

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

PY2023 Quality Measurement Methodology

Prepared for:

Centers for Medicare & Medicaid Services (CMS)

Center for Medicare and Medicaid Innovation (The Innovation Center)

Seamless Care Models Group

7500 Security Boulevard, N2-13-16

Baltimore, MD 21244-1850

Prepared by:

RTI International

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October 21, 2022	- Section 4.5 High Performers Pool, and Section 4.6. Application of Quality Assessment to Final Financial Settlement. Edited to indicate the HPP bonus to be applied as Other Monies Owed. - Standardized the term to 'Settlement' instead of 'Reconciliation' throughout the document.
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Reference documents

ACO REACH Model PY2023: Financial Operating Guide: Overview (PDF)
ACO REACH Model PY2023: Capitation and Advanced Payment Mechanisms (PDF)
ACO REACH Model PY2023: Financial Settlement Overview (PDF)
ACO REACH PY2023 Participant and Preferred Provider Management Guide (PDF)
ACO REACH and KCC Models PY2023: Rate Book Development (PDF)
ACO REACH and KCC Models PY2023: Risk Adjustment (PDF)

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List of Acronyms

ACO	Accountable Care Organization
ACO REACH	Accountable Care Organization Realizing Equity, Access, and Community Health
ACR	Risk-Standardized All-Condition Readmission
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®
CI/SEP	Continuous Improvement/Sustained Exceptional Performance
CMS	Centers for Medicare & Medicaid Services
DAH	Days at Home for Patients with Complex, Chronic Conditions
DCEs	Direct Contracting Entities, this terminology is only used when referring to PY2021 and PY2022 participants during those years
ED	Emergency Department
ESRD	End-Stage Renal Disease
FFS	Medicare Fee-for-Service
FQHC	Federally Qualified Health Center
GPDC	Global and Professional Direct Contracting
HCC	Hierarchical Condition Category
HEDR Adjustment	Health Equity Data Reporting Adjustment
HPP	High Performers Pool
IP	Implementation Period
MIF	Measure Information Form
N/A	Not Applicable
P4P	Pay-for-Performance
P4R	Pay-for-Reporting
PACE	Programs of All-Inclusive Care for the Elderly
PY	Performance Year
QPB	Quality Performance Benchmark
QMMR	Quality Measurement Methodology Report
REACH ACOs	Accountable Care Organizations participating in the ACO REACH Model in PY2023 and subsequent years
RSAAR	A Risk-Standardized Acute Admission Rate
RSRR	Risk-Standardized Readmission Rate
SDOH	Social Determinants of Health
SNF	Skilled Nursing Facility
SSM	Summary Survey Measure
TFU	Timely Follow-Up After Acute Exacerbations of Chronic Conditions
TIN	Tax Identification Number
The Innovation Center	Center for Medicare & Medicaid Innovation
UAMCC	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

This document provides an overview of the quality measurement and performance evaluation methodology for Accountable Care Organizations (ACOs) participating in the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. The ACO REACH Model is a redesigned version of the Global and Professional Direct Contracting (GPDC) Model, which began on April 1, 2021. The ACO REACH Model redesign begins on January 1, 2023 and runs through 2026. For completeness and context, this paper may refer to policies in Performance Year 2021 (PY2021) and PY2022 of the GPDC Model.

The quality approach is discussed at a high level for the entire performance period, and PY2023 is discussed in additional detail. This document includes information on the ACO REACH Model focusing on the Standard, New Entrant, and High Needs Population ACO types. This document may be subject to periodic changes and will be updated to reflect policies applicable during the current PY.

Section 1 provides a brief overview of the ACO REACH Model with context relevant to the quality strategy. **Section 2** provides an overview of the quality performance assessment process and how performance assessment will be applied in PY2023 and subsequent PYs. **Section 3** provides additional details regarding the design of the Quality Measures in use during PY2023 of the ACO REACH Model. **Section 4** provides more details about the quality performance assessment process including benchmark creation and quality scoring and how quality assessment will be applied to the final Financial Settlement. **Section 5** provides a series of worked examples of the application of the quality strategy.

1. Model Background: Context for Quality Approach

1.1 ACO REACH Model Overview

The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model is part of a strategy by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (the Innovation Center) to drive broader health care delivery system reform through the redesign of primary care. Through the ACO REACH Model, CMS aims to improve the quality of care through better care coordination, reaching and connecting health care providers and beneficiaries, including those beneficiaries who are underserved.

CMS plans to leverage lessons learned from other Medicare ACO initiatives, such as the Medicare Shared Savings Program (Shared Savings Program) and the Next Generation ACO (NGACO) Model. The ACO REACH Model will enable CMS to test an ACO model that can inform the Shared Savings Program and future models by making important changes to the GPDC Model in three areas:

1. **Advance Health Equity to Bring the Benefits of Accountable Care to Underserved Communities.** ACO REACH will test an innovative payment approach that requires all model participants develop and implement a robust health equity plan to identify underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations.
2. **Promote Provider Leadership and Governance.** At least 75% control of each REACH ACO's governing body generally must be held by Participant Providers or their designated representatives and at least two beneficiary advocates must be on the governing board (at least one Medicare beneficiary and at least one consumer advocate), both of whom must hold voting rights.
3. **Protect Beneficiaries and the Model with More Participant Vetting, Monitoring and Greater Transparency.** CMS will employ increased up-front screening of applicants, robust monitoring of participants, and greater transparency into the model's progress during implementation, even before final evaluation results, and will share more information on the participants and their work to improve care.

ACO REACH Model participants are referred to as Realizing Equity, Access, and Community Health Accountable Care Organizations (REACH ACOs). REACH ACOs are expected to improve quality of care and health outcomes for Medicare beneficiaries. As such, the ACO REACH Model will include an assessment of quality during each PY using several Quality Measures.

Before describing the quality approach in **Section 2**, **Section 1** briefly reviews several features of the ACO REACH Model that have implications for the model's quality strategy. For more detail on these general model features, please see the financial specification papers and frequently asked questions available on the ACO REACH Model website.¹

¹ Financial specification papers, and FAQs are available at the bottom of the ACO REACH Model main page at [ACO REACH | CMS Innovation Center](#)

1.2 Types of REACH ACOs

REACH ACOs can participate as one of three ACO types in PY2023. The characteristics and criteria that define each type of REACH ACO are as follows:

- **Standard ACOs**—Standard ACOs comprise organizations that generally have substantial experience serving Medicare fee-for-service (FFS) beneficiaries, including Medicare-only and dually eligible beneficiaries. These REACH ACOs also may have prior experience participating in Medicare ACO initiatives.
- **New Entrant ACOs**—New Entrant ACOs consist of organizations that have limited experience serving the FFS Medicare population.
- **High Needs Population ACOs**—High Needs Population ACOs serve FFS Medicare beneficiaries with complex needs. Only beneficiaries who meet one or more of the High Needs eligibility criteria may be aligned to a High Needs Population ACO.² Additionally, High Needs Population ACOs are expected to coordinate care for their aligned beneficiaries using a model of care designed for individuals with complex needs, like the one employed by the Programs of All-Inclusive Care for the Elderly.

CMS develops different Quality Performance Benchmarks (QPBs) for the High Needs Population ACOs and Standard and New Entrant ACOs. Additionally, the benchmarking approach for the claims-based measures differs from the benchmarking approach for CAHPS. Additional details are provided in **Section 4.1** of this document.

1.3 Beneficiary Alignment

Eligible beneficiaries will be aligned to REACH ACOs via claims and voluntary alignment.³ All REACH ACOs are required to meet minimum beneficiary alignment thresholds prior to the start of each PY, as outlined in **Table 1-1**. These minimum aligned beneficiary requirements impact the construction of QPBs that vary by REACH ACO type and are discussed in **Section 4.1**. Table 1-1 summarizes the minimum beneficiary alignment requirements by REACH ACO type, *which apply to all REACH ACOs regardless of whether they began model participation in PY2021, PY2022, or PY2023*.

Table 1-1. Minimum counts of aligned Medicare FFS beneficiaries required by year

REACH ACO Type	Minimum Aligned Medicare FFS Beneficiaries					
	PY2021*	PY2022	PY2023	PY2024	PY2025	PY2026
Standard	5,000	5,000	5,000	5,000	5,000	5,000
New Entrant	1,000	1,000	2,000	3,000	5,000	5,000
High Needs	250	250	500	750	1,200	1,400

* April–December 2021

² High Needs population eligibility criteria: (1) Hierarchical Condition Category (HCC) risk score ≥ 3.0 (for concurrent or prospective Aged and Disabled scores) or > 0.35 (for prospective ESRD scores); (2) HCC risk score ≥ 2.0 and < 3.0 (for concurrent or prospective Aged and Disabled scores) or ≥ 0.24 and < 0.35 (for prospective ESRD scores) with two or more unplanned admissions in the last year; (3) signs of frailty based on hospital bed or transfer equipment use; and (4) signs of mobility impairment based on International Classification of Diseases, Version 10, Clinical Modification (ICD-10-CM) diagnosis codes. More detailed information is available in the appendix of the [ACO REACH Model PY2023: Financial Operating Guide: Overview](#).

³ Please see *Appendix B: Beneficiary Alignment Procedures*, found on page 33 of the *ACO REACH Model PY2023: Financial Operating Guide: Overview*, for more detailed information regarding beneficiary alignment.

2. Quality Overview

2.1 Quality Measures

The mission of Innovation Center models, including the ACO REACH Model, is to lower the cost of care for Medicare beneficiaries while maintaining or improving the quality of care provided. As such, REACH ACOs are expected to meet goals of improved quality of care and health outcomes for the Medicare beneficiaries they serve. The ACO REACH Model quality strategy provides achievable performance criteria that aim to incentivize changes in care delivery that reduce unnecessary utilization while improving quality of care.

To accomplish these goals, the ACO REACH Model will include the assessment of quality performance during each PY using several Quality Measures. Performance on these measures will impact the PY Benchmark for Final Financial Settlement.⁴

In PY2023, REACH ACOs will be assessed using four out of the following five Quality Measures, according to entity type (see **Section 3** for more detailed measure information):

1. Risk-Standardized All-Condition Readmission (ACR) measures how many hospital stays result in a readmission within 30 days after patient discharge. This measure will apply to **All REACH ACOs**.
2. All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC) measures unplanned hospital admissions among Medicare FFS beneficiaries 65 years of age and older with multiple chronic conditions. This measure will apply to **All REACH ACOs**.
3. Days at Home for Patients with Complex, Chronic Conditions (DAH) measures the number of days that adults with complex, chronic disease spend at home or in community settings and out of acute and post-acute care settings (such as inpatient hospital or emergent care settings or post-acute skilled nursing). This measure will apply only to **High Needs Population ACOs**.
4. Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU) is defined as the percentage of acute events related to one of six chronic conditions where follow-up care was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting. Acute events are those that required either an emergency department visit or hospitalization. The six chronic conditions include hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and diabetes. This measure will apply to **Standard and New Entrant ACOs** only and was new in PY2022.
5. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. The ACO REACH CAHPS Survey will use the ACO CAHPS Survey and derive CAHPS Summary Survey Measures (SSMs) for scoring, which will then be combined into a single CAHPS Composite Score. The ACO REACH CAHPS Survey will include additional content relevant to patient/caregiver experience with care delivered by a REACH ACO and apply to all three REACH ACO types, although a separate survey will be administered to High Needs Population ACOs than is administered to Standard and New Entrant ACOs. CAHPS was added to the quality strategy in PY2022. REACH

⁴ Materials providing details about the financial methodology used for the ACO REACH Model, including the Financial Operating Guide: Overview and Financial Settlement Overview papers, are available at <https://innovation.cms.gov/innovation-models/aco-reach>.

ACOs must contract with a CMS-approved CAHPS Survey vendor for each reporting year to administer the CAHPS Survey. This measure will apply to **All REACH ACOs**.

Table 2-1 shows the Quality Measure set by PY. Please note that these Quality Measures and timing are subject to change. Prior to each PY, additional quality guidance will be issued informing REACH ACOs of adjustments to the quality approach, if any.

Table 2-1. Summary table of Quality Measures used by year

Measure	PY2021	PY2022	PY2023	PY2024	PY2025	PY2026	Method of Data Submission
ACR	X	X	X	X	X	X	CMS calculates from claims
UAMCC	X	X	X	X	X	X	CMS calculates from claims
DAH (High Needs Population only)	Y	Y	Y	Y	Y	Y	CMS calculates from claims
TFU (Standard / New Entrant only)	—	Z	Z	Z	Z	Z	CMS calculates from claims
CAHPS	—	X	X	X	X	X	REACH ACO contracts with CMS-approved CAHPS vendor

— = not applicable

X = All REACH ACO Types

Y = High Needs Population ACOs only

Z = Standard and New Entrant ACOs only

2.2 Quality Withhold

The Quality Withhold will be tied to quality reporting and / or quality performance in each PY, as **Table 2-2** displays. For **PY2023** and subsequent PYs, 2% of a REACH ACO's financial benchmark (the Quality Withhold) will be held "at risk" and can be earned back, in part or in full, subject to the REACH ACO's quality performance on the Quality Measures and other related adjustments.

Table 2-2. Portions of Quality Withhold tied to reporting and performance by year

PY	Quality Withhold	Portion Tied to Reporting	Portion Tied to Performance
PY2021*	5%	4%	1%
PY2022	5%	4%	1%
PY2023	2%	0%	2%
PY2024	2%	0%	2%
PY2025	2%	0%	2%
PY2026	2%	0%	2%

*= April–December 2021

Tables 2-3 (Standard and New Entrant ACOs) and 2-4 (High Needs Population ACOs) show how the measures in Table 2-1 map to the Quality Withhold breakdown in Table 2-2. In PY2023 and beyond, Quality Measures are equally weighted in their impact to the Initial Quality Score. Thus, each measure essentially determines one quarter of the 2% Quality Withhold, or up to 0.5% of a REACH ACO's Financial Benchmark.

Table 2-3. P4R and P4P measures by PY: Standard and New Entrant ACOs⁵

PY	Quality Withhold	P4R	P4P
PY2021	5%	4% = claims-based measures (ACR, UAMCC)	1% = Meet benchmark with either ACR or UAMCC
PY2022	5%	2% = claims-based measures (ACR, UAMCC, TFU) 2% = CAHPS	1% = Meet benchmark with either ACR or UAMCC
PY2023–PY2026	2%	—	0.5% = ACR 0.5% = UAMCC 0.5% = TFU 0.5% = CAHPS

— = not applicable.

Table 2-4. P4R and P4P measures by PY: High Needs Population ACOs

PY	Quality Withhold	P4R	P4P
PY2021	5%	4% = claims-based measures (ACR, UAMCC, DAH)	1% = Meet benchmark with either ACR or UAMCC
PY2022	5%	2% = claims-based measures (ACR, UAMCC, DAH) 2% = CAHPS	1% = Meet benchmark with either ACR or UAMCC
PY2023	2%	0.5% = CAHPS	0.5% = ACR 0.5% = UAMCC 0.5% = DAH
PY2024–PY2026	2%	—	0.5% = ACR 0.5% = UAMCC 0.5% = DAH 0.5% = CAHPS

— = not applicable.

CMS maintains the authority to revert measures from P4P to P4R if the measure owner determines that an appropriate benchmark to evaluate performance cannot be established, the measure causes patient harm, or the measure no longer aligns with clinical practice. CMS may also remove measures from use in the evaluation of quality performance.

2.3 Total Quality Score and Quality Withhold Earn Back

CMS will use the Quality Measures (Table 2-1), the Continuous Improvement/Sustained Exceptional Performance (CI/SEP) criteria, and the Health Equity Data Reporting (HEDR) Adjustment (described in more detail in Section 2.5.1) to calculate a Total Quality Score with a value ranging from 0% to 100% for each REACH ACO in each PY. This Total Quality Score will determine the portion of the 2% Quality Withhold that the REACH ACO earns back when calculating the REACH ACO's financial benchmark. For example, a Total Quality Score of 100% would result in a REACH ACO earning back the entire 2% Quality

⁵ No measures are currently planned as Reporting-Only, although if any measures beyond those listed in Table 2-1 are introduced, CMS expects that they will begin as Reporting-Only.

Withhold, whereas a Total Quality Score of 50% would result in a REACH ACO earning back 1% of the 2% Quality Withhold.

2.3.1 Initial Quality Score

For each REACH ACO, in PY2023 and subsequent PYs, there will be four quality measures, each worth 10 points, that CMS will use to calculate an **Initial Quality Score**. The Initial Quality Score will be equal to the percent of possible points (40) earned by the REACH ACO.

In PY2023, **Standard and New Entrant ACOs** will have their Initial Quality Score based on four Pay-for-Performance (P4P) measures (ACR, UAMCC, TFU, and CAHPS) and no Pay-for-Reporting (P4R) measures.⁶ This policy will apply to all Standard and New Entrant ACOs, even those that begin model participation in PY2023.

High Needs Population ACOs will have their Initial Quality Score based on three P4P measures (ACR, UAMCC, and TFU), and the fourth measure, CAHPS, will remain P4R in PY2023. To meet the P4R requirement, High Needs Population ACOs must select and contract with a CMS-approved CAHPS Survey vendor for the reporting year. This policy will apply to all High Needs Population ACOs, even those that begin model participation in PY2023. In PY2024 and subsequent PYs, all four measures will be P4P for High Needs Population ACOs.

To arrive at the Total Quality Score, CMS will apply two adjustments to the Initial Quality Score: (1) the CI/SEP criteria and (2) the HEDR Adjustment.

2.3.2 Quality Performance Benchmarks Overview

CMS will establish QPBs to assess each REACH ACO's performance on each individual Quality Measure. The comparison of a REACH ACO's individual Quality Measure score to the QPB distribution will be used for three purposes: (1) to determine the contribution to the Initial Quality Score of each P4P Quality Measure (out of 10 points); (2) to assess the Exceptional Performance component of the CI/SEP criteria; and (3) to determine eligibility for the High Performers Pool (HPP), which is discussed in Section 2.4, below. Quality Measures for High Needs Population ACOs will have a separate set of benchmarks from Quality Measures for Standard and New Entrant ACOs. Separate benchmarks will be released annually for all P4P measures, including ACR, UAMCC, DAH (High Needs Population ACOs only), TFU (Standard and New Entrant ACOs only), and CAHPS (for Standard and New Entrant ACOs only in PY2023, and all REACH ACOs starting in PY2024). More detailed information regarding construction of the QPBs is available in **Section 4.1** below.

2.3.3 Overview of Adjustments to the Initial Quality Score (1 of 2): Continuous Improvement/Sustained Exceptional Performance (CI/SEP) Criteria

Starting in PY2023 for REACH ACOs that began participation in PY2021 or PY2022 and starting in PY2024 for REACH ACOs that begin participation in PY2023, REACH ACOs are evaluated using a set of **Continuous Improvement/Sustained Exceptional Performance (CI/SEP)** criteria (see Section 4.3 for more details). The CI/SEP criteria are used to determine the CI/SEP Multiplier applied to the Initial Quality Score. REACH ACOs that meet the CI/SEP criteria have a multiplier of 1.0, leaving the Initial Quality Score unchanged. REACH ACOs that do not meet the CI/SEP criteria in a given PY have a multiplier of 0.5, cutting the Initial Quality Score in half. Aside from any HEDR adjustments (discussed in

⁶ In PY2021 and PY2022, a REACH ACO's Total Quality Score is based on a Pay-for-Reporting (P4R) and Pay-for-Performance (P4P).

the next section), a REACH ACO with an Initial Quality Score of 80% that met the CI/SEP criteria would have a Total Quality Score of 80%. A REACH ACO that did not meet the CI/SEP criteria and earned an Initial Quality Score of 80% would have a Total Quality Score of 40%. For PY2023, REACH ACOs that begin participation in PY2023 are not subject to the CI/SEP criteria and will not have a CI/SEP multiplier until PY2024.

2.3.4 Overview of Adjustments to the Initial Quality Score (2 of 2): Health Equity Data Reporting (HEDR) Adjustment

After CMS determines the REACH ACO's Initial Quality Score and whether the REACH ACO meets the CI/SEP criteria, CMS will apply the HEDR adjustment to determine the REACH ACO's Total Quality Score and final Quality Withhold Earn Back.

For the purpose of monitoring and evaluating the ACO REACH Model, CMS is requiring all REACH ACOs to collect and submit to CMS certain beneficiary-reported demographic data starting in PY2023 and certain beneficiary-reported social determinants of health (SDOH) data starting in PY2024 on aligned beneficiaries. Performance on this HEDR requirement will produce an HEDR Adjustment applied to each REACH ACO's Initial Quality Score.

Table 2-5 shows the potential range of impact for the HEDR Adjustment on a REACH ACO's Initial Quality Score. In **PY2023 and PY2024**, there will be no downward adjustment for the failure to report required data; instead, REACH ACOs may earn up to a 10% addition to their Initial Quality Score. Starting in PY2025 for required demographic data and starting in PY2026 for required SDOH data, reporting could result in a downward adjustment to the Initial Quality Score of up to 5% or a positive adjustment of up to 5%. The combined HEDR adjustment is 0 to 10% in PY2023 and PY2024, -5% to 10% in PY2025, and -10% to 10% in PY2026.

Table 2-5. Range of HEDR Adjustment impact on Initial Quality Score by PY

PY	Range of HEDR Adjustment impact on Initial Quality Score	
	Demographic Data	SDOH Data
PY2023	0% to 10% adjustment, based on proportion of aligned population for which data is reported	No impact (reporting optional)
PY2024	0% to 5% adjustment, based on proportion of aligned population for which data is reported	0% to 5% adjustment, based on proportion of aligned population for which data is reported
PY2025	-5% to 5% adjustment, based on benchmark constructed using PY2023 reporting data	0% to 5% adjustment, based on proportion of aligned population for which data is reported
PY2026	-5% to 5% adjustment, based on benchmark constructed using PY2024 reporting data	-5% to 5% adjustment, based on benchmark constructed using PY2024 reporting data

The HEDR Adjustment will be applied *after* the application of the CI/SEP multiplier (1.0 for REACH ACOs meeting the CI/SEP criteria or 0.5 for those that did not meet the CI/SEP criteria) to the Initial Quality Score and the resulting value is the Total Quality Score. Because the HEDR Adjustment will be applied after the CI/SEP multiplier, if a 10% HEDR Adjustment is achieved, but the REACH ACO does not meet the CI/SEP criteria, the REACH ACO will still receive the full 10% adjustment (not 5%) in the resulting Total Quality Score. Importantly, the Total Quality Score will be constrained to 0% to 100% of the Quality Withhold, even if the HEDR Adjustment would result in a score outside of this range.

Additionally, the HEDR Adjustment will be *added* to the product of the Initial Quality Score and the CI/SEP multiplier. For example, a REACH ACO that earns an Initial Quality Score of 80%, passes the CI/SEP criteria, and earns a 4% HEDR Adjustment will have a Total Quality Score of $[80\% \times 1.0] + 4\% = 84\%$.

Please note that beneficiary reporting of demographic and SDOH information is voluntary and REACH ACOs should not impose on the beneficiaries they serve 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.** Additional information regarding this requirement, including required data, data submission process and timing, and assessment of performance, is included in **Section 4.4** below.

2.3.5 Calculating the Total Quality Score and the Quality Withhold Earn Back

The Total Quality Score is calculated by applying these two adjustments to the Initial Quality Score, as described above. The Total Quality Score is multiplied by the 2% Quality Withhold to calculate the Quality Withhold Earn Back. For example, a Total Quality Score of 100% would result in a REACH ACO earning back the entire 2% Quality Withhold, whereas a Total Quality Score of 50% would result in a REACH ACO earning back 1% of the 2% Quality Withhold.

Because the Total Quality Score is constrained to 0% to 100% of the Quality Withhold, the Quality Withhold Earn Back will always be between 0% and 2%, even if the HEDR Adjustment plus the Initial Quality Score would have resulted in a value greater than 100% (or, theoretically, less than 0% in future PYs when downward adjustment is possible).

2.4 High Performers Pool

In **PY2023–PY2026**, REACH ACOs that meet the CI/SEP criteria will be eligible for inclusion in the HPP. The HPP provides an opportunity for a bonus payment based on quality performance or improvement. The HPP will be funded by the total amount of the Quality Withhold that is not earned back by REACH ACOs that meet the CI/SEP criteria. For example, a REACH ACO that meets the CI/SEP criteria and achieves a Total Quality Score of 80% would earn back 80% of the 2% Quality Withhold, or 1.6% of the Financial Benchmark; the remaining Quality Withhold not earned back, 0.4% of the REACH ACO's Financial Benchmark, would be allocated to the HPP.

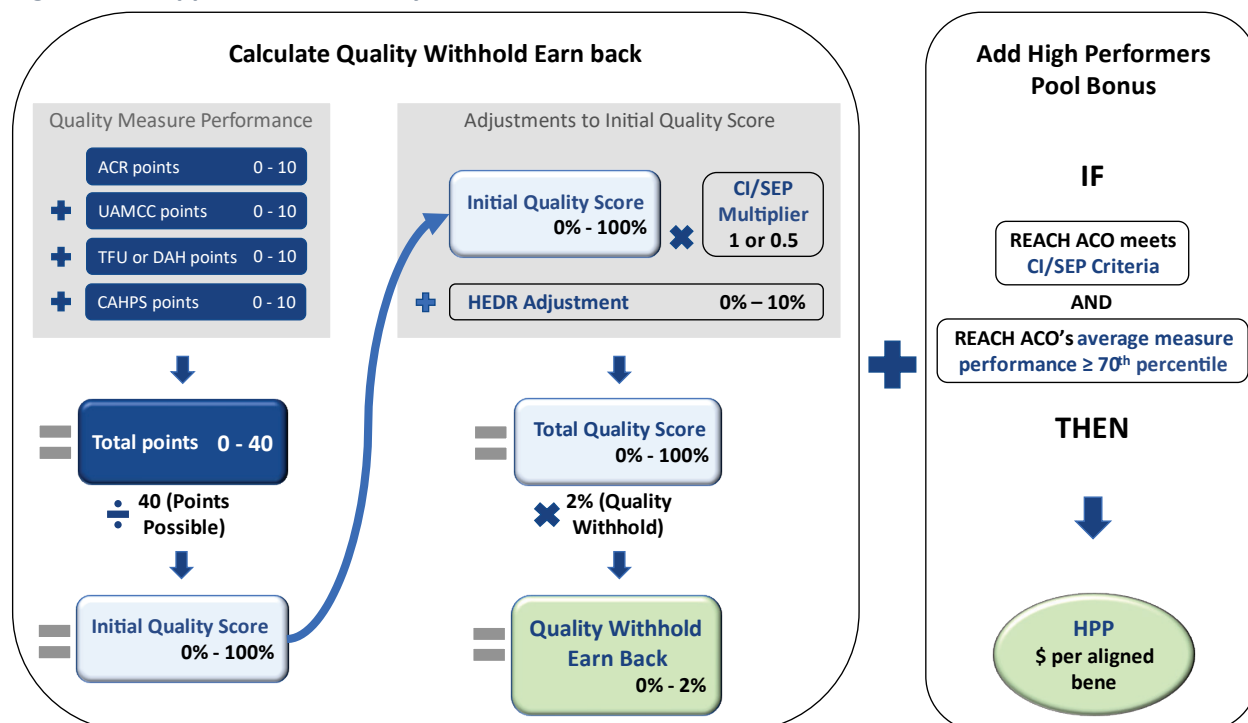
REACH ACOs that meet the CI/SEP criteria and have an average percentile rank of 70% or greater across all claims-based measures will be eligible to receive additional funds from the HPP. The HPP will be distributed proportionally to eligible REACH ACOs based on each qualifying ACO's overall number of beneficiary alignment-months in the PY. As a result, the highest performing REACH ACOs may earn back more than the total 2% Quality Withhold after Financial Settlement (for example, if they have a 100% Total Quality Score and receive distribution from the HPP). CMS will retain the entire forfeited portion of the Quality Withhold from REACH ACOs that fail to meet the CI/SEP criteria. See Section 4.5 for additional detail on how the HPP is identified.

2.5 Overview of Application of Quality Assessment to Final Financial Settlement

Figure 2.1, below, summarizes the calculation of the Quality Withhold Earn Back and the addition of the HPP bonus. First, CMS evaluates the performance of the quality measures and determines the Initial Quality Score. Second, the HEDR bonus is added to the product of the Initial Quality Score and the

CI/SEP multiplier, resulting in the Total Quality Score. This is multiplied by the 2% Quality Withhold to determine the Quality Withhold Earn Back. Finally, if a REACH ACO meets the CI/SEP Criteria and has average measure performance at the 70th percentile or greater, the HPP bonus is added (during financial settlement). See Section 4.6 for more detail regarding the application of quality assessment to the Final Financial Settlement, and Section 5 for worked examples. For more information on how the Quality Withhold is tied to performance for **PY2021** and **PY2022**, please see Appendix D.

Figure 2.1 – Application of Quality Assessment to Final Financial Settlement – Overview



3. Quality Measures, Data Collection, and Performance Rate Calculations

For PY2023, CMS will measure quality of care for REACH ACOs using five measures (see Table 2-1). The ACR and UAMCC measures will be used for all REACH ACO types. DAH will be used only for High Needs Population REACH ACOs. TFU will be used only for the Standard and New Entrant ACOs. Measure Information Forms containing more detailed information for the four claims-based measures, are currently available in the 4i Knowledge Library. PY2023 versions of these will be made available in November 2022.

3.1 Risk-Standardized All-Condition Readmission Measure

3.1.1 ACR Summary

Description: Risk-adjusted percentage of hospitalizations by REACH ACO-assigned beneficiaries that result in an *unplanned* readmission to a hospital within 30 days following discharge from the index hospital admission.⁷

Measure overview: ACR is an outcome measure calculated using 12 consecutive months⁸ of Medicare FFS claims data. The measure is a risk-adjusted readmission rate (RSRR) that adjusts for stay-level factors and clinical and demographic characteristics. Lower RSRRs indicate better performance. This Quality Measure is adapted from the hospital risk-standardized ACR Quality Measure developed for CMS by Yale.⁹

Rationale: Hospital readmissions are costly and often preventable.¹⁰ They are also disruptive to patients and caregivers and put patients at additional risk of hospital-acquired infections and complications.¹¹ Some readmissions are unavoidable, but studies have shown that readmissions also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. High readmission rates and institutional variations in readmission rates indicate an opportunity for improvement. Given that interventions have been able to reduce 30-day readmission rates for a variety of medical conditions, it is important to include an all-condition 30-day readmission rate as a Quality Measure.

3.1.2 ACR Denominator and Numerator Information

Denominator statement: All relevant hospitalizations for REACH ACO-aligned beneficiaries aged 65 or older at non-Federal, short-stay acute care, or critical access hospitals.

⁷ Index hospital admission is any eligible admission to an acute care hospital assessed in the measure for the outcome (readmitted or not within 30 days).

⁸ For PY2021, the full calendar year 2021, including January through March, will be used to calculate ACR and UAMCC.

⁹ Horwitz, L., Partovian, C., Lin, Z., et al. (2011). *Hospital-wide all-cause risk-standardized readmission measure: Measure methodology report*. Prepared for the U.S. Centers for Medicare and Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation.

¹⁰ Jencks, S., Williams, M., & Coleman, E. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, 360(14), 1418-1428.

¹¹ Horwitz, L., Partovian, C., Lin, Z., et al. (2011). *Hospital-wide all-cause risk-standardized readmission measure: Measure methodology report*. Prepared for the U.S. Centers for Medicare and Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation.

Admissions are eligible for inclusion in the denominator if the following criteria are met:

1. Patient is enrolled in Medicare FFS.
2. Patient is actively aligned to a REACH ACO.
3. Patient is age 65 or older.
4. Patient was discharged from a non-Federal acute care hospital.
5. Patient did not die in the hospital.
6. Patient is not transferred to another acute care facility upon discharge.
7. Patient is enrolled in Medicare Part A for the 12 months before and including the date of the index admission.

A hospital readmission within 30 days will also be eligible to be counted as an index admission included in the measure denominator calculation if the patient meets all other eligibility criteria. This allows the measure to capture repeated readmissions for the same patient, whether at the same hospital or another.

Denominator exclusions:

1. Admissions for patients without 30 days of post-discharge data.
2. Admissions for patients lacking a complete enrollment history for the 12 months before admission.
3. Admissions for patients to a Prospective Payment System—exempt cancer hospital.
4. Admissions for patients with medical treatment of cancer.
5. Admissions for primary psychiatric disease.
6. Admissions for rehabilitation care.
7. Admissions for patients discharged against medical advice.

Numerator statement: Risk-adjusted readmissions at a non-Federal, short-stay, acute care, or critical access hospital within 30 days of discharge from an index admission included in the denominator.

Numerator exclusions: Planned readmissions are excluded—scheduled admissions are not considered signals of low care quality. Planned readmissions are identified using procedure and diagnosis codes.

3.2 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)

3.2.1 UAMCC Summary

Description: Rate of risk-standardized, acute, unplanned hospital admissions per 100 person-years among beneficiaries who are 66 years and older at the start of the measurement period, have multiple chronic conditions, and are aligned to the REACH ACO.

Measure overview: Like ACR, UAMCC is an outcome measure calculated using 12 consecutive months of Medicare FFS claims data. The measure is a risk-standardized acute admission rate (RSAAR) that adjusts for age, chronic disease categories, and other clinical risk factors present at the start of the 12-month measurement period. Lower RSAARs indicate better performance. This Quality Measure is adapted from the hospital RSAAR Quality Measure developed for CMS by Yale.

Rationale: Patients with multiple chronic conditions account for a significant proportion of Medicare beneficiaries; they experience high morbidity and costs associated with their disease or diseases, and they are more likely to have unplanned hospital admissions. Unplanned admissions are costly and potentially dangerous. However, research shows that effective health care can lower the risk of admission for patients with chronic disease.^{12,13,14,15,16,17} REACH ACO program goals are fully aligned with the objective of lower patient risk of admission—REACH ACOs are expected to improve quality and outcomes by providing patient-centered care, engaging in effective chronic disease management, promoting care coordination, adopting evidence-based practices, and supporting clinical process improvement.

3.2.2 UAMCC Denominator and Numerator Information

Denominator statement: All REACH ACO-aligned beneficiaries aged 66 years and older at the start of the measurement period with ICD-10 codes that fall into two or more of nine chronic disease groups: (1) acute myocardial infarction, (2) Alzheimer’s disease and related disorders of senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) chronic obstructive pulmonary disease and asthma, (6) depression, (7) heart failure, (8) stroke and transient ischemic attack, and (9) diabetes.

Denominator exclusions:

1. Beneficiaries who do not have 12 months of continuous enrollment in Medicare Part A and Part B during the year prior to the measurement year (to ensure adequate claims data to identify beneficiaries).
2. Beneficiaries who do not have 12 months continuous enrollment in Medicare Parts A and B during the measurement year. Beneficiaries who become deceased or entered hospice during the measurement period are excluded if they do not have continuous enrollment in Medicare Parts A and B until death or upon entering hospice (i.e., the 12-month requirement is relaxed for these beneficiaries).
3. Patients enrolled in hospice during the year prior to the measurement year or at the start of the measurement year.
4. Patients without any visits (Primary Care Qualified Evaluation & Management or other) with any of the Tax Identification Number (TIN) and National Provider ID (NPI) combinations or CMS Certification Number (CCN) and NPI combinations associated with the attributed DCE during the measurement year and the year prior to the measurement year (see TIN and CCN definitions, Appendix B, Terminology List).
5. Patients not at risk for hospitalization at any time during the measurement year.

¹² Brown, R.S., Peikes, D., Peterson, G., et al. (2012). Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs*, 31(6), 1156–1166.

¹³ Chen, J.Y., Tian, H., Taira Juarez, D., et al. (2010). The effect of a PPO pay-for-performance program on patients with diabetes. *The American Journal of Managed Care*, 16(1), e11–19.

¹⁴ United States Congress: Patient Protection and Affordable Care Act, 42 U.S.C. United States Congress. Washington, DC, United States Government Printing Office. Public Law 111–148: 119–906, 2010.

¹⁵ Leong, A., Dasgupta, K., Bernatsky, S., et al. (2013). Systematic review and meta-analysis of validation studies on a diabetes case definition from health administrative records. *PLoS One*, 8(10), e75256.

¹⁶ McCarthy, D., Cohen, A., & Johnson, M. (2013). Gaining ground: Care management programs to reduce hospital admissions and readmissions among chronically ill and vulnerable patients. New York, NY. The Commonwealth Fund.

¹⁷ Sadur, C.N., Moline, N., Costa, M., et al. (1999). Diabetes management in a health maintenance organization. Efficacy of care management using cluster visits. *Diabetes Care*, 22(12), 2011–2017.

Numerator statement: Number of acute *unplanned* admissions per 100 person-years risk for admission. Persons are considered at risk for admission if they are included in the denominator (as described above), alive, enrolled in FFS Medicare, and not currently admitted to an acute care hospital. The outcome includes inpatient admissions to an acute care hospital for any cause during the measurement year unless an admission is identified as “planned.”

Numerator exclusions:

1. Planned admissions are excluded—scheduled admissions are not considered signals of low care quality. Planned admissions are identified using procedure and diagnosis codes.
2. Admissions that occur directly from a skilled nursing facility (SNF) or acute rehabilitation facility.
3. Admissions that occur within a 10-day “buffer period” after discharge from a hospital, SNF, or acute rehabilitation facility.
4. Admissions that occur after the patient has entered hospice.
5. Admissions related to complications from procedures or surgeries.
6. Admissions related to accidents or injuries.
7. Admissions that occur prior to the first visit with the assigned DCE.

3.3 Days at Home for Patients with Complex, Chronic Conditions (DAH)

3.3.1 DAH Summary

Description: Risk factor-adjusted, mortality-adjusted, nursing home transition-adjusted days at home, averaged over all patients within a REACH ACO.

Measure overview: This is a REACH ACO-level measure of days at home or in community settings (i.e., not in acute care, such as inpatient hospital or emergent care settings, or post-acute settings, such as Skilled Nursing Facilities [SNFs]) among adult Medicare FFS beneficiaries with complex, chronic conditions who are aligned to participating REACH ACOs. The measure includes risk adjustment for differences in patient mix across REACH ACOs, with an additional adjustment based on patients’ risk of death. An additional adjustment that accounts for patients’ risk of transitioning to a long-term nursing home is also applied to incentivize community-based care in alignment with the Center for Medicare & Medicaid Services (CMS) policy goals. A higher risk-adjusted score indicates better performance.

Rationale: The primary goal of the DAH measure is to promote high-quality coordinated care to keep adults with complex, chronic conditions in home or community settings and out of select acute, post-acute, or long-term care settings.

Generally, patients prefer to remain at home and avoid unnecessary hospitalizations and time in institutional settings. Days at home are associated with other important outcomes, including social activity and avoiding depression.¹⁸ Timely and appropriate primary care and end-of-life care services can increase the number of days patients spend at home.¹⁹ Several studies demonstrate that time spent at

¹⁸ Lee, H., Shi, S. M., & Kim, D. H. (2019). Home Time as a Patient-Centered Outcome in Administrative Claims Data. *Journal of the American Geriatrics Society*, 67(2), 347–351. doi: 10.1111/jgs.15705

¹⁹ Totten, A. M., White-Chu, E. F., Wasson, N., et al. (2016). *Home-Based Primary Care Interventions*. Rockville, MD.

home differs substantially among older patients, which suggests that there is potential for improving the quality of care and resulting days at home for the elderly population.^{20,21}

3.3.2 DAH Denominator and Numerator Information

Denominator statement: Eligible beneficiaries aligned to participating REACH ACOs.

Eligible beneficiaries are:

1. Adult (age 18 or older);
2. Alive as of the first day of the PY;
3. Continuously enrolled in Medicare FFS parts A and B during the full PY (up to date of death among patients who died) and one full year prior; and
4. Have an average Hierarchical Condition Category (HCC) composite risk score ≥ 2.0 in the year prior to the PY.

The measure includes eligible beneficiaries who are aligned to a participating REACH ACO as determined by the model.

Denominator exclusions: There are currently no denominator exclusions or exceptions for the measure. All patients meeting the denominator inclusion criteria are included.

Numerator statement: The outcome measured for each eligible beneficiary is days spent “at home,” adjusted for clinical and social risk factors, risk of death, and risk of transitioning to a long-term nursing home. Days at home are defined as those days when a beneficiary is alive and not in care.

A “day in care” is defined as any eligible patient day on which a patient receives care in one (or more) of the following specified care settings: inpatient acute and post-acute facilities (short-term acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term care hospitals, and SNFs); emergency departments; and observation stays. There are two exceptions:

1. A patient is always considered “at home” if they are enrolled in hospice, even if they receive care in settings normally counted as “days in care” (i.e., a patient will have no measured days in care as long as they are in hospice).
 - a. Rationale: to promote effective and appropriate care for terminally ill patients
2. Hospital admissions for childbirth, miscarriage, or termination are not counted as “days in care.”
 - a. Rationale: obstetric admissions may not indicate care quality; counting these admissions may create perverse incentives in the care of pregnant patients A “day at home” is defined as any eligible day that is not considered a “day in care” based on the above definition. “Eligible days” are all days in the measurement year that the beneficiary is alive.

²⁰ Burke, L. G., Orav, E. J., Zheng, J., & Jha, A. K. (2020). Healthy Days at home: A novel population-based outcome measure. *Healthcare (Amsterdam, Netherlands)*, 8(1), 100378. doi: 10.1016/j.hjdsi.2019.100378

²¹ Wallace, L., et al. (2019). *2019 Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report*. Yale New Haven Health Services Corporation – Center for Outcomes Research & Evaluation. YNHHS/CORE.

Numerator exclusions: Care in settings not listed above (including outpatient visits and procedures, hospice, residential psychiatric and substance abuse facilities, assisted living facilities and group homes, and home health and telehealth services) are not considered “days in care” in this measure; rather, they are treated as “days at home.”

Finally, days spent in a long-term or residential nursing home (except for SNF care) are not counted as “days in care” by this definition. However, this measure includes an adjustment that accounts for patients’ risk of transitioning to a long-term nursing home, to encourage home- and community-based care in alignment with CMS’s policy goals.

3.4 Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU)

3.4.1 TFU Summary

Description: REACH ACO-level rate of follow-up for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions of interest, which can be attributed to providers participating in the model.

Measure overview: This is a measure of follow-up for patients with chronic conditions who have experienced an acute exacerbation hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes, which can be attributed to providers participating in the Innovation Center ACO REACH Model. Results of the measure are aggregated on a REACH ACO level. The Yale New Haven Health Services Corporation – Center for Outcomes Research & Evaluation respecified the TFU measure, which was originally specified by IMPAQ, NQF #3455.

Rationale: Patients hospitalized or seen acutely in the ED and hospital outpatient departments for exacerbations of chronic conditions are at high risk of readmission and poorly coordinated care, which may increase healthcare spending, worsen healthcare outcomes, and result in poor quality of life. Evidence has shown that delivering clinically appropriate follow-up care and improving care coordination can improve healthcare outcomes, reduce readmissions, and reduce healthcare costs. The intent of the TFU measure is to encourage appropriate follow-up care and improve care coordination at discharge. A systematic review has demonstrated that, when coupled with other types of discharge support, TFU does positively contribute to health outcomes and is a key component of high-quality healthcare. We anticipate the TFU measure will encourage model participants to improve care coordination and produce long-term savings for a given healthcare system.

3.4.2 TFU Denominator and Numerator Information

Denominator statement: The sum of the REACH ACO-level acute exacerbations that require either an ED visit, observation stay, or inpatient stay (i.e., acute events) for hypertension, asthma, HF, CAD, COPD, or diabetes.

An acute event is assigned to [condition] if the primary diagnosis is a sufficient code for [condition] or if the primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].

In cases where the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, the event is assigned to the condition with a sufficient code appearing in the “highest” (closest to primary) diagnosis position.

If there is more than one visit that makes up an acute event, and they are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator exclusions:

The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge but still during the follow-up interval of the prior event for the same reason. To prevent double counting, only the first acute event will be included in the denominator.
2. Acute events after which the patient does not have continuous enrollment for 30 days.
3. Acute events where the discharge status of the last claim is not “to community” (“Left against medical advice” is not a discharge to community.).
4. Acute events for which the calendar year ends before the follow-up window ends (e.g., acute asthma events ending fewer than 14 days before December 31).
5. Acute events where the patient enters an SNF, non-acute care, or hospice care within the follow-up interval.

Numerator statement: The sum of the REACH ACO-level denominator events (Emergency Room [ED], observation hospital stays, or inpatient hospital stay) for acute exacerbations of hypertension, asthma, HF, CAD, COPD, or diabetes where follow-up was received within the time frame recommended by clinical practice guidelines, as detailed below:

1. Hypertension: Follow up within 14 days for high-acuity patients and 30 days for medium-acuity patients
2. Asthma: Follow up within 14 days of the date of discharge
3. HF: Follow up within 14 days of the date of discharge
4. CAD: Follow up within 7 days for high-acuity patients or within 6 weeks for low-acuity patients
5. COPD: Follow up within 30 days of the date of discharge
6. Diabetes: Follow up within 14 days for high-acuity patients

This measure is defined at the REACH ACO level, meaning that results are aggregated for each participating entity in the ACO REACH Model. The follow-up visit must occur within the condition-specific timeframe to be considered timely and for the conditions of the numerator/measure to be met. A TFU visit is defined as a claim for the same patient after the acute event discharge date that is a non-emergency outpatient visit and has a Current Procedural Terminology or Healthcare Common Procedure Coding System code indicating a visit that constitutes appropriate follow-up.

Numerator exclusions: There are currently no numerator exclusions or exceptions for the measure. All patients meeting the numerator inclusion criteria are included.

3.5 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

3.5.1 CAHPS Composite Score Description

Description: A REACH ACO-level summary of patient experience of care from beneficiaries surveyed with the CAHPS. This measure, which is a composite of results across different CAHPS domains, applies to Standard, New Entrant, and High Needs Population ACOs. Eligible REACH ACOs are required to collect and report this measure to CMS, which is done by contracting with and paying for a CAHPS Survey vendor. The vendor conducts the survey using mail and telephone follow-up, and reports results to CMS.

Measure overview: The CAHPS questionnaire used in ACO REACH is the CAHPS for ACO Survey with modifications relevant to patient/caregiver experience with care delivered by a REACH ACO. It is designed to ask patients about their experience with primary care services received from their provider during the past 6 months. Domains in the questionnaire include the extent to which patients could access care and information in a timely manner when needed, how well the patient's provider communicated with them, and whether the provider spoke with the patient about things they could do to promote their health.

Rationale: Person and family engagement in care is important to CMS and part of the agency's quality strategy. Research shows that patients and families who have positive experiences with providers are more likely to be engaged with their care and have better adherence to provider healthcare guidelines.^{22,23,24} Adherence to recommended guidelines such as weight and blood sugar control results in improved population health for all REACH ACO-aligned beneficiaries. Additional research finds that positive patient experience indicates high-quality care has been provided²⁵ and is associated with improved clinical outcomes^{26,27} and reduced costs²⁸ in some settings. Thus, patient experience is a lever capable not only of providing our beneficiaries with a better experience—which itself is valuable—but also capable of spurring long-term benefits in clinical outcomes, population health, and costs within the ACO REACH Model.

CMS measures patient experience through the CAHPS measurement science. This methodology asks patients to what extent certain provider behaviors took place. All the behaviors posed in the surveys are desirable and are hallmarks of quality care. CAHPS surveys give a standardized and objective measure that allows for equitable comparisons between entities.

²² Zolnieriek, K. B., & Dimatteo, M. R. (2009). Physician communication and patient adherence to treatment: a meta-analysis. *Med Care*, 47(8), 826-834. doi:10.1097/MLR.0b013e31819a5acc

²³ Ratanawongsa, N., Karter, A. J., Parker, M. M., Lyles, C. R., Heisler, M., Moffet, H. H., . . . Schillinger, D. (2013). Communication and medication refill adherence: The Diabetes Study of Northern California. *JAMA Intern Med*, 173(3), 210-218. doi:10.1001/jamainternmed.2013.1216

²⁴ Lee, Y. Y., & Lin, J. L. (2009). The effects of trust in physician on self-efficacy, adherence and diabetes outcomes. *Soc Sci Med*, 68(6), 1060-1068. doi:10.1016/j.socscimed.2008.12.033

²⁵ Cook, N., et al. (2015, December). Patient Experience in Health Center Medical Homes. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/26026275>

²⁶ Meterko, M., Wright, S., Lin, H., Lowy, E., & Cleary, P. D. (2010). Mortality among patients with acute myocardial infarction: The influences of patient-centered care and evidence-based medicine. *Health Services Research*, 45(5pl), 1188-1204. doi: 10.1111/j.1475-6773.2010.01138.x

²⁷ Boulding, W., Glickman, S. W., Manary, M. P., Schulman, K. A., & Staelin, R. (2011). Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *Am J Manag Care*, 17(1), 41-48.

²⁸ Anhang Price, R., Elliott, M. N., Zaslavsky, A. M., Hays, R. D., Lehrman, W. G., Rybowski, L., Cleary, P. D. (2014). Examining the role of patient experience surveys in measuring health care quality. *Med Care Res Rev*, 71(5), 522-554. doi:10.1177/1077558714541480

3.5.2 Survey Administration and Procedures

REACH ACOs will be responsible for selecting and contracting with a CMS-approved vendor to administer the CAHPS Survey. In fall 2022, CMS will publish information on REACH ACOs' CAHPS-related responsibilities and timelines in **4i Knowledge Library**. REACH ACOs will need to select and contract with their CAHPS vendor by July 2023. The **CMS ACO REACH Newsletter** will proactively notify REACH ACOs of all CAHPS information.

The CAHPS for ACOs Survey is collected using mixed-mode data collection procedures. Sampled beneficiaries are mailed a pre-notification postcard, followed by up to two survey mailings. After several weeks, sampled beneficiaries who do not respond by mail are contacted by telephone and invited to answer the survey via an interview. Beneficiaries may receive up to six telephone calls. Additional information regarding CAHPS sampling methods, please see Appendix C.

3.5.3 CAHPS Summary Survey Measure Domains

The measures are referred to as summary survey measures (SSMs) because the survey includes multiple questions for most of the measures. The SSMs included in the CAHPS Composite Score used in the calculation of the Initial Quality Score are described in **Table 3-1** below.

Table 3-1. Experience of care SSM domains²⁹

Summary Survey Measure	High Needs	Standard New Entrants
Getting Timely Appts, Care, and Information	+	+
How Well Providers Communicate	+	+
Care Coordination	+	+
Shared Decision Making	+	+
Patient Rating of Provider	+	+
Courteous and Helpful Office Staff	+	+
Health Promotion and Education	+	+
Stewardship of Patient Resources	+	+

3.5.4 CAHPS Denominator and Numerator Information

Denominator statement: The population of interest for the denominator is FFS beneficiaries of each REACH ACO with recent visits for primary care services. We reach this population in several steps:

1. A sample of beneficiaries from claims for primary care services among REACH ACO participating providers is created.
2. A survey is sent to all sampled beneficiaries, telephone follow-up will occur for nonresponse. This 'mail with non-response telephone follow-up' survey methodology ensures that enough

²⁹ For information on the survey items included in each SSM, please see Appendix C, Tables C-2 and C-3.

responses will be received to allow sufficient statistical precision to reliably distinguish between REACH ACOs.

3. The denominator becomes all beneficiaries who answered the survey questions.

Denominator exclusions: A number of beneficiaries are excluded from the CAHPS Measure, including:

1. beneficiaries who received care in recent visits but are now deceased;
2. beneficiaries who are less than 18 years old; institutionalized beneficiaries;
3. beneficiaries receiving Hospice benefit;
4. beneficiaries sampled for some other concurrent CAHPS Surveys;
5. beneficiaries residing outside the United States, Puerto Rico, or the Virgin Islands;
6. beneficiaries receiving less than two primary care service visits with a provider from the REACH ACO during the lookup period; and
7. beneficiaries who have a language or disability barrier that prevents them from completing the survey and do not have a someone who can assist them or proxy for them.

A REACH ACO can be excluded from the CAHPS data collection for a particular PY if that REACH ACO does not have a sufficient number of beneficiaries with recent primary care visits for a reliable CAHPS Survey to be conducted.

Numerator statement: Survey questions included in each SSM will be assigned values based on patient responses and combined to calculate the SSMs. Each question included in an SSM will be equally weighted (See **Section 3.5.5**).

Numerator exclusions: Beneficiaries who elect to not answer a question are excluded from calculation. Similarly, beneficiaries who screen out of a question are excluded from the calculation. An example screening question is whether the provider ordered a blood test, x-ray, or other test in the last 6 months. If the beneficiary answered “no,” to the screening question, the beneficiary would screen out of the measure question about whether someone followed up with them about the results of that test.

3.5.5 Calculation of CAHPS SSM Performance Rates

After the ACO REACH CAHPS survey data is collected, the scoring phase begins. Each SSM will be scored using the CAHPS Macro to calculate the patient-mix-adjusted SSMs for each REACH ACO. We will use the same set of patient-mix adjusters as used in Merit-Based Incentive Payment System (MIPS) and the Shared Savings Program with the exception of Asian language, because we will not have an Asian-language survey in PY2022. The patient-mix adjusters will potentially include age, education, overall and mental health, indicators of Medicaid dual eligibility/eligibility for low-income subsidy status, and information indicating whether another person helped the respondent complete the survey. Since the High Needs survey is a census, we will not assign sampling weights but will investigate nonresponse to determine if nonresponse adjusted weights are necessary.

The patient-mix adjusters will remain the same each year. We will allow the CAHPS Macro to re-estimate the patient-mix adjuster coefficients each survey period.

3.6 Quality Measure Resources

Additional measure documentation will be made available each PY to provide further guidance and technical information. **Table 3-2** displays the forthcoming resources for REACH ACOs for PY2023.

Table 3-2. Quality measure resources

Document	Measure Type	Description	Location
Measure Information Forms (MIFs)	Claims-based measures	Detailed descriptive information on each measure.	• PY2023 MIFs posted to 4i Knowledge Library in November 2022. • PY2021 and PY2022 MIFs are currently available in 4i.
Quality Benchmark Report	All P4P measures	Basis for determining REACH ACO performance on P4P measures.	• The PY2023 CAHPS benchmarks will be released in March 2023. • For the claims-based measures, provisional QPBs are included in each quarterly report.³⁰ • Final benchmarks for the claims-based measures for PY2023 will be made available in June of 2024.
Official CAHPS website and Helpdesk	CAHPS	• Official website and web portal for news and information about the ACO REACH CAHPS Survey, for both CAHPS survey vendors and ACOs. Will contain information on ACO requirements, deadlines, information about survey schedules, and answering patients' survey-related questions with confidence. • Technical assistance to complement the ACO REACH Model Help Desk.	Available beginning February 2023: Website: https://acoreachcahps.org  Email: acoreachcahps@rti.org Prior to February 2023: Website https://gpdccahps.org  Email: gpdccahps@rti.org

³⁰ Final benchmarks for PY2022 will be released in the Global and Professional Direct Contracting Model: QPBs for the 2022 Reporting Year document in June 2023.

4. Quality Performance Scoring and Determination of Quality Withhold Earn Back

4.1 Creation of Quality Performance Benchmarks

As discussed in **Section 2.3.2**, CMS will establish QPBs to assess each REACH ACO's performance on each individual Quality Measure. The comparison of a REACH ACO's individual Quality Measure score to the QPB distribution will be used for three purposes: (1) to determine the contribution to the Initial Quality Score of each P4P Quality Measure (out of 10 points); (2) to assess the Exceptional Performance component of the CI/SEP criteria; and (3) to determine eligibility for the HPP. There will be a separate set of QPBs for Standard and New Entrant ACOs and for High Needs Population ACOs, and for each quality measure included in the ACO REACH Quality Strategy.

In **PY2023–PY2026**, separate benchmarks will be released annually for all P4P measures, including ACR, UAMCC, DAH (High Needs Population ACOs only), TFU (Standard and New Entrant ACOs only), and CAHPS. This section describes construction of QPBs for the claims-based and CAHPS measures. For additional information on how QPBs will be used in the application of quality assessment to Final Financial Settlement, see **Section 4.6** below.

4.1.1 Claims-based Measure Benchmarks

When calculating Quality Measure scores for REACH ACOs, CMS will also calculate scores for non-ACO REACH provider groups. Scores from both REACH ACOs and non-ACO REACH provider groups will be used to generate the QPB distributions for evaluating performance. Non-ACO REACH provider groups, such as physicians, group practices, hospitals, or similar entities, will be identified using all available Medicare FFS data aggregated to individual TINs or CCNs.³¹ Beneficiaries will be aligned to non-ACO REACH provider groups by applying the same rules used to align beneficiaries to REACH ACOs. Additionally, for High Needs Population ACOs, QPBs will likewise be developed using non-ACO REACH participating TINs and CCNs, but subset to claims only for those beneficiaries who meet the High Needs eligibility criteria.

To better ensure comparability with REACH ACOs, TINs and CCNs included in the QPB distributions must also meet minimum aligned beneficiary requirements. For the Standard and New Entrant ACO QPBs, TINs and CCNs must have at least 1,000 aligned beneficiaries to be included in the QPB distribution, whereas for the High Needs Population ACO Quality Benchmarks, TINs and CCNs must have at least 250 aligned beneficiaries who meet High Needs eligibility requirements. Applying these minimum aligned beneficiary counts addresses potential concerns about differences between smaller TIN/CCN-level entities and REACH ACOs. These minimum aligned beneficiary counts for the QPBs are analogous to minimum Beneficiary thresholds for each REACH ACO type as applied in PY2021 and PY2022 (1,000+ beneficiaries for New Entrant ACOs³² and 250+ High Needs beneficiaries for High Needs Population ACOs).

³¹ Note, the non-ACO REACH provider groups included in the quality performance benchmark distribution may be participants in the Shared Savings Program or other APMs.

³² Because the same quality benchmarks are being used for Standard and New Entrant ACOs, TINs and CCNs must meet a minimum of 1,000 aligned beneficiaries to be included in the quality performance benchmark distribution, equivalent to the minimum for participation for New Entrant DCEs in PY2021 and PY2022.

4.1.2 CAHPS Benchmarks

CAHPS QPBs for Standard/New Entrant ACOs

For Standard/New Entrant ACOs, the CAHPS QPBs will be based on entity-level patient-mix-adjusted data from the Shared Savings Program, NGACO, and MIPS combined with REACH ACO scores. For each SSM, entity-level data will be pooled from this combined set of entities to create the SSM-specific QPB distribution and identify decile thresholds for scoring. Each Standard/New Entrant ACO's SSM scores will be compared to this set of decile thresholds.

For PY2023, the Standard/New Entrant ACO CAHPS SSM-specific QPB distributions will be based on pooled data from MIPS, the Shared Savings Program, and NGACOs from 2021 and 2019, combined with PY2022 Data for DCEs. The PY2023 CAHPS QPBs will be provided to participants in early PY2023 prior to the start of the CAHPS data collection in PY2023.

CAHPS QPBs for High Needs Population ACOs

A challenge for creating QPBs for the High Needs Population ACOs is the small number of REACH ACOs and the small number of survey-eligible beneficiaries per REACH ACOs. Given these limitations, the QPBs for the High Needs Population ACOs will be based on more than one year of performance data. CAHPS will be P4R for High Needs Population ACOs in PY2023. In PY2024, the QPBs will be comprised of High Needs Population ACO performance scores from PY2023 and PY2022.

4.2 Quality Measure Scoring for the Initial Quality Score

Once REACH ACO-specific measure data are collected and measure performance rates are calculated, CMS determines how many points a REACH ACO has earned on each measure. An ACO can earn a maximum of 10 points on each measure (note: there are four measures for each ACO for a total of 40 points: three claims-based measures and the composite CAHPS measure, which combines all eight CAHPS SSMs).

Points are earned for each measure based on the REACH ACO's performance compared to measure-specific QPBs. In PY2023 and subsequent PYs, if no beneficiaries are eligible for a P4P claims-based measure's denominator, the REACH ACO will be exempt from scoring on that measure and that measure will not count towards the total number of points possible. Likewise, CAHPS specifies minimum counts of surveyable beneficiaries in order to proceed with the survey (see Appendix C); ACOs will be exempt from CAHPS if they do not meet these thresholds. For example, if a Standard/New Entrant ACO is exempt from CAHPS, the total number of quality points possible for that REACH ACO will be 30; 10 points for each claims-based measure. If a Standard/New Entrant ACO is *not* exempt from the requirement to administer a CAHPS Survey, but a CAHPS Survey is not administered and/or no data is transmitted to CMS, zero points out of 10 will be earned for CAHPS. However, because CAHPS remains P4R in PY2023 for High Needs Population ACOs, if a High Needs Population ACO is exempt from CAHPS data collection in PY2023, that REACH ACO will receive 10 points for meeting the P4R requirement for CAHPS and CAHPS will be included in the total 40 possible points used to determine the Initial Quality Score.

The Initial Quality Score is calculated as the percent of points earned from all measures divided by the total points possible (*i.e.*, 40 points). Additional details on the application of quality assessment to final Financial Settlement are presented in Section 4.6.

4.2.1 Claims-based Measure Scoring

Table 4-1, below, presents the distribution of points (out of 10) awarded for each measure based on how the REACH ACO's quality measure score for the PY compares to the benchmark percentile thresholds (for more on the development of the QPBs, see Section 4.6.1). CMS awards zero points for a measure if a REACH ACO's quality score falls below the 30th percentile benchmark. As shown in the table, REACH ACOs will receive 7.5 points if they meet the 30th percentile benchmark; points awarded increase every 5 percentiles, up to the 90th percentile, where the full 10 points are awarded for the measure.

Table 4-1. Points awarded based on quality performance for claims-based measures

Percentile Threshold Met	<30%	≥30%	≥35%	≥40%	≥45%	≥50%	≥55%	≥60%	≥65%	≥70%	≥75%	≥80%	≥85%	≥90%
Points Awarded	0	7.5	7.75	8	8.25	8.5	8.75	9	9.25	9.5	9.625	9.75	9.875	10

4.2.2 CAHPS Scoring

A REACH ACO's CAHPS score accounts for 10 points out of the total 40 possible points awarded based on quality measure performance. For High Needs Population ACOs, the 10 points associated with CAHPS will be awarded based on the fulfillment of the P4R requirement of successfully contracting with a CAHPS vendor. A Standard or New Entrant ACO's 10 possible points for CAHPS will be determined by their performance on the eight SSMs listed in Section 3.5.3 above.

SSM Scoring Against Benchmarks

To arrive at the final number of points – out of 10 – that a REACH ACO will be awarded for their CAHPS performance, CMS first needs to roll up a REACH ACO's performance on the separate SSMs into a single summary number we are referring to as the 'CAHPS composite score'.

A REACH ACO can earn 10 SSM points for each SSM for a total possible count of 80 SSM points. The SSM points are allocated for each SSM based on a comparison of the REACH ACO's SSM performance against a QPB distribution. **Table 4-2** shows the SSM points out of 10 awarded at each benchmark threshold. Similar to the scoring system for claims-based measures, there are no SSM points awarded for SSM scores that fall below the 30th percentile benchmark.

Table 4-2. SSM points awarded by quality performance for CAHPS SSMs

Percentile Threshold Met	<30%	30%	40%	50%	60%	70%	80%	90%
Points Awarded	0	5.5	6.25	7	7.75	8.5	9.25	10

Standard/New Entrant ACOs Scoring and Final CAHPS Composite Score Construction

For Standard and New Entrant ACOs, the process of determining the 10 SSM points for each SSM is similar to the process described for the claims-based measures. Each REACH ACO will receive 0-10 SSM points for each SSM, and the final CAHPS composite score used in determining a REACH ACO's Total Quality Score is determined by the proportion out of 80 SSM points earned by the REACH ACO. A REACH ACO that earned the maximum SSM points for each SSM will receive 8 x 10 SSM points, and this REACH ACO will receive 80/80 or 100% of the 10 CAHPS composite score points possible. This CAHPS Composite

Score is multiplied by 10 to determine the number of CAHPS points earned out of ten that will be included in the ACO's Initial Quality Score calculation. For example, a REACH ACO that earned the maximum SSM points for each SSM will receive 8 x 10 SSM points. Therefore, this REACH ACO will receive a CAHPS Composite Score of 80/80, or 1, which means that this ACO will earn 10 out of 10 possible CAHPS points towards the numerator of the Initial Quality Score.

The Impact of Unsourced SSMs on the CAHPS Composite Score for Standard and New Entrant ACOs

For a given Standard/New Entrant ACO, CMMI will not assign SSM points if an SSM is based on data from 19 or fewer survey respondents, and we will reduce the number of possible SSM points (the denominator of the CAHPS Composite Score) by 10. For example, if an ACO has 1 SSM out of 8 SSMs that has 19 or fewer respondents, the ACO will only be scored on the 7 SSMs that do have sufficient respondents and the maximum number of SSM points that ACO can earn is 70. The denominator for the calculation of the CAHPS Composite Score for this ACO will therefore be 70 instead of 80. An ACO must have SSM points assigned for 50%, or 4 out of the 8 SSMs, to receive a CAHPS Composite Score.

The SSM results for SSMs with 19 or fewer survey respondents will not be reported in the Annual Quality Report due to case minimum requirements. For patient confidentiality, percentages and numbers at the question level will not be reported if fewer than 11 respondents answered in any category. If an ACO does not receive a CAHPS Composite Score, that ACO's total quality points possible used in the calculation of the Initial Quality Score will be reduced by 10. In other words, the ACO's Initial Quality Score will be based on points earned out of a total possible of 30 points instead of 40.

4.3 Continuous Improvement/Sustained Exceptional Performance Criteria

In **PY2023–PY2026**, the CI/SEP criteria will determine the value of the CI/SEP multiplier applied to the Initial Quality Score (note: this step is prior to the application of the HEDR Adjustment). If a REACH ACO meets the CI/SEP criteria, its Initial Quality Score will be multiplied by 1.0; if the REACH ACO does not meet the CI/SEP criteria, its Initial Quality Score will be multiplied by 0.5. In other words, if a REACH ACO does not meet the CI/SEP criteria, that REACH ACO's Initial Quality Score is automatically cut in half. As a result, the maximum Quality Withhold Earn Back for that REACH ACO would be 1% (not including the HEDR Adjustment).

In PY2023, all claims-based measures will be used in the CI/SEP criteria (ACR, UAMCC, and DAH for High Needs Population ACOs and ACR, UAMCC, and TFU for Standard/New Entrant ACOs). The CI/SEP criteria evaluate performance in the current PY compared to the prior year. The following steps are used to determine if a REACH ACO passes the CI/SEP criteria in PY2023:

1. Continuous Improvement: CI/SEP points are awarded for each claims-based quality measure based on statistically significant change from PY2022 to PY2023:
 - a. -1 point for **declining performance**
 - b. 0 points for **no change in performance**
 - c. +1 point for **improving performance**
2. Sustained Exceptional Performance: Regardless of the change in performance over time, CI/SEP points for a given measure will be set to +1 if a REACH ACO **meets or exceeds** the respective 70th percentile benchmark values in both PY2022 and PY2023. In other words, if a REACH ACO exhibits a statistically significant decline in UAMCC from PY2022 to PY2023, but exhibits

sustained exceptional performance (its score is better than or equal to the 70th percentile in both periods), it will still receive +1 CI/SEP point for that measure.

3. CI/SEP points are summed across all three claims-based measures.

To pass the overall CI/SEP criteria, REACH ACOs must meet **both** conditions listed below:

CONDITION 1: receive +1 CI/SEP point for AT LEAST 1 measure (*i.e.*, the REACH ACO must exhibit continuous improvement OR sustained exceptional performance for at least one measure)

AND

CONDITION 2: have an overall net CI/SEP score greater than or equal to 0.

Standardized score components:

Standardized score components will be used in the evaluation of the continuous improvement for the CI/SEP criteria. The COVID-19 pandemic has shown that external events that impact utilization rates may also affect quality measure scores that are based on utilization, such as UAMCC and ACR. The shift to concurrent benchmarking is one step taken to address this concern. However, by definition, the continuous improvement component of the CI/SEP criteria compares quality measure performance from two periods. Thus, the determination of continuous improvement for PY2023 (and future years) will be based on standardized score components (with the exception of TFU).³³

- Standardized score components are readily available as part of the measure calculation for both **ACR** (Standardized Readmission Rate) and **UAMCC** (Standardized Admission Rate)—these components are typically multiplied by national mean readmission rate and unplanned admission rate, respectively, to calculate the official measure scores. For ACR and UAMCC, the standardized score components are equal to the ratio of a REACH ACO's predicted score to its expected score.
- Because **DAH** is based on three separate regression models, the measure calculation involves three separate standardized scores. For continuous improvement, we will calculate an analogous standardized score component for DAH by dividing the official measure score by the national mean (adjusted days at home) for the DAH measure.
- **TFU** is not a risk-adjusted measure; the scores are simple percentages. As a result, the measure score is not dependent on a national mean rate and the TFU score is more easily interpreted. The calculation of the TFU measure score also does not involve a standardized score component. For this reason, we will use the official TFU score for determining continuous improvement.

Process for determining continuous improvement:

For each quality measure, CMS determines whether REACH ACOs exhibit statistically significant improvement, no statistically significant change, or a statistically significant decline in performance on the measure scores (standardized score components for ACR, UAMCC, and DAH, and observed measure

³³ Because the Sustained Exceptional Performance criteria use ACOs' separate within-year percentile rankings for each year, it is unnecessary to use standardized scores. An ACO's ranking will be equivalent whether standardized or actual scores are used.

scores for TFU). This determination is based on a comparison of 95% confidence intervals (CIs)—CMS calculates 95% CIs for each REACH ACO for each measure and year. For risk-adjusted measures (ACR, UAMCC, and DAH), 95% CIs are estimated using bootstrapping algorithms.³⁴ CIs for TFU are calculated analytically based on the distributional characteristics of proportions. To determine the statistical significance of change in scores, CMS compares the 95% CIs from both periods for each measure and REACH ACO:

- For a given measure, if the 95% CIs from PY2022 and PY2023 overlap for a particular REACH ACO, then the change for that REACH ACO is not considered statistically significant.
- UAMCC and ACR are reverse-scored measures (*i.e.*, higher scores indicate poorer performance)—for these measures:
 - non-overlapping 95% CIs with *lower* scores in PY2023 indicate statistically significant improvement;
 - non-overlapping 95% CIs with *higher* scores in PY2023 indicate statistically significant decline in performance.
- For DAH and TFU:
 - non-overlapping 95% CIs with *higher* scores in PY2023 indicate statistically significant improvement;
 - non-overlapping 95% CIs with *lower* scores in PY2023 indicate statistically significant decline in performance.

4.4 Health Equity Data Reporting (HEDR) Adjustment

As in Section 2.3.4, for the purpose of monitoring and evaluating the ACO REACH Model, CMS is requiring all REACH ACOs to collect and submit to CMS certain beneficiary-reported demographic data starting in PY2023 and certain beneficiary-reported SDOH data starting in PY2024 on aligned beneficiaries. Performance on this HEDR requirement will produce a HEDR Adjustment applied to each REACH ACO's Total Quality Score. Section 4.4 covers details related to the required data elements, scoring methodology, and data submission process.

4.4.1 Required Data Elements

Demographic data: For the ACO REACH Model, the [United States Core Data for Interoperability \(USCDI\) Version 2](#) (V2) data elements are the intended standard for required demographic data, in addition to Medicare Beneficiary Identifier (MBI) for beneficiary identification purposes. However, to allow for additional time for readiness to implement USCDI V2, only data elements from USCDI V1 will be required for PY2023. For PY2024 and subsequent PYs, CMS expects to also require demographic data elements from USCDI V2. The following table (4-3) includes all data elements included in the demographic component of the HEDR requirement for PY2023.

³⁴ Interval estimates for measure scores calculated using risk-adjustment models are more accurately and reliably produced using bootstrapping methods than by using analytic methods

Table 4-3. PY2023 data elements for the demographic component of the HEDR requirement

Data element	Required for HEDR Adjustment credit?	Source
MBI	Yes	CMS
Beneficiary first and last name	Yes	USCDI V1 and V2
Sex Assigned at Birth	Yes	USCDI V1 and V2
Date of Birth	Yes	USCDI V1 and V2
Preferred Language	Yes	USCDI V1 and V2
Beneficiary race	Yes	USCDI V1 and V2
Beneficiary ethnicity	Yes	USCDI V1 and V2
Sexual Orientation	No (but expected to be required for PY2024+)	USCDI V2
Gender Identity	No (but expected to be required for PY2024+)	USCDI V2

For PY2024 and subsequent PYs, CMS does not anticipate making any additional changes to the required dataset, aside from requiring the collection and submission of USCDI V2 data elements (though reserves the right to do so). If any updates are made, CMS will publish them prior to the PY in which they become effective in an updated version of this document.

SDOH data: For PY2023, while there is no positive or negative impact to the HEDR Adjustment for collecting and reporting SDOH data, REACH ACOs are still encouraged to do so in anticipation of meeting the requirement in future PYs and to support the Innovation Center’s health equity data collection objectives. CMS will permit REACH ACOs to choose one of the following SDOH assessment tools for the HEDR requirement:

- [Accountable Health Communities \(AHC\) Health-Related Social Needs \(HRSN\) Screening Tool](#)
- [North Carolina SDOH Screening Tool](#)
- [National Association of Community Health Centers’ \(NACHC’s\) Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences \(PRAPARE\) Screening Tool](#) 

CMS does not anticipate changing the available SDOH screening tools for PY2024 and subsequent PYs, but reserves the right to do so. If any updates are made, CMS will publish them prior to the PY in which they become effective in an updated version of this document.

Frequency of collection: Given the static nature of most demographic data elements, CMS only requires REACH ACOs to *collect* beneficiary-reported demographic data once for each beneficiary. To receive credit for reporting demographic data, however, REACH ACOs should *submit* beneficiary-reported demographic data on each beneficiary to CMS annually. For example, if a REACH ACO collects demographic data from a given beneficiary in April of PY2023 (or alternatively, if the REACH ACO has already collected beneficiary-reported demographic data prior to participation in the ACO REACH Model), the REACH ACO may submit the same data for credit against the HEDR requirement in PY2023, PY2024, PY2025, and PY2026. Submitting the data for PY2023 only, however, will not give the REACH ACO credit for data submission in subsequent PYs.

Due to the dynamic nature of SDOH data, CMS requires that REACH ACOs collect beneficiary-reported data on an annual basis to receive credit for reporting SDOH data. Accordingly, CMS will require REACH ACOs to include the date on which the SDOH data was collected when reporting to CMS. For example, if a REACH ACO collects SDOH data from a given beneficiary in April of PY2024, the REACH ACO may

submit that data for credit toward the HEDR Adjustment in PY2024. In order to get credit towards the HEDR Adjustment for SDOH data in PY2025, the REACH ACO must re-collect SDOH data from the same beneficiary during PY2025. Data submitted with a collection date outside of the PY will not count for credit towards the HEDR Adjustment in the PY.

Beneficiaries declining to share data: As noted in Section 2.3.4, beneficiary submission of demographic and SDOH information is voluntary and REACH ACOs should not impose on the beneficiaries they serve 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. The SDOH data submission template (discussed below) will have the option to indicate whether a given beneficiary declined to share SDOH when asked by the REACH ACO. For the demographic data, if a beneficiary declines to share demographic data for each of the following required data elements, the following answers shown in Table 4-4 should be provided (note: CMS understands that the answers indicating that a beneficiary chose not to disclose are not standardized which may lead to some confusion. The allowed response values are determined by standard-setting organizations, however, and not by CMS. For example, the allowed response values for beneficiary race are determined by the [Office of Management and Budget \(OMB\)](#) ):

Table 4-4. Instructions for REACH ACOs by data element for indicating a beneficiary has declined to disclose

If a beneficiary declines to share this demographic data...	The REACH ACO should report the following to CMS in submitting its completed template
Sex Assigned at Birth	Unknown
Sexual Orientation	Choose not to disclose
Gender Identity	Choose not to disclose
Beneficiary race	Asked but unknown
Beneficiary ethnicity	Asked but unknown

4.4.2 HEDR Adjustment Scoring Methodology

For PYs in which the potential impact of the HEDR Adjustment does not include a downward adjustment for a given data category (i.e., in PY2023 and PY2024 for demographic data and in PY2024 and PY2025 for SDOH data), the HEDR Adjustment will be based on a sliding scale and REACH ACOs will be able to 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 ACO during the performance year for whom the ACO successfully reports all required data elements
- Denominator = Number of beneficiaries with at least 6 months of alignment to the ACO during the performance year

Beneficiaries included in the ACO REACH alignment file as of October 1, 2024, were pre-populated in the HEDR reporting template. ACOs were instructed not to add or remove beneficiaries from the template. The final determination of 6 months of alignment will be based on the end of year final eligibility checks that will be conducted in April 2025. If after the final eligibility checks, a beneficiary has less than 6 months of alignment as of October 1, 2024, the beneficiary will be excluded from both the numerator

and denominator of the HEDR Reporting Rate. No beneficiaries will be added to the HEDR Reporting Rate based on final eligibility checks.

The determination of ‘successful reporting’ will be (1) made at the beneficiary level; (2) assessed separately for demographic and SDOH data; and (3) defined as submitting valid data for all required data elements. The Reporting Rate will be multiplied by the maximum adjustment in Table 2-5 to calculate the HEDR Adjustment. For example, a REACH ACO with a Reporting Rate of 30% for demographic data in PY2023 will receive an HEDR Adjustment of $30\% * 10\% = 3\%$. A REACH ACO with a Reporting Rate of 40% for demographic data and 20% for SDOH data in PY2024 will receive an HEDR Adjustment of $[40\% * 5\%] + [20\% * 5\%] = 3\%$.

For PYs in which the potential impact of the HEDR Adjustment does include a downward adjustment (i.e., PY2025 and PY2026 for demographic data; PY2026 for SDOH data), CMS will construct a benchmark based on the reporting of each data category two years prior in the ACO REACH Model. For example, for determining a REACH ACO’s HEDR Adjustment for reporting demographic data in PY2025, which will be between -5% and 5%, CMS will construct a benchmark based on demographic data reported across all REACH ACOs participating in PY2023. More information about how these benchmarks will be constructed will be made available in a future version of this document.

4.4.3 Data Submission

Format: For PY2023, REACH ACOs must report demographic and SDOH data to CMS using CMS-provided excel templates (note: separate templates are used for submission of demographic data and for submission of SDOH data). The templates for PY2023 are available to potential PY2023 REACH ACOs via the 4Innovation System (4i) Knowledge Library: <https://4innovation.cms.gov/secure/knowledge-management/view/840>.

Each template includes three tabs:

- **Data Element Description:** this tab (1) provides a summary of the data element label, name, and type; (2) indicates whether submitting this data element is required to receive credit for the HEDR Adjustment; and (3) summarizes the data population requirements, including the complete set of data element responses where applicable.
- **Example Data:** this tab provides an example of how the template should be complete using illustrative data.
- **Submission Tab:** this tab should be populated by REACH ACOs and submitted to CMS in order to receive credit for the HEDR Adjustment.

For each beneficiary included in the demographic data submission template, all columns corresponding to required data elements should be completed (see Section 4.4.1 for guidance on how to populate the template for data elements a beneficiary chooses not to disclose). For each beneficiary included in the SDOH data submission template, all columns corresponding to required data for at least one screening tool (AHC’s HRSN Screening Tool, North Carolina SDOH Screening Tool, or NACHC’s PRAPARE Screening Tool) should be populated, unless the beneficiary chooses not to disclose, in which case that should be indicated in a relevant column.

For PY2024 and subsequent PYs, CMS does not anticipate changing these data submission templates, but reserves the right to do so. If any updates are made, CMS will publish them prior to the PY in which they become effective in an updated version of this document.

Additionally, for future PYs, CMS plans to make available to REACH ACOs an alternative Application Programming Interface (API)-based method that can be used to directly collect and submit this data to CMS, utilizing the Fast Healthcare Interoperability Resources data standard. More information will be made available in the future once this functionality has been finalized.

Timing and process: For PY2023, recognizing that SDOH data must be collected during the ACO REACH Model Performance Period and that only beneficiaries with at least 6 months' experience in the PY are considered in the HEDR Adjustment methodology, the demographic and SDOH data submission dates will be lagged by six months. CMS will collect completed data submission templates submitted via File Exchange in 4i on the following four dates for PY2023: 7/1/2023; 10/1/2023; 1/1/2024; and 4/1/2024. CMS expects to establish equivalent deadlines for PY2024, but will finalize those in an updated version of this document prior to PY2024.

For each deadline, each REACH ACO will only be permitted one template submission for demographic data and one template submission for SDOH data; if a REACH ACO submits more than one template for demographic data, for example, for a given deadline, CMS will only use the most recently uploaded template. When submitting data for within given PY, REACH ACOs may provide either full replacement files (all available data on all aligned beneficiaries) or cumulative files (all newly collected since the last file submission). CMS will provide a response file for each submitted template for each collection deadline to identify for which beneficiaries data was successfully reported or, if data was not successfully reported, the source of any errors so that the REACH ACO may correct them in subsequent template submissions.

For subsequent PYs, REACH ACOs must re-submit all beneficiary data. CMS will not carry over submitted data from a prior PY. As a reminder, SDOH data must be collected annually within each PY to satisfy the requirement for that PY, while demographic data only needs to be collected once either before or during the Model Performance Period). Data must be re-submitted on an annual basis to satisfy the HEDR requirement.

4.5 High Performers Pool

In PY2023, REACH ACOs will be eligible to receive additional payments from the HPP if they meet the CI/SEP criteria and have an average percentile rank of 70% or greater across all claims-based quality measures.^{35, 36} The HPP will be funded entirely by the amount of the Quality Withhold that is not earned back by REACH ACOs that meet the CI/SEP criteria. HPP funds will be distributed evenly on a per-beneficiary basis to REACH ACOs that meet the HPP eligibility criteria. HPP bonus payment determination includes the following steps:

1. Determine HPP total fund amount (\$): Sum of Quality Withholds not earned back by all REACH ACOs that meet the CI/SEP criteria.
2. Apply HPP eligibility criteria: CMS determines which REACH ACOs meet the HPP criteria. This includes those that A) meet the CI/SEP criteria and B) have an average percentile rank of at least 70% across all quality measures in PY2023.

³⁵ CAHPS may be included in the HPP criteria in future PYs.

³⁶ REACH ACOs not subject to the CI/SEP (i.e., PY2023 starters in PY2023) are not eligible for HPP funds.

3. Count total number of HPP beneficiaries: CMS sums the number of aligned beneficiaries across each REACH ACO that meets the HPP criteria (this includes Standard and New Entrant ACOs and High Needs Population ACOs).
4. Determine HPP bonus rate (\$) per beneficiary: CMS divides the HPP total fund amount (from step 1) by the total number of HPP beneficiaries (from step 3).
5. HPP bonus applied: REACH ACOs that are eligible for the HPP receive a \$ bonus that is the product of the HPP bonus rate (from step 4) multiplied by the REACH ACO's number of aligned and model eligible beneficiaries. The HPP bonus is added to the ACO's Other Monies Owed during Final Financial Settlement. For a high-performing REACH ACO, the value of the Quality Withhold earned back plus the HPP bonus may exceed the REACH ACO's initial 2% Quality Withhold.

4.6 Application of Quality Assessment to Final Financial Settlement

The process of determining the impact of quality measurement and performance on the PY Benchmark is summarized in this section using PY2023 as an example. The steps are as follows:

- CMS develops QPBs for each 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 points possible (i.e., 40 points).
- (For REACH ACOs that started in PY2021 and PY2022 only) CI/SEP criteria are assessed to determine the CI/SEP multiplier, either 1.0 or 0.5, used to adjust the Initial Quality Score. For a REACH ACO that does not meet the CI/SEP criteria, it's Initial Quality Score 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 HEDR bonus. In PY2023, the HEDR is a 0-10% adjustment added to the Total Quality Score. The HEDR bonus is equal to the percent of beneficiaries for which the REACH ACO submits required demographic data multiplied by 10% (e.g., 50% reporting results in a 5% bonus added to the Total Quality Score). The Total Quality Score is capped at 100%.
- After the CI/SEP and HEDR adjustments, the final Total Quality Score is multiplied by the 2% Quality Withhold to determine the Quality Withhold Earned Back.
- (For REACH ACOs that started in PY2021 and PY2022 only) HPP funds are added to the REACH ACOs' Other Monies Owed for REACH ACOs that meet the HPP criteria.

4.6.1 Step 1. CMS Develops Quality Performance Benchmarks for Each P4P Measure

In **PY2023**, all quality measures will be P4P for Standard and New Entrant ACOs. The claims-based measures will be P4P for High Needs Population ACOs, but CAHPS will remain P4R. For the P4P measures, performance levels for each REACH ACO are determined by comparing their Quality Measure scores with the relevant QPBs. The REACH ACO earns up to 10 points for each measure based on where the measure score falls in comparison to the benchmark threshold values. For High Needs Population ACOs, the 10 points associated with the CAHPS will be awarded based on the fulfillment of the P4R requirement of successfully contracting with a CAHPS vendor.

Historically, QPBs for claims-based measures used in other models have been released prior to the start of a given PY. However, observed and anticipated changes in utilization and outcomes resulting from coronavirus disease 2019, CMS is taking a different approach for ACO REACH quality performance benchmarking for the claims-based measures used in the model. **For PY2022, PY2023 and subsequent PYs**, ACO REACH QPBs for claims-based measures are based only on data from the 12-month period concurrent with the performance year.

Table 4-5 presents hypothetical concurrent QPBs distributions for Standard/New Entrant ACOs (using historical Medicare claims data) for ACR, UAMCC, and TFU. Note that ACR and UAMCC are reverse-scored measures, where higher scores indicate poorer performance. In contrast, for both TFU and DAH, higher scores indicate better performance. This distinction is important when evaluating performance with QPBs. Based on the hypothetical concurrent QPBs, a REACH ACO with a measure score, or RSRR, of 14.90% for ACR would be in the 50th percentile group for that measure (the score exceeds the threshold for the 55th percentile group but is less than the maximum threshold for the 50th percentile group). A REACH ACO with a measure score (RSAAR) of 37.81 admissions per 100 person-years for UAMCC would be in the less than 30th percentile group (that score exceeds the threshold for the 30th percentile group). A REACH ACO with a follow-up rate of 75.52% would be in the 85th percentile group for TFU (the score is less than the threshold for the 90th percentile group but is greater than the maximum threshold for the 85th percentile group). *Table 4-4 illustrates a hypothetical example. These are NOT the final* and are NOT intended to provide an indication of the final QPBs. The layout and application of QPBs for High Needs Population ACOs will be similar to that of Standard and New Entrant ACOs, with

Table 4-5. Hypothetical QPBs for ACR and UAMCC for comparison with Standard and New Entrant ACO measure scores

Percentile	30 th	35 th	40 th	45 th	50 th	55 th	60 th	65 th	70 th	75 th	80 th	85 th	90 th
ACR	15.11	15.06	15.01	14.97	14.92	14.88	14.84	14.80	14.75	14.71	14.66	14.59	14.51
UAMCC	34.68	34.07	33.45	32.87	32.37	31.79	31.25	30.70	30.14	29.46	28.87	28.10	27.06
TFU	63.73	64.94	65.82	66.85	67.65	68.48	69.47	70.34	71.25	72.34	73.56	75.00	76.77

One benefit of the shift to the use of concurrent benchmarks is that corresponding set of QPBs may be calculated for any period. CMS will provide provisional QPBs to REACH ACOs in their quarterly reports; these provisional QPBs will be calculated using data from the same reporting period (e.g., April 1, 2022–March 31, 2023, for PY2023 Q1). The provisional QPBs will be updated in each subsequent quarterly report with data from the same period being used to measure scores. Because the REACH ACO performance scores and QPBs will be based on the same time-period and have the same exact risk adjustment coefficients, REACH ACOs will have a more accurate picture from quarter to quarter of their performance relative to the QPBs. A REACH ACO's Quality Withhold Earn-Back Rate for PY2023 will be based on official QPBs calculated using data from calendar year 2023 and will be determined during final settlement, which will occur in 2024.

For PY2023, the Standard/New Entrant ACO CAHPS QPB distributions will be based on pooled data from 2021, and 2019 for MIPS, Shared Savings Program and NGACOs combined with PY2022 Data for DCEs. CAHPS will be P4R for High Needs Population ACOs.

4.6.2 Step 2. Quality Measure Points Awarded: P4P Quality Measures are Compared Against Their QPBs to Determine Performance Levels

P4R Measures: There are no P4R components for Standard and New Entrant ACOs in PY2023. All measures will be P4P for these REACH ACOs. CAHPS will be P4R in PY2023 for High Needs Population ACOs. High Needs Population ACOs that successfully contract with a CMS-approved CAHPS vendor will receive the full 10 points allocated to CAHPS.

P4P Measures: Each Quality Measure will be worth 10 points. Standard and New Entrant ACOs will have a possible 40 points they can based on four P4P measures. High Needs Population ACOs will have 30 points they can earn based on three P4P measures, with the remaining 10 points determined based on meeting the CAHPS P4R requirement. The QPBs will be used to determine the number of points each REACH ACO will earn for each P4P quality measures. ACOs scoring below the 30th percentile will receive no points for that measure; ACOs scoring at or above the 90th percentile will receive the full 10 points possible for that measure. ACOs scoring between the 30th and 90th percentiles will earn points for the quality measure as indicated in Section 4.2.

4.6.3 Step 3. Calculate the Initial Quality Score

After determining performance levels and points awarded for each measure, CMS calculates the Initial Quality Score.

The Initial Quality Score is equal to the percent of total possible points earned across all measures. There are four Quality Measures (CAHPS, ACR, UAMCC, and DAH/TFU) and each measure is worth 10 points, for a total of 40 possible points. Thus, the Initial Quality Score is the sum of the individual Quality Measure points divided by 40 and converted to a percentage value.

$$\text{Initial Quality Score} = [\sum (\text{Quality Measure Points}) / 40] \times 100\%$$

The Initial Quality Score is a percentage with a possible range from 0% to 100%.

4.6.4 Step 4. Apply CI/SEP Multiplier

The CI/SEP criteria are applied after the calculation of the Initial Quality Score. In order to meet the CI/SEP criteria, a REACH ACO must meet two conditions: 1) the REACH ACO must receive +1 CI/SEP point for at least one measure (i.e., the REACH ACO must exhibit continuous improvement OR sustained exceptional performance for at least one measure), and 2) the REACH ACO must have an overall net CI/SEP score greater than or equal to 0. See Section 4.3 for more detail on the CI/SEP criteria.

The Initial Quality Score is multiplied by

- 1.0 if the REACH ACO meets the CI/SEP criteria, or
- 0.5 if the REACH ACO does not meet the CI/SEP criteria.

4.6.5 Step 5. The HEDR Adjustment Is Applied to Determine the Total Quality Score

As described in Section 4.4, in PY2023, REACH ACOs may receive a bonus to the Initial Quality Score for submitting beneficiary-reported demographic data, 0 to 10% based on the proportion of beneficiaries for whom reporting is complete. The adjustment is applied after the CI/SEP multiplier and cannot increase the resulting Total Quality Score above 100%. For example, a REACH ACO with an Initial Quality Score of 86% that meets the CI/SEP criteria will have its score increased to 96% if it submits beneficiary-

reported demographic data for all eligible beneficiaries. A REACH ACO with an Initial Quality Score of 96% that meets the CI/SEP criteria would have its score increased to 100% for complete reporting of the demographic data. A REACH ACO with an Initial Quality Score of 76% that does not meet the CI/SEP criteria will have a CI/SEP multiplier of 0.5, resulting in a value of 38%; if the REACH ACO completes reporting of demographic data on 90% of eligible beneficiaries, its Total Quality Score with the HEDR adjustment will be $38\% + 9\% = 47\%$.

Total Quality Score (capped at 100%) = (Initial Quality Score * CI/SEP Multiplier) + HEDR Adjustment

4.6.6 Step 6. Total Quality Score is Multiplied by the Quality Withhold to Determine a REACH ACO's Quality Withhold Earn Back

In **PY2023–PY2026**, the Quality Withhold Earn Back is calculated by multiplying the Total Quality Score by the 2% Quality Withhold. The Quality Withhold Earn Back will always be between 0% and 2%.

4.6.7 Step 6. (PY2023–PY2026 only) HPP Funds Are Distributed

In PY2023 and beyond, REACH ACOs will be eligible for a bonus payment from the HPP funds if they meet the CI/SEP criteria and have an average measure percentile rank of at least the 70th percentile. The bonus payment will be attributed on a per-beneficiary alignment-month basis during Final Financial Settlement. As a result, the highest performing REACH ACOs may earn back more than the 2% Quality Withhold. See Section 4.5 for more information.

5. Worked Examples of Quality Score Calculations

In the following subsections we provide worked examples of selected scenarios for PY2023 and subsequent PYs. Please see Appendix D for worked examples that apply to PY2021 and PY2022.

5.1 Worked Examples of the Final Earn-Back Rate Calculation for PY2023–PY2026

From PY2023-PY2026, the Quality Withhold will equal 2% of the Financial Benchmark. The Earn-Back Rate of the Quality Withhold will be determined using four P4P Quality Measures for Standard and New Entrant ACOs. High Needs Population ACOs will have three P4P measures and one P4R measure (CAHPS) in PY2023. All measures are weighted equally in the calculation of the Initial Quality Score. The Total Quality Score incorporates the CI/SEP Gateway Multiplier and, subsequently, the HEDR Adjustment. The Total Quality Score can range from 0% to 100% and is used to determine the Quality Withhold Earn Back. REACH ACOs that meet the CI/SEP criteria and have an average measure score rank of at least the 70th percentile will be eligible for a bonus payment from the HPP on a per-beneficiary basis.

5.1.1 Worked Examples for REACH ACOs that Started Prior to PY2023

Tables 5-1 and **5-2** show calculations accounting for the CI/SEP Gateway criteria in PY2023 under two different scenarios for REACH ACOs that started prior to PY2023. The scenarios assume that PY2023 has multiple P4P measures and no P4R measures.

*High Needs Population ACO that does NOT meet CI/SEP Gateway criteria***Table 5-1. Final Earn-Back Rate calculation, PY2023 example – High Needs Population ACO not meeting CI/SEP Gateway**

Measure		Points Earned	Points Possible
1.	P4P: ACR	7.5	10.0
2.	P4P: UAMCC	8.125	10.0
3.	P4P: DAH (High Needs Population ACOs Only)	7.0	10.0
4.	P4P: TFU (Standard/New Entrant Only)	N/A	N/A
5.	P4R*: CAHPS	10.0	10.0
Total Points		32.625	40.0
<u>Initial Quality Score (0-100%)</u> Points earned / points possible * 100		81.563%	
Adjustments to Total Quality Score	<u>CI/SEP Gateway Multiplier</u> 1.0 if ACO met CI/SEP criteria; 0.5 if ACO did not meet CI/SEP criteria	0.5	
	<u>HEDR Adjustment</u> 0-10% bonus based on percent reporting <i>Assuming reporting on 50% of eligible beneficiaries</i>	5%	
<u>Total Quality Score (0-100%)</u> (Initial Quality Score * CI/SEP Multiplier) + HEDR <i>81.563 * 0.5 + 5</i>		45.781%	
Impact on Financial Settlement	<u>Quality Withhold Earned Back (0-2%)</u> Total Quality Score * 2% Quality Withhold <i>45.781% * 2%</i>	0.916% of the financial benchmark	
	<u>HPP Bonus</u> Must meet CI/SEP criteria AND have average quality measure performance ≥ 70 th percentile	N/A	

Notes: This example assumes the following for the hypothetical High Needs Population ACO: 1) ACR measure score corresponding to the 32.1 percentile; 2) UAMCC measure score corresponding to the 68.9 percentile; 3) DAH measure score corresponding to the 51.0 percentile; 4) completed requirements to contract with CAHPS vendor; 5) the REACH ACO had 628 aligned beneficiaries with at least 6 months of eligibility and reported demographic data on 50% (314) of them; 6) the REACH ACO did not meet the CI/SEP criteria and is also therefore not eligible for the HPP bonus.

Standard ACO meets CI/SEP Gateway criteria**Table 5-2. Final Earn-Back Rate calculation, PY2023 example – Standard ACO meets CI/SEP Gateway**

Measure		Points Earned	Points Possible
1.	P4P: ACR	9.625	10.0
2.	P4P: UAMCC	8.875	10.0
3.	P4P: DAH (High Needs Population ACOs Only)	N/A	10.0
4.	P4P: TFU (Standard/New Entrant Only)	7.75	N/A
5.	P4P: CAHPS	8.031	10.0
Total Points		34.281	40.0
<u>Initial Quality Score (0-100%)</u>		85.570%	
Points earned / points possible * 100			
Adjustments to Total Quality Score	<u>CI/SEP Gateway Multiplier</u> 1.0 if ACO met CI/SEP criteria; 0.5 if ACO did not meet CI/SEP criteria	1.0	
	<u>HEDR Adjustment</u> 0-10% bonus based on percent reporting <i>Assuming reporting on 90% of eligible beneficiaries</i>	9%	
<u>Total Quality Score (0-100%)</u>		94.570%	
(Initial Quality Score * CI/SEP Multiplier) + HEDR $85.570 * 1.0 + 9$			
Impact on Financial Settlement	<u>Quality Withhold Earned Back (0-2%)</u> Total Quality Score * 2% Quality Withhold $94.570\% * 2\%$	1.891% of the financial benchmark	
	<u>HPP Bonus</u> Must meet CI/SEP criteria AND have average quality measure performance $\geq 70^{\text{th}}$ percentile	+ \$ per beneficiary	

Notes: This example assumes the following for the hypothetical Standard ACO: 1) ACR measure score corresponding to the 89.7 percentile; 2) UAMCC measure score corresponding to the 75.2 percentile; 3) TFU measure score corresponding to the 63.4 percentile; 4) CAHPS composite score assuming 64.25 SSM points earned across the eight CAHPS SSMs; 5) the REACH ACO had 10470 aligned beneficiaries with at least 6 months of eligibility and reported demographic data on 90% (9423) of them; 6) the REACH ACO is eligible for the HPP because it met the CI/SEP criteria and had an average percentile rank of 76.1% across the claims-based measures, which is greater than the 70th percentile.

5.1.2 Worked Examples for REACH ACOs That Started in PY2023

REACH ACOs that start in PY2023 are not subject to the CI/SEP criteria and are not eligible for the HPP Incentive Bonus. Tables 5-3 and 5-4 below provide worked examples for Standard and High Needs Population ACOs that started in PY2023.

*High Needs Population ACO (PY2023 Starter)***Table 5-3. Final Earn-Back Rate calculation, PY2023 example – High Needs Population ACO PY2023 Starter**

Measure		Points Earned	Points Possible
1.	P4P: ACR	9.5	10.0
2.	P4P: UAMCC	10.0	10.0
3.	P4P: DAH (High Needs Population ACOs Only)	7.5	10.0
4.	P4P: TFU (Standard/New Entrant Only)	N/A	N/A
5.	P4R*: CAHPS	10.0	10.0
Total Points		37.0	40.0
<u>Initial Quality Score (0-100%)</u> Points earned / points possible * 100		92.50%	
Adjustments to Total Quality Score	<u>HEDR Adjustment</u> 0-10% bonus based on percent reporting <i>Assuming reporting on 90% of eligible beneficiaries</i>	9%	
<u>Total Quality Score (0-100%)</u> <i>Initial Quality Score + HEDR</i> <i>92.50 + 9</i>		100%	
Impact on Financial Settlement	<u>Quality Withhold Earned Back (0-2%)</u> Total Quality Score * 2% Quality Withhold <i>100% * 2%</i>	2% of the financial benchmark	

Notes: This example assumes the following for the hypothetical High Needs Population ACO (PY2023 Starter): 1) ACR measure score corresponding to the 72.3 percentile; 2) UAMCC measure score corresponding to the 94.8 percentile; 3) DAH measure score corresponding to the 30.2 percentile; 4) completed requirements to contract with CAHPS vendor; 5) the REACH ACO had 670 aligned beneficiaries with at least 6 months of eligibility and reported demographic data on 90% (603) of them. The CI/SEP criteria and HPP do not apply.

*Standard ACO (PY2023 Starter)***Table 5-4. Final Earn-Back Rate calculation, PY2023 example – Standard ACO PY2023 starter**

Measure		Points Earned	Points Possible
1.	P4P: ACR	7.75	10.0
2.	P4P: UAMCC	8.0	10.0
3.	P4P: DAH (High Needs Population ACOs Only)	N/A	10.0
4.	P4P: TFU (Standard/New Entrant Only)	8.5	N/A
5.	P4P: CAHPS	9.156	10.0
Total Points		33.406	40.0
<u>Initial Quality Score (0-100%)</u> Points earned / points possible * 100		83.515%	
Adjustments to Total Quality Score	HEDR Adjustment 0-10% bonus based on percent reporting <i>Assuming reporting on 80% of eligible beneficiaries</i>	8%	
<u>Total Quality Score (0-100%)</u> <i>Initial Quality Score + HEDR</i> <i>83.515 + 8</i>		91.515%	
Impact on Financial Settlement	<u>Quality Withhold Earned Back (0-2%)</u> Total Quality Score * 2% Quality Withhold <i>91.515% * 2%</i>	1.8303% of the financial benchmark	

Notes: This example assumes the following for the hypothetical Standard ACO (PY2023 Starter): 1) ACR measure score corresponding to the 39.1 percentile; 2) UAMCC measure score corresponding to the 43.7 percentile; 3) TFU measure score corresponding to the 52.5 percentile; 4) CAHPS composite score assuming 73.25 SSM points earned across the eight CAHPS SSMs; 5) the REACH ACO had 5980 aligned beneficiaries with at least 6 months of eligibility and reported demographic data on 80% (4784) of them. The CI/SEP criteria and HPP Adjustment do not apply.

Appendices

Appendix A—Timelines for PY2023, and for PY2021/PY2022

Figure A-1 shows key time points for the ACO REACH Quality Strategy for PY2023.

Figure A-2 shows key time points for PYs 2021 and PY2022.

Figure A-1. Timeline of Quality Reporting and Performance Assessment Activities for PY2023

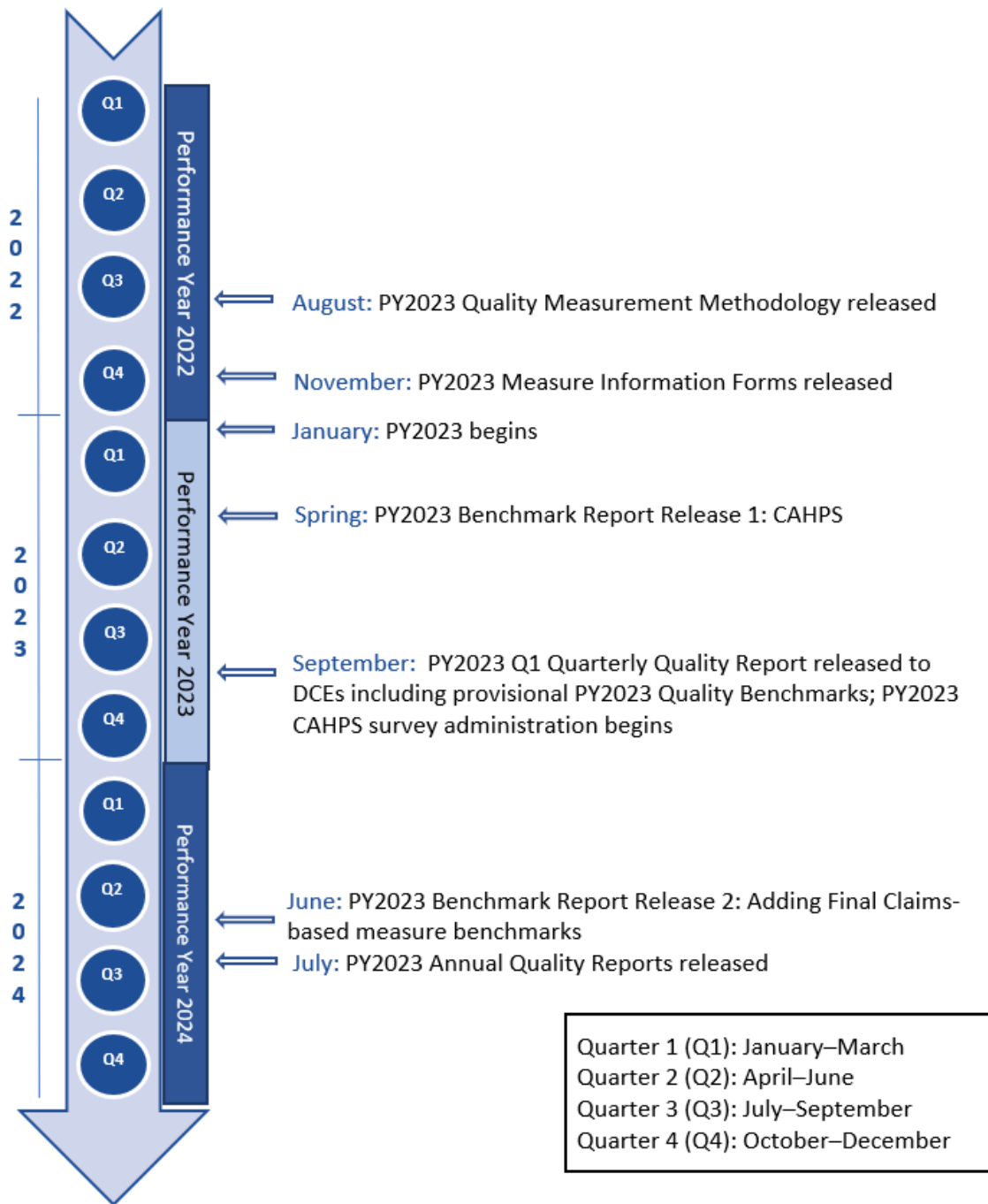
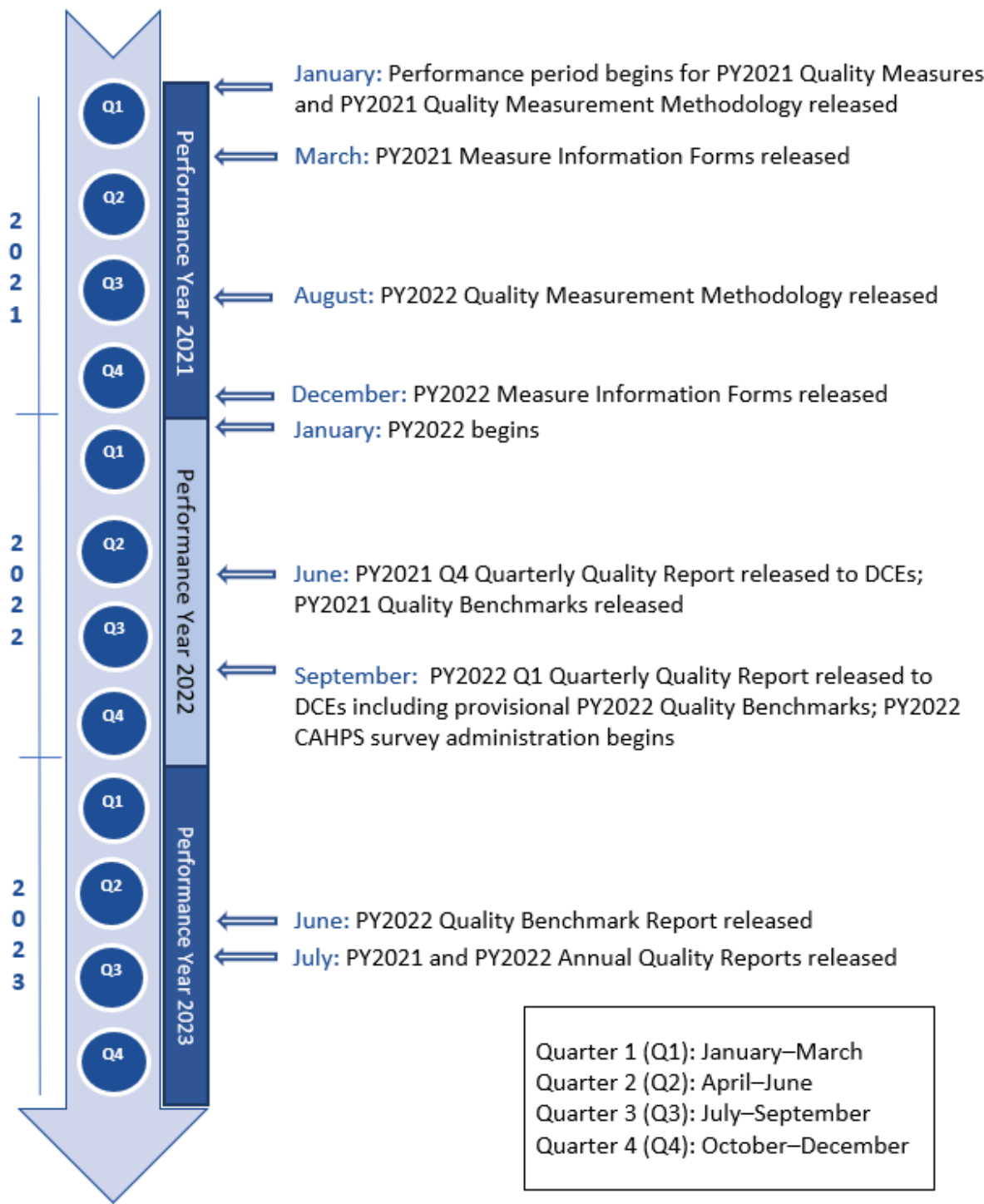


Figure A-2. Timeline of Quality Reporting and Performance Assessment Activities for PY2021 and PY2022



Appendix B—Terminology List (selected)

Beneficiary	A person who has health care insurance through the Medicare program.
CAHPS Composite Score	A REACH ACO-level summary of patient experience of care from beneficiaries surveyed with the CAHPS. This measure which is a composite of results across different CAHPS domains, applies to Standard, New Entrant, and High Needs Population ACOs. Eligible REACH ACOs are required select, contract with and pay for a CAHPS Survey vendor to collect and report data to CMS for this measure. The vendor conducts the survey using mail and telephone follow-up, and reports results to CMS. A REACH ACO's CAHPS composite score accounts for 10 points out of the total 40 possible points awarded based on quality measure performance. A REACH ACO's 10 possible points for CAHPS will be determined by their performance on the eight SSMs listed in Section 3.5.3 above.
CAHPS Summary Survey Measures (SSMs)	The ACO REACH CAHPS Survey will use the ACO CAHPS Survey and derive CAHPS Summary Survey Measures for scoring, which will then be combined into a single CAHPS Composite Measure. The measures are referred to as Summary Survey Measures (SSMs) because the survey includes multiple questions for most of the measures. The SSMs included in the CAHPS Performance Score are described in Table 3-1, and the questions included in each SSM are included in Appendix Tables C-2 and C-3.
Component Quality Score	The percentage of the Quality Withhold for a specific component that the Realizing Equity, Access, and Community Health Accountable Care Organization (REACH ACO) will earn back based on individual measures or components of the quality measurement approach that contribute to the Final Earn-Back Rate.
Continuous Improvement/ Sustained Exceptional Performance (CI/SEP)	To encourage REACH ACOs to deliver high-quality, high-value care, payment for improvement on quality will also be tied to demonstrable continuous improvement in reducing unnecessary or avoidable health care service utilization from PY2023 through PY2026. Specifically, half of the Quality Withhold will be tied to a set of CI/SEP criteria. CMS recognizes that REACH ACOs achieving high performance rates may have less room to show improvement. Accordingly, when establishing these continuous improvement targets, CMS will establish targets that still incentivize higher performing REACH ACOs to continue to improve.
Realizing Equity, Access, and Community Health Accountable Care Organization (REACH ACO)	An organization participating in the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model pursuant to a participation agreement with CMS.
Eligible Earn-Back Rate	In both the Global and Professional Options, a portion of the Performance Year Benchmark will be held at risk, dependent on the REACH ACO's performance on a predetermined set of Quality Measures and CI/SEP. Specifically, this quality incentive will be structured as a quality "withhold," set at 5% of the value of the trended, regionally blended, risk-adjusted benchmark, and will be recalculated for each performance year. The REACH ACO will have the opportunity to earn back some or all of the Quality Withhold, depending on the REACH ACO's performance on the Quality Measure set and CI/SEP. In PY2021 and PY2022, the Eligible Earn-Back Rate will be 5% for all REACH ACOs. From PY2023 through PY2026, the Eligible Earn-Back Rate will be 5% or 2.5% dependent on the REACH ACO's performance on the CI/SEP criteria. If the REACH ACO does not meet the CI/SEP criteria, the REACH ACO's Eligible Earn-Back Rate will only be 2.5%.
Final Earn-Back Rate	Equals the Total Quality Score times the Eligible Earn-Back Rate.

Final Financial Settlement	Final Financial Settlement is conducted approximately seven months after the performance year ends for all ACOs for PY2023-PY2026. This settlement includes claims run-out through the end of the first quarter of the calendar year following the performance year for expenditures incurred in the performance year. Final Financial Settlement is based on risk adjusting the Performance Year Benchmark using the final risk scores for the performance year and then comparing the Performance Year Benchmark with performance year expenditures for aligned beneficiaries to determine Shared Savings or Shared Losses.
Global Option	A full risk option with 100% Shared Savings/Shared Losses and either Primary Care Capitation or Total Care Capitation.
Health Equity Data Reporting (HEDR) Adjustment	For the purpose of monitoring and evaluating the ACO REACH Model, CMS is requiring all REACH ACOs to collect and submit to CMS certain beneficiary-reported demographic data starting in PY2023 and certain beneficiary-reported social determinants of health (SDOH) data starting in PY2024 on aligned beneficiaries. Performance on this Health Equity Data Reporting (HEDR) requirement will produce an HEDR Adjustment applied to each REACH ACO's Initial Quality Score. See Section 2.3.4 for more information.
High Needs Population ACOs	REACH ACOs that serve ACO REACH Model beneficiaries with complex, high needs, including individuals dually eligible for Medicare and Medicaid and Medicare-only beneficiaries who are at risk of becoming dually eligible. These REACH ACOs serve FFS Medicare beneficiaries with complex needs who are aligned to the REACH ACO through voluntary alignment or claims-based alignment. Only beneficiaries who meet one or more of the High Needs eligibility criteria may be aligned to a High Needs Population ACO. Additionally, High Needs Population ACOs are expected to coordinate care for their aligned beneficiaries using a model of care designed for individuals with complex needs, like the one employed by the Programs of All-Inclusive Care for the Elderly. Like New Entrant ACOs, High Needs Population ACOs are required to meet a minimum number of aligned beneficiaries that increases over subsequent years of the program. High Needs Population ACOs must have at least 250 aligned High Needs beneficiaries prior to the start of PY2021 and PY2022, 500 prior to the start of PY2023, 750 prior to the start of PY2024, 1,200 prior to the start of PY2025, and 1,400 prior to the start of PY2026.
High Performers Pool (HPP)	REACH ACOs in the Global and Professional Options will qualify for a bonus from the HPP if they meet the CI/SEP and also demonstrate a high level of performance or meet improvement criteria on a predetermined subset of the Quality Measures from the Quality Measure set. The HPP will be funded from quality withholds not earned back by the REACH ACOs who met the CI/SEP. The funds in the HPP will be distributed to the highest performing REACH ACOs through an HPP Bonus based on quality performance or improvement. The criteria for assessing quality performance or improvement may be based on an individual REACH ACO's performance on the specified measures in the current performance year compared to the prior performance year or may be based on performance against the Quality Measure benchmark, or a combination of both. The criteria for the HPP will be shared prior to PY2023.

New Entrant ACOs	REACH ACOs with limited experience delivering care to Medicare FFS beneficiaries who meet eligibility criteria for New Entrant ACOs. Consists of organizations that have not traditionally provided services to a Medicare FFS population. New Entrant ACOs also use claims-based alignment, but they will likely rely primarily on voluntary alignment to attain the minimum number of aligned beneficiaries, at least in the first few PYs of the model. To qualify as a New Entrant ACO, no more than 50% of a REACH ACO's ACO Participant Providers may have prior experience in any of the ACO initiatives, the Comprehensive End-Stage Renal Disease (ESRD) Care Model, or the Comprehensive Primary Care Plus (CPC+) Model.
Pay-for-Performance	Criteria for achieving payments are based on REACH ACO/DCE performance relative to a quality benchmark or standard.
Pay-for-Reporting	Criteria for achieving payments are based on REACH ACOs/DCEs meeting the level of complete and accurate reporting.
Professional Option	A lower risk option with 50% Shared Savings/Shared Losses and Primary Care Capitation equal to 7% of the total cost of care benchmark for enhanced primary care services.
Quality Performance Benchmark (QPBs)	The distribution of Quality Measure scores used to evaluate the performance of a REACH ACO/DCE.
Quality Measure	A Quality Measure is a numeric quantification of health care quality for a designated accountable health care entity, such as hospital, health plan, nursing home, or clinician. Measures are based on scientific evidence about processes, outcomes, perceptions, or systems that relate to high-quality care.
Quality Withhold	A portion of a REACH ACO financial benchmark that will be held at risk each PY subject to the REACH ACO's quality performance as reflected by the REACH ACO's Quality Measure scores.
Quality Withhold Earn Back	A quantity ranging from 0% to 2% that indicates the portion of the REACH ACO's financial benchmark held "at risk" (i.e. the 2% Quality Withhold) that the ACO will earn back based on its quality performance and reporting. The Quality Withhold Earn Back is equal to the Total Quality Score multiplied by 2%.
Reporting-Only	A Reporting-Only measure does not factor into a REACH ACO's Total Quality Score in any way, although CMS will collect the data for informational purposes (e.g., to determine whether a measure is used in a future PY; to help set the measure's quality benchmark). No measures are currently planned as Reporting-Only.
RSAAR	A Risk-Standardized Acute Admission Rate. Lower RSAARs indicate better performance.
RSRR	Risk-Standardized Readmission Rate. Lower RSRRs indicate better performance.
Standard ACOs	REACH ACOs with substantial experience serving the Medicare FFS beneficiaries, which are likely to have prior experience participating in Medicare ACO initiatives. Composed of organizations that generally have substantial experience serving Medicare FFS beneficiaries, including Medicare-only and dually eligible beneficiaries. These REACH ACOs also most likely have prior experience participating in Medicare ACO initiatives. New organizations, composed of existing Medicare FFS providers and suppliers, may also participate as this REACH ACO type. To qualify as a Standard ACO, the ACO must have a minimum of 5,000 aligned beneficiaries prior to the start of each PY (PY2021–PY2026). Standard ACOs will likely include beneficiaries aligned through both voluntary and claims-based processes.

Tax Identification Number (TIN)	A unique identifier assigned by the Internal Revenue Service. In a health care setting, a TIN could uniquely identify a physician, a group practice, a hospital, or similar entity.
Total Quality Score	The percentage of the earn-back-eligible portion of the Quality Withhold that a REACH ACO will actually earn back based on its quality performance and reporting. Total Quality Score = $\sum$ (Component Quality Scores * Component Quality Withhold Weights).

Appendix C – Sampling Methodology for the ACO REACH Consumer Assessment of Healthcare Providers and systems (CAHPS®)

Vendor Selection

REACH ACOs will be responsible for selecting and contracting with a CMS-approved vendor to administer the CAHPS Survey. In fall 2021, CMS published information on REACH ACOs' CAHPS-related responsibilities and timelines in **The Innovation Center's GPDC Knowledge Library** and on gpdccahps.org.³⁷ For **PY2023**, REACH ACOs will need to select and contract with their CAHPS vendor by July 2023. For PY2023 and subsequent PYs, the **CMS ACO REACH Newsletter** will proactively notify REACH ACOs of all CAHPS information.

Sample Size

Occasionally, CMS may exempt a REACH ACO from CAHPS for a given PY if the REACH ACO's number of survey-eligible aligned beneficiaries is below the minimum number typically required for conducting a reliable CAHPS Survey. These numbers are shown in **Table C-1**. CMS will directly notify exempted REACH ACOs in the Spring of 2023 that they will not need to contract with a CAHPS survey vendor for PY2023. Exempted REACH ACOs may conduct the CAHPS Survey electively, but CMS will not collect their CAHPS scores. See **Section 4.2** for further details on quality measure point attribution for CAHPS-exempt REACH ACOs.

Table C-1. Survey-Eligible Aligned Beneficiaries in a ACO Required for Conducting the ACO REACH CAHPS Survey

Standard and New Entrant ACOs	
ACOs with 100 or more Participant Providers	• CMS will draw a random sample of 860 survey-eligible aligned beneficiaries. • If there are fewer than 860 survey-eligible aligned beneficiaries, but at least 416, all eligible beneficiaries will be surveyed. • If there are fewer than 416 survey-eligible aligned beneficiaries, the survey cannot be conducted.
ACOs with 25 to 99 Participant Providers	• CMS will draw a random sample of 860 survey-eligible aligned beneficiaries. • If there are fewer than 860 survey-eligible aligned beneficiaries, but at least 255, all eligible beneficiaries will be surveyed. • If there are fewer than 255 survey-eligible aligned beneficiaries, the survey cannot be conducted.
ACOs with two to 24 Participant Providers	• CMS will draw a random sample of 860 survey-eligible aligned beneficiaries. • If there are fewer than 860 survey-eligible aligned beneficiaries, but at least 125, all eligible beneficiaries will be surveyed. • If there are fewer than a minimum of 125 survey-eligible aligned beneficiaries, the survey cannot be conducted.
High Needs ACOs	
All ACOs	• All eligible beneficiaries will be surveyed. • If there are fewer than a minimum of 37 survey-eligible aligned beneficiaries, the survey cannot be conducted.

³⁷ The website, <https://acoreachcahps.org>, will be available as a resource beginning February 2023.

CAHPS Questions Making Up Each SSM

The questions making up the ACO REACH CAHPS survey, and the associated SSM they compose, are shown for Standard/New Entrant ACOs in **Table C-2** and for High Needs Population ACOs in **Table C-3**.

Table C-2. Final Standard and New Entrant CAHPS Questions and SSMs

Item #	Full CAHPS Questions Text	Summary Survey Measure (SSM) for Scored Items
1.	Our records show that you visited the provider named below in the last 6 months [PROVIDER NAME]. Is that right? (If no, go to Q26)	N/A
2.	Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?	N/A
3.	How long have you been going to this provider?	N/A
4.	In the last 6 months, how many times did you visit this provider to get care for yourself? (If None, go to Q26)	N/A
5.	In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury or condition that needed care right away? (If no, go to Q7)	N/A
6.	In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	Getting Timely Care, Appts, Info
7.	In the last 6 months, did you make any appointments for a check-up or routine care with this provider? (If no, go to Q9)	N/A
8.	In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	Getting Timely Care, Appts, Info
9.	In the last 6 months, did you contact this provider's office with a medical question during regular office hours? (If no, go to Q11)	N/A
10.	In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?	Getting Timely Care, Appts, Info
11.	In the last 6 months, did you contact this provider's office with a medical question after regular office hours? (If no, go to Q13)	N/A
12.	In the last 6 months, when you contacted this provider's office after regular hours, how often did you get an answer to your medical question as soon as you needed?	Getting Timely Care, Appts, Info
13.	In the last 6 months, how often did this provider explain things in a way that was easy to understand?	How Well Providers Communicate
14.	In the last 6 months, how often did this provider listen carefully to you?	How Well Providers Communicate
15.	In the last 6 months, how often did this provider seem to know the important information about your medical history?	Care Coordination

Item #	Full CAHPS Questions Text	Summary Survey Measure (SSM) for Scored Items
16.	In the last 6 months, how often did this provider show respect for what you had to say?	How Well Providers Communicate
17.	In the last 6 months, how often did this provider spend enough time with you?	How Well Providers Communicate
18.	In the last 6 months, did this provider order a blood test, x-ray, or other test for you? (If no, go to Q20)	N/A
19.	In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?	Care Coordination
20.	In the last 6 months, did you and this provider talk about starting or stopping a prescription medication? (If no, go to Q22)	N/A
21.	When you and this provider talked about starting or stopping a prescription medicine, did this provider ask what you thought was best for you?	Shared Decision Making
22.	In the last 6 months, did you and this provider talk about how much of your personal health information you wanted shared with your family or friends?	Shared Decision Making
23.	Using any number from 0 to 10, where 0 is the worst number and 10 is the best provider possible, what number would you use to rate this provider?	Patient's Rating
24.	In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?	Courteous and Helpful Office Staff
25.	In the last 6 months, how often did the clerks and receptionists at this provider's office treat you with courtesy and respect?	Courteous and Helpful Office Staff
26.	Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, or doctors who specialize in one area of health care. Is the provider named in Question 1 of this survey a specialist?	N/A
27.	In the last 6 months, did you try to make any appointments with specialists? (If no, go to Q29)	N/A
28.	In the last 6 months, how often was it easy to get appointments with specialists?	Access to Specialists (Not Scored)
29.	Your health care team includes all the doctors, nurses and other people you see for health care. In the last 6 months, did you and anyone on your health care team talk about a healthy diet and healthy eating habits?	Health Promotion and Education
30.	In the last 6 months, did you and anyone on your health care team talk about the exercise or physical activity you get?	Health Promotion and Education
31.	In the last 6 months, did you take any prescription medicine? (If no, go to Q34)	N/A
32.	In the last 6 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?	Care Coordination
33.	In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?	Stewardship of Patient Resources

Item #	Full CAHPS Questions Text	Summary Survey Measure (SSM) for Scored Items
34.	In the last 6 months, did anyone on your health care team ask you if there was a period of time when you felt sad, empty, or depressed?	Health Promotion and Education
35.	In the last 6 months, did you and anyone on your health care team talk about things in your life that worry you or cause you stress?	Health Promotion and Education
36.	In general, how would you rate your overall health?	Health Status and Functional Status (Not scored)
37.	In general, how would you rate your overall mental or emotional health?	Health Status and Functional Status (Not scored)
38.	In the last 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem? (If no, go to Q40)	N/A
39.	Is this a condition or problem that has lasted for at least 3 months?	Health Status and Functional Status (Not scored)
40.	Do you now need or take medicine prescribed by a doctor? (If no, go to Q42)	N/A
41.	Is this medicine to treat a condition that has lasted for at least 3 months?	Health Status and Functional Status (Not scored)
42.	What is your age?	N/A
43.	Are you male or female?	N/A
44.	What is the highest grade or level of school that you have completed?	N/A
45.	How well do you speak English?	N/A
46.	Do you speak a language other than English at home? (If no, go to Q48)	N/A
47.	What is the language you speak at home?	N/A
48.	Because of a health or physical problem, are you unable to do or have any difficulty bathing?	ADL (Not scored)
49.	Because of a health or physical problem, are you unable to do or have any difficulty dressing?	ADL (Not scored)
50.	Because of a health or physical problem, are you unable to do or have any difficulty eating?	ADL (Not scored)
51.	Because of a health or physical problem, are you unable to do or have any difficulty getting in or out of chairs?	ADL (Not scored)
52.	Because of a health or physical problem, are you unable to do or have any difficulty walking?	ADL (Not scored)
53.	Because of a health or physical problem, are you unable to do or have any difficulty using the toilet?	ADL (Not scored)
54.	Do you ever use the internet at home?	N/A
55.	Are you of Hispanic, Latino, or Spanish origin? (If no, go to Q57)	N/A
56.	Which group best describes you?	N/A

Item #	Full CAHPS Questions Text	Summary Survey Measure (SSM) for Scored Items
57.	What is your race? Mark one or more.	N/A
58.	Did someone help you complete this survey? (If no, end of survey)	N/A
59.	How did that person help you? Mark one or more.	N/A

N/A=Not applicable (not a part of an SSM). SSMs marked with “Not scored” do not impact CAHPS PY2023 scoring

Table C-3. Final High Needs Population CAHPS Questions and SSMs

Item #	Full CAHPS Text	Summary Survey Measure (SSM) for Scored Items
1.	Our records show that you visited the provider named below in the last 6 months [PROVIDER NAME]. Is that right? (If no, go to Q26)	N/A
2.	Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?	N/A
3.	How long have you been going to this provider?	N/A
4.	In the last 6 months, how many times did you visit this provider to get care for yourself? (If None, go to Q26)	N/A
5.	In the last 6 months, did you contact this provider’s office to get an appointment for an illness, injury or condition that needed care right away? (If no, go to Q7)	N/A
6.	In the last 6 months, when you contacted this provider’s office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	Getting Timely Care, Appts, Info
7.	In the last 6 months, did you make any appointments for a check-up or routine care with this provider? (If no, go to Q9)	N/A
8.	In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	Getting Timely Care, Appts, Info
9.	In the last 6 months, did you contact this provider’s office with a medical question during regular office hours? (If no, go to Q11)	N/A
10.	In the last 6 months, when you contacted this provider’s office during regular office hours, how often did you get an answer to your medical question that same day?	Getting Timely Care, Appts, Info
11.	In the last 6 months, did you contact this provider’s office with a medical question after regular office hours? (If no, go to Q13)	N/A
12.	In the last 6 months, when you contacted this provider’s office after regular hours, how often did you get an answer to your medical question as soon as you needed?	Getting Timely Care, Appts, Info
13.	In the last 6 months, how often did this provider explain things in a way that was easy to understand?	How Well Providers Communicate

Item #	Full CAHPS Text	Summary Survey Measure (SSM) for Scored Items
14.	In the last 6 months, how often did this provider listen carefully to you?	How Well Providers Communicate
15.	In the last 6 months, how often did this provider seem to know the important information about your medical history?	Care Coordination
16.	In the last 6 months, how often did this provider show respect for what you had to say?	How Well Providers Communicate
17.	In the last 6 months, how often did this provider spend enough time with you?	How Well Providers Communicate
18.	In the last 6 months, did this provider order a blood test, x-ray, or other test for you? (If no, go to Q20)	N/A
19.	In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?	Care Coordination
20.	In the last 6 months, did you and this provider talk about starting or stopping a prescription medication? (If no, go to Q22)	N/A
21.	When you and this provider talked about starting or stopping a prescription medicine, did this provider ask what you thought was best for you?	Shared Decision Making
22.	In the last 6 months, did you and this provider talk about how much of your personal health information you wanted shared with your family or friends?	Shared Decision Making
23.	Using any number from 0 to 10, where 0 is the worst number and 10 is the best provider possible, what number would you use to rate this provider?	Patient's Rating
24.	In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?	Courteous and Helpful Office Staff
25.	In the last 6 months, how often did the clerks and receptionists at this provider's office treat you with courtesy and respect?	Courteous and Helpful Office Staff
26.	Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, or doctors who specialize in one area of health care. Is the provider named in Question 1 of this survey a specialist?	N/A
27.	In the last 6 months, did you try to make any appointments with specialists? (If no, go to Q29)	N/A
28.	In the last 6 months, how often was it easy to get appointments with specialists?	Access to Specialists (Not scored)
29.	Your health care team includes all the doctors, nurses and other people you see for health care. In the last 6 months, did you and anyone on your health care team talk about a healthy diet and healthy eating habits?	Health Promotion and Education
30.	In the last 6 months, did you and anyone on your health care team talk about the exercise or physical activity you get?	Health Promotion and Education

Item #	Full CAHPS Text	Summary Survey Measure (SSM) for Scored Items
31.	In the last 6 months, did you take any prescription medicine? (If no, go to Q34)	N/A
32.	In the last 6 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?	Care Coordination
33.	In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?	Stewardship of Patient Resources
34.	In the last 6 months, did you have family or friends involved in your care? (If no, go to Q37)	N/A
35.	In the last 6 months, did this provider involve your family or friends in discussions about your health care as much as you wanted?	Family Support (Not scored)
36.	In the last 6 months, did your family members or friends get as much emotional support as they wanted from this provider?	Family Support (Not scored)
37.	In the last 3 months, did you have any feelings of anxiety or sadness? (If no, go to Q39)	N/A
38.	In the last 3 months, did you get as much help as you wanted for your feelings of anxiety or sadness?	Emotional Support (Not scored)
39.	In the last 3 months, did you have any pain? (If no, go to Q41)	N/A
40.	In the last 6 months, did this provider give you as much help as you wanted for your pain?	Pain (Not scored)
41.	Did someone from this provider's office ever talk with you about what you should do during a health emergency?	Health Emergency (Not scored)
42.	In general, how would you rate your overall health?	Health Status and Functional Status (Not scored)
43.	In general, how would you rate your overall mental or emotional health?	Health Status and Functional Status (Not scored)
44.	In the last 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem? (If no, go to Q46)	N/A
45.	Is this a condition or problem that has lasted for at least 3 months?	Health Status and Functional Status (Not scored)
46.	Do you now need or take medicine prescribed by a doctor? (If no, go to Q48)	N/A
47.	Is this medicine to treat a condition that has lasted for at least 3 months?	Health Status and Functional Status (Not scored)
48.	What is your age?	N/A
49.	Are you male or female?	N/A
50.	What is the highest grade or level of school that you have completed?	N/A
51.	How well do you speak English?	N/A

Item #	Full CAHPS Text	Summary Survey Measure (SSM) for Scored Items
52.	Do you speak a language other than English at home? (If no, go to Q54)	N/A
53.	What is the language you speak at home?	N/A
54.	Because of a health or physical problem, are you unable to do or have any difficulty bathing?	ADL (Not scored)
55.	Because of a health or physical problem, are you unable to do or have any difficulty dressing?	ADL (Not scored)
56.	Because of a health or physical problem, are you unable to do or have any difficulty eating?	ADL (Not scored)
57.	Because of a health or physical problem, are you unable to do or have any difficulty getting in or out of chairs?	ADL (Not scored)
58.	Because of a health or physical problem, are you unable to do or have any difficulty walking?	ADL (Not scored)
59.	Because of a health or physical problem, are you unable to do or have any difficulty using the toilet?	ADL (Not scored)
60.	Do you ever use the internet at home?	N/A
61.	Are you of Hispanic, Latino, or Spanish origin? (If no, go to Q63)	N//A
62.	Which group best describes you?	NA
63.	What is your race? Mark one or more.	N/A
64.	Did someone help you complete this survey? (If no, end of survey)	N/A
65.	How did that person help you? Mark one or more.	N/A

N/A=Not applicable (not a part of an SSM). SSMs marked with “Not scored” do not impact CAHPS PY2023 scoring

Appendix D – PY2021 and PY2022 Quality Strategy Information

Appendix D contains an overview of the information for the PY2021 and PY2022 GPDC quality strategy, including pay for reporting and performance, quality performance reporting, and worked examples of the final earn-back rate calculation for PY2022. Information in Appendix D came directly from the PY2022 Quality Measurement Methodology Report (QMMR). This Appendix refers to ‘Direct Contracting Entities’ or DCEs, rather than REACH ACOs; ‘DCE’ is only used when referring to PY2021 and PY2022 participants during those PYs. For complete/full details for PY2021 and 2022 refer to their respective year's QMMR located in the 4i Knowledge Library.

Pay-for-Reporting in PY2021 and PY2022

For **PY2021** and **PY2022**, performance on P4R components is binary: DCEs either get full credit for reporting (100% Component Quality Score) or no credit (0% Component Quality Score). Claims-based measures (including ACR, UAMCC, DAH, and TFU) are assessed as one combined P4R component (4% in PY2021, 2% in PY2022). This is because reporting of claims-based measures is derived from data in the CMS Integrated Data Repository.³⁸ As such, no action is required by DCEs to satisfy the reporting requirement for claims-based measures.

In **PY2021**, ACR and UAMCC were P4R for Standard and New Entrant DCEs, and ACR, UAMCC, and DAH were P4R for High Needs Population DCEs. All three measures (ACR, UAMCC, and DAH) are claims-based, thus all DCEs (regardless of DCE type) received credit for the 4% of the 5% Quality Withhold tied to reporting.

In **PY2022**, 4% out of the 5% Quality Withhold is again tied to reporting, however, CAHPS which was introduced in PY2022 now determines half, or 2%, of the 4% tied to reporting. For the remaining 2% tied to reporting, the measures are claims-based (including TFU, which was introduced for in PY2022 for Standard and New Entrant ACOs) and thus no action is required by DCEs to satisfy this component of the reporting requirement.

To satisfy the reporting requirement for CAHPS for PY2022, DCEs are responsible for selecting and contracting with a CMS-approved vendor to administer the CAHPS Survey. In fall 2021, CMS published information on DCEs’ CAHPS-related responsibilities and timelines in **The Innovation Center’s Knowledge Library**. DCEs needed to select and contract with their CAHPS vendor by July 2022.

For **PY2022**, CMS exempted DCEs from CAHPS if the DCE’s number of survey-eligible aligned beneficiaries was below the minimum number typically required for conducting a reliable CAHPS Survey. CMS directly notified exempted DCEs in the Spring of 2022 that they did not need to hire a CAHPS survey vendor for **PY2022**. Exempted DCEs may conduct the CAHPS Survey electively but CMS will not collect their CAHPS scores.

Pay for Performance in PY2021 and PY2022

In **PY2021** and **PY2022**, separate performance benchmarks are set for ACR and UAMCC (note: for High Needs Population DCEs, DAH is P4R only). DCEs meeting the performance benchmark for either ACR or UAMCC will earn back the full 1% of the Quality Withhold based on their performance. DCEs that did not

³⁸ The Integrated Data Repository is a high-volume data warehouse that integrates Parts A, B, C, and D and DME claims; beneficiary and provider data sources; and ancillary data such as contract information, risk scores, and more.

meet either of the performance benchmarks will have their Component Quality Score determined by a sliding scale and earn back a portion of the performance-based 1%.

Quality Performance Reporting in PY2021 and PY2022

For **PY2021**, GPDC QPBs were released in June 2022 and were based on a hybrid approach, combining historical and concurrent data from two discontinuous 12-month periods, the calendar years 2019 and 2021. The time frame was split to reflect a pre–coronavirus disease 2019 period and a post–coronavirus disease 2019 “surge” period, respectively. This decision was made because of the observed and expected effects of coronavirus disease 2019 on utilization and outcomes. Changes caused by the coronavirus disease 2019 pandemic have made it inappropriate to use data from the first half of 2020 for benchmarking. A DCE’s Final Earn-Back Rate for PY2021 will be determined during final settlement, which will occur in 2023.³⁹

For **PY2022**, CMS moved to using concurrent benchmarks, using all available and applicable Medicare FFS data from the same 12-month period as the performance year (i.e., January 1, 2022, to December 31, 2022). The use of concurrent benchmarks allows CMS to provide DCEs with provisional quality benchmarks in the PY2022 quarterly quality reports. The provisional quality benchmarks will be based on data from the reporting period for the respective quarter (e.g., for the Q1 PY2022 QQR, the provisional quality benchmark data provided are based on data from April 1, 2021 through March 31, 2022).

Worked Examples of the Final Earn-Back Rate Calculation for PY2022

Table D-1 shows calculations for a DCE that did NOT meet the 30th percentile benchmark threshold in **PY2022**. Please see the PY2022 QMMR available in the 4i Knowledge Base for more information regarding the sliding scale and its application to the P4P Component Quality Score when DCEs do not meet the 30th percentile benchmark on either ACR or UAMCC. **Table D-2** shows a DCE that did meet the 30th percentile benchmark threshold on at least one of ACR or UAMCC.

Table D-1. Final Earn-Back Rate Calculation, PY2022 example

(DCE that does NOT meet 30th percentile benchmark threshold)

Component	Component Quality Score	Component Weight
1. P4P: ACR and UAMCC	80%	1/5
2. P4R: ACR, UAMCC, TFU (for New Entrant and Standard DCEs), and DAH (for High Needs Population DCEs)	100%	2/5
3. P4R: CAHPS	100%	2/5
Total Quality Score	96.0%	
Eligible Earn-Back Rate	5%	
Final Earn-Back Rate	4.8%	

³⁹ For more detailed information regarding the PY2021 settlement process, see the PY2021 Financial Reconciliation Overview paper at <https://innovation.cms.gov/media/document/dc-model-financial-reconcil-guidance>.

Table D-2. Final Earn-Back Rate Calculation, PY2022 example*(DCE that meets 30th percentile benchmark threshold)*

Component	Component Quality Score	Component Weight
1. P4P: ACR and UAMCC	100%	1/5
2. P4R: ACR, UAMCC, TFU (for New Entrant and Standard DCEs), and DAH (for High Needs Population DCEs)	100%	2/5
3. P4R: CAHPS	100%	2/5
Total Quality Score	100%	
Eligible Earn-Back Rate	5%	
Final Earn-Back Rate	5%	