Program Integrity, Eligibility and Compliance in the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model: An Overview of the Model's Vetting, Monitoring, Auditing and Analytic Activities

The CMS Innovation Center currently conducts a comprehensive set of vetting, monitoring, auditing, and analytic activities under the Global and Professional Direct Contracting Model (GPDC Model) aimed at protecting beneficiaries, healthcare providers, and the model's evaluability. Executed in coordination with the CMS Center for Program Integrity (CPI), these activities assess applicants' eligibility under the terms of the model's Request for Applications, participants' compliance with the model requirements as detailed in the model's Participation Agreement, and potential program integrity risks. Each model participant is required to cooperate with CMS' monitoring and auditing activities, and must require its downstream providers and suppliers to cooperate with those activities as well. Failure to comply with model requirements is addressed through a set of escalating remedial actions that include placement on a corrective action plan or, in select instances, immediate termination from the model. We will continue and build on these activities in the redesigned model (to be called the ACO REACH Model) to further strengthen beneficiary and provider protections.

In addition to screening an applicant's program integrity history and compliance with application eligibility requirements and responses to a core set of application evaluation factors, in assessing applications to begin participation in the ACO REACH Model beginning in 2023, CMS may refer possible violations of federal laws by applicants to other federal agencies as part of the application process. For example, CMS may provide certain information, including, but not limited to, application materials to the Federal Trade Commission (FTC), the Antitrust Division of the Department of Justice (DOJ), and/or other federal agencies to protect competition in the regions where the ACO REACH Model will be tested.

The table below captures a non-exhaustive list of tasks that occur under the over-arching activities of vetting, monitoring, auditing, and analytics intended to directly assess or inform future assessments of compliance in the ACO REACH Model. To support transparency regarding the model's impact on beneficiaries and the Medicare program, CMS recently published aggregate information for the model, including the number of aligned beneficiaries, and information on quality and financial performance based on operations and actuarial data (not the model's evaluation), which will be updated quarterly. CMS will also publish evaluation results for the model as they become available.

Vetting Multi-step process used to assess an applicant or downstream participant, at both organizational and provider levels, on their eligibility and appropriateness for participation in the model		
Task	**Description**	**Purpose**
Application Review	Review and score applications for: • Organizational Readiness (including but not limited to ownership, leadership, governance, oversight, partnerships) • Financial Plan/Risk-Sharing Experience • Clinical Care Model (e.g., populations, beneficiary/community engagement, direct patient care experience, etc.) • Data/Technology Capability (e.g., HIT support of clinical care) Refer any application suggesting suspicious activities or suspected violations of federal law to the appropriate Federal agency(ies) (e.g., FTC and DOJ for any suspected anti-competitive practices)	Support informed, non-arbitrary assessment of applications to ensure suitability for participation in model

Vetting Multi-step process used to assess an applicant or downstream participant, at both organizational and provider levels, on their eligibility and appropriateness for participation in the model		
Task	**Description**	**Purpose**
Organizational Screening	Review program integrity history of applicant including relevant owners, executive leaders, and governing body members	Support informed, non-arbitrary assessment of applicant's suitability for the model and identify red flags in terms of business practices, solvency, program integrity
Provider/Supplier Screening	Verify Medicare-enrollment status and program integrity history for health care providers/suppliers the applicant wishes to include as downstream participants in the model	Confirm eligibility to serve as downstream participants in the model
Environmental Scans	Perform searches of public and private sources to identify potential issues and risks associated with an applicant	Augment assessment of applicant's appropriateness for model participation

Monitoring Broad set of periodic and ad hoc activities including reviews, assessments, verifications, and validations to ensure participants and downstream participants are in compliance with model requirements and, in cases of non-compliance, issuance of remedial actions to ensure participants are on a path to compliance		
Task	**Description**	**Purpose**
Health Equity Plan Reviews (New requirement for ACO REACH in 2023)	Assess Health Equity Plans annually to ensure participants' proposed approach satisfactorily meets the criteria for selected goals and measurement, while continuing to protect access and availability of services for beneficiaries, use of evidence-based interventions, community involvement, and evaluation	Ensure compliance with health equity requirements under the model, which are intended to bring the benefits of accountable care to underserved communities
Changes in Name, TIN and Control Reviews	Assess and track any updates to participants' corporate identity, including key identifiers (e.g., TIN, legal name) and any changes in control (e.g., ownership) on a periodic basis. All changes in control and requests to transfer the rights and obligations under the model's Participation Agreement are reviewed for program integrity risks, including changes that could result in the participant no longer satisfying the model's eligibility criteria	Ensure continued participant eligibility and protect beneficiaries by ensuring care is not compromised due to a change in control, including transfer of the Participation Agreement to a new entity
Environmental Scans	Perform searches of public and private sources to identify potential issues and risks associated with a participant and/or downstream participants, with referrals to appropriate Federal agency(s) when suspicious practices/behaviors are identified	Ensure continued appropriateness for model participation
Provider/Supplier Screening	Verify Medicare-enrollment status and program integrity history for health care providers/suppliers the participant wishes to include as downstream participants in the model	Confirm continued eligibility to serve as downstream participants in the model
Board Composition Review	Verify proper representation on participant governing body, including participation of downstream participants (at least 75% control), Medicare Beneficiary (at least one), and Consumer Advocate (at least one), at least annually[1]	Ensure compliance with governing body requirements, which are designed to promote provider/supplier and beneficiary input in participant decision-making and operations

[1] Reflects ACO REACH requirements to begin in January 2023.

Monitoring Broad set of periodic and ad hoc activities including reviews, assessments, verifications, and validations to ensure participants and downstream participants are in compliance with model requirements and, in cases of non-compliance, issuance of remedial actions to ensure participants are on a path to compliance		
Task	**Description**	**Purpose**
Data Access, Use and Destruction Verification	Require annual request of HIPAA-Covered Data with attestation of ability and intent to comply with privacy and security requirements prior to dissemination of data. Communicate data retention and destruction requirements to participants upon exit from the model and verify timely data destruction in accordance with the terms of the Participation Agreement	Ensure request, access, use and disposition of shared beneficiary-identifiable data is in accordance with HIPAA, Federal laws, and model requirements designed to protect beneficiary privacy
Marketing Plan Review	Review participants' plans for conducting marketing activities, including outreach and education regarding voluntary alignment, and any amendments thereto. Content and outreach strategy will be reviewed to ensure compliance with marketing activity requirements in the Participation Agreement, such as the prohibitions on stating/implying that alignment to a participant removes a beneficiary's freedom of choice to see any Medicare-enrolled provider/supplier, and on advertising to beneficiaries any of the participant's other offerings such as their Medicare Advantage plan(s)	Ensure compliance with the marketing requirements, which are designed to prevent inappropriate or misleading outreach
Marketing Materials Review	Review marketing materials and marketing activities on a rolling basis and, as needed, request revisions to ensure compliance with all applicable requirements in the Participation Agreement, which include accurate representation of the model, the use of clear and appropriate level of language, and prohibitions on discriminatory and misleading activities	Ensure compliance with the marketing activity requirements under the model, which are designed to avoid misleading beneficiaries regarding the model
Public Reporting Verification	Verify annually that participants' public-facing websites contain timely, complete and accurate information regarding their participation in the model, the identity of downstream participants, joint venture interests, governing body members, clinical and administrative leadership, and model performance	Ensure compliance with participant reporting and transparency requirements, which are designed to promote transparency
Financial Guarantee Review	Ensure annually that participants secure, maintain and update their selected choice of financial guarantee (e.g., surety bond, line of credit, escrow)	Ensure compliance with financial guarantee requirements, intended to assure CMS is paid any Shared Losses/Monies Owed
Benefit Enhancements/ Beneficiary Engagement Incentives Implementation Plan Review	Annually review participants' implementation plans regarding the proposed use of BEs/BEIs, including their proposed approach to care delivery, determining the downstream participants and beneficiaries who will use them, and their plan for ensuring use of the BE/BEI conforms to the Participation Agreement terms	Protect beneficiaries, providers, and the Medicare Trust Funds by guarding against inappropriate use of BEs/BEIs
Complaints/Grievances Investigation	Work with CMS Regional Office Coordinators, 1-800-Medicare, and the CMS model liaison in the Medicare Beneficiary Ombudsman to investigate issues raised by beneficiaries, providers, and model participants if they arise	Protect beneficiaries, providers, and the Medicare Trust Funds

Monitoring Broad set of periodic and ad hoc activities including reviews, assessments, verifications, and validations to ensure participants and downstream participants are in compliance with model requirements and, in cases of non-compliance, issuance of remedial actions to ensure participants are on a path to compliance		
Task	**Description**	**Purpose**
Beneficiary Notification Review	Review and approve written notices sent annually to aligned beneficiaries by model participants that describe the model, provider participation with the participant, and the beneficiary's alignment to the participant under the model, as well as the beneficiary's right to opt out of having their claims data shared with the participant for certain purposes	Ensure compliance with beneficiary notification requirements, which are intended to provide transparency to beneficiaries
Provider Management	Verify quarterly the accuracy of the participants' list of downstream participants and their related information, including Medicare enrollment status	Ensure current and accurate lists of downstream participants for model operations and public reporting
Financial Performance	Perform quarterly assessments to identify outliers and changes in expenditures and risk adjustment including, but not limited to: • Gross savings and losses • Changes in risk scores to identify potential increases in coding intensity • Changes in demographic and geographic distribution of aligned beneficiaries to monitor for potential selection bias	Validate that model financial calculations (e.g., savings/costs against benchmark) reflect actual performance, rather than anomalies in care delivery and coding practices, to protect beneficiaries and the Medicare Trust Fund
Quality Performance	Assess quality performance annually for all model measures and quarterly for select model measures. Model measures are tied to payment and are as follows: • Risk-standardized all-condition readmissions, • All-cause unplanned admissions for patients with multiple chronic conditions, • Timely follow-up after acute exacerbations of chronic conditions (Standard and New Entrant participants) • Days at Home (High Needs participants), and • Patient experience using CAHPS®[2]	Monitor and assess quality of care (utilization, health outcomes, and beneficiary experience) and conduct analyses on outlier performance

Auditing Set of scheduled and ad hoc audits aimed at verifying compliance with the participation agreement and addressing observed or reported concerns		
Task	**Description**	**Purpose**
Certified Electronic Health Record Technology (CEHRT) Audit	Annually validate participants'/downstream participants' use of CEHRT in accordance with the model requirements	Ensure compliance with model CEHRT requirements, which are designed to promote interoperability

[2] CAHPS®, which stands for Consumer Assessment of Healthcare Providers and Systems, is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Auditing Set of scheduled and ad hoc audits aimed at verifying compliance with the participation agreement and addressing observed or reported concerns		
Task	**Description**	**Purpose**
ACO-Provider Agreements Audit	Verify annually that participants have executed written financial arrangements and fee reduction agreements with downstream participants that satisfy the applicable requirements of the model participation agreement, and that the participant has sent the requisite notifications to its downstream participants and to the executive of each TIN through which a downstream participant bills Medicare	Ensure that downstream participants have agreed to participate with the participant and are aware of and have agreed to comply with applicable model requirements, including requirements specific to the access and use of BEs/BEIs to support care delivery, and have agreed to the applicable Medicare FFS fee reduction
Voluntary Alignment Audit	Validate annually the processes and procedures participants and their downstream participants use to engage beneficiaries and, if applicable, collect their voluntary alignment forms with particular focus on detecting improper practices in securing beneficiary designations in violation of the model Participation Agreement	Ensure compliance with the voluntary alignment requirements in the model Participation Agreement, which are designed to prevent gaming and promote beneficiary choice

Analytics Set of planned and ad hoc analyses aimed at detecting unintended behaviors, patterns, and trends that can be further investigated through additional vetting, monitoring and auditing activities, and subsequently, if necessary, addressed through remedial action or future changes to the terms of the model.		
Task	**Description**	**Purpose**
Beneficiary Alignment	Annually monitor beneficiary alignment for indicators of possible discriminatory practices based on health status and other characteristics of aligned beneficiaries	Identify potential gaming and protect beneficiary choice
Beneficiary Movement	Analyze length of beneficiary alignment to model participants and movement of beneficiaries within and across models/programs (e.g., shifts between Medicare Shared Savings Program and models) and between traditional Medicare and Medicare Advantage (MA) on an annual basis	Identify inappropriate shifting of beneficiaries and protect beneficiary choice
Beneficiary Access to Care and Care Patterns	Annually monitor claims data to identify and assess: • beneficiary access issues and identify changes and trends in utilization of care for beneficiaries aligned to participants in the model compared with other fee-for-service beneficiaries, and differences among model participants on variables such as utilization of post-acute care, primary care, preventive care, surgical care, and other specialty services • changes and trends annually in care subject to capitation payment to assess any reduction in expected clinically appropriate levels of care on services such as post-acute care, primary care, preventive care, surgical care, and other specialty services • indicators that suggest negative impacts on quality, outcomes and cost-sharing as a result of failure to provide medically necessary care or other abusive conduct	Ensure beneficiary safety and access to medically necessary services

Analytics Set of planned and ad hoc analyses aimed at detecting unintended behaviors, patterns, and trends that can be further investigated through additional vetting, monitoring and auditing activities, and subsequently, if necessary, addressed through remedial action or future changes to the terms of the model.		
Task	**Description**	**Purpose**
Beneficiary Access, Care Patterns and Financial Arrangements	Monitor annually trends and changes in access, treatment, coding, quality of care, and outcomes to identify issues warranting further examination of incentive structures in financial arrangements participants have with their downstream participants	Protect beneficiary safety and quality of care
Beneficiary Access, Care Patterns and Participant Characteristics	Monitor annually trends and changes in access, treatment, coding, quality of care, and outcomes before and after alignment based on participant characteristics (e.g., insurer-owned, private equity/venture-backed, physician vs. hospital-led, etc.)	Identify gaming and protect beneficiary safety and choice
Benefit Enhancements/ Beneficiary Engagement Incentives Utilization	Annually compare implementation plans against observed use, and observed use relative to the allowed flexibilities.	Protect beneficiary safety and access to care