ACO REACH

ACO Realizing Equity, Access and Community Health

COLLABORATIVE HEALTH SYSTEMS®

ACO REACH Payments – What to Expect

As a Participant in the REACH Model, you have agreed to a reduction in your Medicare Fee-For-Service payments and to allow CHS to pay your claims in accordance with your REACH Participant Agreement.

CHS, HealthSmart, and ECHO Health Inc. are not replacing CMS or the MAC in this model, they continue to adjudicate your claims. CHS receives a file from CMS to process payments for primary care codes for the REACH Model. Questions regarding claims adjudication and denials should be directed to the MAC.

The Role of the REACH ACO:

- The ACO is making payments for claims that were reduced by CMS as indicated in the weekly claims reduction file we receive from CMS.
- The ACO is NOT adjudicating claims, making denial decisions or replacing any typical processes involving the MAC or CMS.

What You Need to Know:

- You are not receiving claims denials. As a participant in the ACO, you have agreed to reduce your FFS payments by 100% and allow the ACO to pay your claims.
- CMS will provide you with a Remittance or Explanation of Payment (EOP) that reflects the allowed FFS amounts that would be typically paid for all traditional Medicare claims. These EOPs will reflect a payment of zero and the allowed amount (after patient responsibility) will be paid directly to you by the ACO.
- CMS communicates the same data within your EOP to the ACO you are participating with via a weekly Claims Reduction File. The ACO will use this file to pay your claims as adjudicated by CMS and adjust the payment amount based on your agreed-upon contract specifications with the ACO (ex. 110% vs. 100%). **Note that core claims payments will be made at 100% of the allowed amount to keep the process and resulting Remit/EPP documentation clean. Any incentive present in your contract above the allowed amount (e.g. 10%) will be paid monthly via a separate payment stream.**
- CMS did not begin making the appropriate ACO adjusted payments until mid-January. Any claims for dates of services beginning January 1 that were paid before that time are being reprocessed to reverse any payments you may have received to reflect the 100% fee reduction. These EOPs will include the note: “Claim Status Description: Reversal of Previous Payment.” These payments will now be paid by the ACO.
- Any claims for patients with secondary insurance or Medicaid will continue to be forwarded to those payers as they were previously. The secondary payer(s) will continue to pay on the patient responsibility of the claim subject to their benefit schedule.

Adjusted Codes You May See on Your EOP to Reflect the ACO Payment Structure:

Adjustment Group Code:

CO: Contractual Obligations:

This is to reflect that you are being paid under your contractual obligations as a participant with the ACO. As a participant in the REACH Model, your TIN has an executed agreement with CMS called a fee reduction agreement, that has reduced your payments from CMS.

Adjustment Reason Codes:

45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount and must not duplicate provider adjustment amounts (payment and contractual reductions) that have resulted from prior payer(s) adjudication (use only with Group Codes PR or CO depending upon liability)

This is the amount that is above the Medicare allowed amount for this service and cannot be billed to the patient nor paid under the Contractual obligations of the ACO.

132: Prearranged demonstration project adjustment

This is the amount that will be paid by the ACO as the provider is a participant in the REACH Model – a “demonstration project.”