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

Application Process and Results Fact Sheet

June 30, 2022

Overview

On February 24, 2022, the Centers for Medicare & Medicaid Services' (CMS') Center for Medicare and Medicaid Innovation (Innovation Center) released a Request for Applications (RFA) for new applicants interested in joining the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model in Performance Year 2023 (PY2023). The ACO REACH Model is a redesign of the Global and Professional Direct Contracting (GPDC) Model, which began on April 1, 2021. The changes made to the Model reflect the priorities of the Biden-Harris Administration to further test how to promote the provision of equitable and accountable care to Medicare beneficiaries and respond to feedback from stakeholders and participants. The ACO REACH Model was designed around the following priorities: greater focus on health equity and closing disparities in care, an emphasis on provider-led organizations, strengthening beneficiary voices, stronger beneficiary protections through ensuring robust compliance with the Model's requirements, and increased screening of Model applicants and monitoring of Model participants.

CMS is committed to providing transparency throughout the implementation of the ACO REACH Model, and is releasing this Fact Sheet on the application process as part of that commitment. This document covers the following topics:

I. RFA response and results
II. Summary of application screening process
III. Next steps for applicants

The ACO REACH Model is a time-limited test; the first performance year of the redesigned Model starts January 1, 2023 and will span four Performance Years, ending on December 31, 2026. This period, during which participating ACOs will take on responsibility for the cost and quality of care for the Traditional Medicare beneficiaries they serve, is referred to as the Model Performance Period (MPP). A Participation Agreement (PA), the formal document containing all requirements and policies of the Model, will be offered for signature to applicant ACOs accepted under the ACO REACH Model RFA in December 2022. While participation is optional, accepted ACOs must sign the PA in order to participate in the ACO REACH MPP. CMS plans to announce the full list of ACOs participating in PY2023 of the ACO REACH Model in early January 2023, once all accepted ACOs have made final participation decisions (i.e., after the deadline to sign the PA has passed).

CMS is also offering an optional Implementation Period (IP3[1]) to provisionally accepted ACOs (note: all applicant ACOs accepted under the ACO REACH RFA will be referred to as 'provisionally accepted ACOs' prior to being offered the MPP PA for signature; see **Section III** of this document for details). The IP3 is an opportunity to conduct activities in preparation for meeting requirements of the ACO REACH Model. Provisionally accepted ACOs interested in joining the IP3 must sign the IP3 PA in July 2022. Participation in the IP3 is optional; further, participating in the IP3 does not obligate a provisionally 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.

CMS plans to announce the full list of ACOs participating in the IP3 of the ACO REACH Model in early August 2022, once all provisionally accepted ACOs have made final participation decisions about joining IP3 (i.e., after the deadline to sign the IP3 PA has passed). Active participants in the GPDC Model are eligible to transition to the ACO REACH Model MPP, provided they maintain a strong compliance record in 2022 and agree to meet all the ACO REACH requirements beginning January 1, 2023, by signing the ACO REACH Model PA.

I. RFA response and results

CMS received a robust response to the ACO REACH Model RFA: a total of 271 completed applications were submitted. In some cases, the same organization may have submitted multiple applications, for example if it was seeking to participate with separate ACOs in distinct geographies. In this summary, we count each application separately (i.e., an organization submitting two applications would count as two applications in the total). Table 1 and Figure 1 below summarize how the 271 completed applications break down by Model option, ACO type, and applicant composition.

CMS' selection process balanced several factors including: CMS' strategic goal of having Medicare beneficiaries in accountable relationships with health care providers; the need to have sufficient scale to evaluate new features in the Model; the volume of applications submitted; and the need to maintain a Model size that CMS can adequately support. CMS set a high bar for acceptance using a rigorous application review process (described below in **Section II**). CMS provisionally accepted[2] 128 out of the 271 completed applications (47%). Table 2 and Figure 1 summarize how the 128 provisionally accepted applications break down by Model option, ACO type, and applicant composition.

[1] Per page 8 of the RFA, the Implementation Period is referred to as IP3 since it will be the third such Implementation Period over the life of the Model.

[2] Prior to being offered the MPP 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 see **Section III** below for further discussion.

This result represents a lower acceptance rate compared to prior Innovation Center models and reflects the strong interest in this Model combined with CMS' stated goals in redesigning the ACO REACH Model.

Table 1: Total completed applications by Model Option and ACO Type

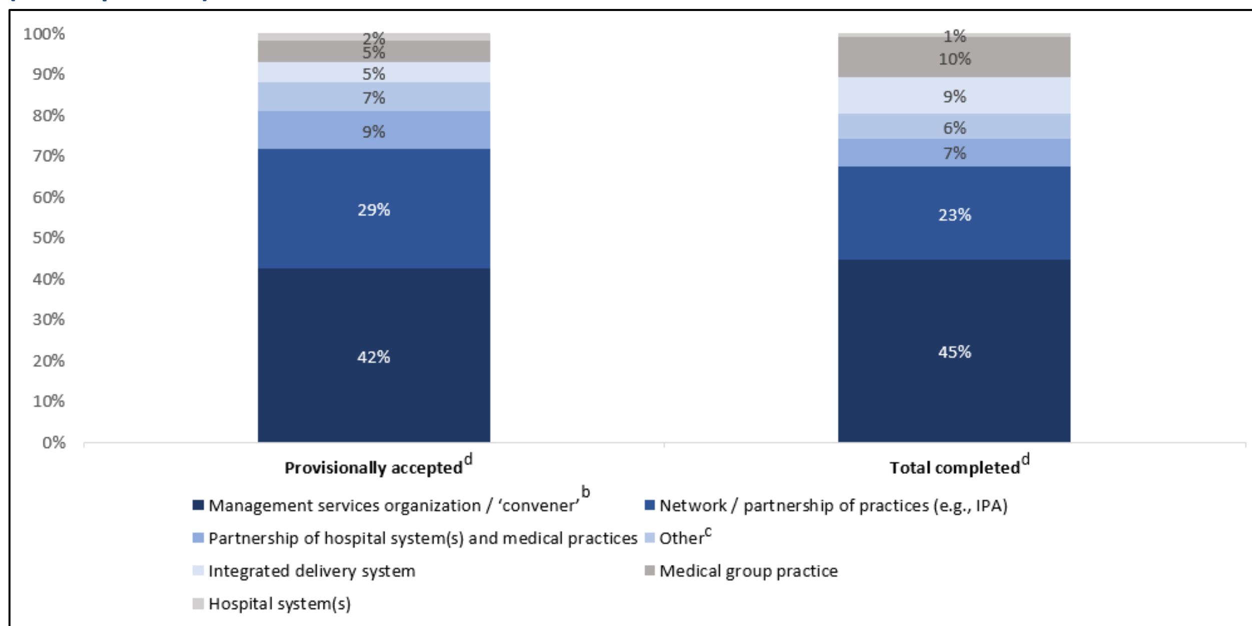
	Standard ACO[a]	New Entrant ACO[b]	High Needs Population ACO[c]	Total
Professional[d]	38	29	22	**89**
Global[e]	122	25	35	**182**
Total	**160**	**54**	**57**	**271**

a) Standard ACOs – ACOs comprised of organizations that generally have experience serving Medicare fee-for-service (FFS) beneficiaries and in FFS-based value-based arrangements. Please see the RFA for more details.
b) 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. Please see the RFA for more details.
c) High Needs Population ACOs – ACOs that serve Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries. Please see the RFA for more details.
d) Professional – A lower-risk option with 50 percent Shared Savings/Shared Losses. Please see the RFA for more details.
e) Global – A full risk option with 100 percent Shared Savings/Shared Losses. Please see the RFA for more details.

Table 2: Provisionally Accepted[1] Applications by Model Option and ACO Type

	Standard ACO	New Entrant ACO	High Needs Population ACO	Total
Professional	19	11	7	**37**
Global	67	9	15	**91**
Total	**86**	**20**	**22**	**128**

Figure 1: Total completed and Provisionally Accepted[1] Applications by applicant composition (self-reported[a])



a) Responses were self-reported by applicants in their applications.
b) Management services organization / 'convener' – an organization that does not itself include Medicare-enrolled providers or suppliers, but instead provides administrative and supportive services to facilitate the participation of partner Medicare-enrolled providers and suppliers in value-based care.
c) Applicant ACOs that selected the 'Other' were prompted for additional detail; responses included: joint venture between a provider practice and a management services organization, alliance of FQHCs/FQHC-based organization, partnership of Integrated Delivery Network and independent physician practices, home care-based provider organization, clinical care support company, and partnership of hospitals, critical access hospitals (CAHs), and rural health clinics (RHCs).
d) May not sum to 100% due to rounding

II. Summary of application screening process

CMS used a detailed application review process to ensure that (1) all applications were reviewed fairly and consistently; (2) provisionally accepted applicants were qualified, aligned with CMS' stated goals for the Model, and well positioned to succeed given the requirements of the ACO REACH Model; and (3) provisionally accepted applicants pose minimal program integrity risks to the ACO REACH Model.

The screening and review process consisted of the following four components, each of which is discussed further below:

1. Application completeness review
2. Assessment of application content
3. Assessment of program integrity risks posed by the applicant
4. Final determination

1. Application completeness review

Each application was reviewed to determine whether it was satisfactorily completed. Applications with blank or placeholder responses that did not address the application questions were determined not to be complete, and therefore were not accepted. The 271 completed applications referenced in **Section I** of this Fact Sheet refer to the submitted applications that passed this completeness review.

2. Assessment of application content

All applications determined to be satisfactorily completed were reviewed by independent Technical Evaluation Panels (TEPs), the members of which had relevant expertise in ACO-based initiatives. The TEPs scored each application according to a scoring rubric developed prior to the close of the application period. The rubric was aligned to the categories and point totals described in Appendix D of the RFA:

- 15 points for Organizational Readiness
- 35 points for Financial Plan and Risk-Sharing Experience
- 35 points for Clinical Care Model
- 15 points for Data and Health Information Technology Capability

The TEPs aligned on a consensus recommendation determination for each application (Accept / Not Accept). CMS further reviewed TEP scores and recommendations to ensure interrater reliability and consistency in determinations.

3. Assessment of program integrity risks posed by the applicant

All applications determined to be satisfactorily completed were also subject to a review of potential program integrity risks, as described in Section V.B of the RFA, that may pose concerns specific to the ACO REACH Model. Using information collected in the application, CMS identified the applicant entity, any parent companies or other interests with at least 5% ownership, the members of the proposed Leadership Team, and the members of the proposed Governing Body. Each of these individuals and organizations was screened to identify program integrity findings that would raise concerns for participation in ACO REACH; specifically, CMS reviewed for concerns including, but not limited to, beneficiary harm, improper or fraudulent billing, improper risk adjustment or coding behavior, and financial insolvency.

4. Final determination

Applications that were found to be satisfactory based on the assessment of application content and the assessment of program integrity risks posed by the applicant were reviewed to make a final determination of the ACOs that would be provisionally accepted to participate in the ACO REACH Model in PY2023. As noted in Section V of the RFA, CMS reserved the right to limit the total number of accepted applications based on the volume of applications received. After completion of steps 1-3, CMS determined that it would not be necessary to limit the total number of accepted applications. As such, all applications that did not pose a material program integrity risk and received a strong score in the assessment of application content were provisionally accepted.

III. Next steps for applicants

As of June 30, 2022, CMS has notified all 271 applicants whether their application was provisionally accepted or not accepted. Before CMS offers the MPP PA for signature to the 128 applicants that were provisionally accepted, several conditions must be met:

- The applicant ACO must meet all applicable requirements of the ACO REACH Model; this includes, but is not limited to:
  - Confirmation that all Governing Body requirements are met (see Section V.C of the RFA);
  - Meeting the minimum number of aligned beneficiaries (see Section VI.B of the RFA);
  - No greater than 50% of the REACH ACO's aligned beneficiary population may have a given medical condition or belong to a specialized sub-population for which a targeted total cost of care initiative exists (see Section V of the RFA);
  - Not more than 50% of the Participant Providers in a New Entrant ACO may have prior experience in one or more of the Medicare value-based initiatives listed on page 61 of the RFA.
- The applicant ACO must notify CMS if the applicant ACO entity undergoes a change in control (including ownership change) or if the applicant ACO's strategy or approach, including expected partner providers and geography, undergoes material changes relative to the description in its application. Before offering a PA to an applicant, CMS will review such changes to determine whether the entity, after such changes, remains eligible for participation in the ACO REACH Model.

We understand that some applicants may be considering multiple Medicare value-based initiatives among which simultaneous participation, by an ACO or its Participant Providers, is prohibited (e.g., the Medicare Shared Savings Program). Accepted applicants may decide not to sign an ACO REACH Model PA, and therefore not to participate in the ACO REACH Model.

For applicants whose applications were not accepted, no further action is required. At this time, CMS is not planning additional application rounds for the ACO REACH Model. We encourage those applicants whose applications were not accepted to review other Medicare value-based initiatives to consider whether there may be alternative ways in which they may partner with CMS in the future.

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