

# ACO REACH Model

## PY 2026 Participant and Preferred Provider Management Guide

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Acronyms

|       |   |
|-------|---|
| 4i    | 4Innovation                                       |
| A&D   | Aged & Disabled                                   |
| ACO   | Accountable Care Organization                     |
| APO   | Advanced Payment Option                           |
| BE    | Benefit Enhancement                               |
| CAH2  | Critical Access Hospital Method 2                 |
| CCM   | Chronic Care Management                           |
| CCN   | CMS Certification Number                          |
| CMMI  | Center for Medicare & Medicaid Innovation         |
| CMS   | Centers for Medicare & Medicaid Services          |
| CPI   | Center for Program Integrity                      |
| DCE   | Direct Contracting Entity                         |
| ESRD  | End Stage Renal Disease                           |
| FQHC  | Federally Qualified Health Center                 |
| GPDC  | Global and Professional Direct Contracting        |
| HCPCS | Healthcare Common Procedure Coding System (HCPCS) |
| MA    | Medicare Advantage                                |
| NPI   | National Provider Identifier                      |
| NPP   | Non-Physician Practitioner                        |
| OACT  | Office of the Actuary                             |
| PCC   | Primary Care Capitation                           |
| PECOS | Provider Enrollment, Chain, and Ownership System  |
| PM    | Payment Mechanism                                 |
| PQEM  | Primary Care Qualified Evaluation and Management  |
| PTAN  | Provider Transaction Access Number                |
| PY    | Performance Year                                  |
| REH   | Rural Emergency Hospital                          |
| RHC   | Rural Health Clinic                               |
| SSN   | Social Security Number                            |
| TCC   | Total Care Capitation                             |
| TIN   | Taxpayer Identification Number                    |

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## Section 1: Introduction

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

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

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

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

Section 4 describes the participant management and screening procedures each provider record must pass in order to participate in the model.

Section 5 describes the Benefit Enhancements and Payment Mechanisms providers may participate in as part of their REACH ACO

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

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

Only Participant Providers are considered for beneficiary alignment and are used for quality measure scoring. Therefore, all REACH ACOs must include Participant Providers. In addition, the Capitation Payment Mechanism chosen by the REACH ACO applies to all Participant Providers. Participant Providers are eligible to qualify for Qualifying Alternative Payment Model Participant (QP) status under the Quality Payment Program (QPP) if they meet the QPP thresholds. For QPP-related questions, please email inquiries to [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or call 866-288-8912. Participant Providers may optionally participate in the Advanced Payment Option (APO) (if the REACH ACO selects Primary Care Capitation (PCC) and APO as its Capitation Payment Mechanisms), Benefit Enhancements (BEs), and Beneficiary Engagement Incentives (BEIs).

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

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

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

<sup>1</sup> Only applicable if the REACH ACO selects PCC and APO.

<sup>2</sup> Further detail on BE and BEI eligibility included in Section 5.

<sup>3</sup> Subject to meeting QPP thresholds.

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

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

- Critical Access Hospitals (CAHs), Methods I and II ('CAH2'<sup>1</sup>).

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

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

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<sup>1</sup> CAH facilities are distinguished by two types of reimbursement for Outpatient Part B services: the Standard Payment Method (Method I) and the Optional Payment Method (Method II, which is also referred to as 'CAH2'). Under the Standard Payment Method, CAH Method I facilities receive reimbursement from their Medicare Administrative Contractor (MAC) for CAH-furnished professional medical services under the Medicare Professional Fee Schedule (MPFS) that are rendered through a hospital outpatient department. Under the Optional Payment Method, physicians or practitioners may reassign billing rights to the CAH, thereby opting not to bill the MAC for professional outpatient services directly and instead receive their professional payment from the CAH. For more information, please review this Medicare Learning Network booklet: <https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf>

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

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

**Table 3.0. Participant Type Identifiers and Medicare Enrollment Forms**

| Participant Type                                      | Individual NPI <sup>1</sup><br>(iNPI) | Taxpayer ID<br>Number <sup>2</sup> | Organization NPI <sup>3</sup><br>(oNPI) | CMS<br>Certification<br>Number <sup>4</sup> | Medicare<br>Enrollment<br>Form <sup>5</sup> |
|---|---------------------------------------|------------------------------------|---|---|---|
| Individual<br>Practitioner <sup>6</sup>               | Required                              | Required                           | Prohibited                              | Prohibited                                  | 855i <sup>7</sup>                           |
| Facility or<br>Institutional<br>Provider <sup>8</sup> | Prohibited                            | Required                           | Required                                | Required                                    | 855A  |
| Organizational<br>Provider <sup>9</sup>               | Prohibited                            | Required                           | Required                                | Prohibited                                  | 855B  |

<sup>1</sup> The NPI for practitioner records.

<sup>2</sup> Either the Employer Identification Number or the Social Security Number.

<sup>3</sup> The Organization NPI to which the physician assigns billing. This is required for Organizational/Group Practices, Facilities, and Institutional Providers.

<sup>4</sup> Only Facilities and Institutional Providers will have a CMS Certification Number.

<sup>5</sup> Certain types of providers/suppliers are prohibited from participating in the ACO REACH model: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers, enrolled in Medicare as Institutional Providers submit Form CMS-855S. Ambulance Service Suppliers and Party B Drug Vendors – technically termed by Medicare Enrollment purposes as "Suppliers:" submits an 855B.

<sup>6</sup> An Individual Practitioner can include a practitioner at a solo practice or sole proprietor that bills for their own services through a corporate entity of which the physician or non-physician practitioner is the sole owner.

<sup>7</sup> See Section 3.1 for additional detail regarding reassignment.

<sup>8</sup> See Section 3.1.2.1 for additional detail regarding practitioners at FQHC/RHC/CAH facilities.

<sup>9</sup> Organizational Providers are non-practitioner clinics and group practice records that submit a Form CMS-855B and are not Institutional Providers.

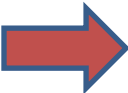
Note that all three participant types are may be Participant Providers and Preferred Providers. However, it is important to carefully consider (1) how each provider or supplier that the REACH ACO wishes to add (as a Participant Provider or Preferred Provider) submits claims to Medicare and (2) how such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

### 3.0.1 Using the 4iInnovation System

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

### 3.0.2 Maintaining Participant Lists across Performance Years

Please note that it is the responsibility of the REACH ACO to maintain the accuracy of the Participant Provider Lists and Preferred Provider Lists for all PYs in which they are participating. In the event of a change to a provider's status, Benefit Enhancements (BEs), or Payment Mechanisms (PMs) that impacts more than one participant list, the ACO must separately update the lists for both periods. **For example, if a provider terminated their relationship with a PY 2025 REACH ACO, the REACH ACO should terminate the provider in their PY 2025 list and separately drop the provider from their PY 2026 list (dropping the provider from the PY 2025 list does not automatically drop the provider from the PY 2026 list).**



REACH ACOs may download their current PY 2025 Provider List from the 4i Participant section using the new "Download Provider List" tab and use the list to populate the bulk upload template for PY 2026. This is the same process completed for PY 2025; however, the new report template will facilitate this process because the fields are an exact match. Please refer to the Participant List Tip Sheet in 4i for more guidance.

### 3.0.3 Certified Electronic Health Record Technology Requirements

ACOs and Participant Providers are required to use Certified Electronic Health Record Technology (CEHRT). REACH ACOs are required to attest that their PY 2026 Participant Providers will use CEHRT or qualify for an exception to the CEHRT use requirement.

*Exceptions include:*

- Failure to meet the low volume threshold as defined in [42 CFR § 414.1305](#);
- Qualifies for reweighting of the MIPS Promoting Interoperability performance category to zero percent of the final score, in accordance with 42 CFR § 414.1380(c)(2)(i) for the applicable year; or
- Is an eligible clinician as defined in 42 CFR § 414.1305 and is not a MIPS eligible clinician as defined in 42 CFR § 414.1310(b)(2), provided they cannot be excluded solely on the basis of being a Qualifying APM Participant or a Partial Qualifying APM Participant.

*Attestations must be completed in 4i in advance of the September 2025 Provider Window; otherwise, REACH ACOs may be subject to compliance actions by CMS, such as a corrective action plan (CAP) or other remedial action.*

### 3.0.4 Adding Records to the Participant List

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

A Participant Provider may include one or more legacy TINs in the 4i submission if that TIN was previously used by the provider but is no longer in use by that provider.<sup>2</sup> A Participant Provider may include a single legacy CCN if the provider is practicing at a Rural Emergency Hospital (REH) that was previously a CAH or if an FQHC, RHC, or CAH underwent a change in circumstances (e.g. change in ownership) resulting in a change in CCN. Submitted legacy TINs and legacy CCNs for Participant Providers will be used in claims-based alignment and are subject to model overlap checks (see Section 3.1.1.2 for additional details on legacy TIN overlap checks).

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<sup>2</sup> Further guidance for how to submit multiple legacy TINs as applicable is available in the Provider Management in 4i Tip Sheets available in the 4i Knowledge Library: <https://4innovation.cms.gov/secure/knowledge-management/view/451>



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

1. If the provider in question (1) bills (at the time of the addition) for items and services they furnish under a TIN that is used by an active Participant Provider in the same REACH ACO (TINs used by *only* Preferred Providers do not qualify), and (2) was not able to bill under that TIN when the ACO submitted its Provider List prior to the start of the PY;<sup>3</sup>
2. If the Participant Provider bills under a TIN that has been acquired by or merged with an existing TIN on the ACO's Participant Provider List since the ACO submitted its Provider List prior to the start of the PY;
3. If (1) the Participant Provider was dropped by CMS from the ACO's final ACO REACH Participant Provider List prior to the start of the PY due to overlaps with another CMMI model or shared savings initiative (e.g., Medicare Shared Savings Program) and (2) that overlap has since been resolved;
4. If the (1) Participant Provider was dropped by CMS from the ACO's final ACO REACH Participant Provider List prior to the start of the PY due to failing PECOS and (2) the Participant Provider is now passing PECOS.

Providers not present on the REACH ACO's Provider List submitted by the final drop deadline prior to the beginning of the Performance Year are not eligible to be added under the third and fourth conditions listed above, as CMS requires a record that these providers were initially submitted by the REACH ACO and initially failed the PECOS and/or overlap check in order to validate eligibility.

**Note:** If you receive a PECOS check error or an overlap error when entering your proposed Participants for PY 2026, do not delete or drop the Participant entry. Leave the entry in 4i so that CMS has an audit trail to verify resolved PECOS and overlap ad hoc additions during PY 2026.

Further details on adding providers during the Performance Year are provided in the PY 2026 Ad Hoc Provider Guidance available in 4i's Knowledge Library.

### 3.0.5 Dropping Records from the Participant List

ACOs may drop providers that have not yet been approved prior to the close of the initial 4i window (prior to the Performance Year) or during respective Ad Hoc window (during the Performance Year). Providers that are dropped from the Participant List *before* the respective 4i window closes are not submitted for CMS review for participation in the model (see Section 4 for approval criteria). Note: if an ACO submits a provider as a Participant Provider during an Ad Hoc window during the Performance Year that they expect will meet conditions 3 or 4 described in Section 3.0.3 and in the PY 2026 Ad Hoc Provider Guidance, the provider must have been included on the REACH ACO's Participant List as a Participant Provider at the close of the initial pre-PY 4i window. Therefore, REACH ACOs are advised not to drop Participant Providers who do not pass the initial PECOS Check and/or Overlap Check on the initial proposed Participant List in order to qualify for those conditions during the Performance Year.

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<sup>3</sup> CMS determines ability to bill based upon the provider's PECOS record.

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

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

#### 3.1.1 Individual Practitioner

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

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

Some Medicare-enrolled physicians or NPPs may practice independently, in a group practice setting, or at multiple practice locations. They may have the following designations:

1. Sole Proprietor: An individual practitioner that has a private practice or a professional corporation, professional association, etc., in which they are the sole owner.
2. Group Practitioner: An individual practitioner in a physician group practice that is not an FQHC/RHC/CAH2.

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

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

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

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

- The Individual NPI (iNPI). This NPI is used to identify services on professional claims at the claim line level ('rendering physician'); and
- The Billing TIN. This TIN may be submitted on professional claims submitted to Medicare but is not a required field. If the Billing TIN is not submitted on the claim, the Billing NPI<sup>5</sup> appearing at the claim header level for professional claims is used to lookup its associated TIN in PECOS.

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

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

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

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

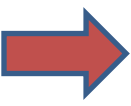
### 3.1.1.1 Sole Proprietors

If the Individual Practitioner is a Sole Proprietor, the relevant TIN to enter in 4i may be the practitioner's Social Security Number (SSN) or a TIN operated by the practitioner's solo practice (i.e., EIN). For Sole

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

Proprietors, the Individual NPI must map to the Sole Proprietor's Billing TIN since there is no reassignment relationship in these cases. It is imperative that the Billing TIN, not the Enrollment TIN, is submitted for Sole Proprietors. In most cases, if the Enrollment TIN and Individual NPI are submitted for a Sole Proprietor, these identifiers will not map to claims. Only the Billing TIN and Individual NPI will map to claims. As such, if a REACH ACO does submit the Enrollment TIN and Individual NPI for a Sole Proprietor record, when the PECOS check is run, the Enrollment TIN will automatically be updated to the Billing TIN, which will be displayed in 4i. The Billing and Enrollment TINs (EIN and SSN) will be used for claims-alignment purposes, and only the Billing (EIN) TIN will be used for capitation purposes. (Note: Sole Proprietor records will be identified as such in 4i once the PECOS check is complete.)



**Note:** If the ACO is unsure of the correct TIN to enter in 4i for a sole proprietor (EIN or SSN), and the provider cannot confirm the information, the ACO should contact the ACO REACH Helpdesk and may make two entries for the sole proprietor: one with the EIN and NPI and the other with the SSN and the NPI. If a second entry is not accepted by 4i after adding the first, the ACO should confirm if the Sole Proprietor section of the first entry's record in 4i is "Yes". If so, 4i has recorded both the EIN and SSN in that entry. If not, the ACO should contact the ACO REACH Helpdesk.

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

#### 3.1.1.2 Legacy Record

A *Legacy Record* identifies the TIN or CCN that was used by a health care professional who is a Participant Provider in a given Performance Year when billing for primary care services during the 24-month *Alignment Period* associated with that Performance Year, but that will not be used by the professional to bill for primary care services during the Performance Year itself. For PY 2026, the ACO should include any Legacy Record used by the Participant provider during the period July 1, 2023 through June 30, 2025. There are two types of legacy records:

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

Only Individual Practitioners are eligible to submit legacy TINs in 4i. Facilities and Institutional Providers are not eligible to submit legacy TINs because the TIN is not used for alignment purposes. For these provider types, the CCN is present on the claim and used for alignment purposes. Individual Practitioners at Rural Emergency Hospitals (REH), that were previously CAHs or RHCs may submit a single legacy facility CCN to ensure that claims incurred when the REH was previously a CAH are considered in alignment processes. FQHCs, RHCs, and CAHs that undergo a change in circumstances (e.g., change in ownership) resulting in a CCN change may also submit legacy CCNs. Other provider types may not submit legacy CCNs. Preferred Providers are eligible to submit legacy TINs (or legacy CCNs, if applicable) for capitation calculation purposes; however, legacy TINs (or any other identifiers) for Preferred Providers are not used for alignment purposes.

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

The ACO REACH model does not require ACOs to obtain written permission from a TIN owner to enter an 'active' Legacy TIN List for PY 2026 or any subsequent performance years. Instead, the REACH ACO should simply notify the 'active' legacy TIN of its usage.

### 3.1.2 Facility or Institutional Provider

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

1. TIN;
2. Organization NPI; and
3. CMS Certification Number.

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

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

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

An Institutional Provider is not an individual physician, non-physician practitioner, or physician group practice.

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

CCNs are assigned by CMS following reviews and inspections of the facilities and institutions. The format for a CCN is SSNNNN or SSNNNNN where “SS” represents a State code and “NNNN” or “NNNNN” represents the type of facility being certified. Section 2779A of the [CMS State Operations Manual](#) describes the complete numbering system for CCNs. For example, the State code 01 represents Alabama and the range of codes 0001-0879 represents acute care hospitals. Therefore, CCN 010800 represents an Alabama acute care hospital. ACOs may use the State Operations Manual reference to verify that the CCNs entered in 4i represent the intended type of facility or institutional provider. Entering the correct CCN affects the ACO’s beneficiary alignment and capitation.

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

Adding a Facility or Institutional Provider does not add all practitioners who practice at or are employed by that Facility or Institutional Provider. For example, adding a hospital does not also add all employed physicians who work at that hospital (though it will cover any institutional claims they submit under the hospital’s CCN, per above). If hospital-employed physicians also practice elsewhere and/or bill professional claims, they must be added as Individual Practitioners (see above) for those claims to be identified for claims-based alignment and capitation purposes.

### 3.1.2.1 Practitioners at FQHC, RHC, or CAH2

For FQHC, RHC, and CAH2s, REACH ACOs may also add the Individual NPIs that identify the practitioners that practice in the FQHC/RHC/CAH2 under the FQHC/RHC/CAH2 Facility or Institutional Provider record for Participant Providers only. The Individual NPI is typically the rendering NPI on the claim header for institutional claims and must be enrolled to bill Medicare in order to be valid. Like Individual Practitioner records (see Section 3.1.1), Individual NPIs<sup>6</sup> added under a FQHC/RHC/CAH2 Facility or Institutional Provider record where the FQHC/RHC/CAH2 Facility or Institutional Provider record is a Participant Provider will count towards voluntary alignment only and be used to determine which attestations are valid.

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

### 3.1.3 Organizational Provider

For purposes of the REACH ACO operating policies and procedures, an *Organizational Provider*

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

is an organizational entity that has an agreement to participate in Medicare. Organizational Providers enroll in Medicare using the CMS 855B form.

Examples of Organizational Providers include but are not limited to:

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

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

Typically, the Organizational NPI is the billing NPI on the claim header based on the corresponding TIN for professional claims. Organizational Providers are not used for claims-based alignment (i.e., adding a Participant Provider as an Organizational Provider Participant Type will not affect the REACH ACO's claims-based alignment, even if the provider record in question is a primary care practice).

Organizational Providers can contribute to Capitation or Advanced Payment Option calculations if the provider in question agrees to receive FFS claims reductions associated with Capitation or APO.

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

## Section 4: Participant Management and Screening Procedures

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

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

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

- PECOS Check for Medicare Enrollment
- ACO REACH Duplicates Check
- 4i Provider Attestation Check
- Preliminary Program Overlaps Check<sup>7</sup>

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

- Program Integrity Screening
- Final Provider Overlaps Check

### 4.1 PECOS Check for Medicare Enrollment

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

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

If a provider fails the PECOS check prior to the beginning of the Performance Year (as of the September 8, 2025 deadline for PY 2026), the provider may still be eligible to be added at a later date during the Performance Year as part of an ad hoc window. In order to be eligible to be added during the Performance Year as a Participant Provider, the provider must then pass the PECOS check as well as meet all eligibility criteria for Participant Provider additions during the PY. Note: REACH ACOs that may decide to re-submit these records during the Performance Year should still attempt to add these

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



records to their Provider List prior to the beginning of the Performance Year, as CMS requires a record of these providers being initially submitted by the REACH ACO. Providers that are not submitted prior to the beginning of the Performance Year may be eligible to be added as Preferred Providers. More details will be included in the PY 2026 Ad-Hoc Provider Guidance.

#### **4.2 ACO REACH Duplicates Check**

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

A Participant Provider may be identified as a Participant Provider by one and only one REACH ACO. A Preferred Provider may be identified as a Preferred Provider or a Participant Provider by another REACH ACO, or as a Preferred Provider/Supplier in another Medicare ACO or other shared savings model/demonstration except for Maryland Total Cost of Care.

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

#### **4.3 4i Provider Attestation**

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

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

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

#### **4.4 Program Integrity Screening**

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

#### 4.5 Provider Overlap Check

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

**Table 4.3. Initiatives for which Provider Overlap is Prohibited for PY 2026**

| Initiative                      | Participant Provider Overlap                                  | Preferred Provider Overlap         |
|---------------------------------|---|------------------------------------|
| Another REACH ACO               | Prohibited  | Allowed                            |
| Medicare Shared Savings Program | Prohibited  | Allowed                            |
| Kidney Care Choices Model       | Prohibited  | Allowed                            |
| GUIDE Model                     | Allowed   | Allowed                            |
| AHEAD Model                     | Overlap permitted for primary care providers with conditions* | Overlap permitted with conditions* |
| TEAM Model                      | Allowed   | Allowed                            |

\* Overlaps are prohibited between AHEAD and ACO REACH for Participants and Preferred Providers that are hospital facilities (acute care hospitals, FQHCs, and RHCs) and are electing a Payment Mechanism (TCC, PCC, and/or APO). Further details can be found in the AHEAD Model Overlaps Policies Fact Sheet: <https://www.cms.gov/files/document/ahead-overlaps-fs.pdf>

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

Selecting Benefit Enhancements (BEs), Beneficiary Engagement Incentives (BEIs), and Payment Mechanisms (PMs) is a 2-step process. First, REACH ACOs must decide which BEs, BEIs, and PMs they will offer their aligned Participant Providers and Preferred Providers through 4i. Second, REACH ACOs must assign BEs, BEIs, and PMs to their aligned Participant and Preferred Providers with whom they have established financial arrangements (as applicable) through 4i. Only records that pass validation in the 4i tool will be accepted for further processing. **To reiterate, REACH ACOs must make BE, BEI, and PM elections on behalf of Participant Providers and Preferred Providers submitted and approved for the final Participant Provider and Preferred Provider List.** The timeline for submitting BEs, BEIs, and PMs for each Performance Year will be shared by CMS. Any elections submitted for providers that were not approved for participation in the model will be rejected. Only REACH ACOs that have signed agreements with CMS, their Participant Providers, and their Preferred Providers may participate in BEs, BEIs, and PMs.

### 5.1 Payment Mechanism Elections

Participant Providers for REACH ACOs participating in Total Care Capitation (TCC) or Primary Care Capitation (PCC) are required to participate in their REACH ACO's selected Capitation Payment Mechanism. In PY 2026, Participant Providers in ACOs that have elected PCC at the entity level will be required to accept 100% PCC claims reduction. REACH ACOs that elect PCC will have the additional flexibility to contract with Participant Providers and Preferred Providers under the Advanced Payment Option (APO). Preferred Providers may elect to participate in their REACH ACO's selected Capitation Payment Mechanism or participate in the Advanced Payment Option. A REACH ACO in the Professional Risk Sharing Option may not select the Total Care Capitation Payment Mechanism.

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

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

<sup>8</sup> An updated version for PY 2026 of the ACO REACH Model will become available summer of 2025.

<sup>9</sup> See REACHPY2024FinancialOperatGde.pdf for more details: <https://4innovation.cms.gov/secure/knowledge-management/view/1241>

providers (non-FQHC/RHC) are not eligible to elect PCC but may elect the APO on an optional basis.

Participant Providers in a REACH ACO that elected TCC must elect reductions of 100% for all Performance Years. Preferred Providers participating in TCC may elect reductions greater than or equal to 1% but less than or equal to 100% for all PYs. Participant Providers and Preferred Providers in a REACH ACO that elected TCC are not eligible to elect the APO. In PY 2025 and 2026, Participant Providers in ACOs that have elected PCC at the entity level, must have 100% claims reduction. Preferred Providers still have the option to elect PCC or not.

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

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

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

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

| <b>Payment Mechanism Elected by the REACH ACO</b>  | <b>Participant Providers</b>                              | <b>Preferred Providers</b>   |
|--|---|--|
| TCC  | Must Participate<br>100% Claims Reduction, all PY's       | Optional for all PY's<br>If selected, 1-100%<br>Claims Reduction, all PY's |
| PCC  | Must Participate<br>100% Claims Reduction, PY 2025 onward | Optional for all PY's<br>If selected, 1-100%<br>Claims Reduction, all PY's |
| APO (Option only available if PCC is also elected) | Optional<br>If selected, 1-100% for all PYs               | Optional<br>If selected, 1-100% for all PYs                                |

**5.2 Benefit Enhancements and Beneficiary Engagement Incentives**

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

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

| <b>Benefit Enhancement Type</b>              | <b>Risk Option</b>      | <b>Participant Type</b>  |
|--|-------------------------|--|
| Telehealth Expansion Waiver                  | Professional and Global | All  |
| Post Discharge Home Visit                    | Professional and Global | Individual Practitioners only <sup>1</sup>                     |
| SNF 3-Day Stay Waiver <sup>2</sup>           | Professional and Global | Facilities with eligible CCN ranges <sup>3</sup>               |
| Care Management Home Visit                   | Professional and Global | Individual Practitioners only <sup>1</sup>                     |
| Concurrent Care for Hospice Beneficiaries    | Global only             | All  |
| Home Health Homebound Waiver                 | Professional and Global | Home Health Agencies only <sup>4</sup>                         |
| Diabetic Shoes Waiver                        | Professional and Global | Nurse Practitioners and Physician Assistants only <sup>5</sup> |
| Cardiac and Pulmonary Rehabilitation Waiver  | Professional and Global | Nurse Practitioners and Physician Assistants only <sup>5</sup> |
| Home Infusion Therapy Waiver                 | Professional and Global | Nurse Practitioners and Physician Assistants only <sup>5</sup> |
| Medical Nutrition Therapy Waiver             | Professional and Global | Nurse Practitioners and Physician Assistants only <sup>5</sup> |
| Hospice Care Certification Waiver            | Professional and Global | Nurse Practitioners and Physician Assistants only <sup>5</sup> |
| <b>Beneficiary Engagement Incentive Type</b> | <b>Risk Option</b>      | <b>Participant Type</b>  |
| Part B Cost Sharing Support                  | Professional and Global | All  |
| Chronic Disease Management Reward            | Professional and Global | All  |

<sup>1</sup> Only refers to Individual Practitioner Provider Record Type. Non-practitioner providers, including Organizational Providers, Facilities, and Institutional Providers are prohibited from the electing the respective BE

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

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

<sup>4</sup> In order to be eligible to submit claims for services furnished under this BE, the individual or entity must be a home health agency that is a Participant Provider or Preferred Provider. Applicable ranges for CCNs for the Home Health Homebound Waiver are the

<sup>5</sup> Only refers to providers that have Nurse Practitioner or Physician Assistant listed as their specialty type.

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

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

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

The SNF Star Rating policy is subject to change and any further updates to the policy will be communicated to REACH ACOs. Note: CAHs with swing bed approval are exempt from meeting the Nursing Home Star Rating criteria outlined above.

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

A Participant Provider or Preferred Provider that is a practitioner may also participate in the Post-Discharge Home Visit Waiver or Care Management Home Visit Waiver. Institutional providers (facilities) cannot participate in either of these two waivers.

A Participant Provider or Preferred Provider that is an individual practitioner and either a nurse or physician assistant may participate in the Diabetic Shoes Waiver, Cardiac and Pulmonary Rehabilitation Waiver, Home Infusion Therapy Waiver, Medical Nutrition Therapy Waiver, and Hospice Care Certification Waiver. Institutional providers (facilities) cannot participate in these waivers.

### 5.3 4i Benefit Enhancement Report

You can review the BEs and PMs applied to your Participant Providers and Preferred Providers as an Excel file or csv available in 4i. This extract is called the Benefit Enhancement Report. Each row represents a record corresponding to a provider's association with the REACH ACO (Value Code 0) or the Provider's BE, BEI, or PM enrollment (Value Codes 1-5, 7-9, A, B, H-K, SF3, or SF4). This report serves as a valuable reference for a Provider's period of alignment to the REACH ACO and the effective start and termination dates of each BE and PM applied to that Provider. A REACH ACO's review of this report is **strongly advised** prior to certifying the PY Participant and Provider Lists, in addition to certifying BE, BEI, and PM elections. Records in this file represent the last status of each record ever attributable to the REACH ACO during a given PY. To download the extract, please follow the below steps:

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

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

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

computer.

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

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