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

Provider Reference Guide

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Welcome to REACH

You have elected to participate in ACO Realizing Equity, Access, and Community Health (REACH), a Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) program for patients with traditional Medicare. Formerly the Global & Professional Direct Contracting (GPDC) Model, CMS has renamed the model to better align the name with the purpose of the model: to improve the quality of care for people with Medicare through better care coordination, reaching and connecting healthcare providers and beneficiaries, including those beneficiaries who are underserved. The REACH Model is a five-year initiative that aims to encourage greater engagement from Medicare fee-for-service beneficiaries, reduce expenditures, improve patient experience and increase overall quality. The model also includes innovative approaches from Medicare Advantage (MA) and commercial risk-sharing arrangements, such as benefit enhancements and beneficiary engagement incentives. Within the model, REACH ACOs contract with Medicare to be held accountable for the total cost of care of attributed beneficiaries. Additionally, REACH looks to transform risk-sharing arrangements, engage beneficiaries and reduce provider burden.

The model leverages lessons learned from the Medicare Shared Savings Program (MSSP) and Next Generation ACO (NGACO) models. It also includes innovative approaches from Medicare Advantage (MA) and commercial risk-sharing arrangements, such as benefit enhancement and patient engagement incentives explained further in this guide. REACH seeks to improve quality of care and health outcomes for patients through alignment of financial incentives to promote effective and appropriate care. The REACH ACO is accountable for the total cost of care of the beneficiaries attributed to it.

Participation in this program will replace the instability of fee for service (FFS) with a monthly capitation payment. Capitated payments (CAP) will be explained further in this guide as there are both primary care capitation (PCC) and total care capitation (TCC) options. In addition to CAP and FFS, if the ACO's total cost of care is lower than the historical cost of care (after a regional and national trend, and risk adjustment have been applied), the ACO will have earned shared savings, which will be distributed to the ACO participating providers as agreed upon.

In addition, the ACO model qualifies as an Advanced Alternative Payment Model (Adv APM) under MACRA. Therefore, if the ACO participants meet the AAPM established criteria, they will not need to report quality under the MIPS model. The Advanced APM status results in a 5% increase in the participating providers' Medicare fee schedule two years post participation in the program for all of the participating providers' traditional Medicare patients.

Congratulations and welcome to ACO REACH!

We look forward to working with you and helping you pave the way for future healthcare.

My REACH ACO

There are several options available in the REACH model. Below are the elections your REACH ACO made. Details on each section are provided in the guide following.

My ACO Name: ______________________________

My ACO Medicare Reference ID: ______________________________

Performance at a Glance: ______________________________

ACO Web Address: ______________________________

My ACO Elections:

Financial Arrangement Options			
Risk Arrangement	☐ Global (100% risk)		☐ Professional (50% risk)
Types of ACO Entrants	☐ Standard	☐ New Entrant	☐ High Needs
Capitation Arrangement	☐ Total Care		☐ Primary Care
Beneficiary Alignment:			
Claims Based (always)	**Voluntary:**	☐ SVA/Paper Based	☐ Electronic
Prospective Plus Alignment	☐ Yes		☐ No

Benefit Enhancements & Beneficiary Engagement Incentives Selected (Waivers)		
3-Day SNF	☐ Yes	☐ No
Post-Discharge Home Visit	☐ Yes	☐ No
Telehealth Expansion	☐ Yes	☐ No
Care Management Home Visits	☐ Yes	☐ No
Home Health Homebound Waiver	☐ Yes	☐ No
Nurse Practitioner Services	☐ Yes	☐ No
Cost-Sharing Support for Part B Services	☐ Yes	☐ No
Chronic Disease Management Reward Program	☐ Yes	☐ No

Additional REACH Team Contacts:

Position	Name	Email	Phone
Executive Director			
Care Coordination			
Risk Adjustment			
Quality			
ACO Medical Director			
Social Worker			
Finance			
Compliance			
Market Manager			
Practice Transformation Coach (PTC)			

ACO REACH Overview

YOUR ROLE AS A PROVIDER

- UNDERSTAND THE BASICS OF THE REACH PROGRAM
- COMPLETE ALL REQUIRED COMPLIANCE TRAINING

What is a REACH ACO (ACO)?

Your ACO is a separate entity of your medical group. An ACO can be made up of a group of doctors, hospitals and other healthcare providers and suppliers who come together voluntarily to coordinate care for the people they serve. Providers with previous experience in risk sharing arrangements with CMS or commercial payers are able to participate in the REACH model. The ACO aims to test whether strong financial incentives, coupled with tools to support increased patient engagement and care coordination, can improve health outcomes and lower expenditures for Medicare beneficiaries.

The ACO is neither a Medicare Advantage (MA) plan nor a Health Maintenance Organization (HMO), nor does the ACO affect a beneficiary's Medicare Supplement coverage. The ACO is not an insurance plan nor does it provide insurance coverage. Prior authorizations are not part of this model. Even while assigned to the ACO, beneficiaries may see any doctor who accepts Original Medicare. Simply put, there is no change to Medicare benefits whether a beneficiary uses a provider participating in the ACO or not.

Additionally, there will be no change to Medicare service, coverage or claims payment processes for beneficiaries treated by participating ACO providers. CMS will continue to be solely responsible for these processes. However, CMS will compare healthcare expenses associated with these beneficiaries relative to a three-year historical cost benchmark. If beneficiary expenses are less than the historical amount — and quality of care standards are met — the ACO will receive 50-100%, depending on professional or global model entered, of the savings or losses.

CMS created the ACO REACH Model to achieve a three-part aim:

1. Improve overall care in a safe environment, equitable to all who seek it, and always available when needed.
2. Improve health accomplished through the practice of proactive, preventive medicine and care coordination.
3. Lower per-capita cost aimed at reducing the upward trend of medical costs associated with the Original Medicare population.

To ensure that savings are accompanied by improved care, CMS will track data for the ACO-assigned population through reports submitted by the ACO and from other sources. All information will remain HIPAA compliant and will be monitored by the ACO Compliance Program.

REACH Payment Mechanisms

There are three types of REACH ACOs, defined based on the experience of the ACO Participating Providers with Medicare (FFS) risk-based contracting and the populations the entities primarily serve. The REACH model features several financial operations and creates a variety of pathways for taking on financial risk. The details related to many of the aspects of the financial methodology, including benchmark calculation, capitation payment options, risk sharing and mitigation details, and reconciliation, are specific to REACH model and risk arrangement type.

Your ACO elections have been highlighted for easy reference on the *"My ACO" Arrangement Overview.*

Your contract with the medical group and/or your ACO will determine how you are paid.

Prior to each quarter, CMS will calculate the monthly capitated payments for the ACO for the upcoming quarter, updated with any adjustments to beneficiary alignment. CMS will distribute directly to the ACO the monthly TCC or PCC payments and, if applicable, the APO payments. The ACO will then pay the CAP payment to the participating and preferred providers as agreed upon.

Capitation Payments

The REACH Models offers two payment mechanisms; Total Care Capitation and Primary Care Capitation. ACOs will receive a monthly capitated payment for certain Part A and B services covered under the FFS program or Original Medicare provided by Participant Providers and those Preferred Providers who elect to participate in the payment mechanism. The amount of the capitated payment made by CMS to the ACO will partially depend on the risk arrangement option and capitation payment mechanism selected by the ACO.

All ACOs must participate in one of the capitation payment mechanisms.

Primary Care Capitation (PCC)

The capitated payment to the ACO applies only to certain primary care services provided to aligned beneficiaries by Participant and Preferred providers participating in PCC. CMS defines primary care-based services as claims lines from professional claims for evaluation and management (E/M) office visits for both new and established patients using the current procedural terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. A list of these codes can be found in Appendix A. Participating and Preferred Providers will continue to receive FFS payment for non-primary care services that are outside the scope of the PCC payment. PCC is required for all ACOs that have selected to participate in the Professional REACH Model. REACH ACOs have a choice between PCC or TCC.

Total Care Capitation (TCC)

Under TCC, the capitated payment to the ACO applies to all services covered by Medicare Parts A and B that are provided to aligned beneficiaries by Participant and Preferred providers participating in TCC. Participating and Preferred Providers will receive FFS payment only for the portion of claims that are outside the scope of the TCC. The TCC payment mechanism is only available to ACOs that have selected to participate in the REACH Model.

Advanced Payment Option (APO)

YOUR ROLE AS A PROVIDER

- REFER WITHIN THE NETWORK OF PREFERRED PROVIDERS.

An ACO electing PCC may also elect to receive reduced FFS payment for non-primary care services under the optional APO. The APO supplemental payment to the ACO applies to the subset of services to aligned beneficiaries not covered by PCC. Each Participating or Preferred Provider may choose a claim reduction amount between 1-100% for the APO payment. Previous CMS Shared Savings Models included population based payments that are similar to APOs under the REACH Model.

Shared Savings/Losses Determination

All Part A and B services for ACO-aligned beneficiaries will count toward shared savings/shared losses. Under the REACH model, *Professional* ACOs will bear risk for 50% of shared savings/losses on the total cost of care (i.e. all Parts A and B services) for their aligned beneficiaries. *Global* ACOs will bear risk for 100% of shared savings/losses on the total cost of care for aligned beneficiaries.

For both TCC and PCC, shared savings/losses are based off the total cost of care and are calculated by comparing the ACOs benchmark with all Medicare expenditures for services delivered to aligned beneficiaries. Medicare expenditures are defined as capitation payments, advanced payments and FFS claims billed for aligned beneficiaries.

At reconciliation, CMS compares the performance year (PY) expenditure against the ACO's benchmark to determine shared savings or losses. The PY expenditure with stop-loss payout and charge applied is then compared to the total benchmark expenditure. The difference between the two terms is expressed as the gross savings/losses per Beneficiary per Month (PBPM).

Provisional Reconciliation

For ACOs that elect provisional reconciliation, CMS will distribute interim shared savings and collect interim shared losses shortly after the end of the PY reflecting cost experience through the first six months of the PY, with a final reconciliation taking place once complete data are available for the full PY (approximately six months after the performance year ends). Refer to *My ACO* for your Arrangement Elections.

Resource for this Section: https://innovation.cms.gov/innovation-models/aco-reach

CHECKLIST OF KEY ACTIVITIES

Getting Started in ACO REACH

Be sure that you and your staff understand the REACH basics and are well prepared to work with your patients who are assigned to the ACO.

- ☐ Review the Provider Reference Guide in its entirety to learn how the ACO works and your responsibilities as a Participating Provider.
- ☐ Complete all ACO training programs including mandatory compliance, care coordination, reporting and analytics, coding and other trainings offered by your ACO.
- ☐ Prepare to address questions regarding REACH basics and the REACH model.
- ☐ Complete office set up to ensure REACH launch readiness. Keep important information accessible to all office personnel, including Key Contacts List, this guide, Preferred Providers aligned with the ACO, and a Participating Providers list.

Know Your Beneficiaries

YOUR ROLE AS A PROVIDER

- KNOW YOUR BENEFICIARY ROSTER
- CONSIDER IMPLEMENTING VOLUNTARY ALIGNMENT WITH BENEFICIARIES THROUGH MEDICARE.GOV

To be aligned to the ACO, a beneficiary must meet eligibility criteria including:

a. Enrolled in Medicare Parts A and B;

b. Not enrolled in Medicare Advantage or any other Medicare managed care plan;

c. Does not have Medicare as a secondary payer;

d. Resident of the U.S.;

e. Resides in a county that is included in the ACO Service Area

Beneficiary alignment in the ACO is prospective for each PY. This means that a list of beneficiaries participating in the program is provided to participating providers at the start of each PY. ACOs assume accountability for the total cost of care of beneficiaries aligned to their entity. CMS uses beneficiary alignment to determine an organization's historical baseline expenditure for purposes of calculating the PY benchmark.

Although alignment is always prospective, ACOs have a choice to select Prospective or Prospective Plus Alignment.

1. **Prospective:** All claims-based alignment and voluntary alignment will be completed prior to the start of each performance year. The number of beneficiaries aligned to your ACO will not increase throughout the year but may decrease as beneficiaries move out of the service area, pass away or change to a Medicare Advantage program.
2. **Prospective Plus:** Allows ACOs to have beneficiaries who have voluntarily aligned to the ACO ***added to their aligned beneficiary population on a quarterly*** basis throughout the performance year.
   - It is important to note with Prospective Plus Alignment, the ACO benchmark will change on a quarterly basis. Depending on the number, health status and frequency of the visits associated with the beneficiaries added to the ACO, this could have a positive or negative effect on the benchmark.

Claims-Based Alignment

A beneficiary is aligned to the ACO for a PY if the plurality of PQEM Services during the two-year alignment period were received from an ACO Participating Provider. At a high level, CMS aligns a beneficiary based on where the beneficiary receives the plurality of their primary care services as evidenced in claims utilization data during the two-year alignment period for each PY.

Voluntary Alignment

Beneficiaries can choose to align to an ACO by designating an ACO Participant Provider as their "primary clinician" or main source of care. Voluntary alignment is done in two ways:

Signed-Attestation based Voluntary Alignment (SVA): Beneficiary identifies a "primary clinician" using the "Voluntary Alignment Form" template from CMS. After notification to CMS, the ACO may use SVA forms via mail, email, patient portals and/or provided at the point of care. The CMS form includes specific instructions to the beneficiary on proper completion and return of the form. Refer to *My ACO* to determine if your ACO has elected to participate in SVA alignment.

Electronic Voluntary Alignment: Beneficiary selects a "primary clinician" on the Medicare.gov website. Instructions for completing that are included in Appendix C. Unlike paper-based alignment, electronic alignment can take place at any time, without notification to CMS.

It is important to note that voluntary alignment takes precedence over claims-based alignment.

If your ACO chooses to participate in VA, your CHS Executive will provide further guidance including workflows, policies and procedures regarding CMS rules for the VA process. More information about VA is included in Appendix D.

Other considerations:

- Beneficiaries can opt out of data sharing at any time by contacting 1.800.MEDICARE and indicating their preference not to share data with the ACO. You cannot do this for them.
- ACO Participant Providers **are prohibited** from completing a Voluntary Alignment Form or designating a clinician on MyMedicare.gov on behalf of the beneficiary.
- If a Voluntary Alignment paper form is returned to your office, the original executed Voluntary Alignment forms and envelopes that they were returned must be kept for CMS auditing. If your ACO is participating in paper-based VA, talk to your ACO Executive Director on what to do with forms returned to your clinic.
- Educating beneficiaries on the benefits of being part of the ACO is important for success of the program and future CMS programs your medical group may participate in. Review the *ACO Overview* section for the beneficiary benefits of the program.

Refer to *My ACO* for your ACO chosen prospective alignment.

CHECKLIST OF KEY ACTIVITIES

Understand Your Patient Population

Familiarize yourself with all of your Medicare Fee-For-Service patients, those who are assigned to your ACO, those who may be assigned once they receive a majority of primary care services from you and those who may voluntarily align to you. How well your patients respond to treatment has a great deal to do with their personal involvement in treatment programs and the degree of responsibility they take for their own health. That's why beneficiary engagement is critical.

- ☐ Review and validate your Medicare ACO beneficiary list, referred to as your *PCP Assignment Workbook*.
- ☐ Correct beneficiary contact information on the Workbook as needed. Let your ACO Executive Director know if you feel patients are misaligned.
- ☐ Review your Provider Workbook for patients who are not yet assigned to your ACO but considered "assignable" once they receive a majority (plurality) of primary care services from you. Work with your ACO team to schedule these beneficiaries.
- ☐ Schedule Annual Wellness Visits (AWV) for all of your Medicare FFS beneficiaries, especially those you haven't seen within the last 12 months.
- ☐ Review the health status of your Medicare ACO patients. Use reports and population health analytic tools provided to stratify your patients based on degree and type of chronic illness.
- ☐ Review your Provider Scorecard, supplied to you upon request by your ACO Executive, for cost and utilization data for your ACO beneficiaries.
- ☐ Encourage patients to use your practice's patient portal, if available.
- ☐ Remind patients they may receive a CAHPS letter from a CMS-approved vendor and stress the importance for them to complete and return this. Appendix B includes a CAHPS survey sample.
- ☐ Ask staff to be proactive in speaking with your patients about any concerns they may have regarding their office visit, their medications or any upcoming tests or specialty appointments.
- ☐ Engage office staff to help you create moments your patients will remember. Look for small but significant ways to create a better patient experience.
- ☐ Establish a policy for snowbird patients. Make sure patients have enough medications until they return and understand they should notify you of their care needs while away.

Improve Care & Lower Total Cost of Care

YOUR ROLE AS A PROVIDER

- COMPLETE AWVS ON ALL MEDICARE PATIENTS
- IF POSSIBLE, COMPLETE THEM IN QUARTER ONE TO IMPROVE OVERALL PATIENT ENGAGEMENT
- COMPLETE AN ADVANCE CARE PLAN AS PART OF THE AWV

Prevention and Annual Wellness Visits (AWV)

AWVs are a covered benefit for people who have Medicare for more than one year. It is not an annual physical exam but rather a "hands off" visit that focuses on prevention. Medicare beneficiaries often do not get the preventive and wellness services they need to stay healthy, avoid or delay the onset of disease, and lead productive lives. This is due, at least in part, to cost-sharing requirements that in the past were barriers to access. All of these issues and more are covered with an AWV at no cost to the beneficiary.

The AWV is a good time to have a discussion with your patients about advance care planning. Advance care planning is having a conversation and making decisions about the care they would like to have for the future of their healthcare. If your patients are unable to make decisions for themselves in the end of life, knowing who will represent them during this time is useful for you in managing their care. Ask your CHS representative about Advance Care Planning Programs that may be available for your ACO.

Who Can Perform An AWV?

Medicare allows certain mid-levels to deliver the AWV provided they are under physician supervision. If time permits, however, it is always recommended that the doctor have a brief discussion with the patient about their health needs.

According to CMS, Medicare Part B covers the AWV if it is furnished by a:

- Physician (doctor of medicine or osteopathy)
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist

A medical professional (including a health educator, a registered dietitian, nutrition professional or other licensed practitioner) or a team of such medical professionals working under the direct supervision of a physician can also complete AWVs. Adding or redeploying a LPN or other mid-level practitioner to increase your capacity to offer AWVs can be cost-effective.

Depending on your location and the type(s) of advance practitioner(s) you use the cost of hiring an additional staff member to handle AWVs can be recouped with one or two additional AWVs per day. A dedicated AWV staffer can conduct up to eight AWVs per day.

Welcome to Medicare and Annual Wellness Visit Codes include GO402, GO438 and GO439.

AWVs are one of the single best tools available to you as an ACO provider.

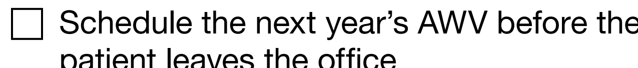
Complete AWVs to:

- Improve care through early identification of health issues
- Improve beneficiary retention in the ACO by educating them on the benefits they receive from participating in the program
- Improve patient satisfaction that may impact quality measures
- Contribute to efficient and cost-effective practices
- Build stronger patient relationships
- Develop a 12-month plan of care for beneficiaries

CHECKLIST OF KEY ACTIVITIES

Annual Wellness Visits (AWVs)

- [ ] Schedule AWVs for all your Medicare Fee-For-Service patients, especially those you haven't seen within the last 12 months
- [ ] Engage an LPN and/or other mid-level(s) in your office, or contracted outside your office, to help perform AWVs
- [ ] Consider providing reimbursable E/M services simultaneously with the AWV. i.e. CPT codes 99201-99215 with a modifier -25
- [ ] Work with your ACO to send AWV reminders to your Medicare beneficiaries. You can also call to let patients know when they are due for an AWV. Schedule AWVs in quarter one if possible during the reminder call to improve patient engagement



- [ ] Schedule the next year's AWV before the patient leaves the office

Care Coordination Resources

YOUR ROLE AS A PROVIDER

- REFER PATIENTS NEEDING ADDITIONAL ASSISTANCE TO THE CARE COORDINATOR

Providers in a value-based environment like REACH, rely on a full care team to work as an extension of them. Care coordinators are the nurses, social workers and other professionals who help to coordinate all of the care patients need to stay in control of their health especially once they are outside of your office. We strongly urge you and your staff to get to know your ACO care coordinator to help manage your most needy patients.

Care coordinators serve as an extension of you, by helping your patient beyond the four walls of your practice and connecting them to the full spectrum of healthcare services available in the community. Here are some of the typical activities of a care coordinator

Monitoring Hospital Discharges – Review admission, discharge and transfer (ADT) feeds from local hospitals. ER visit and SNF admission and discharge information may also be available.

Identifying High-Risk Patients – Review claims and electronic health records data to help prioritize your high-risk patients for care management intervention.

Facilitating Transitions of Care – Develop communication protocols with hospitals and specialists to support follow-up with these patients and decrease potential unnecessary readmission.

Educate and Engaging patients – Provide educational materials on the patient's health condition(s) and provide instructional information to facilitate self-management.

Health Equity Plan (HEP) – 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 ACO will develop and implement an HEP. The purpose of an HEP is for the 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. CHS will collaborate with the ACO to identify health disparities, define health equity goals, describe the health equity strategy, develop a plan for implementing the health equity strategy, and the approach for monitoring and evaluating progress in improving health equity within their aligned beneficiary population.

Performing Environment/Health Equity Assessments – Discover how patients do in their overall environment, exposing potential barriers to care and medication compliance. Social Determinants of Health issues include family and neighborhood patient support, food security and appropriate nutrition, health literacy and adequate transportation and financial resources for care.

Scheduling Appointments – Help facilitate appointments with other providers and ancillary health services.

Accessing Community Resources – Help provide access to various community resources that directly or indirectly support your patient's health.

CHECKLIST OF KEY ACTIVITIES

Care Coordination

- [ ] Get acquainted with the care coordinator assigned to your practice
- [ ] Refer patients to your care coordinator to help with those who are chronically ill or who have recently been discharged from a hospital or other facility
- [ ] Ask your care coordinator to supply a list of available community resources relevant to the chronic illness management needs of your ACO patient panel

Transitions of Care

YOUR ROLE AS A PROVIDER

- REFER PATIENTS NEEDING ADDITIONAL ASSISTANCE TO THE CARE COORDINATOR

The term "transition of care" refers to the movement a patient makes between different healthcare settings and professionals as his or her needs change. A patient may receive care on an outpatient basis from a Primary Care Physician or Specialist, and then move to a hospital where care is provided by a hospitalist or nursing team. If additional care is needed, the patient may move to a skilled nursing facility or other facility before finally returning home where a visiting nurse may provide care.

When a patient leaves an acute healthcare facility, it is crucial to get involved in managing cost, quality and patient experience. Patients often experience fragmented care when transitioning from one care setting to another. Along with care continuum there are many factors that can put a patient at risk for readmission to a hospital, such as:

- Poor medication compliance
- Misunderstanding how their care should be managed
- Not following up with their primary care provider

Essential questions to help you improve transitions of care for your patients include:

- Do you receive ADT notifications of your patients' admissions within 24 hours?
- Do you receive discharge or transfer notifications and summaries within 24 hours?
- Do you schedule a follow-up visit with the patient within 7-14 days of discharge?
- Are you part of a Health Information Exchange within your community?

Transitions of Care and Utilization Reports

Providers working with CHS have access to utilization reports through our population health management tool, Healthy Impact 360 (HI360) to help them gain insight into their patients. Utilization reports derived from claims data provide a snapshot of the degree to which patients are accessing medical services such as hospitalizations, 30-day readmission and emergency department visits.

Care coordinators assigned to the ACO can help manage patients most in need following a hospital or ER visit. Not every one of your recently discharged patients requires extensive follow-up care. Your care coordinator will identify the best candidates for outreach services, including those needing support with medication compliance, health literacy and arranging home care.

The care coordinator will check on your patients within 48 hours of discharge, verify they are taking their medications correctly, and help them connect with needed specialists and community resources, keeping you informed throughout the process. The care coordinator will attempt to schedule a follow-up visit for the patient with you within 7-14 days from hospital discharge.

Transitional Care Management (TCM) Program

YOUR ROLE AS A PROVIDER

- IF YOU ARE NOT PARTICIPATING IN THE TCM PROGRAM, TALK TO YOUR CHS TEAM MEMBERS ABOUT HOW TO GET STARTED

Medicare pays care management services following a discharge from the hospital, skilled nursing facility or other long-term setting such as an inpatient rehabilitation facility. The Transitional Care Management (TCM) Program pays physicians for one face-to-face visit within 14 days of discharge, and for several non-face-to-face services during a beneficiary's transition to his or her community setting.

Examples of non-face-to-face services paid for in the TCM program include:

- Obtain and review discharge information, discharge summary, continuity of care documents
- Review need for, or follow up on, pending diagnostic tests and treatments
- Interact with other healthcare professionals who will assume or reassume care of the beneficiary's system specific problems
- Provide education to the beneficiary, family, guardian, and/or caregiver
- Establish, or re-establish referrals and arrange for needed community resources
- Assist in scheduling required follow-up visits with community provider and services

The PCP does not have to provide the TCM services directly. Non-physician practitioners are legally authorized and qualified to provide the services in the state in which they are furnished. CMS allows all of the health professionals listed below to furnish non-face-to-face TCM services "incident to" the services of a physician.

- Clinical Nurse Specialist
- Nurse Practitioners
- Physician Assistants

The population health tool, HI360, includes a TCM dashboard, which is the hub for reviewing and working all admission, discharge and transfer (ADT) notifications for individual patients from healthcare data clearinghouses and other contracted vendors. Timely outreaches, establishment of care plans, along with regular follow-ups and adjustments as needed will promote adherence to care plans and the best possible health outcomes.

For additional assistance with leveraging the robust features of HI360 to improve your practice's TCM utilization, talk to your CHS representative.

CHECKLIST OF KEY ACTIVITIES

Transitions of Care

- ☐ Consult utilization reports to understand to what degree your patients are accessing medical services.
- ☐ Look to your ACO physician leaders, medical director and CHS representative to set up alerts such as Admissions, Discharges and Transfer (ADT) feeds with the most frequently accessed facilities in your community.
- ☐ Refer to your ACO care coordinators to help you manage transition of care.
- ☐ Give patients "Call Me First" cards as a low-tech solution for getting notified when they visit the hospital, ER or other facility or using another provider.

Manage Chronic Illness

YOUR ROLE AS A PROVIDER

- SEE ALL OF YOUR PATIENTS WITH TWO OR MORE CHRONIC CONDITIONS AT LEAST ONCE EVERY THREE MONTHS.

People with chronic conditions (e.g. diabetes, lung disease, CHF, COPD, ESRD, hypertension and other diseases) face enormous challenges that make day-to-day living difficult and can lead to loss of independence. It is important to look at chronic disease management from a clinical and non-clinical perspective. Care coordinators will help coordinate the patient's care both clinically and non-clinically. By including both perspectives, you are able to paint a picture of the whole patient beyond his or her medical needs and your interaction with them as a patient.

Social determinants of health are a large part of chronic disease management. It is important to consider things like living environment, food availability, safety and security when managing chronic diseases. Working with your care coordination team will provide additional support to the clinical needs of the patient by addressing social needs.

Chronic Care Management (CCM) Services

If your practice has a certified EHR, you may be eligible to participate in the Chronic Care Management (CCM) program offered by Medicare. CCM reimburses you for many of the chronic illness management activities you may already be doing for your Medicare FFS patients with two or more diagnosed chronic conditions expected to last at least 12 months.

BILLING FOR CCM REQUIRES ONLY 20 MINUTES OF CLINICAL STAFF TIME PER CALENDAR MONTH

All of these clinical staff members may provide CCM services "incident to" the services of the billing physician.

- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

In order to bill for CCM services, a comprehensive care plan must be established, implemented, revised and monitored and the beneficiary must be part of the plan's development. Unfortunately, care coordination services provided by an ACO do NOT count for billing of CCM services.

Medicare requires the billing practitioner to furnish an Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE) or comprehensive Evaluation and Management visit to the patient prior to billing the CCM service, and to initiate the CCM service and Patient Agreement as part of this exam/visit.

CPT code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions, cannot be billed during the same service period as:

- CPT codes 99495–99496 (Transitional Care Management)

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- HCPCS codes G0181/G0182 (home health care supervision/hospice care supervision)
- CPT codes 90951–90970 (certain End-Stage Renal Disease services)

All of these codes are included under the Primary Care or Total Care Capitation payments. Despite that, the same theory applies in that they cannot be billed during the same service periods as CPT 99490.

CHECKLIST OF KEY ACTIVITIES

Manage Chronic Illness Checklist

- [ ] Use claims data and information from your ACO to develop strategies that incorporate both the clinical and non-clinical sides of disease management.
- [ ] Leverage your care coordinator to assist in developing care plans for patients; consider existing community-based programs and medication adherence assistance.
- [ ] Think about using a benefit enhancement available through the ACO to support patient self-care medical equipment, such as pulse oximeters or a blood pressure monitor.
- [ ] Participate in Medicare's Chronic Care Management Program (CCM) to receive reimbursement for many of the activities you may already be doing.

Behavioral Health

YOUR ROLE AS A PROVIDER

- REFER PATIENTS WITH MENTAL HEALTH NEEDS TO A BEHAVIORAL HEALTH SPECIALIST

Seniors with diagnosed depression have significantly higher healthcare costs than non-depressed seniors. As a primary care physician you are on the front lines with patients and can help them gain access to the proper resources, ultimately reducing unnecessary emergency room (ER) utilization and avoidable hospital admissions. Primary care providers integrating behavioral health professionals into their practices provide coordination on issues such as obesity, tobacco use, dementia, depression, anxiety and medication noncompliance.

Social workers can help beneficiaries connect with a variety of important non-medical services available within their surrounding community. They are especially helpful locating community resources that are free or nearly free to your patients. Refer to *My ACO* for your resource contact.

Tele Behavioral Health

Mental health professional shortages and transportation constraints may prevent many Medicare beneficiaries from getting the behavioral one word they need. Medicare is continually updating the policy on telehealth visits. Conditions may apply regarding the location of the service provided and eligibility to bill for the service. Talk to your CHS representative for the most current healthcare policy on Tele Behavioral Health.

CHECKLIST OF KEY ACTIVITIES

Behavioral Health

- ☐ Talk to your ACO executive director or medical director to assist in developing a behavioral health strategy for your practice.
- ☐ Consider tele behavioral health as an option for patients in need of services.
- ☐ Consider integrated behavioral health in your facility one or more days per week to improve access for your beneficiaries.
- ☐ Contact your care coordinator if you suspect one of your patients requires behavioral health resources.

Pharm D

YOUR ROLE AS A PROVIDER

- LEVERAGE YOUR CARE COORDINATOR OR PHARM D TO SUPPORT MEDICATION COMPLIANCE
- USE GENERIC PRESCRIPTIONS WHEN APPROPRIATE

Approximately 50% of patients do not take their medications as prescribed and strong evidence shows that many patients with chronic illnesses find it difficult to adhere to their recommended medication regimen. This can create adverse medical outcomes which drive up healthcare costs dramatically.

A monthly medication reconciliation assessment can be performed by the care coordinator for patients who have been identified as high need. The medication reconciliation typically occurs over the phone and helps expose any medication adherence barriers, including financial need.

If adherence issues or other barriers exist, a Pharm D will help identify any obstacles your patients may have with purchasing their medications and work to find solutions.

Commonly Understood Reasons for Medication Non-Compliance

- Patients may forget to take their medications.
- They might not be able to afford their prescriptions.
- They may not have transportation to the pharmacy.
- They may be confused about which medications to continue or discontinue after a hospital visit or after seeing another provider.
- They may fear or not like the side effects or have difficulty taking the medication (especially with injections or inhalers).

PRESCRIBING GENERIC MEDICATIONS OFTEN SUPPORTS MEDICATION ADHERENCE DUE TO REDUCED OR ELIMINATED COPAYS REQUIRED BY THE PATIENT.

Understanding your Network

YOUR ROLE AS A PROVIDER

- REFER WITHIN YOUR NETWORK OF PREFERRED PROVIDERS.

As a participating provider in an ACO, you are ultimately responsible for your beneficiary's health outcomes and spending, not just in your office, but also beyond the four walls of your practice. As the PCP, you can have a large say in how healthcare dollars are spent on your patients' behalf, which allows you to help your patients receive the highest quality care delivered efficiently.

Preferred Providers in an ACO have agreed to provide high-quality care to your patients while working to control the cost of that care. Preferred Providers may participate in benefit enhancements approved and available through the ACO as well as alternative payment arrangements. ACO Preferred Providers have agreed to take a reduction in the Medicare Fee Schedule allowed for their services. The reduced amount is then used for the ACO to develop new programs or offerings to the ACO patients.

The ACO Network may be composed of multiple specialists, pharmacies, long-term care facilities, skilled nursing facilities, home health agencies, palliative care groups, behavioral health centers, urgent care centers, labs and imaging in your area. Collaborating closely with other providers will help reduce the highly fragmented care your patients would otherwise receive from so many disparate providers.

As an ACO participating provider, referring your patients to high-quality and efficient specialists and facilities who desire to work within the ACO network helps to achieve the goal of improved care at lower cost.

Your ACO Executive Director has identified high-quality preferred providers in your community and those with whom you may be able to develop a closer working relationship. Refer to *My ACO* for a list of your ACO preferred providers.

Identifying preferred providers takes experience. If you know of partner providers, or are interested in program development with preferred providers, talk to your CHS representative. CHS offers an array of programs including dialysis, remote patient monitoring, colorectal screening and Annual Wellness Visit initiatives.

CHECKLIST OF KEY ACTIVITIES

Use your Preferred Provider Network

- ☐ Strive to work within your network of preferred providers when possible. Refer to *My ACO* for this list. The providers on this list are the highest quality and most cost-efficient specialists, facilities and other healthcare providers in your area.
- ☐ Consider having high-value specialists co-locate at your facility one or more days a week to improve ease of access for your patients and coordination of care.
- ☐ Consider expanding testing and specialized medical services in your practice.

Patient Care Access

YOUR ROLE AS A PROVIDER

- OFFER SERVICES TO PATIENTS OUTSIDE THE FOUR WALLS OF YOUR CLINIC TO BEST MEET THEIR NEEDS.

Access to healthcare means having timely use of health services to support the best health outcomes. Access to healthcare consists of four components:

- **Coverage:** facilitates entry into the healthcare system. Uninsured people are less likely to receive medical care and more likely to have poor health status.
- **Services:** having a usual source of care is associated with adults receiving recommended screening and prevention services.
- **Timeliness:** ability to provide healthcare when the need is recognized.
- **Workforce:** capable, qualified, culturally competent providers. Medicare offers extended telehealth services to patients in many geographical areas.

Access to comprehensive, quality healthcare services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all.

Ways to improve healthcare access at your facility.

- Team up with Independent Transportation Networks – use a benefit incentive to specify the plan and use.
- Introduce a mobile clinic that will go to the patient vs. them coming to you.
- Offer expanded clinic hours to include weekends and evenings.
- Offer a remote monitoring program for high-risk patients.
- Expand telehealth services.
- Work with local home care agency or your ACO to offer home care visits for the most vulnerable patients. Consider use of the Home Health Benefit Enhancement available through the ACO.

Benefit Enhancements & Beneficiary Incentives

YOUR ROLE AS A PROVIDER

- USE THE BENEFICIARY ENHANDEMENTS AND INCENTIVES WHENEVER POSSIBLE TO PROVIDE HIGH-QUALITY CARE WHILE REDUCING THE COST OF THAT CARE.

In order to emphasize high value services and support the ability of ACOs to engage the care of beneficiaries, CMS has designed Benefit Enhancements (BE) and Beneficiary Engagement Incentives (BEI) that will potentially motivate and encourage beneficiaries to become actively involved in their care.

The ACO may choose not to implement some or all of the BEs and BEIs offered. Before using any of the BE or BEIs, the ACO is required to submit to CMS an implementation plan for use. Requirements for the implementation plan are specific to each BE and BEI. Refer to *My ACO* for the list of BEs and BEIs selected by your ACO.

Beneficiary Enhancements

Three-Day SNF Rule Waiver: would conditionally waive the requirement for the three-day hospital inpatient stay before admission to a SNF.

Telehealth Expansion: would conditionally waive the rural geographic requirement for an originating site and allow the beneficiary's place of residence to serve as an originating site when telehealth services are furnished by preferred providers, and also include coverage of certain tele dermatology and tele ophthalmology services furnished by ACO Participants and Preferred Provider through asynchronous technologies.

Post Discharge Home Visits: would allow auxiliary personnel (e.g. licensed clinicians) to perform "incident to" care management home visit services to non-homebound aligned beneficiaries under the general supervision of an ACO Participant Provider or Preferred Provider up to 12 times within a performance year.

Care Management Home Visits: this enhancement waives the supervision level for "incident to" services to allow personnel under a physician's general supervision to make home visits under certain conditions. This enhancement is used for patients who are determined to be at risk of hospitalization but do not qualify for Medicare coverage of home health services.

Home Health Homebound: this enhancement waives the requirements that a patient must be confined to the home to receive Medicare reimbursement for quality home health services for eligible beneficiaries.

Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit: this enhancement is available for Global ACOs and 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.

Beneficiary Incentives

Beneficiary incentives permit ACOs to provide beneficiaries with items such as a blood pressure cuffs to help them track their blood pressure. CMS understands that it is the goal of the ACO to promote collaboration between Participants and Providers/Suppliers and beneficiaries to improve beneficiaries' healthcare quality and outcomes.

- There is a reasonable connection between the items/services and the medical care of the beneficiary.
- The items/services are preventive care items.
- The items/services advance a clinical goal for the beneficiary (such as adhering to a treatment plan or managing a chronic condition).

Cost-Sharing Support for Medicare Part B Services: this beneficiary engagement incentive would allow ACOs to make payments to a Participating or Preferred Provider to cover some or all of the amounts of beneficiary cost sharing not collected.

Chronic Disease Management Reward: allows the ACO to provide a gift card reward (maximum of $75 per year) to certain ACO beneficiaries for the purpose of incentivizing participation in a qualifying Chronic Disease Management Program.

Quality Improvement Program

YOUR ROLE AS A PROVIDER

- SEE YOUR PATIENTS WITH MULTIPLE CHRONIC CONDITIONS FREQUENTLY
- USE YOUR CARE COORDINATOR TO PROVIDE ADDITIONAL OUTREACH
- HAVE AVAILABLE APPOINTMENTS FOR PATIENTS NEEDING URGENT CARE

The mission of the REACH program is to lower the cost of care for Medicare beneficiaries while maintaining or improving the quality of care provided. ACOs are expected to improve quality of care and health outcomes for Medicare beneficiaries. The REACH program assesses quality during each performance year using several quality measures. Performance on the identified quality measures will impact the performance year benchmark used to determine shared savings/losses.

Starting in PY2023, quality will be assessed on the following claims-based measures:

1. **Risk Standardized All Condition Readmission:** measures how many hospital stays result in a readmission within 30 days after patient discharge.
2. **All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions:** measures unplanned hospital admissions among Medicare FFS beneficiaries 65 years of age and older with multiple chronic conditions.
3. **Timely Follow-up after Acute Exacerbations of Chronic Conditions:** measures the percentage of ED visits, observation stays and inpatient admissions for exacerbations of six conditions where a patient received follow-up within timeframes recommended by clinical practices.

CMS continues to develop additional quality measures for future performance years (PY). Prior to each PY, CMS will provide additional guidance on adjustments made to the quality measures. Your CHS team will keep you abreast of any quality measure changes. Appendix B contains more detailed information on quality measures.

The population health tool, Healthy Impact 360 (HI360), will be used to acquire needed data to monitor and prepare for future quality reporting. Using HI360 will provide actionable insights to help you provide better care and treatment plans for your patients. HI360 provides multiple data points to drive clinical insights and support you caring for patients with innovative solutions. Work with your CHS representative for additional HI360 training and information.

CAHPS Survey (Consumer Assessment of Healthcare Providers and Systems)

The CAHPS survey focuses on how the beneficiary views his or her relationship with you and your team. This is how you are being evaluated by your patients!

CAHPS results are calculated at the ACO level. If the ACO score is low, ACO leadership may want to meet with providers to create an action plan for making improvements. Your team can make a positive impact on these measures by improving communication with beneficiaries, helping them receive timely appointments and answering general questions.

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The following seven questions have been found to be highly correlated with higher CAHPS scores.

1. Gives easy instructions on taking meds
2. Gives easy-to-understand information
3. Office follows up with test results
4. Provider explains in a way you understand
5. Provider talks about prescription medications taken
6. Provider listens carefully to you
7. Provider knows your important medical history

Best Practices

- To minimize unplanned admissions for beneficiaries with multiple chronic conditions, the key is to see them frequently and have your Care Coordinator talk with them regularly to assess their status. Work with your office manager to keep late morning and later afternoon appointments open for work-ins and encourage your beneficiaries to call you before seeking care at any other location or with any other provider.
- Minimize readmissions by seeing beneficiaries within three days of discharge from an inpatient setting to reconcile medications, review discharge instructions and revise the beneficiary's individualized care plan.
- This site provides a sample of the CAHPS survey questions as they are sent to your patients. https://acocahps.cms.gov/globalassets/aco---epi-2-new-site/pdfs-for-aco/survey-instruments/2020-aco-survey/2020-cahps-for-acos-survey---sample-copy.pdf

CHECKLIST OF KEY ACTIVITIES

Quality

- [ ] Familiarize yourself with the 11 REACH Quality Measures located in Appendix C.
- [ ] Use Care Coordination to assist with patients who have multiple chronic conditions or frequent hospitalizations.
- [ ] Consider use of a "Gold Card" allowing your ACO patients the nurse call line for use in more emergent situations. This will put them to the head of the line for appointment times and follow-up.

Clinical Documentation Improvement and Risk Adjustment

YOUR ROLE AS A PROVIDER

- DOCUMENT ACCURACY OF DISEASE BURDEN TO THE HIGHEST SPECIFICITY AT EVERY VISIT

Many physicians believe their patients are sicker than the average patient, but the documentation and ICD-10 coding in the EMR does not support that belief. If ICD-10 coding is imprecise, much of your hard work treating your sickest patients may go unnoticed—and unrewarded—by CMS. Because CMS, like Medicare Advantage health plans, can only understand your patients' health conditions through the numeric, data-driven language of documentation and ICD-10 coding, it is important that your documentation supports accuracy of disease burden.

The greater the number and complexity of illnesses a patient has, the higher the Risk Score and the more Medicare expects to pay annually for that patient's care. The collective goal of every provider in your ACO is to provide high-quality and efficient care so that healthcare spending is less than the benchmark set by CMS.

One of CMS's goals in the REACH program is to set fair and accurate benchmarks. This goal is reflected in accurate risk adjustment given its effect on the benchmark. Two challenges of coding intensity.

Overpayments and excessive investments in coding intensity activities. CMS has set in place measures to limit the risk score growth or changes in coding behavior; Coding Intensity Factor, normalizing risk scores and 3% +/- risk score cap.

It is up to you to document all chronic, acute and historical conditions in the Progress Note and to submit the ICD-10 codes on the claim (or encounter data). Recall that in each calendar year, chronic conditions that require you to Monitor, Evaluate, Address and/or Treat (meet the "MEAT") must be documented and submitted.

CHS offers several Risk Adjustment webinars and newsletters that can help you identify opportunities within your patient population. Reach out to your CHS Executive for more details.

CHECKLIST OF KEY ACTIVITIES

Documentation, Coding and Risk Scores

- ☐ Follow the golden rule, "If it's not documented, it didn't happen."
- ☐ Always document and code thoroughly, precisely and accurately.
- ☐ Document chronic and historical conditions, such as diabetes, congestive heart failure or amputations, at least once annually.
- ☐ Make sure to use "incident-to" billing where appropriate when billing for a service provided by a mid-level.
- ☐ Pay special attention to your patients with ESRD and confirm they are properly classified.
- ☐ Diagnoses should be documented accurately (meet the MEAT) and precisely in the EMR and progress note to the highest level of specificity.
  - Monitoring
  - Evaluating
  - Assessing
  - Treating
- ☐ Review Pre-Visit Planning Notes, if available, in the EMR and communicate with the certified coders that are available to you.

Ensuring Compliance

The Compliance Department ensures that the ACO complies with the following sources of regulation:

1. The REACH Model requirements
2. Federal and state laws and regulations
3. Internal business practices and ethical standards

Compliance is charged with overseeing the implementation of, and ensuring adherence to, the CMS regulatory requirements outlined by the REACH Model. This also requires adherence to all applicable federal and state laws and regulations. Such laws include, but are not limited to, Anti-Kickback, Stark, Civil Monetary Penalties (CMP) and Sunshine laws. All regulations, requirements, requests and oversight related to the REACH Model come from CMS. Refer to *My ACO* for your compliance officer and contact information.

The ACO must have an anonymous reporting system. Although Compliance encourages anyone who has information regarding suspected compliance problems to contact us right away, we understand that sometimes anonymity is necessary and preferable. In these situations, the ACO has an anonymous reporting hotline that anyone may call at any time to report anything that he/she suspects to be a compliance issue. No one needs permission to call this hotline.

The hotline number(s) and directions on leaving anonymous messages on the hotline are listed on the *My ACO* form at the beginning of this guide.

Compliance Training

The ACO is required to have compliance training for ACO Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities. The compliance training must be performed within the PY annually.

CHS offers compliance training for you and your staff via an online portal. Talk to your CHS Executive about how to get access to begin your ACO Mandatory Compliance Training.

RESOURCES

CHS Website:
https://www.collaborativehealthsystems.com/

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

NAACOs; National Association of Accountable Care Organizations:
https://www.naacos.com/

APG; American Physician Group:
https://www.apg.org/

ACO REACH Tip Sheets:
https://www.collaborativehealthsystems.com/chs-tip-sheets/

Who is Collaborative Health Systems?

Founded by Primary Care Providers in 2012, Collaborative Health Systems (CHS) nimbly operates on the dynamic edge of healthcare transformation. We stay abreast of changing opportunities in the regulatory environment so that we can actively engage in influencing the future of healthcare while driving performance for our partners. We help transform the system to meet the needs of the patients and providers.

CHS collaborates with more than
3,500 provider partners
caring for
more than 180,000 patients
across 23 states
to support the delivery of
high-quality, personalized care.

Our core belief is that providers are in the best position to influence the quality and cost of healthcare, and we want to make sure they succeed. Through active collaboration with our provider partners, we provide customized and comprehensive solutions that include administrative and management services such as care coordination and quality reporting, risk management and contracting, population health capabilities, and actionable data insights. CHS provides additional services to secure and deliver favorable value-based contracts with commercial and other health plans.

CHS is able to leverage the robust resources of Centene Corporation — a Fortune 50, leading multi-national healthcare enterprise committed to transforming the health of the community, one person at a time. We are here to help our partners weather any challenge they may face.

Appendix A

Primary Care Based Services included Under Primary Care Capitation

Administration of HRA	
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
Office or Other Outpatient Services	
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
Domiciliary, Rest Home or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Professional services provided in a non-skilled nursing facility *(note: per the proposed Medicare Shared Savings Program methodology, claims will be excluded from alignment if a beneficiary has a SNF stay with overlapping dates of service)*	
99304	Initial Nursing Facility Care
99305	Initial Nursing Facility Care
99306	Initial Nursing Facility Care
99307	Subsequent Nursing Facility Care
99308	Subsequent Nursing Facility Care

99309	Subsequent Nursing Facility Care
99310	Subsequent Nursing Facility Care
99311	Subsequent Nursing Facility Care
99312	Subsequent Nursing Facility Care
99313	Subsequent Nursing Facility Care
99314	Subsequent Nursing Facility Care
99315	Nursing Facility Discharge Services
99316	Nursing Facility Discharge Services
99317	Nursing Facility Discharge Services
99318	Other Nursing Facility Care
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Prolonged care for outpatient visit	
99354	Prolonged visit, first hour
99355	Prolonged visit, add'l 30 mins
Telephone Visits – Online Digital or Audio Only	
99421	Online digital, Established Patient, 5–10 mins
99422	Online digital, Established Patient, 10–20 mins
99423	Online digital, Established Patient, 21+ mins
99441	Phone, Established Patient, 5–10 mins – Note: for PHE only
99442	Phone, Established Patient, 10–20 mins – Note: for PHE only
99443	Phone, Established Patient, 21+ mins – Note: for PHE only

Chronic Care Management (CCM) Services	
99487	Extended care coordination time for especially complex patients (first 60 mins)
99489	Add’l care coordination time for especially complex patients (30 mins)
99490	Comprehensive care plan establishment/implementations/revision/monitoring
G0506	Add’l work for the billing provider in face-to-face assessment or CCM planning
Behavioral Health Integration (BHI) Services	
99484	Monthly services furnished using BHI models
99492	Initial psychiatric collaborative care management, first 70 mins
99493	Subsequent psychiatric collaborative care management, first 60 mins
99494	Initial or subsequent psychiatric collaborative care management, add’l 30 mins
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Advance Care Planning	
99497	ACP first 30 mins – Note: subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation
99498	ACP add’l 30 mins – Note: subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
Depression and alcohol misuse	
G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
Professional Services Provided in ETA Hospitals	
G0463	Professional Services Provided in ETA Hospitals
Virtual check-ins	
G2010	Remote evaluation, Established Patient – Note: for PHE only
G2012	Brief communication technology-based service, 5-10 mins of medical discussion – Note: for PHE only

Appendix B: Quality Measures

Domain	Measure Title	Method of Data Submission	Pay for Performance Phase In R—Reporting P—Performance
Care Coordination/ Patient Safety	Risk-Standardized, All Condition Readmission	Claims	PY2021: P & R PY2022: P & R PY2023-2026: P
	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims	PY2021: P & R PY2022: P & R PY2023-2026: P
	Days at Home (for High Needs Population ACO)	Claims	PY2021-2022: R PY2023-2026: P
	Timely Follow-Up After Acute Exacerbations of Chronic Conditions (for Standard ACO or New Entrant ACO)	Claims	PY2021: N/A PY2022: R PY2023-2026: P
Patient/Caregiver Experience	Consumer Assessment of Healthcare Providers and Systems® (CAHPS)	Survey	PY2021: N/A PY2022: R PY2023-2026: P

Appendix C: Electronic Voluntary Alignment

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

Choose Your Primary Clinician on Medicare.gov

Why Choose Your Primary Clinician on Medicare.gov?

Your primary clinician can help you make health care decisions and can improve how you manage your health care.

Your primary clinician is a health care provider—a doctor, physician assistant, nurse practitioner, or certified nurse specialist—who is responsible for coordinating your overall care, no matter where you choose to get health care services.

When you choose a primary clinician that participates in the ACO REACH Model, a Medicare model that aims to improve the quality and value of the care you receive, they get access to tools and services to better coordinate your care and improve your health.

Things to Think About When Choosing Your Primary Clinician

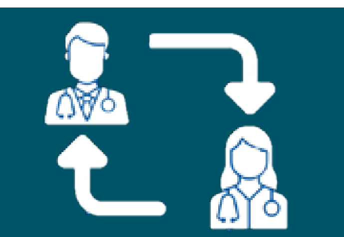
Choose A Provider

You can choose any health care provider as your primary clinician—for example, your primary care doctor, nurse practitioner, or physician assistant.

Maintain Flexibility

You can still go to any health care provider who accepts Medicare, even after you choose a primary clinician.

Change Anytime



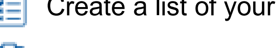
You can choose a different health care provider as your primary clinician at any time. Your primary clinician will remain the same unless you make a change on Medicare.gov.

To Indicate Your Primary Clinician:

Visit the Medicare Find and Compare Health Care Providers webpage (https://go.cms.gov/3h2KHWI) and follow the directions under "Add your favorite providers."

Your Secure Medicare Account

Visit Medicare.gov to log into (or create) your secure Medicare account. Your Medicare account gives you personalized information about your Medicare benefits and services at any time. You can:



- Create a list of your favorite health care providers and choose a primary clinician.
- Find preventive services.
- Check your health and prescription drug plan enrollment.

Need help choosing your primary clinician on Medicare.gov or have any questions on the ACO REACH Model? Call 1-800-MEDICARE (TTY users should call 1-877-486-2048) or your Primary Care Practice. If you do not have internet access, we encourage you to work with family or friends, or check in with your local State Health Insurance Assistance Program (SHIP) office, library, place of worship, or community center for help.

Appendix D: Voluntary Alignment Fact Sheet

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

Do's and Don'ts: Educating Beneficiaries on Voluntary Alignment

If you choose to educate beneficiaries:

DO Make the official CMS Voluntary Alignment Beneficiary Fact Sheet accessible to all beneficiaries in your ACO.

DON'T Coerce, withhold medical services, limit (or threaten to limit) access to care, or provide any incentive to beneficiaries to influence their attestation decision.

DON'T Enter a beneficiary's choice of primary practitioner on Medicare.gov on behalf of the beneficiary. You may offer technical support, as needed.

How VA Works

- A beneficiary may be voluntarily aligned to the ACO if the practitioner is on the ACO's Participant Provider List.
- Voluntary alignment takes precedence and has priority over the claims-based alignment.
- The most recent valid voluntary alignment attestation (either MVA or SVA) will take precedence.

ACO REACH Voluntary Alignment Fact Sheet

Medicare beneficiaries can voluntarily align with their primary practitioner on Medicare.gov or by submitting a Voluntary Alignment Form. Voluntary alignment increases patient-centeredness by prioritizing patient choice when assigning responsibility for coordinating a patient's care to a health care provider. CMS uses beneficiaries' attestations as the prioritized method of attribution in the ACO Realizing Equity, Access, and Community Health (REACH) Model.

What Is Voluntary Alignment?

Voluntary Alignment (VA) is a process that allows beneficiaries to choose the health care providers with whom they want to have a care relationship. Beneficiaries may choose to align to an Accountable Care Organization (ACO) voluntarily by designating a Participant Provider affiliated with the ACO as their primary clinician or main source of care.

How Does a Beneficiary Voluntary Align to an ACO?

- Medicare beneficiaries can register on Medicare.gov and log in to attest to their primary practitioner, referred to as Medicare.gov voluntary alignment (MVA), or submit a Voluntary Alignment Form to their primary practitioner, referred to as Signed- Attestation Based Voluntary Alignment (SVA). Their primary practitioner is the health care provider they choose to be responsible for providing and coordinating their overall care.
- When a beneficiary chooses a primary practitioner, it allows the ACO to gain better insight into the beneficiary's health and conditions via additional information contained in risk scores and practice feedback reports. This can lead to improved patient-centered care for the beneficiary.
- Attesting to a primary practitioner doesn't affect beneficiaries' Medicare benefits or restrict their ability to seek care from any practitioner. Beneficiaries can change their primary practitioner at any time.

Eligibility Criteria for Beneficiary Attribution

- Enrolled in Medicare Parts A and B
- Medicare as the primary payer
- Not covered under Medicare Advantage or other Medicare managed care plan
- Resident of the United States
- Reside in a county that is included in the ACO's service area

For High Needs Population ACO

- Have one or more conditions that impair the beneficiary's mobility
- Have at least one significant chronic or other serious illness. More information can be found in The Financial Overview: https://innovation.cms.gov/media/document/dc-financial-op-guide-overview

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