

Center for Medicare and Medicaid Innovation

Data Reporting Implementation Guide

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Revision History

Version	Date	Changes to prior version
1.1	01/31/2024	• Q5: clarifying CMS approved data collection sources for the Data Reporting • Q17: clarifying how ACOs should approach Data Reporting submission when a beneficiary passes away • Q18: clarifying whether ACOs must pre-approve Data Reporting screeners prior to data collection • Q33: clarifying the attributes for the beneficiaries on the HDR prepopulated list
1.1	02/02/2024	• Q42-Q44: New FAQs added regarding HDR application
1.1	02/13/2024	• Q6: clarifying CMS approved Third-Party Vendors
1.1	02/21/2024	• Q36: clarifying how to successfully submit the Data Reporting template for incomplete SDoH assessments • Q44: clarifying the differences between the North Carolina Department of Health and Human Services (NCDHHS) assessment and the HDR NCDHHS assessment
1.2	07/22/2024	• Q5: resolve an unintentional duplicate question • Establish tentative PY2025 submission schedule • Q14: issued a clarifying response concerning OMB's guidance
1.3	04/04/2025	• Q38-Q40: Conforming changes to reflect Executive Orders 14151 and 14168

Purpose

The purpose of this Implementation Guide is to guide provider organizations and Accountable Care Organizations (ACOs) in their implementation of the Data Reporting requirement (formerly known as the Health Equity Data Reporting requirement). Consistent with the Innovation Center's commitment to addressing disparities in health care access and outcomes, current and future value-based payment models will require the collection and analysis of standardized data elements to advance whole-person care, expand access, and improve health outcomes.

The purpose of the Data Reporting requirement is to help identify and address disparities in health outcomes, access to care, and quality of care among different populations. By collecting and then analyzing data on disparities, healthcare organizations and providers can better understand the needs of the populations they serve and develop targeted interventions to improve health outcomes and reduce disparities.

Using standardized measures, standard definitions, and common terminology gives CMS, REACH ACOs, and stakeholders actionable data to compare and evaluate performance over time. The United States Core Data for Interoperability (USCDI) creates a foundational language for broader sharing of electronic health information to improve patient health, which are required pursuant to the 21st Century Cures Act. The Office of the National Coordinator for Health Information Technology (ONC) is leading the effort to improve Electronic Medical Record (EMR) / Electronic Health Record (EHR) interoperability.¹

The ACO REACH Model is one of several models in the CMS Innovation Center that are implementing the Data Reporting requirement beginning in performance year (PY) 2023.² While the primary source of information related to the Data Reporting requirement and Data Reporting Adjustment (DR Adjustment) remains ACO REACH Quality Measurement Methodology, this overview has been developed to provide additional clarity in response to stakeholder feedback.³

¹ For additional resources, please visit: <https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi>

² For more details on ACO REACH, please visit the model website: <https://innovation.cms.gov/innovation-models/aco-reach>

³ For more information, please review Sections 2.3.4 and Section 4.4 of the ACO REACH Quality Measurement Methodology Paper

Tentative dates related to Data Reporting for PY 2025 of ACO REACH

Event	Tentative date
Data Reporting data collection	Demographic: collected once per model lifecycle per beneficiary (not required in PY 2024 – PY 2026) SDoH: collected annually Please note that for PY2025 and PY2026, data must be collected annually between January 1 – December 31
Period to submit SDoH data to production Health Data Reporting ⁴ (HDR) application opens	January 15, 2026
Period to submit demographic and SDoH (mandatory PY2024+) data to production HDR closes	March 13, 2026
REACH ACOs receive aggregated Data Reporting score within the PY 2026 Annual Quality Report	~August 12, 2026

Note: please refer to the integrated calendar for a list of all deadlines and events associated with ACO REACH, accessible here: <https://4innovation.cms.gov/secure/knowledge-management/view/403>

⁴ The Innovation Center's Health Data Reporting (HDR) application is the conduit for submitting Data Reporting data to CMS. This application has been designed to give CMMI models the ability to collect quality measure data, clinical data, utilization, and other health-related data from various types of Alternative Payment Model (APM) participants.

Screening Tools

1. Which SDoH screening tools are permitted in the ACO REACH Model?

Social Determinants of Health Screening Tools

Overview

CMS is providing three options for screening templates that may be used to collect beneficiary reported SDoH data (also referred to as upstream drivers of health data) in the ACO REACH Model. CMS chose these three screening tools because they are among the most represented SDoH tools in the healthcare market today. CMS does not anticipate any additional changes to the required SDoH tools, aside from requiring the collection and submission of updated versions of the USCDI V2 data elements but reserves the right to do so. If any updates are made, CMS intends to publish them prior to the PY in which they become effective in an updated version of this guide.

Standardized Screening for Health-Related Resource Needs in North Carolina

Description

The North Carolina Department of Health and Human Services (DHHS), in partnership with stakeholders from across NC, developed a standardized set of SDoH screening questions. Please note that at present, the NC screening tool only has associated Logical Observation Identifier Names and Codes (LOINC) for the *ValueSet* values (for example, “Yes” and “No” responses).

Licensure and Cost

The NC screening tool was adapted from PRAPARE and AHC. There is no licensing fee to use this screening tool.

Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool

Description

The ACH HRSN screening tool was developed by CMS to use in the AHC Model. AHC provided support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their HRSN.⁵

Licensure and Cost

CMS secured permission from the original authors of the screening questions AHC HRSN to use, copy, modify, publish, and distribute the questions for CMS use only. The authors of the screening questions have asked to be cited and alerted that their questions will be used, but do not seek financial compensation.⁶

National Association of Community Health Centers’ (NACHC’s) Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) Screening Tool

⁵ For more details regarding the AHC model, please visit: <https://innovation.cms.gov/innovation-models/ahcm>

⁶ For more details regarding the AHC Citation Guide, please visit:
<https://innovation.cms.gov/media/document/ahcm-screening-tool-citation>

Description

The PRAPARE tool was created by National Association of Community Health Centers (NACHC) and the Association of Asian Pacific Community Health Organizations (AAPCHO) for use across health care settings. It is a nationally validated assessment tool with the following core domains: personal characteristics, family and home, money and resources, and social and emotional health.⁷ Please note that there are a series of questions that are included in the PRAPARE assessment that are not included in this template for submission. For example, question 1 (Q1) (ethnicity), Q2 (race), Q5 (preferred language), Q9 (address), and Q12 (primary insurance) are not required as these data are routinely collected by CMS through Medicare enrollment and administrative claims. Also note that two of the possible 'Optional' PRAPARE assessment questions are included in this template and should be collected and submitted to CMS if available.

Licensure and Cost

For details regarding license agreements, please review PRAPARE's license agreement webpage.⁸

2. How should REACH ACOs select from the screening tools?

Social Determinants of Health Screening Tools

REACH ACOs and their contracted providers may choose to collect beneficiary-level SDoH data using one or all three of the SDoH screening tools e.g., AHC HRSN, PREPARE, or NC. REACH ACOs should choose the SDoH screening tool that best aligns with their internal information systems and connections with contracted providers and facilities. REACH ACOs and contracted providers may use one or all three of the screening tools, however, only one screening tool should be used to record responses from a given beneficiary. All responses collected from a single beneficiary must come from a single screening tool. While different screening tools may be used for different beneficiaries within a REACH ACO or a contracted provider's panel, REACH ACOs and their contracted providers cannot use questions from different screening tools to collect responses from a single beneficiary.

CMS understands that REACH ACOs and their contracted providers may already use SDoH screening tools that may differ or may operate in States that have SDoH reporting requirements that may differ from the three SDoH screening tools permitted. However, for the purpose of standardization, REACH ACOs and Participant and Preferred providers must use one of the three screening tools permitted e.g., AHC HRSN, PREPARE, or NC.

Data Collection

3. How can beneficiary data be collected and submitted?

CMS recognizes that REACH ACOs and their aligned provider organizations may need to navigate several obstacles to adhere to the Data Reporting requirements. CMS recognizes that provider organizations within a given REACH ACO, and even the REACH ACO itself, may have data flows from multiple sources, including one or more EMR/EHR systems, surveys, in-office questionnaires, and other means. To streamline a REACH ACO's implementation of the Data Reporting policy, CMS will not dictate the

⁷ For more details, please visit: <https://prapare.org/>

⁸ For more details, please visit: <https://prapare.org/license-agreements/>

internal data collection workflow. So long as the required beneficiary-level elements are collected and reported on beneficiaries aligned to the REACH ACO for a given PY, the requirement will be satisfied.

4. What data collection or acquisition sources are permitted?

Data Reporting data may be collected by REACH ACOs or their contracted Participant and Preferred providers through multiple sources including but not limited to the following:

- Documenting directly in the Excel template CMS provides
- Electronic medical records or electronic health records
- Paper surveys (in office or mailed)
- Patient portal questionnaires
- Digital tools, including internal screeners

Note – while various sources are acceptable, CMS requires that all responses adhere to the production template’s valid values.

5. **NEW 02/13/2024:** What guidance can CMS provide on the Usage of Third-Party Vendors for Performing ACO Activities such as Data Reporting?

ACOs may use third-party vendors in performing ACO Activities such as Data Reporting. ACO must ensure that it has written arrangements in place with such a third-party vendor performing ACO Activities that are necessary for evaluation, including Data Reporting. In addition, ACOs must maintain the privacy and security of all ACO REACH Model-related information that identifies individual Beneficiaries in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules and all relevant HIPAA Privacy and Security guidance applicable to the use and disclosure of Protected Health Information (PHI) by covered entities and business associates, as well as other applicable federal and state laws and regulations. Among other requirements, ACOs should ensure that ACO Activities related to Data Reporting comply with the provisions under Section 5.04.M of the Agreement related to unsolicited contacts.

CMS notes that Data Reporting should not consist of purchased datasets. ACO are responsible for making a reasonable effort to collect social determinants of health data from REACH Beneficiaries, as detailed in this guidance document.

For more details regarding this requirement, please refer to Section 5.04.M, Section 5.09, Section 9.04.H, Section 13.01.D, Section 13.01.A.2 of the ACO REACH Participation Agreement (“the Agreement”).

6. How should REACH ACOs navigate the requirement with many EMR/EHRs at play?

CMS recognizes that REACH ACOs may be contracted with provider organizations with varying levels of capacity to collect and submit SDoH data. Furthermore, CMS recognizes that many REACH ACOs and provider organizations may already collect similar data elements within their EMR/EHR.

CMS recommends that REACH ACOs and provider organizations collecting beneficiary-level information utilize whichever of the three SDoH screening tools best aligns with their internal capacity. For example, a given provider practice can use one or all three SDoH screening tools so long as each aligned beneficiary has a complete response by the established deadline.

7. Is data mapping or cross walking permitted for SDOH survey questions?

CMS requires that REACH ACOs use one of the approved SDOH survey templates, without making modifications to the questions or response options, however CMS recognizes that REACH ACOs may need to perform data mapping as necessary. While various sources are acceptable, CMS requires that all responses adhere to the production template's valid values.

8. What to select if drop down option is not available in template?

CMS understands that a beneficiary may respond to a SDOH question with a value that may not be available in the template drop down. For example, a beneficiary's preferred language may not be listed in the drop down of 183 languages that are based on the ISO 639-1 language codes in accordance with HL7 US Core IG guidance. Please select the response that most closely aligns with their response.

9. **UPDATED 9/03/2024** - When can beneficiary data be collected?

For PY2024+, REACH ACOs should collect data within the calendar year. For example, data must be collected from January 1 – December 31 of the performance year for each submission cycle.

10. How long should beneficiary-level data collected for Data Reporting be retained?

CMS will provide an updated version of this guide which outlines CMS's position regarding the retention of beneficiary level data collected for Data Reporting requirement.

11. What resources exist for beneficiaries whose preferred language is Spanish?

CMS is providing a Spanish language translation for each question and a valid response for the SDOH questions in an updated pre-submission template, [accessible via this link](#). In addition, there are several Spanish language resources produced for each SDOH screening tool that are accessible below. REACH ACOs may leverage these resources to capture responses from Medicare beneficiaries who speak Spanish. Note – currently the HDR application can only accept English language valid values, therefore, all responses captured in Spanish must be translated to English.

- **PRAPARE:** <https://prapare.org/knowledge-center/prapare-implementation-and-action-toolkit/prapare-implementation-and-action-toolkit-spanish/>
- **AHC:** <https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-spanish>
- **NC:** <https://www.ncdhhs.gov/sdoh-screening-tool-spanish-2>

12. What resources exist for beneficiaries who are Limited English Proficient (LEP) or whose preferred language is neither Spanish nor English?

CMS acknowledges that beneficiaries speak, read, and write a variety of languages other than English or Spanish. In the event a REACH ACO and/or Participant or Preferred Provider cannot ascertain Data Reporting responses from a beneficiary due to a language barrier, the REACH ACO may choose to indicate the beneficiary refused to respond to SDOH prompts where applicable.

13. UPDATED 5/30/2024: Regarding the collection of SDOH or Health-related Social Need (HRSN) data, what guidance can CMS provide on the steps healthcare providers are expected to follow if a situation requires intervention? Further, please identify the various levels of advancement (i.e. social worker, state Department of Health (DOH), police etc.) based on a beneficiary's response(s).

Health care providers should use their judgment to initiate follow-up actions after identifying a health-related social need (HRSN) through screening. Possible actions include:

Action	Definition
Adjustment	Activities that focus on altering clinical care to accommodate identified social barriers
Assistance/Assisting	To give support or aid; to help
Coordination	Process of organizing activities and sharing information to improve effectiveness
Counseling	Psychosocial procedure that involves listening, reflecting etc. to facilitate recognition of course of action/solution
Education	Procedure that is synonymous with those activities such as teaching, demonstration, instruction, explanation, and advice that aim to increase knowledge and skills, change behaviors, assist coping and increase adherence to treatment
Provision	To supply/make available for use
Referral	The act of clinicians/providers sending or directing a patient to health care professionals and/or programs for services (e.g., evaluation, treatment, aid, information, etc.).

Many providers develop protocols to initiate referrals to community-based resources based on the patient's HRSNs (e.g. providing information about local food pantries or nonprofits that assist with housing issues). Protocols and policies for following up on HRSNs can be tailored to the resources available in the health care provider's community. For example, in [Accountable Health Communities](#) (AHC) model, which evaluated navigation to community-based resources as a strategy to address HRSNs, the awardees used a wide range of personnel to assist with referrals and other follow-up actions, including Community Health Workers, social workers, administrative staff, and volunteers. Depending on the patient's circumstances, these navigators also sometimes helped with referrals to other health care services and supports (e.g. to behavioral health providers). Some key lessons learned about SDOH/HRSN screening and referral in the AHC model are available [here](#). Case studies that explore how health care providers developed referral protocols for patients are also available on the [AHC model webpage](#).

Beneficiary Choice

14. What types of beneficiary and provider outreach are permitted?

Beneficiary reporting of SDOH information is voluntary, and REACH ACOs should not impose on beneficiaries any requirement to report such information or impose on its Participant Providers and Preferred Providers any requirement to collect such information from beneficiaries who choose not to report it. Beneficiary incentives to report SDOH information are not permitted. REACH ACOs that

document and submit a beneficiary's choice not to disclose such data will receive credit for reporting that data.

15. What if the REACH ACO has not seen the beneficiary or is unable to reach the beneficiary?

If the REACH ACO has not seen the beneficiary or is unable to reach the beneficiary, this does not constitute that the beneficiary declined to respond. The REACH ACO must document that the beneficiary declined to respond to receive credit.

16. What to do if a beneficiary declines to share Data Reporting responses?

REACH ACOs should not impose on beneficiaries any requirement to report such information or impose on its Participant Providers and Preferred Providers any requirement to collect such information from beneficiaries who choose not to report it. REACH ACOs that document and submit a beneficiary's choice not to disclose such data will receive credit for reporting that data. If data are being submitted directly by the beneficiary, for example a paper survey or patient portal questionnaire, a beneficiary may still decline to respond to the survey questions. To receive credit, the beneficiary should clearly document that the beneficiary declined to disclose the information on the form submitted.

The SDoH data submission template includes an "assessment declined" field which is intended to indicate whether a given beneficiary declined the entire survey when asked. If the answer "Yes," is provided, all SDoH fields are expected to be blank. If the answer is "No," any one of the three assessment options should be partially or fully complete. If a blank response is provided, the answer will be interpreted as refused.

17. What to do if there are beneficiaries with unique care needs?

CMS recognizes that some beneficiaries may have unique care needs that prevent them from submitting responses to SDoH questions directly. CMS will allow a proxy (i.e., caregivers, family members, friends, neighbors, power of attorney, authorized representatives) to respond on behalf of beneficiaries, **so long as beneficiaries have not declined to respond**. CMS defines a proxy caregiver as an individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long-term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis in managing a patient's complex health care and assistive technology activities at home; and helping to navigate the patient's transitions between care settings.⁹

18. UPDATED 01/30/2023: What if the beneficiary passes away during the PY?

REACH ACOs only need to submit data on beneficiaries who are included in the pre-populated production template from the HDR application. Beneficiaries who do not contribute at least 6-months of eligibility as of October 1 of the PY will not count in the REACH ACO's denominator for the Reporting Rate. In other words, if the beneficiary dies mid-performance year, and does not contribute at least 6-months of alignment eligibility during the PY, the beneficiary will not be included in the denominator for the Data Reporting Adjustment (DR Adjustment) calculation.

⁹ For additional information on the definition of proxy caregivers, please visit [link](#)

19. UPDATED 01/30/2023: Are ACOs required to receive CMS approval of beneficiary outreach screeners prior to collecting data for the Data Reporting requirement? (Where the beneficiary outreach is the tool ACOs use to collect data to meet the Data Reporting requirement).

No, CMS does not require ACOs submit beneficiary outreach screeners for review prior to data collection. This includes cover letters which may orient the beneficiary to the outreach screeners.

20. UPDATED 11/14/2024: Can REACH ACOs or their Participant/Preferred Providers send text messages to REACH-aligned beneficiaries for Data Reporting?

Pursuant to Agreement Section 5.04.M.2, REACH ACOs and Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities **are prohibited** from using Marketing Materials and conducting Marketing Activities, including conducting screening related to the **Data Reporting requirement**, through the use of door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence, approaching Beneficiaries in common areas, such as parking lots, hallways, lobbies, sidewalks, or using telephonic solicitation, **including text messages and leaving voicemail messages**. However, such activity is permitted in common areas of a health care setting. ACOs may wish to consult counsel in determining the implications for their respective situation.

Data Reporting Submission

21. What is the difference between the HDR Test Environment and HDR Production Environment?

The HDR Test Environment (portalval.cms.gov) is designed to orient ACO staff to the HDR application but is not designed to receive personally identifiable information (PII) or personal health information (PHI). ACO staff may access and navigate the HDR Test Environment to familiarize themselves with the application in advance of the production submission period. The HDR Production Environment (portal.cms.gov) is designed to receive and validate PII/PHI submitted by ACOs during the production period, which will occur in mid-January 2024 for PY2023. **This site will not be accessible until the production period opens.** For more information regarding the HDR Test Environment, please review the [HDR Test and Validation User Manual available here](#).

22. What is the required submission frequency?

Social Determinants of Health

Due to the dynamic nature of SDOH data, CMS requires REACH ACOs to collect beneficiary-reported data on an annual basis to receive credit for reporting SDOH data. CMS will require REACH ACOs to include the date on which the SDOH data was collected when reporting to CMS. If a REACH ACO collects SDOH data from a given beneficiary in August of PY 2024, the REACH ACO may submit that data for credit toward the DR Adjustment in PY 2024. To receive credit towards the DR Adjustment for SDOH data in PY 2025, the REACH ACO must recollect SDOH data from the same beneficiary in PY 2025. Data

submitted with a collection date outside of the PY will not count for credit towards the DR Adjustment in the PY.

For PY2024 – PY2026, REACH ACOs should collect data within the calendar year. For example, data must be collected from January 1 – December 31 of the performance year for each submission cycle.

23. How are the pre-production templates and the HDR production templates different?

CMS has provided REACH ACOs with various templates associated with the Data Reporting policy. The pre-production template can be accessed through 4i's Knowledge Library. The pre-production template can be used to collect beneficiary data up until when the production template becomes available in Health Data Reporting (HDR) application. The pre-production template is intended to help REACH ACOs and contracted providers capture beneficiary responses. The production template will only be accessible through the HDR application with certain pre-populated fields. Data should be transferred from the pre-production template to the production template before submission as the production template has metadata that support data validation. **Only the production template downloaded from HDR may be submitted to HDR.**

24. Where can the pre-production and production templates be accessed?

The pre-production template is currently accessible to REACH ACOs in 4i's Knowledge Library [here](#). The production template will not be available until the mid-January 2024. To access the HDR Production Environment, please [navigate to the HDR application](#). Note – only REACH ACO-designated staff may gain access to the HDR application and must have an established 4i account.

25. How should the production template be used?

In the HDR Production Environment, CMS will provide the REACH ACO production templates that will contain pre-populated fields for patient identifiers. All required fields should be completed using the drop-down options for each beneficiary. Please note, only one SDoH screening tool must be completed per beneficiary. The other screening tools may be left blank for the beneficiary.

26. What if the pre-populated data in the HDR production template is old?

CMS understands that the pre-populated data in the production template may be different from the data that the REACH ACO has, for example, a beneficiary may have a change in their Medicare Beneficiary Identification (MBI) number. CMS will share the most recent data available at the time that the production template is generated. However, REACH ACOs should not make changes to pre-populated data in the HDR production template, as this will result in errors during data validation in the HDR application. If the Medicare Beneficiary Identification (MBI) has changed, the ACO should use the other pre-populated fields to perform the appropriate linkage. CMS may revisit this HDR limitation in future PYs.

27. How can data be transferred from the pre-production template to the production template?

If the REACH ACO has collected data in the pre-production template, the REACH ACO should transfer data from the pre-production template in 4i to the production template from HDR before submitting.

Please ensure that all cell entries are consistent with valid value codes. REACH ACOs only need to transfer data for pre-populated beneficiaries in the HDR template.

Alternatively, the REACH ACO can also input data directly from their systems into the production template from HDR.

28. Where should the production template be submitted?

The production template should be submitted through the production environment of the HDR application, which is accessible to ACO-delegated representatives via portal.cms.gov.¹⁰ The Innovation Center's HDR application is the conduit for submitting Data Reporting data to CMS. This application has been designed to give CMMI models the ability to collect quality measure data, clinical data, utilization, and other health-related data from various types of Alternative Payment Model (APM) participants.

29. Who can access and submit to the HDR Application?

Prior to each submission period, CMS will request that REACH ACOs indicate which REACH ACO staff should have access to the HDR application. CMS requires that all REACH ACO staff who access HDR, establish 4i accounts first. The same account credentials used to access 4i will apply to the HDR application. Note, REACH ACO representatives are responsible for managing access to the 4i and HDR applications. Please ensure the appropriate representatives have access to the HDR application and are familiar with the application's environment in advance of the applicable deadlines. For more details regarding the HDR application, [please review the Data Reporting resources on 4i here](#).

30. What file types can be uploaded to the HDR Application?

The HDR application can accept following file type: .xlsx.

31. What are the file naming convention for the files that are uploaded to HDR?

There is no file naming convention required by the HDR application.

32. What is the submission window for Performance Year 2025?

The HDR application will accept PY 2025 Data Reporting submissions from January 16, 2026, until March 15, 2026, at 11:59PM ET. Please follow the ACO REACH calendar for more accurate information.

33. Are multiple submissions permitted?

If a REACH ACO submits multiple files to the HDR application for a given template, CMS will use **only** the most recent (last) accepted file submission. Please ensure that uploaded files are **full replacement files**.

34. How will the HDR application validate the data that are submitted?

When a REACH ACO submits data to the HDR application, data validation will be conducted. Data validation will verify that all required fields are completed with a valid response.

¹⁰ Note, the HDR production environment will only be accessible in January 2026

35. Will partial responses at a beneficiary level be accepted?

The Data Reporting bonus will be based on the proportion of beneficiaries for whom *required* SDoH data fields are *complete*. However, if the REACH ACO documents that a beneficiary declined to disclose the data, the REACH ACO will still receive credit.

36. **UPDATED 01/31/2023:** Which beneficiaries should be included on the submission?

Each PY, REACH ACOs will be able to download a pre-production template and a production template. REACH ACOs will be able to download a production template from the HDR application, which will be populated with the list of beneficiaries aligned to the REACH ACO as of October 1 of the PY identified by their Medicare Beneficiary Number (MBI). REACH ACOs only need to submit Data Reporting data on beneficiaries who are included in the pre-populated production template from the HDR application. Beneficiaries who do not contribute at least 6-months of eligibility as of October 1 of the PY will not count in the REACH ACO's numerator or in the denominator for the Reporting Rate. ACOs may use their discretion if beneficiaries who do not have 6-months of alignment eligibility are on the Data Reporting list, however, as a reminder, the ACO REACH Model uses the Risk Score Report to establish how many months of alignment eligibility a given beneficiary contributes within a PY. Note, ACOs should ensure that the pre-populated fields on the HDR production file remain unchanged when submitted to the HDR application, i.e., if the beneficiary's MBI changed, please submit using the old version of the MBI. CMS may revisit this HDR limitation in future PYs.

37. **UPDATED 06/30/2024:** What is the relationship between the new Healthcare Common Procedure Coding System (HCPCS) code, G0136, and the ACO REACH Data Reporting Requirement?

Please refer to questions outlined below concerning which fields are required to receive full credit for the Data Reporting requirement in ACO REACH. Like other screenings, the goal of using a health-related social needs screening tool with all beneficiaries is to identify needs and have an opportunity to intervene/address those needs across the entire population of beneficiaries. The goal of the G0136 SDOH Risk Assessment that was introduced in the [CY 2024 Medicare Physician Fee Schedule final rule](#) is to identify which HRSNs are posing or may pose issues in diagnosis, treatment, and management of a specific patient's health conditions where there is reason to believe that this may in fact be the case.

More information about the stand-alone code G0136 can be found [here](#). The HRSN screening tools that exist in ACO REACH meet the criteria for the SDOH assessment required for G0136, in that they are standardized, evidence-based tools that include questions about housing insecurity, food insecurity, transportation needs, and utility difficulties. It is therefore possible that administration of the screening tool for some beneficiaries could be part of meeting the criteria for billing G0136. If the tool is administered in connection with a qualifying visit (E/M visit, including hospital discharge or transitional care management; behavioral health office visits; or the Annual Wellness Visit (AWV)), and the provider has reason to believe that an unmet need might interfere with or influence diagnosis, treatment, choice of treatment, or plan of care for this beneficiary, then the completion of the HRSN screening tool by the beneficiary may satisfy requirements to bill G0136. Note that, except when billed in connection with an AWV, patient cost sharing will apply to G0136.

Data Reporting Scoring

38. UPDATED 04/04/2025: What fields must be populated to receive full credit?

Please note that the HDR application is for general use across CMMI. This means that HDR will accept partial responses for most questions, and the reporting requirements imposed by HDR may diverge from what CMS requires for the ACO REACH Model. Please refer to the tables below for a list of which fields must be provided to receive full credit.

Social Determinants of Health

As a reminder, the submission of SDoH data becomes required in **PY2025** in ACO REACH. REACH ACOs should submit responses to the two required questions *Date SDoH Assessment is Completed* and *Beneficiary Declined Assessment* for all pre-populated beneficiaries and should populate responses for the SDoH screening assessment option that was chosen for a given beneficiary unless the beneficiary declined the assessment.

The SDoH data submission template includes an “*assessment_declined*” field which is intended to indicate whether a given beneficiary declined the entire survey when asked. If the answer “Yes,” is provided, all SDoH fields are expected to be blank. If the answer is “No,” any one of the three assessment options should be partially or fully complete. If a blank response is provided, the answer will be interpreted as refused.

Data Element Name	Performance Years			
	2023	2024	2025	2026
<i>Model short name</i>	Pre-populated (Not required for PY 2024-PY2026)			
<i>ACO (Entity) Participant ID</i>				
<i>Medicare Beneficiary Identifier (MBI)</i>				
<i>Beneficiary first name</i>				
<i>Beneficiary last name</i>				
<i>Beneficiary sex</i>				
<i>Date of Birth</i>				
<i>Date SDoH Assessment is Completed</i>	Required			
<i>Beneficiary Declined Assessment</i>				
<i>SDoH Screening Tools (NC, ACH, PRAPARE)*</i>	Optional (required to choose one screening tool per beneficiary)			

**Note: for brevity, the questions for each SDoH screener are not provided in the table above but are all optional fields to allow flexibility to respond to one of the three permitted SDoH screening tools and to permit blank responses if a beneficiary declines to respond to part of the assessment and a ‘declined to respond’ option is not available within the screening tool valueset options.*

39. Updated to Align with Executive Orders 14151 and 14168: What is the range of the Data Reporting Adjustment Impact on Initial Quality Score?

In previous guidance, as outlined in the Quality Measurement Methodology, CMS indicated that the range of the DR Adjustment Impact on the Initial Quality Score would incrementally increase with each

PY, as outlined below. Based on stakeholder feedback, CMS has modified the adjustment impact to remove the downward adjustment, as outlined below in **red**.

Performance Year	Original		Revised	
	Demographic Data	SDoH Data	Demographic Data	SDoH Data
2023	0 to +10 percentage point adjustment, based on proportion of aligned population for which data is reported	No impact (reporting optional)	No change	
2024	+5 percentage point adjustment, ACOs are held harmless	0 to +5 percentage point adjustment, based on proportion of aligned population for which data is reported	ACOs automatically receive +5 percentage points for Demographic Data and up to +5 percentage points based on submitted SDoH data)	
2025	Not required (+5 percentage point adjustment, ACOs are held harmless)	0 to +5 percentage point adjustment, based on proportion of aligned population for which data is reported	ACOs automatically receive +5 percentage points for Demographic Data and up to +5 percentage points based on submitted SDoH data)	
2026	Not required (No adjustment tied to demographic data)	0 to +5 percentage point adjustment, based on proportion of aligned population for which data is reported	0 to +5 percentage points for submitted SDoH data only	

40. What is the Data Reporting scoring methodology?

The DR Adjustment will be based on a sliding scale such that REACH ACOs can receive partial credit. CMS will calculate a Reporting Rate by dividing the following numerator by the following denominator:

- Numerator = Number of beneficiaries with at least 6 months of alignment to the REACH ACO during the PY as of October 1 for which the REACH ACO successfully reports all required data elements.
- Denominator = Number of beneficiaries with at least 6 months of alignment to the REACH ACO during the PY as of October 1 of the PY, based on April 1 of PY +1 final eligibility checks. If during the April 1, 2024, final eligibility checks, it is identified that the beneficiary lost eligibility during the performance year, those beneficiaries will be excluded from the calculation.

CMS determines the Reporting Rate (1) at the beneficiary level; (2) assessed separately for required data; and (3) defined as submitting valid data for all required data elements. To calculate the DR Adjustment, the Reporting Rate will be multiplied by the maximum adjustment. For PY 2024, this will be 10%, 5% for demographic data and 5% based on the proportion of aligned population for which SDoH data is reported. For example, a REACH ACO with a Reporting Rate of 80% for demographic data and 20% for SDoH data in PY 2024 will receive a DR Adjustment of $[100\% * 5\%] + [20\% * 5\%] = 6.0\%$. Please note that the Total Quality Score is capped at 100%. (Also, note, this example has been modified to reflect that ACOs are held harmless for Demographic Data reporting for PY 2024—see table on page 17 for more information.)

41. What is the scoring timeline?

REACH ACOs will receive scores with their Annual Quality Reports at Final Financial Settlement in August or September of the year following the performance year (PY + 1).

42. What is the impact to final settlement?

The process of determining the impact of quality measurement and performance on the PY Benchmark is described in the PY 2024 Quality Measurement Methodology Report (QMMR) as follows:

- CMS develops Quality Performance Benchmarks (QPBs) for each Pay for Performance (P4P) measure.
- Quality Measure points are awarded: P4P Quality Measures are compared to their respective QPBs to determine performance levels and the corresponding number of points earned (each measure is worth 10 points).
- The Initial Quality Score is calculated as the percentage of points earned from all measures out of the total possible points (40).
- CI/SEP criteria are assessed to determine the CI/SEP multiplier, either 1.0 or 0.5, used to adjust the Initial Quality Score. The Initial Quality Score of a REACH ACO that does not meet the CI/SEP criteria will be multiplied by 0.5; the modifier is 1.0 for a REACH ACO that meets the CI/SEP criteria, resulting in no change to the Initial Quality Score.
- The Total Quality Score is adjusted based on the Data Reporting bonus. In PY 2024, the Data Reporting is an adjustment between 0% and 10% added to the Total Quality Score. The Data Reporting requirement bonus is contingent upon the percentage of beneficiaries for which the REACH ACO submits required SDOH data. The Total Quality Score is capped at 100%.
- After the CI/SEP and DR adjustments, CMS multiplies the final Total Quality Score by the 2% Quality Withhold to determine the Quality Withhold Earned Back.
- HPP funds are added to the REACH ACOs' Other Monies Owed for REACH ACOs that meet the HPP criteria.

HDR Application Questions

43. Why can I not edit the HDR dropdown list of valid responses in the HDR Submission Template?

The valid responses may not be modified. Please use one of the valid responses provided in the dropdown. If you are copying and pasting values, please ensure that you paste values using the correct format for the corresponding field/column, including capital and lower-case letters.

44. Where can I see the results of a submission to the HDR application?

After HDR completes validation of the uploaded submission file, the user will be able to use the Upload History tab to review the results of a submission. Please refer to the diagram below for a visual example.

1/23/2024 4:14 PM by [REDACTED]		All Status Reports	
ACOREACH-ACOREACH1-Submission...xlsx	ID: [REDACTED]	Rejected 4,782 total errors 26,609 total warnings	Status Report

45. UPDATED 01/15/2026: We noticed that the North Carolina Department of Health and Human Services (NCDHHS) screening tool linked [here](#) and the NC screening questions included in the DATA REPORTING template are not aligned. Which version should we use?

The ACO REACH Data Reporting template now aligns with the latest version of NC SDOH screening tool document (version 2019); therefore, ACOs should use the ACO REACH Data Reporting template as found on the HDR portal.

46. UPDATED 01/16/2025: Sampled Patient File

Thank you for reaching out regarding your question about a sampled patient list for ACO REACH. If you open the template you see in the HDR application, you will see your sample list of patients prefilled. The template therefore includes your list of patients. Please let us know if you have any additional questions.

47. UPDATED 01/16/2025: First 1000 rows highlighted and do not carry forward

Please note that only the first 1000 lines of the ACO REACH data submission template are formatted by default. The highlighting is just a formatting convention and will not materially impact your submission.

For all other questions...

48. Where should questions related to DATA REPORTING for the ACO REACH Model be directed?

In the event this guide does not address a question related to the DATA REPORTING policy in the ACO REACH Model, please submit an inquiry to the ACO REACH Model Help Desk at ACOREACH@cms.hhs.gov.