBP in NGACO, the Advanced Payment Option prospective monthly payments will be reconciled at Final Financial Settlement with the actual amount of the reduction to claims payments during the Performance Year.

Please refer to the Capitation and Advanced Payment Mechanisms paper and Companion guide available on our website for more details: <https://innovation.cms.gov/innovation-models/direct-contracting-model-options>.

### **F. Financial Methodology: Beneficiary Alignment and the Performance Year Benchmark for Each of the Three ACO Types**

In this section, we describe the unique beneficiary alignment requirements and the specific financial benchmarking methodology for each of the three ACO types. In general, the benchmarking methodology for Standard ACOs will serve as the framework for the benchmarking methodology for the other two ACO types, so we will describe this methodology first and refer back to it. Detailed financial methodology papers are also available on our website (<https://innovation.cms.gov/innovation-models/direct->

[contracting-model-options](#)). These financial methodology papers address a variety of issues, including providing additional details regarding the benchmarking methodology (see Table 6.12 below), Capitation Payment Mechanisms, and the methodology for calculating Shared Savings/Shared Losses. A more detailed summary table comparing the different design elements of the three ACO types has been provided in Appendix B of this RFA. CMS will provide applicants approved for participation in PY2023 with a preliminary Performance Year Benchmark prior to signing the MPP Participation Agreement. This preliminary Performance Year Benchmark will be updated in each Quarterly Benchmark Report and finalized after the performance year ends for purposes of Financial Settlement (the MPP Participation Agreement will provide the specific details regarding the quarterly updates).

**Table 6.12. Alignment and Financial Benchmarking Methodology for Each of the Three ACO Types**

	<b>Standard</b>	<b>New Entrant</b>	<b>High Needs Population</b>
<b>Description</b>	ACOs with substantial historical experience serving Medicare FFS beneficiaries	ACOs with limited historical experience delivering care to Medicare FFS beneficiaries. Beneficiaries aligned via claims in any base year must not exceed 3,000 <sup>2</sup>	ACOs that focus on beneficiaries with complex, high needs including dually eligible individuals. Beneficiaries aligned via claims in any base year must not exceed 3,000 <sup>3</sup>
<b>Alignment Options</b>	1. Voluntary <sup>1</sup> 2. Claims-based	1. Voluntary 2. Claims-based	1. Voluntary 2. Claims-based <i>Under both alignment methodologies, aligned beneficiaries must meet high needs eligibility criteria</i>
<b>Performance Year Benchmark Overview: Voluntarily aligned beneficiaries<sup>1</sup></b>	For PY2021-PY2024: - Regional expenditures (ACO REACH /KCC Rate Book <sup>17</sup> ) - Aligned beneficiary historical expenditures not incorporated For PY2025-PY2026: - Blends regional expenditures with aligned beneficiary recent historical expenditures	For PY2021-PY2024: - Regional expenditures (ACO REACH / KCC Rate Book) - Aligned beneficiary historical expenditures not incorporated For PY2025-PY2026: - Blends regional expenditures with aligned beneficiary recent historical expenditures	For PY2021-PY2024: - Regional expenditures (ACO REACH / KCC Rate Book) - Aligned beneficiary historical expenditures not incorporated For PY2025-PY2026: - Blends regional expenditures with aligned beneficiary recent historical expenditures

<sup>17</sup> The ACO REACH / KCC Rate Book has previously been referred to as the DC/KCC Rate Book.

	Standard	New Entrant	High Needs Population
<b>Performance Year Benchmark Overview: Claims-based aligned beneficiaries</b>	Blends regional expenditures (ACO REACH / KCC Rate Book) with aligned beneficiary historical expenditures (CY2017-19)	For PY2021-PY2024: - Regional expenditures (ACO REACH / KCC Rate Book) - Aligned beneficiary historical expenditures not incorporated For PY2025-PY2026: - Blends regional expenditures with aligned beneficiary recent historical expenditures	For PY2021-PY2024: - Regional expenditures (ACO REACH / KCC Rate Book) - Aligned beneficiary historical expenditures not incorporated For PY2025-PY2026: - Blends regional expenditures with aligned beneficiary recent historical expenditures

- Beneficiaries aligned via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking purposes. This determination will be made anew each performance year (for example, a beneficiary aligned only via voluntary alignment in PY2023 would be subject to the benchmark for voluntarily aligned beneficiaries in PY2023, but if the same beneficiary were to be aligned by both claims and voluntary alignment in PY2024, that beneficiary would be subject to the benchmark for claims-aligned beneficiaries in PY2024).*
- If the 3,000 aligned beneficiaries threshold is exceeded, ACOs will have the opportunity to participate as a Standard ACO, provided the model 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.*
- If the 3,000 aligned beneficiaries threshold is exceeded, High Needs Population ACOs’ benchmarking methodology will follow the Standard ACO methodologies, though High Needs Population ACOs will continue to be High Needs Population ACOs subject to the High Needs Population ACO-specific requirements, including that all aligned beneficiaries satisfy the additional High Needs eligibility criteria.*

**1. Standard ACO**

It is anticipated that the ACO REACH Model will attract organizations that have previously participated in section 1115A shared savings models (e.g., Next Generation ACO Model and Pioneer ACO Model) and/or the Shared Savings Program. In addition, CMS anticipates that new organizations, composed of existing Medicare FFS providers and suppliers, may be created in order to participate in the ACO REACH Model. In either case, providers and suppliers participating within these organizations—referred to as Standard ACOs—would have substantial experience serving Medicare FFS beneficiaries. Organizations interested in serving as Standard ACOs must indicate their preferred ACO type in their response to this RFA. Summary alignment and benchmarking information for Standard ACOs is provided in Table 6.13 below and then described in more detail in the remainder of this section.



**Table 6.13. Alignment and Financial Benchmarking Methodology for Standard ACOs**

	<b>Prospective Benchmarking Methodology for Voluntary alignment</b>	<b>Prospective Benchmarking Methodology for Claims-based alignment</b>
Historical Baseline	<ul style="list-style-type: none"> <li>Regional expenditures, measured via the ACO REACH / KCC Rate Book, through PY2024</li> <li>Incorporates historical expenditures for voluntarily aligned beneficiaries beginning in PY2025</li> </ul>	<ul style="list-style-type: none"> <li>Blends regional expenditures (ACO REACH / KCC Rate Book) with historical expenditures (2017, 2018, and 2019)</li> </ul>
Regional Expenditure	<ul style="list-style-type: none"> <li>ACO REACH / KCC Rate Book</li> </ul>	<ul style="list-style-type: none"> <li>ACO REACH / KCC Rate Book</li> </ul>
Risk Adjustment	Yes	Yes
Discount (Global only) and Quality Withhold	Yes	Yes

*Alignment Requirements*

Alignment options available to Standard ACOs are premised on the notion that certain types of organizations that would be interested in the ACO REACH Model will have Participant Providers that will have had past experience providing services to Medicare FFS beneficiaries. Standard ACOs have two beneficiary alignment options available to them, which are claims-based alignment and voluntary alignment. For Standard ACOs, voluntary alignment will take precedence over claims-based alignment if each alignment methodology would align a beneficiary to two different ACOs. Standard ACOs will be required to have a minimum of 5,000 aligned beneficiaries prior the start of each Performance Year, as well as at least 3,000 beneficiaries that would have been aligned during at least one base year (CY2017, 2018, or 2019).

As noted above, the benchmarking approach for Standard ACOs differs for beneficiaries aligned via claims-alignment and beneficiaries aligned via voluntary alignment. Beneficiaries aligned via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking purposes. This determination will be made anew each performance year (for example, a beneficiary aligned only via voluntary alignment in PY2023 would be subject to the benchmark for voluntarily aligned beneficiaries in PY2023, but if the same beneficiary were to be aligned by both claims and voluntary alignment in PY2024, that beneficiary would be subject to the benchmark for claims-aligned beneficiaries in PY2024).

*Benchmarking Methodology for Beneficiaries with Claims-Based Alignment*

Under both Global and Professional, CMS will use a prospective benchmarking methodology to determine the Performance Year Benchmark for Standard ACOs. A per-beneficiary per-month (PBPM) benchmark will be developed for both the Aged & Disabled (A&D) and End Stage Renal Disease (ESRD) beneficiary categories, identified based on the reason for entitlement to Medicare. Development of the Performance Year Benchmark will include five steps (described in more detail below): (1) calculation of the historical

baseline expenditures, (2) trending the historical baseline expenditures forward, (3) blending the historical baseline expenditures with regional expenditures using the ACO REACH / KCC Rate Book, (4) risk adjustment, and (5) applying necessary adjustments for quality performance and the discount (Global only). The Performance Year Benchmark is used to calculate Shared Savings or Shared Losses for the Performance Year. The Performance Year Benchmark is also used to derive the monthly capitated payments paid to ACOs during the Performance Year under both the Total Care Capitation Payment and the Primary Care Capitation Payment Capitation Payment Mechanisms. For purposes of calculating monthly capitated payments during the Performance Year and for Provisional Financial Settlement, if applicable, CMS will estimate certain inputs of the Performance Year Benchmark that are not finalized until after the end of the performance year (such as the quality adjustment). These estimates will be finalized and incorporated into the Performance Year Benchmark during the Final Financial Settlement process.

*Historical Baseline Expenditures*

CMS will determine the historical baseline expenditures for beneficiaries who are aligned to the Standard ACO through claims-based alignment, using the Parts A and B expenditures for those beneficiaries during a baseline period. (The benchmark calculation methodology for beneficiaries aligned to a Standard ACO on the basis of voluntary alignment, which is a different variant of this methodology, is described in more detail later in this section). For the duration of the ACO REACH Model’s model performance period, the baseline period will be a fixed period of the following three base years: 2017, 2018, & 2019. This period represents the most recent full calendar years for which full expenditure experience and claims run-out was complete at the beginning of the model performance period. These base years will be weighted to give additional weight to the more recent base years, in recognition that the population of base year aligned beneficiaries for more recent base years is likely more comparable to the population of aligned beneficiaries for the relevant performance year.

**Table 6.14. Historical Base Year Weighting for the Baseline Period (CY2017, CY2018 and CY2019)**

CY2017	CY2018	CY2019
Base Year 1 (BY1)	Base Year 2 (BY2)	Base Year 3 (BY3)
10% weight	30% weight	60% weight

The *baseline period* will be static across all of the performance years of the model. However, the *historical baseline expenditures* will be updated each year, as CMS will use an ACO’s most recent Participant Provider List to identify the beneficiaries who would have been aligned to the ACO for each of the base years and their associated expenditures. For example, the historical baseline expenditures that were used for the purpose of calculating Performance Year Benchmarks for PY2021 were determined based on the ACOs’ Participant Provider Lists for PY2021. For PY2023, the same baseline period will be used, but the historical baseline expenditures will be determined based on the ACO’s Participant Provider List for PY2023.

If CMS determines that the ACO does not have sufficient claims history to construct the historical baseline expenditures for any the three Base Years, CMS will not use that Base Year in the calculation. If two Base Years are determined to have sufficient claims history, CMS will average the two Base Years, with the more recent Base Year weighted two-thirds and the less recent Base Year weighted one-third. If only one Base Year is determined to have sufficient claims history, CMS will weight that year at 100% for calculating the historical baseline expenditures.

### *Prospective Trend and Regional Geographic Adjustment Factor*

Building on the experience of the NGACO Model and consistent with the goal of further aligning with MA payment methodologies, CMS will utilize a prospective trend that will be based on the projected US Per Capita Cost (USPCC) growth trend, developed annually by the CMS Office of the Actuary (OACT) and announced in the annual Announcement of Calendar Year (CY) Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies released the first Monday in April of the prior calendar year. The USPCC annual growth trend will be applied to the ACO's historical baseline expenditures. CMS will apply the Aged & Disabled and Dialysis-only ESRD ("ESRD") USPCC growth trends to the historical baseline expenditures for the Aged & Disabled and ESRD populations of aligned beneficiaries, respectively.

Under limited circumstances, additional adjustments to the expenditure trend may be made. For example, CMS may retrospectively apply an adjustment to the benchmark to take into account differences between the projected USPCC expenditure trend for the FFS population as a whole, and the observed expenditure trend for the subset of FFS beneficiaries that are alignment eligible under the ACO REACH Model, should these values meaningfully differ for Aged & Disabled or ESRD populations. As an additional example, CMS may use an adjusted projected trend figure in response to unforeseeable events that have a substantial impact on Medicare FFS expenditures (such as hurricanes or other natural disasters). Adjustments to the trend would be intended to prevent ACOs from being unfairly financially disadvantaged or rewarded for major payment changes beyond their control.

Furthermore, the trended historical baseline expenditures will be adjusted to reflect the anticipated impact of changes in the regional Geographic Adjustment Factors (GAFs) applied to payment amounts under the Medicare FFS payment systems. This GAF adjustment is intended to prevent the benchmark from being unfairly understated (or overstated) because of differences in the local geographic price adjustments that Medicare uses to calculate provider and supplier payments between the baseline period and the performance year. This process accounts for variations in the cost-of-doing-business adjustments that Medicare applies under most of its FFS fee schedules (e.g., the Medicare area wage index, and the geographic practice cost index), which are typically updated annually.

### *Regional Expenditures – ACO REACH / KCC Rate Book*

CMS will incorporate regional expenditures into the ACOs' historical baseline expenditures, in order to further align Medicare FFS and MA payment policies, as well as to move toward a more predictable calculation of benchmarks in risk-based Medicare FFS models. CMS will use the most recently available MA Rate Book data to derive each ACO's regional expenditures. The MA Rate Book establishes county-level rates for MA Plans for Aged and Disabled beneficiaries and state-level rates for ESRD beneficiaries. For purposes of the ACO REACH Model, CMS will make adjustments to the MA Rate Book as discussed in more detail below to make it appropriate for use in the model, establishing the ACO REACH / KCC Rate Book (used in the ACO REACH Model and Kidney Care Choices (KCC) models), which will be made available to ACOs in advance of each performance year. CMS will blend the regional expenditures with the ACO's historical baseline expenditures, which have been trended forward to the performance year in determining the Performance Year Benchmark. The composition of the Performance Year Benchmark will be a weighted average of the historical baseline expenditures and regional expenditures, with the percentage of the benchmark contributed by the regional expenditures increasing each Performance Year.

To develop the ACO REACH / KCC Rate Book, CMS will make adjustments to the MA Rate Book methodology to ensure that the rates used for this model serve as an accurate representation of regional costs for purposes of benchmarking. First, CMS will remove the impact of certain adjustments that are incorporated into the MA Rate Book for purposes of MA plan payment, but that are not relevant to the ACO REACH Model, such as the Quality Bonus Payment (QBP) percentage based on star ratings. Second, CMS will make adjustments to account for differences in expenditure types that are included for purposes of the MA Rate Book, but are not relevant for purposes of the ACO REACH Model. For example, the FFS quartile adjustments to the county Aged & Disabled rates will be removed for the ACO REACH / KCC Rate Book. Third, CMS will make adjustments to account for differences between the subset of FFS beneficiaries eligible to be aligned to ACOs and Medicare FFS beneficiaries generally. For example, ACO aligned beneficiaries must be enrolled in both Medicare Parts A and B (see the beneficiary eligibility section for other differences between the ACO REACH Model eligible population and the general FFS population). Please refer to the ACO REACH / KCC Rate Book Development paper for more details: (<https://innovation.cms.gov/media/document/dc-kcc-ratebookdev>).

To account for where the aligned beneficiaries live for the calculation of an ACO’s regional expenditures, CMS will calculate a weighted average of the county rates (or state level rates for ESRD beneficiaries) from the ACO REACH / KCC Rate Book that correspond to where the ACO’s aligned beneficiaries live. CMS will make use of the most recently available ACO REACH / KCC Rate Book data to derive these rates.

Regional expenditures based on where beneficiaries aligned to the ACO for the historical baseline period reside will be combined with the ACO’s trended, historical baseline expenditures through blending to calculate a weighted payment rate. In order to account for potential shifts in the distribution of county of residence for beneficiaries aligned in the performance year compared to the beneficiaries that would have been aligned in the historical baseline period, the ratio of the ACO’s historical baseline expenditures to the ACO’s regional expenditures in the baseline period will serve as an adjustment factor to the ACO’s Performance Year regional expenditures. Please refer to section 4.1.7 of the ACO REACH Model Financial Operation Guide: Overview paper for more details (<https://innovation.cms.gov/media/document/dc-financial-op-guide-overview>).

The proportion of regional expenditures that will be blended with the historical baseline expenditures will increase incrementally over the course of the model performance period, beginning with regional expenditures comprising 35% of the benchmark in PY2021 and increasing to 50% of the benchmark by PY2025. This transition toward an increasing percentage of regional expenditures comprising the benchmark is highlighted in Table 6.15 below.

**Table 6.15: Composition of the Performance Year Benchmark**

<b>PY2021 &amp; PY2022</b>	<b>PY2023</b>	<b>PY2024</b>	<b>PY2025 &amp; PY2026</b>
65% Historical Baseline Expenditures	60% Historical Baseline Expenditures	55% Historical Baseline Expenditures	50% Historical Baseline Expenditures
35% Regional Expenditures	40% Regional Expenditures	45% Regional Expenditures	50% Regional Expenditures

For purposes of incorporating regional expenditures into an ACO’s benchmark, the ACO’s region will include all counties in which one or more beneficiaries aligned to the ACO in the baseline period reside. Note that the “region” for purposes of the financial benchmarking methodology is defined at the county-level and calculated for each ACO, and that this “region” is separate and distinct from the ACO’s “service

area” which is used for purposes of beneficiary alignment and marketing activities.

CMS will establish limits on the maximum upward and downward adjustment that can result from incorporating regional expenditures into the benchmark. Specifically, CMS will limit the overall upward adjustment from incorporating the regional expenditures to a flat dollar amount equal to five percent of the FFS USPCC for the performance year. CMS will limit the overall downward adjustment from incorporating the regional expenditures to a flat dollar amount equal to two percent of the FFS USPCC for the performance year. For example, in a hypothetical performance year in which the FFS USPCC (Aged & Disabled) estimate is \$1,000.00 PBPM, the maximum upward adjustment to the historical benchmark (Aged & Disabled) would be \$50.00 PBPM and the maximum downward adjustment to the historical benchmark (Aged & Disabled) would be \$20.00 PBPM.

While CMS will not distinguish between “efficient organizations” (i.e., lower cost than region) and “inefficient organizations” (i.e., higher cost than region) for purposes of determining the percentage of regional expenditures that comprise the benchmark, we believe that the limit on the maximum upward adjustment resulting from incorporating regional expenditures allows for a meaningful reward for ACOs that are efficient relative to their region, while mitigating potential windfall savings for those ACOs with significantly lower costs than their region. Imposing a more modest limit on the negative regional adjustment continues to drive higher-cost ACOs towards efficiency compared with their region, while maintaining an attainable objective that does not discourage participation in the model by those organizations whose aligned beneficiaries have historically incurred above average costs for their region.

#### *Risk Adjustment*

A risk score will be calculated using the prospective CMS HCC risk adjustment model for each beneficiary who is aligned to the Standard ACO for a specific performance year (PY2021-PY2026). Additional information regarding the risk adjustment methodology is outlined below in the ‘Risk Adjustment in Global and Professional Options’ section.

#### *Discount and Quality Incentives*

CMS will apply a series of adjustments to the trended, regionally blended, risk adjusted benchmark at this stage in the calculation of the Performance Year Benchmark. These adjustments will serve to incentivize quality performance, reward higher performing ACOs, and help to generate savings under the model.

#### *Discount Applied to the Performance Year Benchmark (Global Only)*

CMS will apply a discount to the trended, regionally blended, risk adjusted benchmark for ACOs participating in Global. As ACOs in Global will retain 100% of savings relative to the Final Performance Year Benchmark achieved during the performance year, applying this discount to the benchmark will provide the primary mechanism for CMS to obtain savings from ACOs participating in this risk sharing option. This discount is set at two percent of the benchmark for PY2021 and PY2022. The discount will increase to three percent for PY2023 and PY2024, and then to 3.5% for PY2025 and PY2026, thereby requiring continuous improvement from participants in Global. The Performance Year Benchmark for ACOs participating in Professional does not include this discount.

#### *Quality Incentive*

In both Global and Professional, a portion of the Performance Year Benchmark will be held “at risk,” dependent on the ACO’s quality performance. Specifically, this quality incentive will be structured as a

quality “withhold,” set at two percent of the value of the trended, regionally blended, risk adjusted benchmark for PY2023 and all subsequent performance years, and will be recalculated for each performance year. The ACO will then have the opportunity to “earn back” some or all of the quality withhold, depending on the ACO’s performance on a pre-determined set of Quality Measures (see Appendix C for the set of measures for PY2023) and, starting in PY2023 for ACOs that began participation in PY2021 or PY2022 and starting in PY2024 for ACOs that begin participation in PY2023, continuous improvement/sustained exceptional performance (CI/SEP) criteria.

An ACO’s performance on the Quality Measures can be assessed either as ‘pay-for-reporting,’ where the ACO receives full credit simply for reporting any required data to CMS for the purpose of measuring the ACO’s performance, or ‘pay-for-performance,’ where the ACO’s actual quality performance is compared to a benchmark. Pay-for-reporting results in the ACO receiving a binary score: either 0% or 100% for each Quality Measure. Pay-for-performance results in the ACO receiving a score between 0-100% for each Quality Measure, based on its performance relative to the Quality Measure benchmark. For PY2023 and all subsequent performance years, CMS will assess the ACO’s performance on the Quality Measures as pay-for-performance, unless a new Quality Measure (beyond those listed in Appendix C) is introduced. The ACO’s average score across all Quality Measures is referred to as the ACO’s Total Quality Score (see below as well as Section VII.B for information on how the Total Quality Score is used in financial calculations).

CMS is introducing the CI/SEP criteria (in PY2023 for ACOs that began participation in PY2021 or PY2022 and in PY2024 for ACOs that begin participation in PY2023) to encourage ACOs to deliver high quality, high value care by tying a portion of the financial methodology to quality improvement. Specifically, beginning for PY2023 (or, if applicable, PY2024), half of the quality withhold for ACOs in their second or a subsequent performance year in the model will be tied to a set of CI/SEP criteria. CMS will provide methodological details on the CI/SEP criteria in its PY2023 update to the Quality Measurement Methodology paper (<https://innovation.cms.gov/innovation-models/gpdc-model>), which is expected to be released in the summer of 2022. Performance on the CI/SEP criteria will be assessed as a binary metric: pass or fail. CMS recognizes that ACOs achieving high quality performance scores may have less room to show improvement. Accordingly, when establishing these continuous improvement targets, CMS will establish targets that still incentivize higher performing ACOs to continue to improve. ACOs’ quality performance on each measure will continue to be assessed for each performance year and will serve as the baseline for the ACOs’ ongoing quality improvement activities in future performance years.

For PY2023-PY2026 (or, if applicable, PY2024-PY2026), the amount of the quality withhold that an ACO earns back will be calculated as a function of the ACO’s Total Quality Score for each performance year multiplied by 2% if the ACO passes the CI/SEP criteria or by 1% if the ACO does not pass the CI/SEP criteria. For example, an ACO with a 95% Total Quality Score that meets the CI/SEP criteria will earn back 1.9% [= 95% \* 2%] of the 2% quality withhold, whereas an ACO that does not meet the CI/SEP criteria would earn back 0.95% [=95% \* 1%] of the 2% quality withhold. An ACO that achieves a full (100%) Total Quality Score and also meets the CI/SEP criteria will earn back the full amount of the quality withhold for the performance year. Please see Section VII.B for additional information on the calculation of the quality withhold earn back.

#### *High Performers Pool (HPP)*

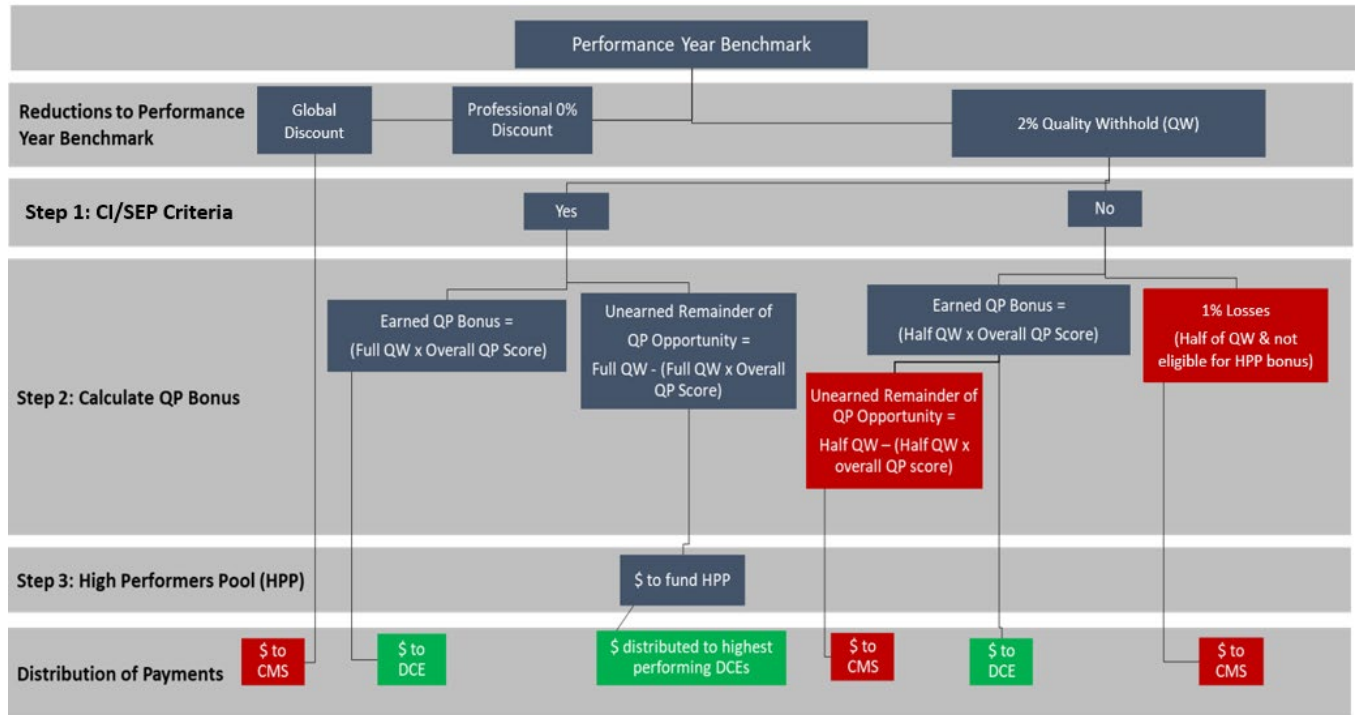
Starting in PY2023 for ACOs beginning participation in PY2021 or PY2022 and starting in PY2024 for ACOs

beginning participation in PY2023, the ACO REACH Model will also test the use of a High Performer's Pool (HPP) to further incentivize high performance and continuous improvement on the Quality Measure set provided in Appendix C. ACOs will qualify for a bonus from the HPP if they meet the CI/SEP criteria and also demonstrate a high level of performance or meet improvement criteria on a pre-determined subset of the Quality Measures from the Quality Measure set. The HPP will be "funded" from quality withholds not earned back by the ACOs who met the CI/SEP criteria. For example, an ACO that earns back 1.9% of its 2% quality withhold (by passing the CI/SEP criteria and achieving a 95% Total Quality Score, per the example above) contributes the remaining 0.1% of its Performance Year Benchmark (that is, the remainder of its quality withhold) to the HPP. The funds in the HPP will be distributed to the highest performing ACOs through an HPP Bonus based on quality performance or improvement. The criteria for assessing quality performance or improvement may be based on an individual ACO's performance on the specified measures in the current performance year compared to the prior performance year, or may be based on performance against the Quality Measure benchmark, or a combination of both. The methodology for distribution of the funds in the HPP will be shared prior to PY2023 in the PY2023 update to the Quality Measurement Methodology paper, referenced above. ACOs beginning participation in PY2023 will not qualify to earn HPP bonuses or contribute dollars to the HPP in PY2023 because they are not subject to the CI/SEP criteria until PY2024.

In order to account for potential variation in the size of organizations that may qualify to receive an HPP Bonus, the funds from the HPP will be distributed to ACOs proportionally, based on each qualifying ACO's overall number of beneficiary alignment-months in the performance year relative to the overall number of beneficiary alignment-months for all ACOs that qualify for this bonus. The highest performing ACOs may earn a net surplus as a result of their quality performance bonus and HPP Bonus.

If an ACO meets the CI/SEP criteria but fails to earn back 100% of the quality withhold as a result of its quality performance, the amount that the ACO fails to earn back will go into the HPP pool, for eligible high performing ACOs to earn. However, if the ACO fails to meet the CI/SEP criteria, it would lose 50% of the quality withhold amount and these dollars would be retained by CMS and not added to the HPP pool. In such an instance, any amount of the remaining 50% of the quality withhold amount not "earned back" would also be retained by CMS, and would not be distributed through the HPP. Using the examples from the previous section, the ACO passing the CI/SEP criteria with a 95% Total Quality Score would contribute the 0.1% of the quality withhold that it did not earn back to the HPP [=2% - 1.9%], whereas the ACO failing the CI/SEP criteria with a 95% Total Quality Score would not contribute the 1.05% of the quality withhold that it did not earn back to the HPP.

**Figure 6.2 Overview of Discount, Quality Performance, and Quality Bonus (PY2023-PY2026\*)**



CI/SEP = Continuous Improvement/Sustained Exceptional Performance  
HPP = High Performers Pool  
QP = Quality Performance  
QW = Quality Withhold

\* = For REACH ACOs that apply to participate in the ACO REACH model through this RFA and begin participation in the model performance period in PY2023, the CI/SEP criteria and HPP Quality Bonus will not be effective until PY2024. For all other REACH ACOs (who began participation in the model performance period in PY2021 or PY2022), the CI/SEP criteria and HPP Quality Bonus will be effective in PY2023 and each subsequent performance year.



**Table 6.16: Application of Discount and Quality Withhold to the Performance Year Benchmark**

	<b>Global</b>	<b>Professional</b>
<b>PY2021 (Apr-Dec 2021)</b>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 2% discount applied to the benchmark;</li> <li>• 5% of benchmark subject to quality withhold, which may be earned back based on quality performance score (4% pay-for-reporting measures; 1% pay-for-performance). There will be no CI/SEP criteria or HPP Bonus.</li> </ul>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 5% of benchmark subject to quality withhold, which may be earned back based on quality performance score (4% pay-for-reporting measures; 1% pay-for-performance). There will be no CI/SEP criteria or HPP Bonus.</li> </ul>
<b>PY2022</b>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 2% discount applied to the benchmark;</li> <li>• 5% benchmark subject to quality withhold, which may be earned back based on quality performance score (4% pay-for-reporting measures; 1% pay-for-performance). There will be no CI/SEP criteria or HPP Bonus.</li> </ul>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 5% of benchmark subject to quality withhold, which may be earned back based on quality performance score (4% pay-for-reporting measures; 1% pay-for-performance). There will be no CI/SEP criteria or HPP Bonus.</li> </ul>
<b>PY2023</b>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 3% discount applied to the benchmark;</li> <li>• 2% of benchmark subject to quality withhold (the entire 2% is pay-for-performance), which may be earned back based on the quality performance score and, for ACOs that began participation in PY2021 or PY2022, the CI/SEP criteria. If ACO meets CI/SEP criteria, eligible for consideration for HPP Bonus.</li> </ul>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 2% of benchmark subject to quality withhold (the entire 2% is pay-for-performance), which may be earned back based on the quality performance score and, for ACOs that began participation in PY2021 or PY2022, the CI/SEP criteria. If ACO meets CI/SEP criteria, eligible for consideration for HPP Bonus.</li> </ul>
<b>PY2024</b>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 3% discount applied to the benchmark;</li> <li>• 2% of benchmark subject to quality withhold (the entire 2% is pay-for-performance), which may be earned back based on the quality performance score and the CI/SEP criteria. If ACO meets CI/SEP criteria, eligible for consideration for HPP Bonus.</li> </ul>	<p>Benchmark is adjusted as follows:</p> <ul style="list-style-type: none"> <li>• 2% of benchmark subject to quality withhold (the entire 2% is pay-for-performance), which may be earned back based on the quality performance score and the CI/SEP criteria. If ACO meets CI/SEP criteria, eligible for consideration for HPP Bonus.</li> </ul>

	<b>Global</b>	<b>Professional</b>
<b>PY2025 &amp; PY2026</b>	Benchmark is adjusted as follows: <ul style="list-style-type: none"> <li>• 3.5% discount applied to the benchmark;</li> <li>• 2% of benchmark subject to quality withhold (the entire 2% is pay-for-performance), which may be earned back based on the CI/SEP criteria and quality performance score.</li> <li>• If ACO meets CI/SEP criteria, eligible for consideration for HPP Bonus.</li> </ul>	Benchmark is adjusted as follows: <ul style="list-style-type: none"> <li>• 2% of benchmark subject to quality withhold (the entire 2% is pay-for-performance), which may be earned back based on the CI/SEP criteria and quality performance score.</li> <li>• If ACO meets CI/SEP criteria, eligible for consideration for HPP Bonus.</li> </ul>

*Benchmarking Methodology for Beneficiaries Aligned Solely through Voluntary Alignment*

The ACO REACH Model places a high emphasis on voluntary alignment, providing additional opportunities for active beneficiary choice and new tools for ACOs to engage and communicate with beneficiaries. Though also initially offered in the Shared Savings Program and the NGACO Model, voluntary alignment plays a modest role in beneficiary alignment to ACOs in those initiatives, with the vast majority of beneficiaries aligned to an ACO through claims-based alignment. With an increased emphasis on voluntary alignment in the ACO REACH Model, the characteristics of beneficiaries aligned to an ACO in a performance year may differ from those aligned in the baseline period, creating a potential for asymmetry that may under-predict or over-predict expenditures for voluntarily aligned beneficiaries. As a result, CMS will test a new prospective benchmarking methodology to calculate a Performance Year Benchmark for beneficiaries that are aligned to an ACO solely through voluntary alignment. This new approach will further provide CMS with the ability to incorporate aligned beneficiary expenditure experience into the Performance Year Benchmark over time, as voluntarily aligned beneficiaries begin to accumulate claims history under the ACO REACH Model (see methodology below).

In addition to the goals outlined above, this approach will seek to meet the following objectives:

- Test a benchmarking approach that departs from an organization’s historical expenditures, towards a payment mechanism that uses fully regional rates.
- Provide an incentive for efficient organizations to compete for and engage with beneficiaries in managing their care.
- Provide the basis for the financial methodology for New Entrant ACOs, described in section VI.F.2, as these organizations will not have sufficient FFS experience to establish a historical baseline for the initial performance years of the model.

This alternative benchmarking methodology will apply only for those beneficiaries who are aligned to the ACO solely through voluntary alignment and who meet certain alignment criteria. This will include a determination from CMS that the beneficiary is *newly aligned* to the ACO. Specifically, CMS will confirm that the beneficiary has not previously been aligned to the ACO through claims-based alignment. CMS will also establish claims-based exclusion criteria, which will identify low utilization by voluntarily aligned beneficiaries of services furnished by Participant Providers, to ensure that ACOs establish and maintain a meaningful primary care relationship with each beneficiary who voluntarily aligns to the ACO during their

participation in ACO REACH Model's model performance period (PY2021 – PY2026).

This alternative benchmarking methodology will apply for PY2021 – PY2024 for individual beneficiaries aligned to an ACO solely on the basis of voluntary alignment (i.e., who were not aligned to the ACO via claims-based alignment). Beginning in PY2025, for beneficiaries aligned to an ACO solely on the basis of voluntary alignment, the benchmark will be derived from a blend of regional expenditures and the ACO's recent historical expenditures for beneficiaries aligned via voluntary alignment in prior Performance Years (as described below). CMS will continue to monitor this policy as additional data becomes available from early Performance Years, and may make modifications to improve this benchmarking approach for future Performance Years.

#### Incorporating the Experience of Voluntarily Aligned Beneficiaries into the Historical Baseline

CMS will incorporate the experience of voluntarily aligned beneficiaries into the historical baseline used to develop the Performance Year Benchmark for beneficiaries who are aligned to the ACO solely through voluntary alignment in PY2025-PY2026. Prior to PY2025, only the regional rates will be used to establish the historical baseline for these beneficiaries. As described in the above sections, regional expenditures will be determined through the use of the ACO REACH / KCC Rate Book. CMS will use the beneficiary's county of residence during the performance year for purposes of identifying the applicable regional expenditures. We will distinguish between Aged & Disabled beneficiaries and ESRD beneficiaries in determining the applicable regional expenditures and calculating the benchmark expenditures for voluntarily aligned beneficiaries.

For PY2025 and PY2026, the same benchmarking methodology as applies for the claims-based aligned beneficiaries will be followed, with one exception. Whereas for claims-based alignment, the baseline period is a fixed three-year window (CY2017–CY2019), the benchmarking methodology for these voluntarily aligned beneficiaries will use expenditures for more recent calendar years to calculate the historical experience. For PY2025, CMS will establish a historical baseline period which uses expenditure data for CY2021, CY2022, and CY2023. These base years will be weighted at 10%, 30%, and 60%, respectively (ACOs starting in PY2022 will not have 2021 experience, so the base years will be CY2022 and CY2023, with a one-third weighting for CY2022 and two-thirds weighting for CY2023; ACOs starting in PY2023 will only have 2023 experience, so will have only a single base year of CY2023). For PY2026, the baseline period will encompass CY2022, CY2023, & CY2024, which will be weighted at 10%, 30%, and 60%, respectively (ACOs starting in PY2023 will not have 2022 experience, so the base years will be CY2023 and CY2024, with a one-third weighting for CY2023 and two-thirds weighting for CY2024).

Incorporating the historical experience of voluntarily aligned beneficiaries will allow CMS to capture any differences in the characteristics (e.g., overall health status, expenditures) of beneficiaries that voluntarily align versus those that are aligned through the claims-based algorithm over the course of the model. In addition, using more recent calendar years as the baseline period for beneficiaries that are aligned to the ACO solely through voluntary alignment allows CMS to draw on historical experience from a period in which the ACO was more likely to have been engaged in the care of beneficiaries who were also aligned solely through voluntary alignment.

#### Risk Adjustment

Consistent with the methodology for beneficiaries aligned to a Standard ACO via claims-based alignment,

a risk score will be calculated using the prospective CMS HCC risk adjustment model for each beneficiary who is aligned to a Standard ACO via voluntary alignment. Additional information regarding the risk adjustment methodology is outlined below in the ‘Risk Adjustment in the ACO REACH Model’ section.

Discount, Quality Incentive, and HPP

Consistent with the methodology for beneficiaries aligned to a Standard ACO via claims-based alignment, CMS will apply a discount (Global only) and quality withhold to establish the Performance Year Benchmark for beneficiaries aligned to a Standard ACO via voluntary alignment. ACOs may earn back some or all of the quality withhold and, starting in PY2023, for ACOs that began participation in PY2021 or PY2022, or PY2024, for ACOs that begin participation in PY2023, may be eligible to receive a bonus from the HPP based on their quality performance.

## 2. New Entrant ACO

An objective of the ACO REACH Model is to incent organizations that have not traditionally provided services to a Medicare FFS population to join a risk-based total cost of care model for the Medicare FFS population. The opportunity for organizations to participate in the ACO REACH Model as New Entrant ACOs is designed to advance this objective. Beneficiary alignment to a New Entrant ACO will initially be driven primarily by voluntary alignment and, consequently, payments will be heavily based on regional expenditures and the ACO REACH / KCC Rate Book.

**Table 6.17. Alignment and Financial Benchmarking Methodology for the New Entrant ACOs**

	<b>Prospective Benchmarking Methodology for Voluntary alignment</b>	<b>Prospective Benchmarking Methodology for Claims-based alignment</b>
Historical Baseline	<ul style="list-style-type: none"> <li>Regional expenditures, measured via the ACO REACH / KCC Rate Book, for PY2021-PY2024</li> <li>Incorporates recent ACO claims expenditure experience beginning in PY2025</li> </ul>	<ul style="list-style-type: none"> <li>Regional expenditures, measured via the ACO REACH / KCC Rate Book, for PY2021-PY2024</li> <li>Incorporates recent ACO claims expenditure experience beginning in PY2025</li> </ul>
Regional Expenditure	<ul style="list-style-type: none"> <li>ACO REACH / KCC Rate Book</li> </ul>	<ul style="list-style-type: none"> <li>ACO REACH / KCC Rate Book</li> </ul>
Risk Adjustment	Yes	Yes
Discount (Global only) and Quality Withhold	Yes	Yes

Organizations that intend to participate in the ACO REACH Model as a New Entrant ACO must specify this selection as part of their application.

For each Applicant ACO that applies as a New Entrant ACO and is selected to participate in the Model, CMS will use a set of criteria to determine the ACO’s eligibility to participate as a New Entrant ACO after CMS finalizes the organization’s list of Participant Providers for PY2023. These criteria will include the following:

- New Entrant ACOs must identify any “legacy” TIN under which a Participant Provider billed prior to

affiliating with the ACO, commonly referred to as a “legacy TIN.” CMS will use this legacy TIN information to align beneficiaries to the ACO based on claims where such alignment does not interfere with the operation of other initiatives such as the Shared Savings Program. This approach is intended to help ensure that ACOs treated as new entrants should not more properly be treated as Standard ACOs based on the number of beneficiaries that can be aligned to an ACO based on claims.

- Not more than 50% of the Participant Providers in a New Entrant ACO may have prior experience in the 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. Organizations found ineligible to participate as New Entrant ACOs on the basis of this criterion will have the opportunity to participate as a Standard ACO, provided all other model requirements are met.
- New Entrant ACOs may not have more than 3,000 beneficiaries that are “alignable” through claims-based alignment in any of the base years (CY2017, CY2018, and CY2019), as this suggests that the organization has significant experience serving Medicare FFS beneficiaries. For purposes of this criterion, CMS will assess the volume of services historically provided by the applicant’s Participant Providers to Medicare FFS beneficiaries to determine the population of beneficiaries who would have been aligned to the applicant in each of the three base years on the basis of claims. Organizations found ineligible to participate as New Entrant ACOs on the basis of this criterion will have the opportunity to participate as a Standard ACO, provided all other model requirements are met.
- New Entrant ACOs must have the capability to assume risk for the total cost of care of an aligned Medicare FFS beneficiary population. For purposes of this assessment, CMS may solicit information from the ACO regarding the organization’s prior experience with risk-based or capitated arrangements, including but not limited to MA plans, PACE programs, and private health plans.

#### *Alignment Requirements*

In an effort to encourage organizations new to Medicare FFS to participate in the ACO REACH Model, CMS will provide an alignment “glide path” to allow these New Entrant ACOs an adequate time to grow their population of aligned beneficiaries. Voluntary alignment and claims-based alignment will serve as the sources of beneficiary alignment for these ACOs.

Organizations that fail to meet the applicable requirement regarding the minimum number of aligned beneficiaries prior to the start of each performance year will not be permitted to continue to participate in the ACO REACH Model. New Entrant ACOs will be required to increase the minimum number of aligned beneficiaries to 2,000, 3,000 and 5,000 prior to the start of PY2023, PY2024 and PY2025 respectively. They will further be required to attain a minimum of 5,000 aligned beneficiaries prior to the start of PY2026 as described in Table 6.18 below. Note that these minimum alignment requirements apply to all New Entrant ACOs, regardless of whether they begin participation in PY2021, PY2022, or PY2023. Further, by PY2025 and also for PY2026 the New Entrant ACO must have more than 3,000 beneficiaries aligned using claims-based alignment prior to the start of the relevant performance year. If this is not the case, the ACO will not be permitted to continue participating in the model.

**Table 6.18: Minimum Number of Aligned Beneficiaries for New Entrant ACOs**

Performance year	Minimum number of aligned beneficiaries at the start of the PY
PY2021 (April-December 2021)	1,000
PY2022 (CY2022)	1,000
PY2023 (CY2023)	2,000
PY2024 (CY2024)	3,000
PY2025 (CY2025)	5,000 (more than 3,000 aligned using claims-based alignment)
PY2026 (CY2026)	5,000 (more than 3,000 aligned using claims-based alignment)

*Benchmarking Methodology*

## Baseline Expenditures

As New Entrant ACOs will not have substantial Medicare FFS experience prior to starting participation in the ACO REACH Model, the Performance Year Benchmarks for these organizations will not reflect the historical spending experience of their aligned beneficiaries for the first four Performance Years of the model performance period. For PY2021-PY2024, CMS will use regional expenditures as the basis for determining the Performance Year Benchmark for all beneficiaries that are aligned to a New Entrant ACO regardless of how long the beneficiary has been aligned to the ACO or whether the beneficiary is aligned to the ACO on the basis of claims or voluntary alignment. As described in the above sections, regional expenditures will be determined through the use of the ACO REACH / KCC Rate Book. CMS will use the beneficiary’s county of residence during the performance year for purposes of identifying the applicable regional expenditures. We will distinguish between Aged & Disabled beneficiaries and ESRD beneficiaries in calculating the regional expenditures for aligned beneficiaries.

## Incorporating recent Claims Expenditure Experience into the Performance Year Benchmark Beginning in Performance Year 2025

Starting for PY2025, CMS will begin to incorporate aligned beneficiary experience from the recent years to develop a historical baseline for New Entrant ACOs. Specifically, CMS will develop a historical benchmark that incorporates the experience of beneficiaries aligned to the ACO in prior Performance Years. Beginning for PY2025, CMS will establish a historical baseline period which uses expenditure data for CY2021, CY2022, and CY2023. These base years will be weighted at 10%, 30%, and 60%, respectively (ACOs starting in PY2022 will not have 2021 experience, so the base years will be CY 2022 and CY 2023, with a one-third weighting for CY2022 and two-thirds weighting for CY2023; ACOs starting in PY2023 will only have 2023 experience, so will have only a single base year of CY2023). For PY2026, the baseline period will encompass CY2022, CY2023, & CY2024, which will be weighted at 10%, 30%, and 60%, respectively (ACOs starting in PY2023 will not have 2022 experience, so the base years will be CY2023 and CY2024, with a one-third weighting for CY2023 and two-thirds weighting for CY2024). In establishing the historical spending during this baseline period, CMS will incorporate expenditures for beneficiaries who were aligned to the ACO on the basis of claims in the baseline period, as well as for beneficiaries who aligned to the ACO via voluntarily alignment during those base years by designating a Participant Provider as their primary clinician. Further information on the historical baseline period for New Entrant ACOs will be included in the MPP Participation Agreement.

Using expenditure data from prior Performance Years allows CMS to establish a historical baseline for an organization that otherwise does not have substantial Medicare FFS experience. In addition, incorporating the historical experience of aligned beneficiaries will allow CMS to better reflect any differences in the characteristics (e.g., overall health status, expenditures) and total expenditures for beneficiaries that are aligned to the ACO, rather than using the regional average.

#### Risk Adjustment

A risk score will be calculated using the prospective CMS HCC risk adjustment model for each beneficiary who is aligned to the New Entrant ACO. Additional information regarding the risk adjustment methodology is outlined below in the ‘Risk Adjustment in the ACO REACH Model’ section.

#### Discount, Quality Incentive, and HPP

Consistent with the methodology for Standard ACOs, to establish the Performance Year Benchmark for New Entrant ACOs, CMS will apply a discount (Global only) and quality withhold. ACOs may earn back some or all of the quality withhold and, starting for PY2023, for ACOs that began participation in PY2021 or PY2022, or PY2024, for ACOs that begin participation in PY2023, may be eligible to receive a bonus from the HPP based on their quality performance.

### 3. High Needs Population ACO

An important goal of the ACO REACH Model is to enable organizations that focus on high needs populations to participate in the ACO REACH Model in order to test models of care tailored to these populations and to do so while allowing these beneficiaries to remain in Medicare FFS, if that is their preference. To support this goal, the ACO REACH Model will allow organizations focused on complex, high needs beneficiaries (who may also be dually eligible or at risk of becoming dually eligible)—referred to as High Needs Population ACOs—to participate in the ACO REACH Model in order to test whether provider-led entities can replicate the successful clinical approaches of PACE and similar models of care for a broader Medicare FFS population. These approaches generally aim to enable individuals to continue living in non-institutional, community settings as long as medically and socially feasible and rely on interdisciplinary teams that typically (1) emphasize preventative care, meet regularly to update the care plan in response to changes in beneficiaries’ functional and health status and provide regular clinical monitoring (which helps to reduce hospitalization due to ambulatory sensitive conditions); and (2) manage beneficiaries’ care across all settings, which helps to facilitate smooth transitions between settings and reduce re-hospitalizations.

High Needs Population ACOs may serve Medicare FFS beneficiaries that:

- Have one or more developmental or inherited conditions or congenital neurological anomalies that impair the Beneficiary’s mobility or the Beneficiary’s neurological condition. Such conditions or anomalies could include cerebral palsy, cystic fibrosis, muscular dystrophy, metabolic disorders, or any other condition as specified by CMS (see [the PY2022 Financial Operating Guide Overview](#) for an ICD-10 code list for PY2022; CMS will specify any changes to this list in advance of PY2023 and each subsequent performance year); **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 as determined by CMS based on criteria specified by CMS in advance of the relevant Performance Year; **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 (see [the PY2022 Financial Operating Guide Overview](#) for a list of codes for PY2022; CMS will specify any changes to this list in advance of PY2023 and each subsequent performance year).

Organizations interested in serving as High Needs Population ACOs must indicate their preferred ACO type in their responses to this RFA. CMS will select organizations to participate as High Needs Population ACOs that have experience serving high cost, high acuity individuals and, where applicable, in providing a range of Medicaid-covered services and demonstrate an ability to coordinate services across Medicare and Medicaid for dually eligible beneficiaries, and prevent unnecessary utilization of higher cost institutional care in Medicare and Medicaid. They must also demonstrate 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. On an optional basis, at states’ discretion, we will work with such applicants and state Medicaid agencies to explore potential Medicaid contracting strategies – and as applicable, necessary authorities – that could replicate and/or support High Needs Population ACO payment approaches in the Medicaid program. The goal would be to maximize provider accountability and flexibility to provide the full range of services necessary to promote community integration for dually eligible individuals. We believe that multiple existing Medicaid authorities could support the delivery and financing of Medicaid services furnished by Participant Providers and Preferred Providers to dually eligible individuals, but this will depend on how each state administers its Medicaid program.

In general, the New Entrant ACO parameters will apply to High Needs Population ACOs. In addition, a High Needs Population ACO can participate in the ACO REACH Model under either Professional or Global.

**Table 6.19 Alignment and Financial Benchmarking Methodology for High Needs Population ACOs**

	<b>Prospective Benchmarking Methodology for Voluntary alignment</b>	<b>Prospective Benchmarking Methodology for Claims-based alignment</b>
Historical Baseline	<ul style="list-style-type: none"> <li>• Regional expenditures, measured via the ACO REACH / KCC Rate Book, for PY2021-PY2024</li> <li>• Incorporates recent ACO historical expenditures beginning in PY2025</li> </ul>	<ul style="list-style-type: none"> <li>• Regional expenditures, measured via ACO REACH / KCC Rate Book, for PY2021-PY2024</li> <li>• Incorporates recent ACO historical expenditures beginning in PY2025</li> </ul>
Regional Expenditure	<ul style="list-style-type: none"> <li>• ACO REACH / KCC Rate Book</li> </ul>	<ul style="list-style-type: none"> <li>• ACO REACH / KCC Rate Book</li> </ul>
Risk Adjustment	Yes	Yes



	<b>Prospective Benchmarking Methodology for Voluntary alignment</b>	<b>Prospective Benchmarking Methodology for Claims-based alignment</b>
Discount (Global option only) and Quality Withhold	Yes	Yes

*Alignment Requirements*

CMS will align individuals to a High Needs Population ACO if they meet the above high needs criteria prior to initial alignment and are otherwise eligible for voluntary or claims-based alignment to an ACO. Additionally, unlike PACE, the population being served by this High Needs Population ACO will not be limited to individuals who are 55 years of age or older. In recognition that the health of High Needs beneficiaries can deteriorate quickly and eligibility determinations must be made in a timely manner in order to provide the necessary support to at-risk beneficiaries when they need it most, we will check High Needs eligibility quarterly. CMS will determine whether beneficiaries who would otherwise be aligned to a High Needs Population ACO either through claims or voluntary alignment satisfy the high-needs eligibility criteria four times each performance year. Once a beneficiary is determined to be High Needs-eligible, they will be aligned starting in the next quarter, e.g., January 1, April 1, July 1, or October 1 as applicable (unless the beneficiary ceases to meet general eligibility requirements, dies, or is otherwise retrospectively removed from alignment). Please refer to Appendix B of the Financial Operation Guide Overview paper for more details: (<https://innovation.cms.gov/media/document/dc-financial-op-guide-overview>).

ACOs focused on serving complex, high-risk individuals may be unable to achieve the required minimum of 5,000 aligned Medicare FFS beneficiaries applicable to Standard ACOs, because high needs individuals do not exist in most health care markets in sufficient concentration to meet this threshold. Rather than excluding such organizations from participation in the ACO REACH Model, CMS will establish an alignment “glide path” for High Needs Population ACOs. Specifically, CMS will align Medicare FFS beneficiaries to these High Needs Population ACOs based on voluntary and claims-based alignment. These High Needs Population ACOs will be required to meet an increasing minimum number of aligned beneficiaries, with a minimum of at least 250 beneficiaries prior to the start of PY2021 and PY2022, 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. Note that these minimum alignment requirements apply to all High Needs Population ACOs, regardless of whether they begin participation in PY2021, PY2022, or PY2023. No beneficiary will be aligned to a High Needs Population ACO prior to meeting the High Needs eligibility criteria. However, once a beneficiary has been confirmed to meet the High Needs eligibility criteria and is aligned to a High Needs Population ACO, that beneficiary will be considered High Needs-eligible for the remaining duration of the model performance period (i.e., all subsequent performance years) and will remain eligible for alignment to the same High Needs Population ACO even if he or she ceases to meet High Needs eligibility requirements (as long as he or she continues to meet the model’s general alignment eligibility requirements). This will ensure that High Needs Population ACOs do not lose aligned beneficiaries as a result of providing high quality care.

*Benchmarking Methodology*

## Baseline Expenditures

For the initial performance years, due to the low volume of aligned beneficiaries that we generally expect for High Needs Population ACOs, it will not be possible to construct a credible benchmark on the basis of the historical expenditures of aligned beneficiaries. For PY2021 – PY2024, CMS will use regional expenditures as the basis for determining the Performance Year Benchmark for all beneficiaries that are aligned to a High Needs Population ACO regardless of how long the beneficiary has been aligned to the ACO or whether the beneficiary is aligned to the ACO on the basis of claims or voluntary alignment. As described in the above sections, regional expenditures will be determined through the use of the ACO REACH / KCC Rate Book. CMS will use the beneficiary's county of residence during the performance year for purposes of identifying the applicable regional expenditures. We will distinguish between Aged & Disabled beneficiaries and ESRD beneficiaries in calculating the regional expenditures for aligned beneficiaries.

If, however, a High Needs Population ACO exceeds 3,000 beneficiaries aligned through claims prior to the start of PY2021-PY2024 or for any of the three base years (CY2017-CY2019), its benchmarking methodology will follow the approach for beneficiaries aligned to a Standard ACO via claims. Once a High Needs Population ACO reaches this threshold number of beneficiaries aligned via claims, a baseline approach can reliably be used to set its benchmark without needing to rely entirely on average regional expenditures. A High Needs Population ACO that exceeds 3,000 claims-aligned beneficiaries would not be subject to any other changes to the benchmarking methodology and it would be allowed to continue its focus on high needs beneficiaries.

### Incorporating Recent Claims Expenditure Experience into the Performance Year Benchmark Beginning in Performance Year 5 (2025)

Starting for PY2025, CMS will begin to incorporate aligned beneficiary experience from the recent years to develop a historical baseline for High Needs Population ACOs. Specifically, CMS will develop a historical benchmark that incorporates the experience of beneficiaries aligned to the ACO in prior Performance Years. Beginning for PY2025, CMS will establish a historical baseline period which uses expenditure data for CY2021, CY2022, and CY2023. These base years will be weighted at 10%, 30%, and 60%, respectively (ACOs starting in PY2022 will not have 2021 experience, so the base years will be CY2022 and CY2023, with a one-third weighting for CY2022 and two-thirds weighting for CY2023; ACOs starting in PY2023 will only have 2023 experience, so will have only a single base year of CY2023). For PY2026, the baseline period will encompass CY2022, CY2023, & CY2024, which will be weighted at 10%, 30%, and 60%, respectively (ACOs starting in PY2023 will not have 2022 experience, so the base years will be CY2023 and CY2024, with a one-third weighting for CY2023 and two-thirds weighting for CY2024). In establishing the historical spending during this baseline period, CMS will incorporate beneficiaries who were aligned to the ACO on the basis of claims in the baseline period, as well as beneficiaries who aligned to the ACO via voluntary alignment during those base years by designating a Participant Provider as their primary clinician. Further information on the historical baseline period for High Needs Population ACOs will be included in the MPP Participation Agreement.

Incorporating the historical experience of aligned beneficiaries will allow CMS to better reflect any differences in the characteristics (e.g., overall health status, expenditures) and total expenditures for beneficiaries that are aligned to the ACO, rather than using the regional average.

## Risk Adjustment

A risk score will be calculated using the CMMI HCC concurrent risk-adjustment model for each beneficiary who is aligned to the High Needs Population ACO. Additional information regarding the risk adjustment methodology is outlined below in the 'Risk Adjustment in the ACO REACH Model' section.

## Discount, Quality Incentive, and HPP

Consistent with the methodology for Standard ACOs, as described above, to establish the Performance Year Benchmark for High Needs Population ACOs, CMS will apply a discount (Global only) and quality withhold. ACOs may earn back some or all of the quality withhold and, starting for PY2023, for ACOs that began participation in PY2021 or PY2022, or PY2024, for ACOs that begin participation in PY2023, may be eligible to receive a bonus from the HPP based on their quality performance.

## Health Equity Benchmark Adjustment

Starting for PY2023, CMS will apply an adjustment to increase the benchmark for ACOs serving higher proportions of underserved beneficiaries. CMS will identify underserved beneficiaries using a composite measure that incorporates a combination of Area Deprivation Index<sup>18</sup> (percentile score from 1-100) and Dual Medicaid Status (Medicare only vs. Full or Partial Dual Eligibility). The area-level measure (Area Deprivation Index) captures local socioeconomic factors correlated with medical disparities and underservice<sup>19</sup>, while the beneficiary level measure (Dual Medicaid Status) captures economic challenges directly affecting individual beneficiaries' ability to access high-quality care<sup>20</sup>. CMS may explore other variables to include in this assessment and will notify applicants prior to the start of PY2023 if any other variables are included. Because Area Deprivation Index is measured as a percentile (continuous variable), while Medicaid Status is a binary metric, a simple blending of the variables would underweight the Area Deprivation Index. Therefore, CMS will calculate the measure by starting with the Area Deprivation Index for a given beneficiary's census block group of residence (scored from 0-99 based on percentile relative to the nation), and applying a 25-point increase to the score for dually eligible beneficiaries. For example, a dually eligible beneficiary residing in a census block group with an Area Deprivation Index in the 75<sup>th</sup> percentile would receive a score of 75 + 25, for a total of 100.

CMS will then stratify all aligned beneficiaries based on this composite measure, and identify the top decile for an upward adjustment (\$30 per beneficiary per month (PBPM)) and the bottom five deciles for a smaller downward adjustment (\$6 PBPM). Each ACO will then receive a net benchmark adjustment based on the number of its aligned beneficiaries in each category. For example, an ACO with 100

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<sup>18</sup> 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.

<sup>19</sup> Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Office of the Assistant Secretary for Planning and Evaluation (ASPE).

[https://aspe.hhs.gov/sites/default/files/migrated\\_legacy\\_files//171041/ASPESESRTCfull.pdf](https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//171041/ASPESESRTCfull.pdf)

<sup>20</sup> Segal, Misha; Rollins, Eric; Hodges, Kevin; Roozeboom, Michelle. Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations. Medicare & Medicaid Research Review.

[https://www.cms.gov/mmrr/downloads/mmrr2014\\_004\\_01\\_b01.pdf](https://www.cms.gov/mmrr/downloads/mmrr2014_004_01_b01.pdf)

beneficiaries scoring in the top decile and 500 beneficiaries in the bottom five deciles in a given month would receive a net neutral benchmark impact for that month  $[(\$30\text{PBPM} \times 100) - (\$6 \text{ PBPM} \times 500) = 0]$ . Simulations of this policy suggest that most ACOs will be impacted marginally by this adjustment (within +/- 0.2% impact on the Performance Year Benchmark), with maximum effects on the Performance Year Benchmark of approximately +1% for the handful of ACOs with the highest proportion of underserved beneficiaries and approximately -0.5% for the handful of ACOs with the lowest proportion of underserved beneficiaries. This benchmark adjustment will be finalized after the performance year ends, when final alignment data is available, and will be applied at Final Financial Settlement.

### **Risk Adjustment in the ACO REACH Model**

#### *CMS HCC Prospective Risk Adjustment Model*

CMS will use the CMS-HCC prospective risk adjustment model for Standard ACOs and New Entrant ACOs. For PY2023, CMS expects to continue applying the same version of the CMS-HCC prospective risk adjustment model (i.e., the 2020 CMS-HCC risk adjustment model or Version 24 (v24)) that is being applied in the ACO REACH Model for PY2021 and PY2022, and also in the MA program in 2021<sup>21</sup>; however, the applicable risk adjustment model for PY2023 and subsequent performance years will be outlined in the MPP Participation Agreement. The CMS-HCC prospective risk adjustment model has the benefit of being well tested and understood with regard to predictive payment accuracy, in addition to being accepted by stakeholders. Consistent with the experience in MA, it is expected that the CMS-HCC prospective risk adjustment model will have predictable impacts for the larger populations aligned to Standard and New Entrant ACOs.

#### *CMMI HCC Concurrent Risk Adjustment Model*

CMS will use the CMMI-HCC concurrent risk adjustment model for the comparatively smaller populations aligned to the individual High Needs Population ACOs. In general, the CMMI-HCC concurrent risk adjustment model closely imitates the CMS-HCC prospective risk adjustment model; however, a key difference between the two models is that the CMS-HCC prospective model risk scores are based on beneficiary diagnoses collected in the year prior to the performance year, while the concurrent model's risk scores are based on beneficiary diagnoses collected in the performance year. As with the CMS-HCC prospective risk adjustment model, for the CMMI-HCC concurrent risk adjustment model ICD-CM-10 diagnosis codes are classified into diagnosis groups, which represent well-specified medical conditions. The diagnosis groups are aggregated into condition categories, which are related both clinically and with respect to cost. Hierarchies are imposed among related condition categories, so that an individual is coded for only the most severe manifestation among related diseases. In comparison to the CMS-HCC prospective risk adjustment model, however, under the CMMI-HCC concurrent risk adjustment model health status conditions contribute more to risk scores than demographic factors, and within health status conditions, acute conditions contribute more to risk scores than chronic conditions. The key benefit of the CMMI-HCC concurrent risk adjustment model is that it generates risk scores that more accurately reflect high costs incurred during the performance year, for example, those costs associated with rapidly deteriorating health. In CMMI simulations, this concurrent model outperforms the prospective model for

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<sup>21</sup> Information on the 2020 CMS-HCC risk adjustment model or V24 can be found in the MA 2020 and 2021 Advance Notices and Rate Announcements.

the High Needs population, which is why it will be used for High Needs Population ACOs. In subsequent performance years, CMS will continue to test if this concurrent model better addresses the payment risk experienced by organizations providing services to a smaller high needs population that tends to be more expensive and subject to broader swings in health care cost variation over time.

#### *Coding Intensity Mitigation Strategy*

There are multiple approaches at the Model, ACO, and/or beneficiary level that could be applied to control potential increases in coding intensity and risk score growth for both the CMS-HCC prospective risk adjustment model and the CMMI-HCC concurrent risk adjustment model. A single solution is unlikely to solve for all increases in coding intensity simultaneously, and so a multi-pronged approach is preferable. For PY2023, CMS will continue to use a normalization factor (estimated prospectively, adjusted retrospectively) and a model level coding intensity adjuster, the Coding Intensity Factor (CIF), that is designed to preserve a budget neutral application of both risk adjustment models. Under certain circumstances, CMS will also be applying an ACO-specific symmetric 3% risk score cap to the ACO's average risk score. ACO-specific risk scores for the performance year will be compared to the average risk score from the population of beneficiaries that would have been aligned to the ACO during a reference year. The purpose of this ACO-specific symmetric 3% risk score cap is to further constrain risk score growth for those specific ACOs exhibiting comparatively higher levels of growth.

Starting for PY2024, the application of the symmetric 3% risk score cap will be modified to: 1) adopt a static reference year population for the remainder of the model performance period (as a substitute for the rolling reference year population), and 2) cap the ACO's CMS-HCC prospective risk adjustment model or the CMMI-HCC concurrent risk adjustment model risk score *growth relative to demographic risk score growth* in determining the ACO-specific symmetric 3% risk score cap thresholds (e.g., if an ACO's demographic risk score growth from the reference year to the performance year is +1%, then the symmetric 3% risk score cap for the ACO's average CMS-HCC prospective risk adjustment model or the CMMI-HCC concurrent risk adjustment model risk score growth will constrain growth between -2% to +4%). By adopting a static reference year population, risk score growth for those ACOs exhibiting progressively higher levels of risk score growth over time will be further constrained across performance years by limiting risk score growth in the reference population. By directly linking the independently calculated ACO-specific demographic risk score growth to the application of the symmetric 3% risk score cap, the constraint on risk score growth will be directly connected to positive or negative changes in ACO-specific demographic information, which does not include diagnoses and thus is not subject to inflated reporting of diagnosis information. As a result, beginning in PY2024, the implementation of the symmetric 3% risk score cap is expected to more appropriately constrain risk score growth based on the true health status of the aligned beneficiaries as measured by their demographic risk score. Additional information on the technical application of the 3% symmetric cap will be provided in the annual ACO REACH/KCC Risk Adjustment methodology overview paper.

Additionally, CMS will evaluate and monitor risk scores over the course of the entire model performance period. Evaluation and monitoring could include comparing risk scores for beneficiaries aligned to the Standard, New Entrant, and High Needs Population ACOs with other beneficiaries in the FFS program and will be conducted for each performance year. Likewise, it could be important to conduct trend analyses in risk score increases from year to year throughout the model performance period, but also with regard to the period prior to the start of the model performance period.

CMS may implement additional coding intensity measures if an unacceptable level of coding intensity is identified during the evaluation and monitoring process. CMS recognizes that different results may materialize from the CMS-HCC prospective model versus the CMMI-HCC concurrent model. In general, however, CMS believes that over the course of the model performance period, the coding intensity patterns and the response to the unique coding intensity guardrails put into place will provide a wealth of new risk adjustment information for the agency to consider.

Additional information regarding the ACO REACH Model’s risk adjustment methodology is provided in the ACO REACH Risk Adjustment paper.

### G. Medicare Part D

CMS is interested in exploring ways in which ACOs can support beneficiaries in their management of and adherence to prescription drugs. Part D prescription drug spending is not included in the ACO REACH Model benchmarks. ACOs are only accountable for total Parts A and B expenditures for aligned beneficiaries. CMS will continue to look at options for Part D integration for future performance years of the ACO REACH Model.

### H. Benefit Enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS has designed policies using the authority under Section 1115A(d)(1) of the Act to conditionally waive certain Medicare payment requirements as necessary solely for purposes of testing the ACO REACH Model. An ACO may choose not to implement all or any of these Benefit Enhancements. Applicants will be asked to provide information regarding their proposed implementation of these Benefit Enhancements, but acceptance into the ACO REACH Model is not contingent upon an ACO agreeing to implement any particular Benefit Enhancement.

The table below includes Benefit Enhancements available for PY2021 and PY2022, and newly available for PY2023. We may consider additional Benefit Enhancements for future years beyond PY2023.

**Table 6.20: Benefit Enhancements**

Benefit Enhancements Available for PY2021 & PY2022	New Benefit Enhancement for PY2023
<ul style="list-style-type: none"> <li>• 3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement</li> <li>• Telehealth Benefit Enhancement</li> <li>• Post-Discharge Home Visits Benefit Enhancement</li> <li>• Care Management Home Visits Benefit Enhancement</li> <li>• Home Health Homebound Waiver Benefit Enhancement</li> <li>• Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse Practitioner Services Benefit Enhancement</li> </ul>

Following acceptance into the ACO REACH Model, each ACO will be required to provide additional information to CMS, to enable the ACO’s use of the optional Benefit Enhancements that it has elected to implement. The ACO will be required to submit a separate implementation plan for each optional Benefit Enhancement it wishes to offer. This implementation plan will be required to include, for example: (1) descriptions of the ACO’s planned strategic use of the Benefit Enhancement; and (2) self-monitoring plans

reflecting meaningful safeguards to prevent unintended consequences.

As part of the ACO REACH Model monitoring and oversight strategy, CMS will incorporate a variety of program integrity safeguards (described in Section VIII) to ensure that these Benefit Enhancements do not result in program or patient abuse.

### **Benefit Enhancements Available for PY2021 and PY2022**

Beginning in PY2021, the ACO REACH Model offers Benefit Enhancements, or conditional waivers of certain Medicare payment rules, to test whether additional flexibilities will achieve lower costs and improved patient outcomes and care coordination. Two of these Benefit Enhancements have not previously been included in an Innovation Center model, including: Home Health Homebound Waiver Benefit Enhancement and Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement. Benefit Enhancements will be available under both the Professional and Global risk sharing options, with the exception of the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement which is limited to Global ACOs only due to their election of 100% risk sharing and option for Total Care Capitation Payment. CMS believes the added financial risk will encourage Global ACOs to use this Benefit Enhancement prudently, considering their financial responsibility, while maximizing beneficiary care.

#### *3-Day Skilled Nursing Facility (SNF) Rule Waiver Benefit Enhancement*

CMS will make available to ACOs a conditional waiver of the three-day inpatient stay requirement prior to admission to a skilled nursing facility (SNF) or an acute-care hospital or CAH with swing-bed approval (swing-bed hospital) for SNF services. This Benefit Enhancement will allow eligible Beneficiaries to receive Medicare-covered SNF services from qualified SNFs or swing-bed hospitals that are Participant Providers or Preferred Providers either directly or with an inpatient stay of fewer than three days.

A REACH Beneficiary will be eligible to receive covered SNF services under the terms of this Benefit Enhancement if (1) the beneficiary does not reside in a SNF or long-term care setting at the time of the admission to the SNF or swing-bed hospital; and (2) the beneficiary meets all other CMS criteria for coverage of SNF services, including that the beneficiary must:

- Be medically stable;
- Have confirmed diagnoses (e.g., does not have conditions that require further testing for proper diagnosis);
- Not require inpatient hospital evaluation or treatment; and
- Have an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

ACOs will identify the SNFs and swing-bed hospitals with which they will offer this Benefit Enhancement. These SNFs and swing-bed hospitals may be either Participant Providers or Preferred Providers. Through the application and implementation plan, ACOs may be asked to describe how the identified Participant Providers and Preferred Providers have the appropriate staff capacity and necessary infrastructure to carry out proposed care coordination activities. In addition to the information the ACO includes in its implementation plan, a SNF must have an overall rating of three or more stars under the CMS 5-Star

Quality Rating System in at least seven of the previous twelve months, as reported on the Nursing Home Compare website.

#### *Telehealth Benefit Enhancement*

CMS will make available to ACOs a conditional waiver of the interactive telecommunications system requirement under section 1834(m)(1) of the Act and 42 C.F.R. § 410.78(b) with respect to otherwise covered dermatology and ophthalmology services furnished using asynchronous store and forward technologies. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient's condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for dermatology and ophthalmology services furnished to eligible beneficiaries using asynchronous telehealth in single or multimedia formats that is used as a substitute for an interactive telecommunications system. Distant site practitioners will bill for these services using Innovation Center specific asynchronous telehealth codes (G9868 – G9870). The distant site practitioner must be a Participant Provider or Preferred Provider who has elected to participate in this Benefit Enhancement.

CMS will also waive the rural geographic component of originating site requirements, allow the originating site to include a beneficiary's home, and waive the originating site fee requirement when the beneficiary's home serves as the originating site for telehealth services furnished to a REACH Beneficiary by a Preferred Provider approved to participate in the Benefit Enhancement. Please note, the Bipartisan Budget Act of 2018 added section 1899(l) to the Act, which affords Participant Providers the same flexibilities without the need for CMS to issue a waiver of applicable Medicare requirements for purposes of testing the ACO REACH Model. Participant Providers may receive payment for telehealth services furnished to REACH Beneficiaries pursuant to Section 1899(l) of the Act, which provides an exception to the originating site requirements in section 1834(m)(4)(C)(i) and (ii) of the Act to allow for Medicare payment for otherwise covered telehealth services furnished to aligned beneficiaries by physicians or other practitioners who are Participant Providers.

#### *Post-Discharge Home Visits Benefit Enhancement*

CMS will make available to ACOs a conditional waiver of the requirement for direct supervision to allow payment for certain home visits furnished to eligible, non-homebound beneficiaries by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a)(1)) under general supervision, rather than direct supervision, incident to the professional services of physicians or other practitioners that are Participant Providers or Preferred Providers.

Payment will be made for these home visits only when they are furnished following the beneficiary's discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility. Further, the beneficiary must not qualify for Medicare coverage of home health services (or qualifies for Medicare coverage of home health services on the sole



basis of living in a medically underserved area). Lastly, a beneficiary would not be eligible to receive covered home visits under this Benefit Enhancement if they are receiving services under the Care Management Home Visits Benefit Enhancement or the Home Health Homebound Waiver Benefit Enhancement.

Specifically, under this Benefit Enhancement, a beneficiary is eligible to receive up to nine post-discharge home visits within 90 days following discharge. The nine home visit services do not accumulate across multiple discharges; if the beneficiary is readmitted within 90 days of the initial discharge and before receiving nine home visits, the beneficiary may receive only nine home visits in connection with the subsequent discharge.

#### *Care Management Home Visits Benefit Enhancement*

CMS will make available to ACOs a conditional waiver of the requirement for direct supervision to allow for payment for certain home visits that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization. The items and services provided as part of these home visits are those that would be covered under Medicare Part B as “incident to” the services of a physician or other practitioner, and would be furnished by auxiliary personnel (as defined in 42 C.F.R. § 410.26(a) (1)) under general supervision, rather than direct supervision. These care management home visits are intended to supplement, rather than substitute for, visits to a primary care practitioner in a traditional routine outpatient health care setting. As such, these home visits are not intended to be performed on an ongoing basis, nor to serve as a substitute for the Medicare home health benefit or as the primary mechanism to meet beneficiaries’ care needs.

An eligible beneficiary is permitted to receive up to 20 care management home visits within a calendar year. Further, Participant Providers and Preferred Providers who have elected to participate in this Benefit Enhancement will be able to receive payment for services furnished to eligible beneficiaries under the following circumstances:

- The beneficiary is determined to be at risk of hospitalization;
- The beneficiary does not qualify for Medicare coverage of home health services (unless the sole basis for qualification is living in a medically underserved area);
- The beneficiary is not currently utilizing the Post-Discharge Home Visits Benefit Enhancement or the Home Health Homebound Waiver Benefit Enhancement; and
- The services are furnished in the beneficiary’s home by auxiliary personnel under the general supervision of a Participant Provider or Preferred Provider who is a physician or other practitioner after a Participant Provider or Preferred Provider has initiated a care management plan that includes such services.

#### *Home Health Homebound Waiver Benefit Enhancement*

Currently, to receive Medicare reimbursement for home health care services, a Medicare beneficiary must be homebound as required by §1814(a)(2)(C) and §1835(a)(2)(a). CMS guidance (Medicare Benefit Policy Manual, Chapter 7, Section 30.1.1) states that:

- 1) The beneficiary either (a) must need the assistance of a supportive device, special transportation,

or another individual to leave their residence OR (b) have a condition that makes leaving his or her home medically contraindicated; and

2) There must be a normal inability to leave the home AND leaving home must require a considerable and taxing effort.

The current homebound requirement focuses on a beneficiary's functional limitations rather than the underlying health condition or comorbidities often present in this population. Unless homebound status is certified, skilled nursing care services in the home are not reimbursable by Medicare for a beneficiary residing in their home.

This Benefit Enhancement targets those beneficiaries with multiple chronic conditions who are at risk of an unplanned inpatient admission using different criteria than in Medicare law today. Specifically, to qualify for home health services under this waiver, beneficiaries must (1) otherwise qualify for home health services under 42 C.F.R. § 409.42 except that the beneficiary is not required to be confined to the home; (2) meet the eligibility criteria as defined by CMS of at least two chronic conditions<sup>22</sup>; **and** have one of the three following indicators: inpatient service utilization, frailty, and/or social isolation. CMS will provide the ACO with a template form for purposes of documenting these criteria ("Home Health Homebound Waiver Form"). The ACO shall ensure that a completed and certified "Home Health Homebound Waiver Form" is maintained in the beneficiary's medical records.

A beneficiary would not be eligible to receive covered home health services under this Benefit Enhancement if they are receiving services under the Post-Discharge Home Visits Benefit Enhancement or the Care Management Home Visits Benefit Enhancement. ACOs participating in this Benefit Enhancement will identify home health providers that are Participant Providers or Preferred Providers who would offer these services to eligible beneficiaries. Participant Providers and Preferred Providers will use the criteria described above, as well as their own clinical judgement to determine if a beneficiary is eligible and would benefit from receiving home health services under the Benefit Enhancement. All other requirements regarding Medicare coverage and payment for home health services would continue to apply. The services would be furnished in the beneficiary's home or place of residence during the certified episode of care period.

#### *Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit Enhancement*

This Benefit Enhancement eliminates the requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care (sometimes referred to as "conventional care") as a condition of electing the hospice benefit. Currently, under Section 1812(d)(2)(A) of the Act and its implementing regulations, "*if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to [Medicare] payment made under this title with respect to— (i) hospice care provided by another hospice program ....(ii) services furnished during this period that are determined to be (I) related to the treatment of the individual's*

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<sup>22</sup> To determine if a beneficiary has a chronic condition, the healthcare provider should consider whether the beneficiary is diagnosed with a condition that requires ongoing assessment and treatment that is documented in the beneficiary's plan of care. The Center for Medicare and Medicaid Services' list of chronic conditions provides examples of eligible clinical conditions here: [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC\\_Main](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main).

*condition with respect to which a diagnosis of terminal illness has been made or (II) equivalent to (or duplicative of) hospice care.”* Under the ACO REACH Model CMS allows ACOs that select to offer the Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit Enhancement to provide care to beneficiaries that have waived their rights to Medicare payment of services related to the treatment of their terminal condition as a result of electing hospice care. This Benefit Enhancement is currently limited to ACOs participating in the Global risk sharing option. All expenditures incurred by Medicare on behalf of such beneficiaries, whether for hospice or non-hospice services, would be included as part of total cost of care of the ACO for the relevant performance year.

Similar to the approach used for the 3-Day SNF Rule Waiver Benefit Enhancement, ACOs must identify the hospices that will offer this Benefit Enhancement. Likewise, ACOs must identify non-hospice providers and suppliers to participate under this Benefit Enhancement. These hospices and non-hospice providers and suppliers must be either Participant Providers or Preferred Providers. CMS will ask ACOs to include the following information in their implementation plans for this Benefit Enhancement: (1) a description of how the identified Participant Providers and Preferred Providers will have the appropriate staff capacity and necessary infrastructure to carry out proposed care coordination activities; (2) an explanation of how the ACO will ensure, working with participating hospices and non-hospice providers and suppliers, that an appropriate plan of care will be developed for all beneficiaries receiving concurrent care and that these beneficiaries will be fully informed of what care or services would be included in their care plan, what would not, what clinician or organization would be providing which services, how care coordination would be achieved, and whether there are any limitations, including any services that will be provided for transitional purposes only; and (3) an explanation of how the ACO will ensure that the beneficiary or, as applicable, his or her representative is fully aware of the care plan and informed of the beneficiary’s right to revoke the hospice election at any time consistent with current law.

Medicare will retain its existing claims-based edits to prevent non-hospice claims from processing while a beneficiary is under hospice election, except with respect to services furnished by those hospice and non-hospice providers and suppliers identified by the ACO as participating in this Benefit Enhancement. Medicare FFS claims submitted by these organizations will be paid by Medicare if they are otherwise appropriate for payment absent the restrictions on paying claims for a beneficiary that has elected hospice.

### **New Benefit Enhancement for PY2023**

In addition to the Benefit Enhancements detailed above, CMS plans to offer a new Benefit Enhancement for PY2023: The Nurse Practitioner Services Benefit Enhancement. This Benefit Enhancement was developed based on feedback from current model participants and stakeholders and experience from other Innovation Center models.

#### *Nurse Practitioner (NP) Services Benefit Enhancement*

Beginning in PY2023 the ACO REACH Model plans to make available a new set of Benefit Enhancements to model participants – the Nurse Practitioner (NP) Services Benefit Enhancement. This Benefit Enhancement would allow ACOs to increase flexibility in care delivery, improving care coordination for their aligned beneficiary populations.

The NP Services Benefit Enhancement seeks to limit Medicare expenditures by providing a streamlined

approach for certifying and ordering care, avoiding duplicative work. This Benefit Enhancement would capitalize on established relationships between a beneficiary and a NP to reduce impediments to better coordinate care for beneficiaries and bridge potential gaps in coverage to provide more equitable access to health care. Eligible NPs must serve as either Participant Providers or Preferred Providers. Building upon NP authorization of Home Health, as authorized by section 3708 of the CARES Act, this Benefit Enhancement would allow ACOs to extend flexibilities under which NPs could undertake the following activities to the extent permitted under applicable state law:

- ▶ **NP Hospice Care Certification** – Under existing Medicare law at section 1814(a)(7)(A)(i)(I) of the Act, only a treating physician may certify a beneficiary’s need for hospice care. We believe that waiving this requirement to allow NPs to provide the initial certification that a patient is terminally ill and in need of hospice care is necessary to test the ACO REACH Model. This flexibility is expected to provide a REACH beneficiary a more seamless transition to hospice care, reducing complexity in accessing hospice care and delays in placement and improving the quality of care for beneficiaries for whom such treatment is appropriate.
- ▶ **NP Certification of Need for Diabetic Shoes** – Under existing Medicare law at section 1861(s)(12)(A), only a treating physician who is managing a beneficiary’s diabetic condition may document and certify a beneficiary’s need for diabetic shoes. Under the applicable local coverage determination, CMS permits Nurse Practitioners practicing “incident to” the physician supervising the beneficiary’s diabetic condition to certify the need for diabetic shoes. We believe that waiving this requirement to allow NPs to document and certify a beneficiary’s need for diabetic shoes, regardless of whether such certification is incident to the care of a supervising physician, is necessary to test the ACO REACH Model. This would allow NPs treating REACH Beneficiaries with diabetes to document and certify the need for therapeutic shoes, which is expected to reduce delays in patients accessing this benefit and avoid the costs of an additional clinician visit. We do not intend to waive any requirements at section 1861(s)(12)(B) and (C), including that a podiatrist or other qualified individual prescribe the particular type of shoes and fit and furnish the shoes.
- ▶ **NP Certification of Cardiac Rehabilitation Care Plan of Cardiac Rehabilitation** – Under existing Medicare law at section 1861(eee)(2)(C), only a treating physician may establish, review, and sign a written care plan for a beneficiary’s cardiac rehabilitation. We believe that waiving this requirement to allow NPs to establish, review, and sign a written care plan for a REACH Beneficiary’s cardiac rehabilitation is necessary to test the ACO REACH Model. Such a flexibility is expected to increase an NP’s involvement in a REACH Beneficiary’s heart treatment, improving quality by easily connecting REACH Beneficiaries to these critical treatments when medically necessary and appropriate, and reducing cost by decreasing the number of clinician visits that a REACH Beneficiary would need to obtain these services.
- ▶ **NP Certification of Plan of Care for Home Infusion Therapy** – Under existing Medicare law at section 1861(iii)(1)(A), NPs may be “applicable providers” for the purpose of providing care related to home infusion therapy, permitting NPs to be the attending care provider for a patient receiving home infusion therapy. However, section 1861(iii)(1)(B) and 42 CFR 414.1515(b) require a physician exclusively to establish and periodically review a plan prescribing the type, amount, and duration of infusion therapy services to be furnished to a beneficiary. In addition, 42 CFR 414.1515(c) requires that an ordering physician sign and date a home infusion therapy plan. We believe that it is

necessary for testing the ACO REACH Model to waive these requirements to allow an NP to establish, review, sign, and date a REACH Beneficiary's home infusion therapy plan of care prescribing the type, amount, and duration of infusion therapy services to be furnished to a REACH Beneficiary. This Benefit Enhancement is expected to promote a REACH Beneficiary's quality of care by increasing his or her access to home infusion care, and by positioning an NP who treats the REACH Beneficiary to determine the best treatment plan for that beneficiary. In addition, this flexibility could drive down cost to the Medicare program by reducing the number of office visits a REACH Beneficiary would require.

- ▶ **NP Referrals for Medical Nutrition Therapy** – Under existing Medicare law at section 1861(vv)(1) and the regulations at 42 CFR 410.132(a), referrals for medical nutrition therapy may only be made by a physician. We believe that it is necessary to waive these requirements for the purpose of testing the ACO REACH Model to allow NPs to make such referrals. This Benefit Enhancement would allow NPs treating REACH Beneficiaries with diabetes or renal disease to refer such beneficiaries to dietitians or nutrition professionals for medical nutrition therapy. Medical nutrition therapy has been shown to be an effective and affordable way to achieve better care for patients and lower costs for health systems.<sup>23</sup>

#### I. Health Equity Plan

As outlined in the Paving the Way to Health Equity 2015-2021 Report, CMS has piloted agency-wide initiatives such as the CMS Disparities Impact Statement, Medicare Social Determinants of Health (SDOH) data collection, the Mapping Medicare Disparities Tool, and the CMS Health Equity Awards to promote health equity.<sup>24</sup> The CMS Disparities Impact Statement is a tool created by the CMS Office of Minority Health (OMH) and can be retrieved [here](#).

Starting in PY2023, the Innovation Center is requiring all ACOs participating in the ACO REACH Model to develop and implement a Health Equity Plan based on the CMS Disparities Impact Statement. The Innovation Center will provide ACOs with a template based on the Disparities Impact Statement to identify health disparities<sup>25</sup>, define health equity goals, establish a health equity strategy, and a plan for implementing the health equity strategy and monitoring and evaluating progress in an effort to achieve health equity for underserved communities (as that term is defined in Appendix A).

ACOs will submit to CMS, in a form and manner and by a date specified by CMS, a Health Equity Plan in advance of each PY, and at such other times specified by CMS. In advance of a submission deadline, CMS will provide the ACO with a list of components that the ACO shall include in its Health Equity Plan and the requirements regarding the content and use of the Health Equity Plan will be described in the MPP Participation Agreement. ACOs must use the template language provided by CMS to develop their Health Equity Plan. ACOs will be required to report to CMS demonstrating their progress in implementing their Health Equity Plan and achieving their health equity goals, including but not limited to: certain health

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<sup>23</sup> <https://pubmed.ncbi.nlm.nih.gov/30055973/>

<sup>24</sup> [CMS Paving the Way to Health Equity Report \(2015-2021\)](#)

<sup>25</sup> For disparities and recommended mitigating actions involving protected classes of beneficiaries, ACOs will be required to submit data substantiating the disparity and demonstrating that the data supports the need for protected class-conscious interventions, and that there is no protected class-neutral intervention that will address the disparity.

equity metrics, outcomes resulting from an entity's Health Equity Plan, and updates to an entity's health equity strategy.

## **VII. Quality and Performance**

The reporting of Quality Measures and the collection of survey data are key for CMS to verify clinical improvements, assess patient health outcomes and care coordination activities, and ensure continued quality of care for the beneficiaries. To ensure that ACOs meet the specified goals of improved quality of care and health outcomes for Medicare beneficiaries, during PY2021 – PY2026 the ACO REACH Model will include the assessment of ACO quality performance based on claims-based quality measures as well as information from administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys starting in PY2022.<sup>26</sup>

CMS has designed the Quality Measures and performance standards that will apply to ACOs under the ACO REACH Model to reduce the burden of measure reporting, while focusing on continuous improvement and sustained exceptional performance. The quality strategy is designed to provide achievable performance criteria that incentivize practice transformations necessary to reduce utilization and improve quality of care. Appendix C lists the Quality Measures that will be assessed in PY2023 and whether the assessment will be pay-for-performance or pay-for-reporting. Performance on the Quality Measure set will result in a Total Quality Score between 0 – 100%, which will be applied to the quality withhold as described in Section VI.F for the purposes of calculating the ACO's performance year benchmark. Specifications for the Quality Measure set and scoring principles will be reviewed annually and may be subject to revision each performance year. If any newly developed measures are introduced in PY2024 or subsequent performance years, the assessment of those new measures will not be pay-for-performance until the measures have been tested and found valid and reliable (i.e., assessment would begin as pay-for-reporting).

### **A. Quality Monitoring**

To ensure Quality Measures are reported accurately and completely, CMS may conduct data validation audits of ACO quality data. These audits may involve ad hoc or scheduled desk reviews, focused audits, or full audits. These efforts will be in addition to the overall program monitoring and oversight strategy described in the Monitoring and Oversight section of this RFA.

### **B. Quality in Calculating the Performance Year Benchmark**

Quality performance scores achieved on the Quality Measure set will partly determine the magnitude of the financial opportunity for ACOs in that CMS will apply a quality withhold to the Performance Year Benchmark calculation. When calculating an ACO's preliminary Performance Year Benchmark prior to a performance year, CMS will use as a placeholder the most recent Total Quality Score an ACO has achieved for purposes of Final Financial Settlement for a past performance year. Because preliminary Performance Year Benchmarks are calculated prospectively for each performance year before the prior performance year is complete, the placeholder Total Quality Score for a given preliminary Performance Year Benchmark will generally be the ACO's Total Quality Score from two performance years prior. Once the quality scores

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<sup>26</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

from the prior performance year are finalized as part of the Final Financial Settlement for the prior performance year, the Performance Year Benchmark will be updated with the more recent placeholder score. If an ACO does not yet have a quality score to use as a placeholder, 100% will be used. Beginning with PY2023 for ACOs that started participation in the ACO REACH Model in PY2021 or PY2022 and beginning with PY2024 for ACOs that started participation in PY2023, ACOs that meet or exceed pre-defined CI/SEP criteria can earn back all or a portion of their quality withhold based on their quality performance scores. Those that do not meet the CI/SEP criteria can earn back up to half of their quality withhold based on their quality performance scores. The CI/SEP criteria will be provided prior to the start of PY2023. The highest performing ACOs that meet or exceed the CI/SEP criteria may also earn a bonus payment from the High Performers Pool (HPP), as described above in the Financial Benchmarking Methodology. The HPP will be funded from the quality withholds not earned back by ACOs that also meet or exceed the CI/SEP criteria, based on their quality performance on the Quality Measure set. ACOs that are not subject to the CI/SEP criteria or that do not meet or exceed the CI/SEP criteria are not eligible for consideration for HPP Bonus payments and any portion of their quality withhold that is not earned back will not be included in the HPP, but will be retained by CMS. For more details please refer to the Financial Settlement Overview paper (<https://innovation.cms.gov/media/document/dc-model-financial-reconciliation-guidance>) and Quality Overview paper (<https://innovation.cms.gov/media/document/gpdc-py2022-quality-measures-method>) (though please note that these documents are intended to describe the policy details specific to PY2022 and may not accurately reflect changes to the ACO REACH Model design made via this RFA; these documents will be updated for PY2023 during 2022).

### **C. Demographic Data Collection and Reporting**

Beginning in PY2023, ACOs will be required to collect and submit beneficiary-reported demographic data on an annual basis to CMS for purposes of monitoring and evaluating the ACO REACH Model as described in more detail in Section IX CMS Monitoring. Submitted demographic data must consist of all elements as specified in the United States Core Data for Interoperability Version 2 (USCDI v2), which includes race, ethnicity, language, gender identity and sexual orientation. Please refer to the official documentation on USCDI v2 for details (<https://www.healthit.gov/isa/uscdi-data-class/patient-demographics#uscdi-v2>).<sup>27</sup>

ACOs will have two options for submitting the beneficiary-reported demographic data to CMS. First, prior to PY2023, CMS will make available to ACOs a questionnaire that can be used to directly collect and submit this demographic data to CMS. This questionnaire will utilize the Fast Healthcare Interoperability Resources (FHIR) data standard. Second, ACOs will also have the option to collect and submit demographic data outside of the CMS-provided questionnaire using a CMS-provided excel template, provided that such data meets the USCDI v2 demographic data specification. CMS will provide additional details and technical assistance for implementation prior to PY2023.

In PY2023, CMS is proposing to reward ACOs for successful reporting<sup>28</sup> of required beneficiary-reported demographic data to CMS by providing a bonus to the ACO's Total Quality Score of up to 10 percentage

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<sup>27</sup> For additional information, see the ONC Health IT Standards Bulletin (May 2021) for a discussion of certified health IT capabilities for the electronic capture, exchange, and use of race and ethnicity data at [https://www.healthit.gov/sites/default/files/page/2021-05/Standards\\_Bulletin\\_2021-2.pdf](https://www.healthit.gov/sites/default/files/page/2021-05/Standards_Bulletin_2021-2.pdf).

<sup>28</sup> CMS plans to publish additional details regarding this methodology, including what qualifies as 'successful reporting' of demographic data for a given beneficiary, prior to the start of PY2023.

points; there will be no downward adjustment for non-submission and ACO Total Quality Scores will not be permitted to exceed 100%. For example:

- An ACO that has a quality score of 80% (based on its performance on the Quality Measure set) and does not report demographic data will have a final Total Quality Score of 80%.
- An ACO that has a quality score of 80% (based on its performance on the Quality Measure set) and receives the full 10 percentage point bonus will have a final Total Quality Score of 90%.
- An ACO that has a quality score of 95% (based on its performance on the Quality Measure set) and receives the full 10 percentage point bonus will have a final Total Quality Score of 100%.

To encourage reporting of as much demographic data as possible, the 10 percentage point bonus will be awarded on a sliding scale and ACOs will be able to receive partial credit. CMS will calculate a Reporting Rate by dividing the following numerator by the following denominator:

- Numerator = Number of beneficiaries with at least 6 months of alignment to the ACO during the performance year for whom the ACO successfully reports all required demographic data
- Denominator = Number of beneficiaries with at least 6 months of alignment to the ACO during the performance year

In addition, as noted above, beneficiary submission of demographic information is voluntary and ACOs should not impose on the beneficiaries they serve any requirement to report such information or impose on its Participant Providers and Preferred Providers any requirement to collect such information from those beneficiaries who opt not to report it. ACOs that document a beneficiary's choice not to disclose demographic data (e.g., answering 'Prefer not to say' on a survey) will receive credit for reporting that data.

The ACO's Reporting Rate will be multiplied by 10 percentage points to calculate the Total Quality Score bonus the ACO receives. In future performance years, CMS may institute a downward adjustment to the Total Quality Score for the failure to report or adjust the reward for successful submission.

ACOs will also be encouraged to collect and submit beneficiary-level data on social determinants of health (SDOH) to CMS. The CMS-provided questionnaire (described above) will contain an optional section on SDOH using a validated assessment tool. Failure to submit the optional SDOH data will not have any impact on a participant ACO's quality score in PY2023. While SDOH data submission is considered optional for PY2023, CMS expects to include submission of SDOH data as a component of quality performance in future Performance Years.

### **VIII. ACO Monitoring and Oversight**

Participants will be required to comply with rigorous safeguards that will be specified in the IP3 Participation Agreement and the MPP Participation Agreement and to cooperate with CMS monitoring activities.

Under the terms of the IP3 Participation Agreement and the MPP Participation Agreement, participating ACOs will be required to have a compliance plan with at least the following attributes:

- Designated compliance officer, who is not legal counsel to the ACO and who reports directly to the



ACO's governing body;

- Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;
- Compliance training for the ACO and its Participant Providers and Preferred Providers;
- A method for employees or contractors of the ACO, Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer; and
- A requirement for the ACO to report probable violations of law immediately to an appropriate law enforcement agency.

The ACO's compliance plan must be updated, as necessary, to reflect changes in laws and regulations.

#### **IX. CMS Monitoring**

As part of testing the ACO REACH Model, CMS will implement a monitoring plan designed to protect beneficiaries and address potential program integrity risks. CMS will employ a range of methods to monitor and assess compliance by the ACO and its Participant Providers and Preferred Providers with the requirements of the ACO REACH Model, including, but not limited to:

- Audits of charts, medical records, Implementation Plans, and other data from the ACO and its Participant Providers and Preferred Providers and claims analyses to identify fraudulent behavior or program integrity risks such as inappropriate reductions in care, efforts to manipulate risk scores for aligned populations, overutilization, and cost-shifting to other payers or populations;
- Review of demographic data to identify program integrity risks, such as discriminatory behavior in Marketing Activities in a manner prohibited under the terms of the IP3 Participation Agreement and the MPP Participation Agreement, and to monitor the ACO's implementation of its Health Equity Plan;
- Interviews with any individual or entity participating in ACO activities, including members of the ACO leadership and management, Participant Providers, and Preferred Providers;
- Site visits to the ACO and its Participant Providers and Preferred Providers;
- Feedback from beneficiaries and their caregivers; and
- Documentation requests sent to the ACO, its Participant Providers, and/or Preferred Providers, including surveys and questionnaires.

Using some or all of these methods and other similar monitoring techniques, CMS may conduct comprehensive annual audits related to compliance with the MPP Participation Agreement and the IP3 Participation Agreement and to identify potential program integrity risks, with more limited targeted or ad-hoc audits as necessary. These audits will include targeted assessments for each ACO type, such as a review of charts and medical records for beneficiaries aligned to High Needs Population ACOs to ensure that beneficiary eligibility requirements are fully met and documented.

#### **X. Remedial Actions**

Noncompliance with the terms of the IP3 Participation Agreement and the MPP Participation Agreement will trigger appropriate actions based on the nature of the noncompliance, degree of severity, and the ACO's compliance record while in the model. If CMS determines that any provision of MPP Participation Agreement may have been violated, CMS may take one or more of the following actions (note: only a subset of the following remedial actions would be relevant and therefore available to address violations of the terms of the IP3 Participation Agreement):

- Notify the ACO and, if appropriate, the Participant Provider or Preferred Provider of the violation;
- Require the ACO to provide additional information to CMS or its designees;
- Conduct on-site visits, interview beneficiaries, or take other actions to gather information;
- Place the ACO on a monitoring and/or auditing plan developed by CMS;
- Require the ACO to remove a Participant Provider or Preferred Provider from the Participant Provider List or Preferred Provider List and to terminate its arrangement, immediately or within a timeframe specified by CMS, with such Participant Provider or Preferred Provider with respect to this Model;
- Require the ACO to terminate its relationship with any individual or entity performing functions or services related to ACO Activities or Marketing Activities;
- Prohibit the ACO from distributing Shared Savings to a Participant Provider or Preferred Provider;
- Request a corrective action plan (CAP) from the ACO that is acceptable to CMS, by a deadline established by CMS;
- Amend the MPP Participation Agreement without the consent of the ACO to deny, terminate, or amend the use of any Capitation Payment Mechanism or the APO by the ACO, Participant Providers, or Preferred Providers;
- Amend the MPP Participation Agreement without the consent of the ACO to deny, terminate, or amend the use of Enhanced PCC by the ACO, in which case, CMS will calculate PCC Payment without the Enhanced PCC;
- Prohibit the ACO from accessing any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act;
- Amend the MPP Participation Agreement without the consent of the ACO to deny the use of one or more Benefit Enhancements by the ACO or any Participant Provider or Preferred Provider and to require that the ACO terminate any agreements effectuating such Benefit Enhancements by a date determined by CMS;
- Prohibit the ACO, a Participant Provider or a Preferred Provider from furnishing any in-kind remuneration or from implementing one or more Beneficiary Engagement Incentives;
- Discontinue the provision of data sharing and reports to the ACO;
- Prohibit the ACO from participating in Paper-Based Voluntary Alignment, Distributing Marketing Materials, or conducting Marketing Activities, including Voluntary Alignment Activities; and

- Retroactively reverse the alignment of Beneficiaries to the ACO that is based solely on Voluntary Alignment, to include Prospective Plus Alignment.

## **XI. Data Sharing and Reports**

### **A. Data Sharing**

The exchange of timely, appropriate and useful data continues to be a top priority for CMS. The ACO REACH Model will build upon the data sharing strategies and data reports established in earlier shared savings initiatives and other Innovation Center models.

CMS plans to make several types of Medicare data available to ACOs participating in the ACO REACH Model to develop and implement care coordination and quality improvement activities. For the model performance period, ACOs will be permitted to use data provided for purposes of clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation. The data may be used only in a manner consistent with the terms of the applicable CMS agreements, including the MPP Participation Agreement and HIPAA-Covered Data Disclosure Request Form. All requests for data will be granted or denied at CMS' sole discretion based on CMS' available resources and technological capabilities, the limitations in applicable CMS agreements, and applicable law.

During each performance year, CMS will offer ACOs an opportunity to request certain beneficiary-identifiable data and reports.<sup>29</sup> As noted above, no beneficiary-identifiable data will be shared for purposes of participation in IP3. The protections described in the Data Suppression and Beneficiary Data Sharing Opt Out section will be applied to most individually identifiable data. The data that the ACO may request include:

- Alignment reports describing the beneficiaries aligned to the ACO.
- Risk score reports that provide individual risk scores for each aligned beneficiary.
- Claim and Claim Line Feed (CCLF) files for services furnished by Medicare-enrolled providers and suppliers to aligned beneficiaries during the performance year. CMS will additionally provide ACOs with historical CCLF files, which will capture a 36-month lookback of claims for newly aligned beneficiaries.
- Fee Reduction Files including claim-level data to assist the ACOs in implementing Capitation Payment Mechanisms and, if applicable, the Advanced Payment Option.

CMS will also periodically provide aggregate reports that do not include Beneficiary identifiable data. As with the reports described above, the reports below will be provided at CMS' sole discretion based on CMS' available resources and technological capabilities, the limitations in applicable CMS agreements, and applicable law. These aggregate reports may include:

- Utilization and Expenditure data.

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<sup>29</sup> Note: individually identifiable beneficiary data that CMS shares with ACOs for health care operations may not be used for other purposes (e.g. marketing of non-ACO products).

- Benchmark and other financial reports. Please review Section VI for further information on these reports.
- Quality reports. Please review Sections VI and VII for more information on quality data sharing.

CMS has not yet determined whether it will provide demographic and social determinants of health data to ACOs, or, if CMS were to provide such data, whether such data would be beneficiary-identifiable or de-identified. CMS will clarify its intended policy related to such data sharing for PY2023 during 2022.

## **B. Data Suppression and Beneficiary Data Sharing Opt Out**

ACOs will be required to provide aligned beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences and opt out of data sharing.

Reports containing individually identifiable data will not include beneficiaries who opt out of data sharing with the ACO. Moreover, the ACO REACH Model will honor the data sharing opt-out decisions by beneficiaries who were previously given that choice while an aligned beneficiary in another Medicare shared savings initiative. Data sharing will be offered for all aligned beneficiaries who were either: (1) not previously aligned to any ACO; or (2) previously aligned to the ACO REACH Model ACO or another ACO and did not opt out of data sharing. A beneficiary who has opted out of data sharing remains aligned to the ACO. Aggregate reports will incorporate de-identified data from aligned beneficiaries who have opted out of data sharing. The data and reports provided to the ACO will also omit individually identifiable substance use disorder data for all beneficiaries.<sup>30</sup> Aggregate reports will incorporate de-identified substance use disorder data.

Under the terms of the MPP Participation Agreement, if a Participant Provider is terminated from the ACO and an aligned beneficiary solely had a care relationship with that terminated Participant Provider and no other Participant Provider in the prior twelve months, CMS will suppress that beneficiary's identifiable data and not include it as part of data sharing. If another Participant Provider in the ACO establishes a care relationship with a beneficiary whose data is suppressed, data sharing of the beneficiary's identifiable data will be resumed.

Participant Providers and Preferred Providers will submit claims to the relevant Medicare Administrative Contractor (MAC) for services delivered to all aligned beneficiaries, including those who have opted out of data sharing or whose claims data are otherwise suppressed. These claims remain necessary for a number of purposes including claims-based alignment, risk adjustment, cost sharing, stop-loss, monitoring, and model evaluation. Additionally, services furnished to beneficiaries who have opted out of data sharing or whose claims data are otherwise suppressed will still be included in the determination of the performance year expenditures that will be compared against the ACO's Performance Year Benchmark in the Financial Settlement process. However, claims for services furnished to a beneficiary who has opted out of claims data sharing and claims for the diagnosis and treatment of a substance use disorder will not be subject to the ACO's selected Capitation Payment Mechanism or, if selected by the ACO, the Advanced Payment Option.

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<sup>30</sup> In future performance years, CMS may consider allowing aligned beneficiaries to opt into data sharing for substance use disorder claims.

All ACOs must agree to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data received from CMS and to prevent unauthorized use or access to it.

## **XII. Evaluation**

All ACOs will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the model by CMS and/or its designees, which may include: participation in surveys; interviews; site visits; and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation.<sup>31</sup> The evaluation will assess the impact of the ACO REACH Model on the goals of better health, better health care, and lower per beneficiary expenditures. The evaluation will be used to inform policy makers about the effect of the ACO REACH Model concepts. To do so, the evaluation will seek to understand the behaviors of providers, suppliers, and beneficiaries, the impacts of increased financial risk, the effects of various payment arrangements and Benefit Enhancements, the impact of the model on beneficiary engagement and experience, and other factors associated with patterns of results. The evaluation will use beneficiary-level demographic data and data on SDOH submitted to CMS by ACOs to compare how ACOs perform on cost and quality metrics across specific subpopulations of beneficiaries, distinguished by demographic factors and presence of SDOH. Each ACO must require its Participant Providers and Preferred Providers to participate and cooperate in any such independent evaluation activities conducted by CMS and/or its designees. If an ACO does not provide the data necessary for CMS and/or its designees to complete the evaluation, upon request, CMS may terminate the ACO's MPP Participation Agreement.

## **XIII. Information Resources for Beneficiaries and Providers**

The primary resource for beneficiaries with questions about the ACO REACH Model will be 1-800-MEDICARE. CMS has developed scripts for customer service representatives (CSRs) that will answer anticipated questions related to the model. Questions that CSRs cannot answer will be triaged to CMS Regional Offices. ACOs will also be required to establish processes to answer beneficiary queries. Because of potentially substantial enhancements to certain Medicare benefits in the ACO REACH Model, CMS will develop processes for ACOs and CMS to notify and educate beneficiaries of these changes. Finally, CMS will maintain an email inbox for inquiries related to the ACO REACH Model at [ACOREACH@cms.hhs.gov](mailto:ACOREACH@cms.hhs.gov)

## **XIV. Application Scoring and Selection**

CMS will assess applications in accordance with specific criteria in five key 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. These domains and associated point scores are detailed in Appendix D of this RFA. In addition, applicants should demonstrate that their organizational structure promotes the goals of the model by including a diverse set of providers and suppliers who demonstrate a commitment to high quality care. Lastly, applicants with prior participation in a CMS program, demonstration, or model will be asked to demonstrate routine compliance with the terms of such CMS programs, demonstrations, or models.

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<sup>31</sup> In accordance with 42 C.F.R. 403.1110(b), "Any State or other entity participating in the testing of a model under section 1115A of the Act must collect and report such information, including 'protected health information' as that term is defined at 45 C.F.R. 160.103, as the Secretary determines is necessary to monitor and evaluate such model. Such data must be produced to the Secretary at the time and in the form and manner specified by the Secretary."

As part of the ACO REACH Model application process, applicants will be asked questions specific to their proposed implementation of Benefit Enhancements, Beneficiary Engagement Incentives, and Capitation Payment Mechanisms. Acceptance into the ACO REACH Model is not contingent upon an ACO implementing any particular Benefit Enhancement, Beneficiary Engagement Incentive, or risk sharing option. Responses to questions regarding proposed implementation of these approaches will assess interest in model design elements, assist with CMS planning, and model implementation.

A panel of experts that may include individuals from the Department of Health and Human Service (HHS) and HHS contractors will review complete applications from eligible applicants, with an emphasis on expertise in provider payment policy, care improvement and care coordination. Final selection for participation in the model will be based on an assessment of the five domains, listed above, as well as assessments of program integrity risks and potential market effects. **Depending on the volume of applications received, CMS may choose to limit the total number of accepted applications.** Further, CMS may choose to interview applicants and/or conduct pre-selection reviews of applicants during the application process in order to better understand applicant organizations and the individuals and entities the Applicant ACO expects will be Participant Providers and Preferred Providers.

#### **XV. Duration of the ACO REACH Model**

The ACO REACH Model consists of six performance years (PY2021-PY2026). The first performance year began on April 1, 2021, and extended until December 31, 2021. Subsequent performance years each last 12 months and align with calendar years. The ACO REACH Model also includes three optional Implementation Periods (IP) leading up to the first performance year for each of the model's three cohorts. The first IP, for ACOs whose first performance year was PY2021, occurred from October 1, 2020 through March 31, 2021. CMS offered a second IP for ACOs whose first performance year was PY2022, which ran from August 1, 2021 through December 31, 2021. CMS will offer a third IP (IP3) for ACOs whose first performance year is PY2023, running from August 1, 2022 through December 31, 2022.

CMS may modify or terminate the model at any time if it is determined that it is not achieving the aims of the initiative or as required under section 1115A of the Act.

#### **XVI. Learning and Diffusion Resources**

CMS will support ACOs in accelerating their progress by providing them with opportunities to both learn about achieving performance improvements and share experiences with one another and with participants in other Innovation Center initiatives. This will be accomplished through a "learning system" for the ACOs. The learning system will use various group-learning approaches to help ACOs effectively share experiences, track progress, and rapidly adopt new methods for improving quality, efficiency, and population health. ACOs are required to participate in the learning system by attending periodic conference calls and meetings and actively sharing tools and ideas.

#### **XVII. Public Reporting**

The ACO REACH Model emphasizes transparency and public accountability. At a minimum, ACOs will be required to publicly report information regarding their (1) organizational structure, including identification of the members of the ACO's governing body and Participant Providers and Preferred Providers; (2) Shared Savings and Shared Losses information; and (3) performance on the Quality Measures. Specific public reporting requirements will be clearly described in the MPP Participation

Agreement.

#### **XVIII. Termination**

CMS may immediately or with advance notice terminate an ACO's IP3 Participation Agreement or MPP Participation Agreement at any point during the model for non-compliance with the terms and conditions of the relevant agreement, or as otherwise specified in the IP3 Participation Agreement or MPP Participation Agreement or required by section 1115A(b)(3)(B) of the Act. An ACO may give CMS notice of termination at any time, with an effective date of termination at least 30 days after notice is given. Starting in the ACO's second performance year, the Termination Without Liability (TWL) deadline is the later of either: (1) February 28 of the performance year; or (2) 30 days after CMS distributes the Performance Year Benchmark Report for the performance year to the ACO. The TWL date will be no later than August 31 of a performance year. ACOs that provide notice of termination prior to the TWL date for a performance year with an effective termination date of no greater than 30 days after the TWL deadline will not be held financially liable for that performance year, meaning the ACO will not earn shared savings or owe shared losses for that year. There will be no TWL in an ACO's first performance year of participation.

To determine whether ACOs can succeed in improving quality and reducing costs over a longer period of time, ACOs will be incentivized to participate in the model for a minimum of two performance years (i.e., PY2023 and PY2024 for ACOs starting the ACO REACH Model in PY2023). During the first performance year of participation (PY2023), these ACOs will be subject to a 2% "retention withhold," in the amount of an additional 2% discount applied to the ACO's Performance Year Benchmark. If the ACO provides notice of termination on or before PY2024's TWL date, the ACO will not have the 2% retention withhold refunded. If, on the other hand, the ACO does not provide notice of termination on or before the TWL date for PY2024, the ACO will "earn back" the 2% retention withhold at Financial Settlement for PY2023.

Alternatively, the ACO may choose to secure a "retention guarantee amount," calculated to be equivalent to the retention withhold (i.e., 2% of the ACO's Performance Year Benchmark), either with the same financial guarantee the ACO will be required to secure to ensure its ability to repay CMS Shared Losses or Other Monies Owed, or a separate financial guarantee. If an ACO begins participation in PY2023, secures a retention guarantee amount, and provides notice of termination on or before the TWL date for PY2024, CMS would collect the retention guarantee amount under the terms of the ACO's financial guarantee and the ACO would be required to ensure that the financial guarantee, or part of the financial guarantee, securing the retention guarantee amount remains in effect until Final Financial Settlement for PY2023 is complete. An ACO that begins participation in PY2023 and selects to secure a retention guarantee amount but does not provide notice of termination on or before the TWL date for PY2024 would be required to ensure the financial guarantee, or part of the financial guarantee, securing the retention guarantee amount remains in effect until the TWL date for PY2024.

#### **XIX. Amendment**

CMS may modify the terms of the ACO REACH Model in response to stakeholder input, to reflect the agency's experience with the model, or as may be required under section 1115A of the Act or any other applicable provision of law. The terms of the ACO REACH Model as set forth in this Request for Applications may differ from the terms of the model as set forth in the MPP Participation Agreement between CMS and the ACO. Unless otherwise specified in the MPP Participation Agreement, the terms of

the MPP Participation Agreement, as amended from time to time, shall constitute the terms of the ACO REACH Model's Model Performance Period. The terms of the ACO REACH Model as set forth in this Request for Applications may also differ from the terms of the model as set forth in the IP3 Participation Agreement between CMS and the ACO. Unless otherwise specified in the IP3 Participation Agreement, the terms of the IP3 Participation Agreement, as amended from time to time, shall constitute the terms of the ACO REACH Model's Third Implementation Period.



## Appendices

### Appendix A: Glossary of Key Definitions

The following terms have the meaning set forth below. CMS may modify these definitions as it further refines the ACO REACH Model.

**ADVANCED PAYMENT OPTION (APO):** A supplemental payment mechanism available for selection by the ACO for a Performance Year if the ACO also has selected PCC Payment for that Performance Year. If the ACO selects the APO, CMS will make a prospective monthly APO payment to the ACO for APO Eligible Services furnished to REACH Beneficiaries by those Participant Providers and Preferred Providers participating in the APO.

**BENEFICIARY ENGAGEMENT INCENTIVES:** For purposes of the ACO REACH Model only, the term “Beneficiary Engagement Incentive” means chronic disease management rewards and cost-sharing support for Part B services furnished in accordance with the MPP Participation Agreement. Acceptance into the ACO REACH Model is not contingent upon the ACO implementing any particular Beneficiary Engagement Incentive.

**BENEFIT ENHANCEMENTS:** For purposes of the ACO REACH Model, CMS will use the authority under section 1115A(d)(1) of the Act to conditionally waive certain Medicare payment requirements in order to further emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries. This suite of payment rule waivers is referred to as Benefit Enhancements. Acceptance into the ACO REACH Model is not contingent upon the ACO implementing any particular Benefit Enhancement.

**COVERED SERVICES:** The scope of health care benefits described in sections 1812 and 1832 of the Act for which payment is available under Part A or Part B of Title XVIII of the Act.

**DISCOUNT:** The discount is a fixed percentage adjustment to the trended, regionally blended, risk adjusted historical expenditures for ACOs participating in Global to determine the Performance Year Benchmark. This discount is utilized in Global only, serving as the primary mechanism for CMS to obtain savings from ACOs participating in this risk sharing option. This discount is set at two percent of the trended, regionally blended, risk adjusted historical expenditures for PY2021 and PY2022 and increases to three percent for PY2023 and PY2024, and then to 3.5% for PY2025 and PY2026. For example: Baseline, trend, and risk adjustment calculations indicate that an ACO is projected to spend \$10,000 per beneficiary. If the ACO’s discount is 2%, the Performance Year Benchmark will be \$9,800 per beneficiary prior to the application of the quality withhold.

**FEE REDUCTION:** A reduction in Medicare FFS payments to the Participant Providers and/or Preferred Providers who, pursuant to a written agreement with the ACO, have agreed to receive such reduced FFS payment for covered services furnished to Beneficiaries under the ACO’s selected Capitation Payment Mechanism and, if applicable, the APO. The projected total annual amount taken out of the base Medicare FFS rates will be distributed to the ACO in monthly capitated payments.

**FINAL FINANCIAL SETTLEMENT:** means the process during which CMS compares the ACO’s final Performance Year Benchmark against the ACO’s Performance Year expenditures for REACH Beneficiaries to determine the amount of Shared Savings or Shared Losses, calculates the amount of Other Monies Owed, and calculates the net amount owed by either CMS or the ACO for the Performance Year.

**FINANCIAL SETTLEMENT:** means either Final Financial Settlement or, if applicable, Provisional Financial Settlement.

**HEALTH DISPARITY:** Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes that are experienced by underserved populations.

**HIGH NEEDS POPULATION ACCOUNTABLE CARE ORGANIZATION (ACO):** ACO that serves beneficiaries with complex, high needs including individuals dually eligible for Medicare and Medicaid and Medicare-only beneficiaries that are at risk of becoming dually eligible.

**INDIRECT OWNERSHIP INTEREST:** Any ownership interest in an entity that has an ownership interest in the subject entity.

**KEY EXECUTIVES:** Individuals who manage or have oversight responsibility for the organization, its finances, personnel, quality improvement, and compliance, including without limitation, a Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operations Officer (COO), Chief Informational Officer (CIO), medical director, compliance officer, or an individual responsible for maintenance and stewardship of clinical data.

**MARKETING ACTIVITIES:** The distribution of Marketing Materials or other activities, including Voluntary Alignment Activities, conducted by or on behalf of the ACO or its Participant Providers or Preferred Providers, when used to educate, notify, or contact beneficiaries regarding the ACO's participation in the ACO REACH Model.

**MARKETING MATERIALS:** General audience materials such as brochures, advertisements, outreach events, letters to beneficiaries, webpages, mailings, social media, or other materials sent by or on behalf of the ACO or its Participant Providers or Preferred Providers when used to educate, notify, or contact beneficiaries regarding the ACO REACH Model.

**MEDICALLY NECESSARY:** Reasonable and necessary as determined in accordance with section 1862(a) of the Act.

**NEW ENTRANT ACO:** An accountable care organization with limited experience delivering care to Medicare FFS beneficiaries that meets the eligibility criteria for New Entrant ACOs.

**NPI:** National provider identifier.

**OTHER MONIES OWED:** Any monetary amount owed to CMS by the ACO or vice versa that is neither Shared Savings nor Shared Losses. It includes payments made through Capitation Payment Mechanisms and the Advanced Payment Option. For example, if the ACO selects to receive APO payments, such payment is reconciled following the end of the performance year. Any excess payments will be recouped from the ACO as Other Monies Owed, but are not considered Shared Losses. There may also be cases in which the ACO has been underpaid in monthly Capitation Payment Mechanism payments because of an estimate made by CMS. In these cases, CMS may owe the ACO additional money, but that money is Other Monies Owed and not considered Shared Savings.

**OWNERSHIP INTEREST:** Possession of equity in the capital, the stock, or the profits of the subject entity.

**PARENT ORGANIZATION:** Parent organization means the legal entity that exercises a controlling interest, through the ownership of shares, the power to appoint voting board members, or other means, in an organization, directly or through a subsidiary or subsidiaries, and which is not itself a subsidiary of any other legal entity.

**PARTICIPANT PROVIDER:** An individual or entity that: (1) is a Medicare-enrolled provider or supplier (as such terms are defined in 42 C.F.R. § 400.202); (2) is identified on the ACO's list of Participant Providers by name, individual National Provider Identifier (NPI), organizational NPI, TIN, Legacy TIN or CCN (if applicable), and CMS Certification Number (CCN) (if applicable); (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; (4) is not a Preferred Provider nor a Prohibited Participant; and (5) has agreed, pursuant to a written agreement with the ACO, to participate in the model and to comply with care improvement objectives and model quality performance standards. The Capitation Payment Mechanism chosen by the ACO will apply to all Participant Providers that have an agreement with that ACO, except that for PY2021 only, Participant Providers in an ACO that has selected Primary Care Capitation may elect not to participate in Primary Care Capitation payment.

**PARTICIPANT PROVIDER LIST:** The list that identifies each Participant Provider that is approved by CMS for participation in the ACO REACH Model and specifies the Fee Reductions agreed to by each Participant Provider under the ACO's selected Capitation Payment Mechanism, which Participant Providers, if any, are participating in the Advanced Payment Option if selected by the ACO (and the applicable Fee Reduction agreed to by each such Participant Provider), and the Benefit Enhancements and Beneficiary Engagement Incentives, if any, in which each Participant Provider participates, as updated from time to time in accordance with the MPP Participation Agreement.

**PERSON WITH AN OWNERSHIP OR CONTROL INTEREST:** A person that (1) has an ownership interest equal to 5 percent or more in the subject entity; (2) has an indirect ownership interest equal to 5 percent or more in the subject entity; (3) has a combination of direct and indirect ownership interests equal to 5 percent or more in the subject entity; or (4) has an ownership interest equal to 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a subject entity if that interest equals at least 5 percent of the value of the property or assets of the subject entity.

**PERSON:** An individual or entity, including a corporation.

**PREFERRED PROVIDER:** A Medicare provider or supplier that: (1) is a Medicare-enrolled provider (as defined at 42 C.F.R. § 400.202) or supplier (as defined in 42 C.F.R. § 400.202); (2) is identified on the ACO's list of Preferred Providers by name, NPI, individual TIN, organizational TIN, Legacy TIN or CCN (if applicable), and CMS Certification Number (CCN) (if applicable); (3) bills for items and services it furnishes to Medicare FFS beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations; (4) is not a Participant Provider nor a Prohibited Participant; and (5) has agreed to participate in the model pursuant to a written agreement with the ACO.

**PREFERRED PROVIDER LIST:** The list that identifies each Preferred Provider that is approved by CMS for participation in the ACO REACH Model and specifies which Preferred Providers, if any, have agreed to participate in the ACO's selected Capitation Payment Mechanism and, if selected by the ACO, the Advanced Payment Option (along with the applicable Fee Reductions agreed to by each Preferred Provider), and designates the Benefit Enhancements and Beneficiary Engagement Incentives, if any, in which each Preferred Provider participates, as updated from time to time in accordance with the MPP Participation Agreement.

**PRIMARY CARE QUALIFIED EVALUATION AND MANAGEMENT (PQEM) SERVICES:** A claim for a primary care service provided by a primary care specialist or one of the selected non-primary care specialists. For PY2022, PQEM services are the subset of the Qualified Evaluation & Management (QEM) services identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in [the PY2022 Financial Operating Guide Overview](#).

**PROHIBITED PARTICIPANT:** An individual or entity that is: (1) a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier; (2) an ambulance supplier; (3) a drug or device manufacturer; and/or (4) excluded or otherwise prohibited from participation in Medicare or Medicaid.

**PROVISIONAL FINANCIAL SETTLEMENT:** means the process during which CMS compares the ACO's provisional Performance Year Benchmark to the ACO's provisional Performance Year expenditures to determine the amount of provisional Shared Savings or Shared Losses, calculates the provisional net amount owed by either CMS or the ACO for the Performance Year, and if the ACO's first Performance Year is Performance Year 2021, calculates the provisional amount of Other Monies Owed. Provisional Financial Settlement will apply for Performance Year 2021 and is available for selection by the ACO for Performance Year 2022 and each subsequent Performance Year. Provisional Financial Settlement will be followed by Final Financial Settlement.

**REACH BENEFICIARY:** A Medicare beneficiary who has been aligned to an ACO as described in Section VI.B. for a given Performance Year.

**RURAL AREA:** means an area in which at least 40 percent of the Federal Information Processing Standard (FIPS) codes occur within Rural-Urban Commuting Area (RUCA) codes 4-10, or a census tract with RUCA codes 2 or 3 that is at least 400 square miles in area with a population density of no more than 35 people per square mile.

**SHARED LOSSES:** Any monetary amount owed to CMS by the ACO due to expenditures for Medicare Parts A and B items and services furnished to REACH Beneficiaries during a performance year (inclusive of capitated payments under Total Care Capitation payment or Primary Care Capitation payment and, if applicable, Advanced Payment Option payments paid by CMS to the ACO, as well as FFS claims paid by CMS directly to Medicare providers and suppliers) in excess of the ACO's final Performance Year Benchmark for that performance year. CMS determines Shared Losses in accordance with the ACO's selected risk sharing option and selected Capitation Payment Mechanism.

**SHARED SAVINGS:** The monetary amount owed to the ACO by CMS due to expenditures for Medicare Parts A and B items and services furnished to REACH Beneficiaries during a performance year (inclusive of capitated payments under Total Care Capitation payment or Primary Care Capitation payment and, if applicable, Advanced Payment Option payments paid by CMS to the ACO, as well as FFS claims paid by CMS directly to Medicare providers and suppliers) that are lower than the ACO's final Performance Year Benchmark for that performance year. CMS determines Shared Savings in accordance with the ACO's selected risk sharing option and selected Capitation Payment Mechanism.

**STANDARD ACO:** An accountable care organization with substantial experience serving Medicare FFS beneficiaries and most likely prior experience participating in Medicare ACO initiatives.

**SUBJECT ENTITY:** An entity identified in the application questions in Appendix D for which CMS seeks information regarding individuals or entities with an ownership or control interest.

**TIN:** Federal taxpayer identification number.

**UNDERSERVED COMMUNITY:** 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."

**VOLUNTARY ALIGNMENT:** 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 his or her 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.

**Appendix B: Summary Table of ACO Types by Design Elements**

**Summary Table of ACO Types by Design Elements**

	<b>Standard</b>	<b>New Entrant</b>	<b>High Needs Population</b>
<b>Description</b>	<ul style="list-style-type: none"> <li>ACOs with substantial historical experience serving Medicare FFS beneficiaries and most likely prior experience participating in Medicare ACO initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>ACOs with limited historical experience delivering care to Medicare FFS beneficiaries. Beneficiaries aligned via claims must not exceed 3,000 in any base year (2017-2019). If the number of beneficiaries aligned via claims in any of the base years exceeds this threshold, the ACO will have the opportunity to participate as a Standard ACO, provided model requirements are met.</li> <li>For PY2025-2026, ACOs must have 5,000 beneficiaries at a minimum, more than 3,000 of which must be aligned on the basis of claims.</li> </ul>	<ul style="list-style-type: none"> <li>ACOs that serve beneficiaries with complex, high needs including dually eligible individuals.</li> </ul>

	Standard	New Entrant	High Needs Population
<b>Beneficiary Alignment Options</b>	<ul style="list-style-type: none"> <li>• <b>Voluntary</b><sup>32</sup>: based on beneficiary’s selection of a Participant Provider as their “primary clinician” or their main source of care</li> <li>• <b>Claims-based</b>: based on the beneficiary’s receiving the plurality of primary care services from Participant Providers, provided the beneficiary has not voluntarily aligned with another ACO.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Voluntary</b>: based on beneficiary’s selection of a Participant Provider as their “primary clinician” or their main source of care</li> <li>• <b>Claims-based</b>: based on the beneficiary’s receiving the plurality of primary care services from Participant Providers, provided the beneficiary has not voluntarily aligned with another ACO</li> <li>• Qualify for alignment “glide path.”</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Voluntary</b>: based on beneficiary’s selection of a Participant Provider as their “primary clinician” or their main source of care</li> <li>• <b>Claims-based</b>: based on the beneficiary’s receiving the plurality of primary care services from Participant Providers, provided the beneficiary has not voluntarily aligned with another ACO</li> <li>• Qualify for alignment “glide path.”</li> </ul>

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<sup>32</sup> Beneficiaries aligned via both voluntary and claims-based alignment will be treated as having claims-based alignment for benchmarking purposes. This determination will be made anew each performance year (for example, a beneficiary aligned only via voluntary alignment in PY2023 would be subject to the benchmark for voluntarily aligned beneficiaries in PY2023, but if the same beneficiary were to be aligned by both claims and voluntary alignment in PY2024, that beneficiary would be subject to the benchmark for claims-aligned beneficiaries in PY2024).

	<b>Standard</b>	<b>New Entrant</b>	<b>High Needs Population</b>
<b>Overview of Benchmarking Methodology: Voluntary Alignment</b>	<ul style="list-style-type: none"> <li>• Prospective benchmark</li> <li>• Risk adjusted</li> <li>• Discounted for Global</li> <li>• For PY2021-PY2024: <ul style="list-style-type: none"> <li>- Regional expenditures (ACO REACH / KCC Rate Book).</li> <li>- Aligned beneficiary historical expenditures not incorporated.</li> </ul> </li> <li>• For PY2025-PY2026: <ul style="list-style-type: none"> <li>- Blend of regional expenditures with aligned beneficiary recent historical expenditures.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Prospective benchmark</li> <li>• Risk adjusted</li> <li>• Discounted for Global</li> <li>• For PY2021-PY2024: <ul style="list-style-type: none"> <li>- Regional expenditures (ACO REACH / KCC Rate Book).</li> <li>- Aligned beneficiary historical expenditures not incorporated.</li> </ul> </li> <li>• For PY2025-PY2026: <ul style="list-style-type: none"> <li>- Blend of regional expenditures with aligned beneficiary recent historical expenditures.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Prospective benchmark</li> <li>• Risk adjusted, with the intent to better address costlier expenditures for high needs populations.</li> <li>• Discounted for Global</li> <li>• For PY2021-PY2024: <ul style="list-style-type: none"> <li>- Regional expenditures (ACO REACH / KCC Rate Book).</li> <li>- Aligned beneficiary historical expenditures not incorporated.</li> </ul> </li> <li>• For PY2025-PY2026: <ul style="list-style-type: none"> <li>- Blend of regional expenditures with aligned beneficiary recent historical expenditures.</li> </ul> </li> </ul>
<b>Overview of Benchmarking Methodology: Claims-based Alignment</b>	<ul style="list-style-type: none"> <li>• Prospective benchmark</li> <li>• Risk adjusted</li> <li>• Discounted for Global</li> <li>• Blend of regional expenditures (ACO REACH / KCC Rate Book) with aligned beneficiary historical expenditures (CY2017-19).</li> </ul>	<ul style="list-style-type: none"> <li>• Prospective benchmark</li> <li>• Risk adjusted</li> <li>• Discounted for Global</li> <li>• For PY2021-PY2024: <ul style="list-style-type: none"> <li>- Regional expenditures (ACO REACH / KCC Rate Book).</li> <li>- Aligned beneficiary historical expenditures not incorporated.</li> </ul> </li> <li>• For PY2025-PY2026: <ul style="list-style-type: none"> <li>- Blend of regional expenditures with aligned beneficiary recent historical expenditures.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Prospective benchmark</li> <li>• Risk adjusted, with the intent to better address costlier expenditures for high needs populations.</li> <li>• Discounted for Global</li> <li>• For PY2021-PY2024: <ul style="list-style-type: none"> <li>- Regional expenditures (ACO REACH / KCC Rate Book).</li> <li>- Aligned beneficiary historical expenditures not incorporated.</li> </ul> </li> <li>• For PY2025-PY2026: <ul style="list-style-type: none"> <li>- Blend of regional expenditures with aligned beneficiary recent historical expenditures.</li> </ul> </li> </ul>



	<b>Standard</b>	<b>New Entrant</b>	<b>High Needs Population</b>
<b>Health Equity Benchmark Adjustment</b>	<ul style="list-style-type: none"> <li>Beginning PY2023, the health equity benchmark adjustment will be applied.</li> </ul>	<ul style="list-style-type: none"> <li>Beginning PY2023, the health equity benchmark adjustment will be applied.</li> </ul>	<ul style="list-style-type: none"> <li>Beginning PY2023, the health equity benchmark adjustment will be applied.</li> </ul>
<b>Benefit Enhancements and Beneficiary Engagement Incentives</b>	<ul style="list-style-type: none"> <li>Yes, generally via Participant Providers and Preferred Providers.</li> </ul>	<ul style="list-style-type: none"> <li>Yes, generally via Participant Providers and Preferred Providers.</li> </ul>	<ul style="list-style-type: none"> <li>Yes, generally via Participant Providers and Preferred Providers.</li> </ul>
<b>Capitation to ACOs</b>	<ul style="list-style-type: none"> <li>Total care capitation or primary care capitation required.</li> </ul>	<ul style="list-style-type: none"> <li>Total care capitation or primary care capitation required.</li> </ul>	<ul style="list-style-type: none"> <li>Total care capitation or primary care capitation required.</li> </ul>
<b>Participant Providers &amp; Preferred Providers</b>	<ul style="list-style-type: none"> <li>Participant Providers and Preferred Providers required; defined at the TIN/NPI level.</li> </ul>	<ul style="list-style-type: none"> <li>Participant Providers and Preferred Providers required; defined at the TIN/NPI level.</li> </ul>	<ul style="list-style-type: none"> <li>Participant Providers and Preferred Providers required; defined at the TIN/NPI level.</li> </ul>

	<b>Standard</b>	<b>New Entrant</b>	<b>High Needs Population</b>
<b>Payment to Participant Providers and Preferred Providers</b>	<ul style="list-style-type: none"> <li>Participant Providers and Preferred Providers receive payments for Part A and Part B services from the ACO and/or CMS based on their contractual arrangement with the ACO. The payments from the ACO may include sub-capitation and other value-based payments. All Participant Providers must participate in the Capitation Payment Mechanism selected by the ACO for PY2022 and all subsequent performance years. Preferred Providers have the option to participate in the Capitation Payment Mechanism. Both Participant and Preferred Providers also have the option to participate in the Advanced Payment Option, if the ACO elects to do Primary Care Capitation.</li> </ul>	<ul style="list-style-type: none"> <li>Participant Providers and Preferred Providers receive payments for Part A and Part B services from the ACO and/or CMS based on their contractual arrangement with the ACO. The payments from the ACO may include sub-capitation and other value-based payments. All Participant Providers must participate in the Capitation Payment Mechanism selected by the ACO for PY2022 and all subsequent performance years. Preferred Providers have the option to participate in the Capitation Payment Mechanism. Both Participant and Preferred Providers also have the option to participate in the Advanced Payment Option, if the ACO elects to do Primary Care Capitation.</li> </ul>	<ul style="list-style-type: none"> <li>Participant Providers and Preferred Providers receive payments for Part A and Part B services from the ACO and/or CMS based on their contractual arrangement with the ACO. The payments from the ACO may include sub-capitation and other value-based payments. All Participant Providers must participate in the Capitation Payment Mechanism selected by the ACO for PY2022 and all subsequent performance years. Preferred Providers have the option to participate in the Capitation Payment Mechanism. Both Participant and Preferred Providers also have the option to participate in the Advanced Payment Option, if the ACO elects to do Primary Care Capitation.</li> </ul>
<b>Service Area</b>	<ul style="list-style-type: none"> <li>Defined by the physical practice location of the ACO's Participant Providers.</li> </ul>	<ul style="list-style-type: none"> <li>Defined by the physical practice location of the ACO's Participant Providers.</li> </ul>	<ul style="list-style-type: none"> <li>Defined by the physical practice location of the ACO's Participant Providers.</li> </ul>

## Appendix C: Global and Professional Quality Measures for PY2023

The following Quality Measures are the measures CMS expects to use in establishing quality performance standards in PY2023 of the model.

### Quality Measures

Domain	Measure Title	Method of Data Submission	Pay-for-Performance Phase In R—Reporting P—Performance PY2023
Care Coordination/ Patient Safety	Risk-Standardized, All Condition Readmission	Claims	P
Care Coordination/ Patient Safety	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	P
Care Coordination/ Patient Safety	Timely Follow-up after Acute Exacerbations of Chronic Conditions	Claims	P
Care Coordination/ Patient Safety	Days at Home for Patients with Chronic, Complex Conditions High Needs Population ACOs	Claims	P
Patient/Caregiver Experience (if the ACO is not a High Needs ACO)	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) <sup>33</sup>	Survey	P
Patient/Caregiver Experience (if the ACO is a High Needs ACO)	Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	Survey	R

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<sup>33</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

## Appendix D: Application Template

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at [https://www.cms.gov/AboutWebsite/02\\_Privacy-Policy.asp](https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp). The application can be found and completed at: <https://innovation.cms.gov/innovation-models/aco-reach>.

CMS provides no opinion on the legality of any contractual or financial arrangement that the applicant may disclose, propose, or document in this application. The receipt by CMS of any such information in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules, or regulations, and will not preclude CMS, HHS, the HHS Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules, and regulations.

Questions about the application for the ACO REACH Model should be directed to [ACOREACH@cms.hhs.gov](mailto:ACOREACH@cms.hhs.gov).

### I. APPLICATION INFORMATION

#### A. Risk Sharing Option

1. Global for PY2023-PY2026
2. Professional for PY2023 (subject to change via ACO selections for subsequent performance years)

#### B. ACO Type

1. Standard ACO
2. New Entrant ACO
3. High Needs Population ACO

#### C. Alignment Frequency for PY2023

1. Prospective Alignment (all-claims-based and voluntary alignment will be completed prior to the start of each Performance Year)
2. Prospective Plus Alignment (beneficiaries added to the Applicant ACO's aligned population prior to the start of each of the first three quarters of each Performance Year through voluntary alignment)

**D. Alternative Payment Mechanisms for PY2023:** The Applicant ACO's selected Capitation Payment Mechanism and selection to participate in the Advanced Payment Option, if applicable, is separate from the Applicant ACO's risk sharing option selection. The alternative payment mechanisms dictate the method of payment for Participant Provider claims and certain Preferred Provider claims and the monthly payments received by the Applicant ACO.

1. For Global:

- i. Total Care Capitation Payment
- ii. Primary Care Capitation Payment with Advanced Payment Option
- iii. Primary Care Capitation Payment without Advanced Payment Option

2. For Professional:

- i. Primary Care Capitation Payment with Advanced Payment Option
- ii. Primary Care Capitation Payment without Advanced Payment Option

**II. BACKGROUND INFORMATION**

**A. Applicant ACO Organization Information**

- Organization Name:
- Prior Legal Business Names (LBNs):
- Doing Business As (DBA):
- Prior DBA(s):
- Organization TIN/EIN:
- Organization DUNS:
- Street Address:
- City:
- State:
- ZIP Code<sup>34</sup>:
- Website, if applicable:

**B. Contact Information**

For Primary Application Contact, Secondary Application Contact, Executive Contact, and IT/Technical Contact:

- Full Name:
- Title/Position:
- Business Phone Number:
- Business Phone Number Extension:
- Alternate Phone Number:
- Email Address:
- Street Address:
- City:
- State:
- ZIP code:

**C. ACO Organization Profile**

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<sup>34</sup> ZIP Code is a registered trademark of the United States Postal Service.

1. Please identify what type of entity best describes the Applicant ACO (note: we are looking for the description of the Applicant ACO itself, not the individuals and entities the Applicant ACO expects will be Participant Providers). Check only one:
  - i. Medical group practice
  - ii. Network of individual practices (e.g., IPA) / partnership of medical practices
  - iii. Hospital system(s)
  - iv. Integrated delivery system
  - v. Partnership of hospital system(s) and medical practices
  - vi. Management services organization / 'convener' (i.e., an organization that does not itself include Medicare-enrolled providers or suppliers, but instead provides administrative and supportive services to facilitate the participation of Medicare-enrolled providers or suppliers (Participant Providers) in value-based care).
  - vii. Other (please describe):
  
2. Please provide an executive summary describing the Applicant ACO including: a narrative description of entities and individuals that comprise the ACO, the history / context surrounding the formation of the ACO, the ACO's strategy and goals, the ACO's planned focus (geographic, beneficiary populations, planned care coordination, etc.), and the historical and expected role of the Applicant ACO relative to the individuals and entities the Applicant ACO expects will be Participant Providers (e.g., the ACO's experience providing direct patient care vs providing supportive services to Medicare healthcare providers).
  
3. Please indicate whether the Applicant ACO is currently or formerly operated, managed, or led by an entity that is participating in or formerly participated in any of the following initiatives listed below. Please also indicate whether the Applicant ACO applied to participate in any of the following initiatives on its own behalf or on behalf of any other organization. Check all that apply.
  - i. None
  - ii. Accountable Health Communities Model
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - iii. ACO Investment Model (AIM)
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - iv. Advance Payment ACO Model
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - v. Bundled Payment for Care Improvements (BPCI) Model
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - vi. Bundled Payment for Care Improvements (BPCI) Advanced Model

- a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- vii. Care Management for High-Cost Beneficiaries Demonstration
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- viii. Comprehensive ESRD Care (CEC) Model
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- ix. Comprehensive Kidney Care Contracting (CKCC) Options of the Kidney Care Choices (KCC) Model
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- x. Comprehensive Primary Care (CPC) Initiative
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- xi. Comprehensive Primary Care Plus (CPC+) Model
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- xii. Independence at Home Medical Practice Demonstration (IAH)
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- xiii. Kidney Care First (KCF) Option of the KCC Model
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- xiv. Maryland Total Cost of Care Model, Maryland Primary Care Program
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- xv. Medicare Health Care Quality Demonstration Programs (including Indiana Health Information Exchange and North Carolina Community Care Network)
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:
- xvi. Medicare Shared Savings Program (Shared Savings Program)
  - a. Contract ID number (if applicable):
  - b. Application or Participation date(s):
  - c. Application Response: Accept, Deny, Withdrawn:

- xvii. Multi-payer Advanced Primary Care Practice Demonstration with a Shared Savings arrangement (MAPCP)
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - xviii. Next Generation ACO (NGACO) Model
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - xix. Nursing Home Value-Based Purchasing Demonstration
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - xx. Program of All-Inclusive Care for the Elderly (PACE)
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - xxi. Pioneer ACO Model
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - xxii. Physician Group Practice Transition Demonstrations
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - xxiii. Primary Care First (PCF) Model Options
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
  - xxiv. Vermont Medicare ACO Initiative
    - a. Contract ID number (if applicable):
    - b. Application or Participation date(s):
    - c. Application Response: Accept, Deny, Withdrawn:
4. Please describe the Applicant ACO's relationship (e.g., geographic, years of experience, relative dominance in major areas of service delivery, ownership interest) to other health care entities in its market. Please include information on what other organizations are the Applicant ACO's main competitors in its primary service area and the Applicant ACO's market share in its primary service area for professional and hospital services.
  5. To assist the Federal Trade Commission (FTC) and the Antitrust Division of the Department of Justice (DOJ) in their activities to protect competition in the regions in which the ACO REACH Model will be tested, CMS may provide certain information, including aggregate claims data regarding allowed charges and fee-for-services payments for your organization, to FTC and the Antitrust Division of DOJ to assist in their monitoring of the competitive effects of potential ACOs in these regions. Please confirm that you understand and agree



that CMS may also share a copy of your application (including all information and documents submitted with the application) with the FTC and the Antitrust Division of the DOJ.

- i. Yes
- ii. No

### **III. ORGANIZATIONAL READINESS (15 points)**

#### **A. Incorporation, Licensure, and Structure**

1. Please attach a copy of a certificate of incorporation or other documentation that the Applicant ACO is recognized as legal entity by the state in which it is located. Organizations that have not yet formed a legal entity will need to provide this information prior to executing an IP3 Participation Agreement or an MPP Participation Agreement with CMS.
2. Please attach documentation demonstrating that the Applicant ACO has been licensed by the state(s) in which it is located as a risk-bearing entity, or that it is exempt from such licensure and/or other such requirements, as follows:
  - i. If the Applicant ACO has been licensed as a risk-bearing entity in state(s) in which it will operate, upload a copy of the appropriate certification or documentation.
  - ii. If the Applicant ACO is required to obtain licensure as a risk-bearing entity in state(s) in which it will operate, but the ACO is not yet currently licensed as a risk-bearing entity in one or more of those states, please describe the progress the Applicant ACO has made toward obtaining such licensure.
  - iii. If the state(s) in which the Applicant ACO will operate does not have a licensure requirement for risk-bearing entities, or if the Applicant ACO does not meet the applicable definitions established by state regulators, please upload an attestation made by the leadership of the Applicant ACO indicating that this is so.
3. Please attach a proposed organizational chart for the Applicant ACO. The proposed organizational chart should depict the legal structure and the proposed operational composition of the ACO itself, including the proposed governing body; the leadership team; any relevant operating bodies or committees (e.g., compliance team, data team); persons with an ownership or control interest (as that term is defined in Appendix A) in the ACO; and any individuals or entities that the Applicant ACO expects will perform functions or services related to the Applicant ACO's participation in the ACO REACH Model (e.g., third party vendors, partners). Note: Inclusion of the individuals and entities the Applicant ACO expects will be Participant Providers and Preferred Providers in the proposed organizational chart for the Applicant ACO is optional.
4. Please complete the following table to provide CMS with a full and complete understanding of the ownership interests in the Applicant ACO, as well as the ownership interests in the entities with an ownership interest in the Applicant ACO. Each party with at least 5% ownership interest in the Applicant ACO should be listed.

Name of person with ownership or control interest in Applicant ACO (as that term is defined in the RFA)	Percent ownership interest in the Applicant ACO	Type; select from: -Private individual -Publicly traded company -Privately held company -Investment firm (private equity, venture capital, etc.) -Other (please describe)	If privately held company, investment firm, or other, please provide a complete description of all ownership interests in the privately held company, investment firm, or other, including their name, percent ownership and description (private individual, public company, private company, investment firm, other)*

\*If the privately held company with an ownership or control interest in the Applicant ACO is a subsidiary of another privately held company, please list the parent company(ies) and ownership interests in that privately held company.

**B. Leadership Team**

1. Please indicate whether the Applicant ACO has or will have a leadership team exclusive to the ACO.
  - i. Yes
  - ii. No
2. Please complete the table below with information specific to the Applicant ACO's proposed leadership team. The leadership team may include, but is not limited to: Key Executives (as that term is defined in Appendix A of the RFA); finance officers; clinical improvement officers; compliance officers; information systems leadership; and the individual responsible for maintenance and stewardship of clinical data. For each identified leadership team member, please attach a resume or curriculum vitae (CV). If specific individuals have not yet been identified, please write "TBD" and provide the anticipated date by which the individual will be identified in the "Leadership Team Member" column, and indicate the "Position/Role" you intend for the TBD individuals to serve.

**Applicant ACO's Proposed Leadership Team**

Leadership Team Member	Position/Role	CV or resume attached	Ownership or control interest?*

\* Indicate whether the individual has an ownership or control interest (as that term is defined in Appendix A) in the Applicant ACO, or is a person with an ownership or control interest in an entity that the Applicant ACO expects will be a Participant Provider or Preferred Provider. If so, please indicate the entity in which the individual has an ownership or control interest, identify the nature and amount of the ownership or control interest.

3. Please summarize the background and experience of each individual selected for the Applicant ACO's proposed leadership team, specifically explaining why the Applicant ACO

believes each such individual possesses the experience and skills to realize the goals of the ACO REACH Model, as described in the RFA, and otherwise lead the Applicant ACO to success in the Model by improving care quality and reducing program expenditures.

**C. Governing Body**

1. Please select one of the following descriptions of the Applicant ACO’s legal entity status:
  - i. Applicant ACO will be a legal entity that is the same as the legal entity of the individuals and entities the Applicant ACO expects to be Participant Providers, all of whom bill under a single TIN.
  - ii. Applicant ACO will be a legal entity separate from the legal entity of any of the individuals and entities the Applicant ACO expects to be Participant Providers or Preferred Providers.
  - iii. Unsure.
  
2. Please complete the table below with information specific to the Applicant ACO's proposed governing body. If the Applicant ACO expects an individual to be a Participant Provider or a representative thereof, please also provide the Legal Name of the entity under which the individual is expected to participate in the ACO. If specific individuals have not yet been identified, please write “TBD” and provide the anticipated date by which the individual will be identified in the “Name” column, and indicate the “Title of Role” you intend for the TBD individuals to serve.

**Applicant ACO’s Proposed Governing Body**

Name	Legal Business Name (if applicable)	Title of Role	CV or resume attached	Percent of Board Control	*Other Board commitment(s)	**Ownership or control interests

\* Indicate whether the individual is or will be concurrently serving on another governing body (e.g., whether individual is on one or more other Board of Directors). If so, please identify the applicable organization and the term of the individual’s commitment to the organization’s governing body.

\*\* Indicate whether the individual is a person with an ownership or control interest (as that term is defined in Appendix A) in the Applicant ACO and/or an individual or entity that the Applicant ACO expects will be a Participant Provider or Preferred Provider. If so, please indicate the entity in which the individual has an ownership or control interest and identify the nature and amount of the ownership or control interest.

3. Please summarize the background and experience of each individual selected for the Applicant ACO’s proposed governing body, specifically explaining why the Applicant ACO believes each individual possesses the experience and skills to realize the goals of the ACO REACH Model, as described in the RFA, and otherwise provide appropriate responsibility for oversight and strategic direction of the Applicant ACO and for holding ACO management accountable for the ACO’s activities.

**D. Oversight and Representation**

1. Please upload the compliance plan intended for use by the Applicant ACO and specify whether the proposed compliance officer reports directly to the proposed governing body.

2. Please describe how responsibilities and accountability will be shared across the leadership team and governing body structures in the Applicant ACO. Please also describe how the leadership team and/or governing body structures will inform the owners of the Applicant ACO regarding the Applicant ACO's performance in the ACO REACH Model and the activities the Applicant ACO is undertaking for the purpose of its participation in the ACO REACH Model.
3. Please describe how the governing body will ensure that the interests of beneficiaries and providers and suppliers will be represented adequately. Specifically, explain the following:
  - i. The role of the independent Medicare beneficiary(ies) who will participate in the governing body;
  - ii. The role of the independent consumer advocate(s) who will participate in the governing body;
  - iii. Any means by which the Applicant ACO will ensure beneficiary representation and/or consumer representation (e.g., through a committee, meeting and/or communication infrastructure); and
  - iv. The rationale for the proposed or existing composition of the governing body and voting power distribution.

**E. Information on Individuals and Entities that the Applicant ACO expects will be Participant Providers and Preferred Providers**

1. Please describe the planned or actual contractual and/or employment relationships, and ownership interests, between and among the Applicant ACO and any individuals or entities that the Applicant ACO expects will be Participant Providers and Preferred Providers.
2. For the individuals and entities the Applicant ACO expects will be Participant Providers and Preferred Providers, please report in the table below information regarding the provider and/or supplier types; the total number of clinicians within each provider/supplier type; the number of clinicians for whom the Applicant ACO is the primary employer, the number of clinicians for whom a non-Applicant ACO hospital is the primary employer, the number of clinicians for whom a non-Applicant ACO group practice with 10 or more clinicians is the primary employer, and the number of clinicians for whom a non-Applicant ACO group practice with fewer than 10 clinicians is the primary employer; and the geographic location(s) (by ZIP code) of the provider/suppliers included.

Provider/Supplier Type	Total clinicians	Primary Employer*				Geographic location(s) (ZIP Code™)
		Applicant ACO	Non-Applicant ACO hospital**	Non-Applicant ACO group practice*** with ≥ 10 clinicians	Non-Applicant ACO group practice*** with < 10 clinicians	
Primary care						
Cardiology						
Endocrinology						
Nephrology						

Provider/Supplier Type	Primary Employer*					Geographic location(s) (ZIP Code™)
	Total clinicians	Applicant ACO	Non-Applicant ACO hospital**	Non-Applicant ACO group practice*** with ≥ 10 clinicians	Non-Applicant ACO group practice*** with < 10 clinicians	
Oncology						
Gastroenterology						
General surgery						
Specialty surgery						
Other specialty						
Specialty hospital						
Pharmacy						
Mental or behavioral health facility						
Hospital(s) receiving disproportionate share (DSH) payments from Medicare or Medicaid						
Critical Access Hospital (CAH)						
Other rural hospital						
Dialysis facility						
Federally Qualified Health Center						
Rural Health Clinic						
Other community health centers						
Skilled Nursing Facility (SNF)						
Inpatient Rehabilitation Facility (IRF)						
Home Health Agency (HHA)						
Other Nursing Care						
Nurse Practitioners/Physician Assistants						

\* “Primary employer” means the employer on whose behalf the clinician delivers healthcare services (for all patients, not just Medicare beneficiaries), and that the clinician considers to be their primary place of employment (e.g., accounts for the majority of the clinician’s income).

\*\* “Non-Applicant ACO hospital” means a hospital that is neither the Applicant ACO nor directly owned by the Applicant ACO, one of the ACO’s parent organizations, or one of the ACO’s subsidiaries.

\*\*\* “Non-Applicant ACO group practice” means a group practice that is neither the Applicant ACO nor directly owned by the Applicant ACO, one of the ACO’s parent organizations, or one of the ACO’s subsidiaries.

3. Please describe how the Applicant ACO plans to coordinate care, improve care quality, reduce program expenditures, and otherwise succeed under the ACO REACH Model with its Participant Providers and Preferred Providers. In particular, please describe how your expected mix of providers and suppliers will allow your Applicant ACO to ensure that it will serve a diverse population of REACH Beneficiaries that includes no more than 50% of patients from a population targeted by another current or announced CMS total cost of care initiative, achieve the goals of the ACO REACH Model as described in the RFA, and otherwise reduce health care costs, improve beneficiary quality of care, and address health disparities.

**F. Disclosures**

1. Please disclose the following with respect to the Applicant ACO, persons with an ownership or control interest (as that term is defined in Appendix A of the RFA) in the Applicant ACO, Key Executives (as that term is defined in Appendix A of the RFA), equity partners (e.g., private equity or venture capital), and individuals and entities that the Applicant ACO expects will be Participant Providers or Preferred Providers: (i) any sanctions or corrective action plans imposed under Medicare, Medicaid, or state licensure authorities within the last three years (including corporate integrity agreements); (ii) any fraud investigations initiated, conducted, or resolved within the last three years; (iii) any outstanding debts owed to the Medicare program, including any debts owed under an Innovation Center model, or any agency of the federal government; (iv) any awards of a CMS contract in the past 5 years, and, if applicable, the contract number and period of performance for such award; (v) whether any such individuals or entities are on a government suspension, debarment, or exclusion list relating to procurement and non-procurements; (vi) any instances of criminal conduct; and (vii) any instances of bankruptcy.

Individual or entity	Federal or State Agency or Accrediting Body	Description of Infraction (including date)	Resolution Status (including date)

**G. Information on ACO partners / vendors**

1. In the table below, please list separately any core ACO functions, including but not limited to such third parties identified in response to Section III.A.3 above, beneficiary engagement and communication, care coordination, marketing, data and analytics, provider contracting, financial analysis and management, payment processing, and legal and compliance, that the Applicant ACO expects will be contracted out and performed by a third party partner or vendor. For each expected function that will be contracted out please complete the additional fields.

Description of core ACO function that the Applicant ACO expects will be performed by a third party partner or vendor	Brief description of the activities expected to be performed	Expected contract size (in dollars per year) and duration	Name of the third party partner or vendor (if known)	If a vendor is identified, has the vendor been involved in either (1) any fraud investigations initiated, conducted, or resolved within the last three years, or (2) any instances of criminal conduct?

**IV. FINANCIAL PLAN AND RISK-SHARING EXPERIENCE (35 points)**

**A. Revenue Sources**

1. What percentage of the Applicant ACO’s total clinical revenues in the last fiscal year was derived from the following sources? (the Applicant ACO may approximate this through summation of revenue received by all individuals and entities the Applicant ACO expects will be Participant Providers and Preferred Providers for clinical services (e.g., fee-for-service, per-member per-year, per-member per-month, per-episode)).
  - i. Medicare fee-for-service
  - ii. Medicare Advantage
  - iii. Other Medicare health plan (e.g., PACE, Medicare cost plans)
  - iv. Medicaid
  - v. TRICARE
  - vi. Indian Health Service
  - vii. Commercial health plans
  - viii. Self-pay patients
  - ix. Other (please describe):
2. Please describe any other sources of revenue from non-clinical services that the Applicant ACO and its expected Participant Providers and Preferred Providers received in the last fiscal year. Please identify the product or service sold, the percentage of the Applicant ACO’s total revenues (including revenues from clinical services) in the last fiscal year that such revenue comprises, and whether the Applicant ACO expects to receive revenues from such products or services while participating in the ACO REACH Model.

**B. Risk-Sharing Experience**

1. Please describe up to five (5) instances of the Applicant ACO’s performance under prior or current outcomes-based contracts by completing the table below as follows:
  - i. Under “Arrangement,” please provide a name for the arrangement if applicable; if not, simply number the arrangement.
  - ii. Under “Other Party(ies),” please identify the other entity with whom the Applicant ACO entered into the arrangement (whether a payer, a provider/supplier entity,

CMS or CMMI, etc.). Please specifically note any expected Participant Providers or Preferred Providers, if applicable.

- iii. Under “Number of Years,” please indicate the number of years the arrangement was active (and note if it is still active).
- iv. Under “Applicant ACO’s Role,” please indicate whether the Applicant ACO served as the primary administrator or operator of the arrangement, whether some or all of the Applicant ACO’s expected Participant Providers or Preferred Providers participated in the arrangement as direct patient care providers, or both, or otherwise describe the functions and services the Applicant ACO was contracted to provide.
- v. Under “Number of Beneficiaries,” please indicate the number of beneficiaries included in the arrangement if the arrangement spanned a single year, or, if the arrangement spanned multiple years, the annual average number of beneficiaries included.
- vi. Under “Scope,” please provide details on the elements covered in the arrangement (e.g., risk and accountability, payment mechanism or approach, whether there were quality incentives).
- vii. Under “Results” please indicate gross or shared savings generated, data on cost reduction and/or improvement in quality outcomes, or other measures of success. Please provide numerical data where possible.

Arrangement	Other Party(ies)	Number of Years	Applicant ACO’s Role	Number of Beneficiaries	Scope	Results

- 2. Please indicate the percentage of the Applicant ACO’s clinical revenues in the last fiscal year derived from outcomes-based contracts (the Applicant ACO may approximate this through summation of revenue received by the expected Participant Providers derived from outcomes-based contracts). (NOTE: ACO total revenues include: (1) basic payments received by the expected Participant Providers for clinical services (e.g., fee-for-service, per member per year, per member per month, or per episode); (2) supplemental payments the expected Participant Providers received or paid due to risk as part of a financial or cost settlement for shared savings or shared losses; (3) supplemental payments received as quality or cost bonuses (pay-for-performance) for all expected Participant Providers. Total revenue excludes revenues not related to clinical services (e.g., rent, investments) and any revenues specified above that are received by the Applicant ACO). In addition, please describe how the Applicant ACO calculated the percentage of revenue cited (e.g., the expected Participant Providers and services included).



### **C. Implementation Plan**

1. Please describe, in detail, how the Applicant ACO intends to fund and structure its arrangements with Participant Providers and Preferred Providers for the ACO REACH Model. In providing your response, please address the following:
  - i. How will you implement the capitated payments made by CMS in compensating Participant Providers and Preferred Providers?
  - ii. How will your arrangements address Shared Savings and Shared Losses?
  - iii. How will the Applicant ACO fund its administrative activities?
  - iv. How will you use any Shared Savings not distributed to Participant Providers or Preferred Providers?
  - v. Will the Applicant ACO's arrangements with Participant Providers and Preferred Providers address processes or outcomes related to promoting health equity? If so, please provide details.

### **V. CLINICAL CARE MODEL (35 points)**

For A through F, please highlight any experience with Medicare beneficiaries.

#### **A. Care Coordination**

1. Please describe the Applicant ACO's historical and planned approach for using interdisciplinary care teams to coordinate care. Please describe the roles the Applicant ACO plans to establish within a care team, and the process by which the care team will communicate internally and with the appropriate providers/suppliers.
2. Please describe the Applicant ACO's historical and planned processes for incorporating medication management and tracking medication adherence into its care coordination approach.
3. Please provide a narrative description and quantitative documentation of at least one illustrative instance in which the Applicant ACO designed, implemented, and assessed the effectiveness of specific care improvement interventions. Include information on how the problem(s) were identified, why and how the intervention(s) were selected and designed, how progress (or lack thereof) was measured, and any corrective action or adjustments made.
4. For High Needs Population ACO applicants only: Please describe the Applicant ACO's existing capabilities to coordinate services for patients between primary care providers/suppliers, behavioral health providers/suppliers, and Long-Term Services and Supports (LTSS) providers/suppliers.

#### **B. Population Health**

1. Please describe the Applicant ACO's historical and planned population health management and/or population health tools. If applicable, please describe the metrics the Applicant ACO has historically used or plans to use to understand how to deploy clinicians, invest resources, and generally improve quality outcomes while containing or reducing cost of care in managing the Applicant ACO's aligned beneficiary population.

2. Please describe the Applicant ACO's previous experience with furnishing care to underserved communities. Please describe the underserved community(ies) to whom the Applicant ACO has furnished care, and the Applicant ACO's approach to furnishing care specific to the needs and health disparities of such underserved community(ies).
3. Please describe the metrics, if any, the Applicant ACO has previously used for identifying health inequities in its patients served, and the processes the Applicant ACO has used to make improvements to address and mitigate identified health disparities in any identified underserved community.
4. For High Needs Population ACO applicants only: Please describe the Applicant ACO's experience and expertise in serving high cost, high acuity individuals.

#### **C. Care Management**

1. Please describe the Applicant ACO's current or planned methods and processes for coordinating care throughout an episode of care and during care transitions, such as a discharge from a hospital or a transfer of care between providers (both inside and outside the ACO).
2. Please describe the Applicant ACO's historical and planned approaches to improving beneficiary access to care.

#### **D. Beneficiary Engagement**

1. Please describe the Applicant ACO's historical and planned approach to conducting beneficiary outreach. Please describe the goals of the Applicant ACO's beneficiary outreach strategy, the modes of communication you have used or will use to conduct outreach, and how you measure success as it relates to your outreach efforts.
2. Please describe the Applicant ACO's historical and planned approach for evaluating patient, caregiver, and/or family experience of care and satisfaction, the frequency and method(s) through which the Applicant ACO requests such feedback, and how the Applicant ACO has and/or intends to use such feedback to improve its care delivery approach. Please provide at least one concrete example of the Applicant ACO improving its care delivery processes as a result of feedback from patients or patients' caregivers or families.
3. Please describe the Applicant ACO's approach to engaging patients regarding advanced medical directives, hospice care, palliative care, and generally end-of-life care. Please describe specifically the processes employed by the Applicant ACO to ensure that such end-of-life care is respectful of patients' wishes, and that the use of hospice and palliative care are timely and appropriate.
4. Please describe how the Applicant ACO plans to recruit beneficiaries through voluntary alignment. Please describe the safeguards the Applicant ACO has implemented or will implement to ensure that, in conducting voluntary alignment activities, the Applicant ACO does not coerce a beneficiary into voluntary alignment, and to otherwise ensure that beneficiary freedom of choice is honored.

#### **E. Patient Centeredness**

1. Please describe the Applicant ACO's historical and planned processes to ensure that the Applicant ACO furnishes individualized care, such as through the use of personalized care plans.
2. Please describe the Applicant ACO's historical and planned efforts to provide patients with access to their own medical records, and processes for shared decision-making between providers/suppliers, patients, and, if applicable, caregivers. Please describe any decision support tools for use by providers/suppliers and/or patients/caregivers, and any tools or approaches for fostering what might be termed "health literacy" in patients and their families.
3. Please describe the Applicant ACO's historical and planned processes for ensuring that the Applicant ACO provides culturally-competent care, and Applicant ACO's historical and planned approaches for providing high-quality-care to patients who do not speak English or for whom English is a second language.

#### **F. Community Engagement**

1. Please describe the history of collaboration among major stakeholders in the community(ies) being served and commitment from relevant community stakeholders to achieve seamless and comprehensive care. Please include specific examples of community stakeholders with whom the Applicant ACO has a relationship and the nature of each relationship.
2. Please describe the Applicant ACO's historical and planned approaches to address the social determinants of health (e.g., access to transportation, housing stability, food security, income) of aligned beneficiaries.

### **VI. DATA AND HEALTH INFORMATION TECHNOLOGY CAPABILITY (15 points)**

#### **A. Technical Capability**

1. Please describe the Applicant ACO's capabilities to utilize tools to ingest bulk Medicare claims data related to the Applicant ACO's aligned population for purposes of clinical treatment, care management and coordination, quality improvement activities, population-based activities relating to improving health or reducing health care costs, and provider incentive design and implementation. In providing your response, please address whether the Applicant ACO's current software can ingest, process, and transmit data in a FHIR-compliant format, and the Applicant ACO's experience developing and/or using application programming interfaces (APIs) to ingest, transmit, or otherwise use data.
2. Please describe the Applicant ACO's capabilities and ability to securely transfer patient data and care plans between health care settings both inside and outside the Applicant ACO for purposes of care management and care coordination.
3. Please describe the Applicant ACO's data security controls that support identifying, detecting, preventing, responding to, and recovering from security incidents.

**C. Data & Health Information Technology to Inform Clinical Care**

1. Please describe the Applicant ACO’s and expected Participant Providers’ ability to use electronic health record (EHR) data and digital tools to understand patient risk, risk stratify patients, and use this information for decision-making.
2. Please describe the Applicant ACO’s historical and planned use of health information technology (“health IT”) tools, including internally and to support providers/suppliers and patients. Please describe specifically how any identified health IT tools have assisted in the Applicant ACO’s transition, or that of the Applicant ACO’s expected Participant Providers and, if applicable, its expected Preferred Providers, to outcomes-based contracts, and the limitations of using health IT in this transition.
3. Please describe the Applicant ACO’s historical and planned collection and use of demographic (including race, ethnicity, and language preference) data, social determinants of health data, and/or other data to address health disparities.

**VII. Attestation and Signature**

I have read the contents of this application. By my signature, I certify to the best of my knowledge, information, and belief that the information contained herein is true, correct, and complete, that I am authorized to sign this application on behalf of the ACO. I understand that the applicant must not engage in anti-competitive practices, and if it has engaged in such practices, it may not get accepted into the Model. If accepted into the Model, I understand that CMS can rescind the offering of a Participation Agreement or terminate the Participation Agreement if it is determined that the applicant has engaged in anti-competitive practices. I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify CMS of this fact immediately and to provide the correct and/or complete information.

[signature block]