Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model
Application Process and Results Frequently Asked Questions
Revised August 15, 2022

Why did CMS decide to offer an RFA for ACO REACH?
ACOs are a critical component of CMS' goals to advance health equity, support high-quality, person-centered care, and promote affordability and sustainability in Medicare. ACOs bring together groups of doctors, hospitals, and other health care providers to deliver coordinated care to beneficiaries. Providing an opportunity for another cohort to join the ACO REACH Model allows CMS to build momentum of provider-led organizations participating in risk-based models, helps to ensure CMS has the scale required to evaluate the new policies included in the ACO REACH Model, particularly those related to advancing health equity, and increases the number of beneficiaries in relationships with health care providers who are accountable for their care.

When will provisionally accepted[1] applicants begin participation?
Provisionally accepted applicants that continue to meet all conditions and requirements for participation will have the option to join the Implementation Period (IP3), beginning on August 1, 2022, and ending on December 31, 2022. The Model Performance Period (MPP) for the redesigned ACO REACH Model, during which participating ACOs will take on risk for the cost and quality of care for the traditional Medicare beneficiaries they serve, begins on January 1, 2023. The MPP will span four Performance Years, ending on December 31, 2026.

The IP3 is an opportunity to conduct activities in preparation for meeting ACO REACH Model requirements. Participation in the IP3 does not obligate an accepted applicant to participate in the MPP, and choosing not to participate in the IP3 does not prevent a provisionally accepted ACO from participating in the MPP. CMS will not share data with participants in the IP3 and participating ACOs do not take on responsibility for the cost and quality of care for Medicare beneficiaries during the IP3.

What innovations or benefits will these organizations offer to patients?
ACOs participating in the model will be expected to offer high-quality, coordinated care to their patients. Participating health care providers are incentivized to collaborate across multiple treatment plans, spend more time with patients with complex, chronic conditions and ultimately, improve patient health outcomes. Patients will be empowered to engage in their health care with support from organizations that help them to navigate the complex health care system.

Some examples of what organizations currently participating in the GPDC model offer Medicare patients:

- **Efforts to improve diabetes control.** A physician-owned and physician-directed organization that was established during COVID serves a diverse, complex patient base in a large urban area. In less than a year, this organization reported the number of Medicare beneficiaries with good diabetes control (based on A1c levels) has increased from 55 percent to 73 percent.
- **Preventive, dental, and behavioral health care for underserved patients.** An organization partnering with Federally Qualified Health Centers furnished preventive health services, dental services and behavioral health to underserved patients in rural communities of Massachusetts and Georgia.
- **Access to care in the home**. An organization in a southwest state offers its patients several enhanced services concurrent with other Medicare services using the flexibilities offered under this model

[1] Prior to being offered the Model Performance Period (MPP) Participation Agreement (PA) for signature, we refer to all accepted applications as 'provisionally accepted' due to the remaining conditions that must be satisfied before a given applicant begins participation in the MPP. Please review the ACO REACH Model Application Process and Results Fact Sheet, available on the ACO REACH Model website, for further information.

including: primary care home visits for home-bound patients, palliative care, nutrition counseling, and pain management.

- **Team-based care to meet patient needs.** An organization's care management team helps bridge care gaps between primary, specialty and emergency care that could result in hospital readmission. By identifying these gaps and coordinating additional medical and community resources to address patient care needs, patients are able to remain at home during recovery.
- **Social needs and community-building.** To address social isolation that has affected Medicare beneficiaries during the COVID pandemic, one organization has a community room in its clinics that offers free yoga classes, monthly birthday parties, holiday celebrations, and "tell my story" days.
- **Pharmacy coordination / medication management.** An organization's multi-disciplinary team incorporates a pharmacist and offers medication management support to help patients keep track of their medication(s), a frequent source of confusion, and identify any contra-indicated prescriptions, which can result when care is not coordinated across specialists.

When will CMS announce the list of provisionally accepted ACOs, which ACOs are participating in the third Implementation Period (IP3) and which ACOs are participating in PY2023 of the ACO REACH Model?

CMS announced the list of provisionally accepted ACOs on August 15, 2022. Provisionally accepted ACOs that remain eligible to participate in ACO REACH had until late July 2022 to decide whether to participate in the IP3 and have until late December 2022 to decide whether to participate in PY2023. Additionally, CMS published the list of ACOs participating in the IP3 on August 15, 2022. CMS will publish the list of ACOS participating in PY2023 in early January 2023. As CMS has done in the past, we will include supplementary information on the participating ACOs in these announcements as available, including ACO type, risk sharing option, state(s) where the ACO operates, and ACO website.

Why were less than 128 provisionally accepted ACOs named in the August 15 announcement, when CMS has stated previously that 128 ACOs were provisionally accepted?

As noted in the August 15 announcement, the number of provisionally accepted applicants named is less than 128, since CMS has not included any organizations that have withdrawn their application after receiving provisional acceptance.

What other information is CMS planning to publish related to the ACO REACH Model, and when?

CMS is planning to publish additional materials related to the ACO REACH Model, including information related to performance under the Global and Professional Direct Contracting (GPDC) Model[2] during PY2021 and PY2022, including:

- Methodology papers covering the details of the financial, quality, and alignment policies under the redesigned ACO REACH Model. These policy papers will be made available during the late summer of 2022 on the ACO REACH Model website under the 'Methodology Paper' header.
- Additional information for the health equity related policies will be made available during the late summer of 2022 on the ACO REACH Model website.
- Aggregate data on overall quality performance, financial performance, and model payments under the GPDC Model. This information will be updated on a quarterly basis and made available on the GPDC Model website under the 'Additional Information' header.
- Participant level data on performance in PY2021 of the GPDC Model, once such data is finalized in late 2021. This data will be made available on the GPDC Model website.

Will there be other opportunities to apply for participation in the ACO REACH Model?

[2] The ACO REACH Model is a redesign of the GPDC Model, which began on April 1, 2021. The ACO REACH Model is a time-limited test; the first performance year of the redesigned model starts January 1, 2023 and the Model will span four Performance Years, ending on December 31, 2026.

At this time, CMS is not planning any other application opportunities for the ACO REACH Model.

What does this announcement mean for beneficiaries?
There are no immediate implications for beneficiaries based on this announcement. All beneficiaries aligned to REACH ACOs participating in the ACO REACH Model remain in Traditional Medicare and retain all of their rights, coverage, and benefits, including the freedom to see any Medicare provider or supplier. Like previous ACO models, the ACO REACH Model prohibits limited networks, prior authorization or any other means of restricting care. Beneficiaries aligned to a REACH ACO always maintain the freedom to see any Medicare-enrolled provider or supplier. CMS expects that beneficiaries whose primary care provider is part of a REACH ACO may see and feel improvements in the quality of health care they are getting because of the ACO REACH Model. For example, they may receive increased access to telehealth, home visits after leaving the hospital, cost sharing support to help with co-pays, or other enhanced services and incentives. Moreover, the new health equity provisions are expected to provide greater access to the benefits of value-based care for underserved communities, reaching beneficiaries who have not previously received coordinated care.

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

In addition, CMS will closely monitor levels of care provided over time and compare care delivery patterns to a reference population to determine if REACH ACOs are stinting on beneficiary care. CMS also will conduct compliance audits throughout the year, investigate beneficiary complaints, and conduct beneficiary experience of care surveys (CAHPS) annually to measure changes in beneficiary satisfaction. Lastly, CMS will monitor whether beneficiaries aligned to REACH ACOs participating in the model are being shifted into or out of Medicare Advantage.

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

Will CMS provide a reconsideration process for organizations whose applications were not accepted?
CMS will not be providing a reconsideration process for organizations whose applications were not accepted or details regarding why an application was not accepted. This is consistent with the approach the Innovation Center has taken in prior voluntary models. Applicants may reference the ACO REACH Model Request for Applications (RFA) and the ACO REACH Model Application Process and Results Fact Sheet for information on the selection criteria and process that CMS employed in reviewing all applications.

Will CMS share the names of the applicants who were accepted and not accepted?
CMS is sharing the names of provisionally accepted ACOs on August 15, 2022. CMS is not planning on sharing the list of ACOs whose applications were not accepted.