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

PY 2025 Quality Measurement Methodology Report

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Reference documents

The following documents can be found on the ACO REACH model web page under “Methodology Papers”:

ACO REACH Model PY 2025: Financial Operating Guide: Overview (PDF)
ACO REACH Model PY 2025: Capitation and Advanced Payment Mechanisms (PDF)
ACO REACH Model PY 2025: Financial Settlement Overview (PDF)
ACO REACH PY 2025 Participant and Preferred Provider Management Guide (PDF)
ACO REACH and KCC Models PY 2025: Rate Book Development (PDF)
ACO REACH and KCC Models PY 2025: Risk Adjustment (PDF)

Contents

Section **Page**

Overview **1**

1. Model Background: Context for Quality Approach **2**

1.1 Accountable Care Organization Realizing Equity, Access, and Community Health Model Overview ... 2

1.2 Types of REACH ACOs ... 2

1.3 Beneficiary Alignment ... 3

2. Quality Overview **4**

2.1 Quality Measures ... 4

2.2 Quality Withhold ... 5

2.3 Total Quality Score and Quality Withhold Earn Back ... 7

2.3.1 Initial Quality Score ... 7

2.3.2 Quality Performance Benchmarks Overview ... 7

2.3.3 Overview of Adjustments to the Initial Quality Score (1 of 2): Continuous Improvement/Sustained Exceptional Performance Criteria ... 7

2.3.4 Overview of Adjustments to the Initial Quality Score (2 of 2): Health Equity Data Reporting Adjustment ... 8

2.3.5 Calculating the Total Quality Score and the Quality Withhold Earn Back ... 9

2.4 HPP ... 9

2.5 Overview of Application of Quality Assessment to Final Financial Settlement ... 9

3. Quality Measures, Data Collection, and Performance Rate Calculations **11**

3.1 ACR ... 11

3.1.1 ACR Summary ... 11

3.1.2 ACR Denominator and Numerator Information ... 11

3.2 UAMCC ... 12

3.2.1 UAMCC Summary ... 12

3.2.2 UAMCC Denominator and Numerator Information ... 13

3.3 DAH ... 14

3.3.1 DAH Summary ... 14

3.3.2 DAH Denominator and Numerator Information 15
3.4 TFU 16
3.4.1 TFU Summary 16
3.4.2 TFU Denominator and Numerator Information 16
3.5 CAHPS 17
3.5.1 CAHPS Composite Score Description 17
3.5.2 Survey Administration and Procedures 18
3.5.3 CAHPS SSM Domains 19
3.5.4 CAHPS Denominator and Numerator Information 19
3.5.5 Calculation of CAHPS SSM Performance Rates 20
3.6 Quality Measure Resources 20

4. Quality Performance Scoring and Determination of Quality Withhold Earn Back 22

4.1 Creation of QPBs 22
4.1.1 Claims-Based Measure Benchmarks 22
4.1.2 CAHPS Benchmarks 22
4.2 Quality Measure Scoring for the Initial Quality Score 23
4.2.1 Claims-Based Measure Scoring 24
4.2.2 CAHPS Scoring 24
4.3 CI/SEP Criteria 26
4.3.1 Standardized Score Components 26
4.4 HEDR Adjustment 27
4.4.1 Required Data Elements 28
4.4.2 HEDR Adjustment Scoring Methodology 29
4.4.3 Data Submission 30
4.5 HPP 31
4.6 Application of Quality Assessment to Final Financial Settlement 31
4.6.1 Step 1. CMS Develops QPBs for Each P4P Measure 32
4.6.2 Step 2. Quality Measure Points Awarded: P4P Quality Measures Are Compared Against Their QPBs to Determine Performance Levels 33
4.6.3 Step 3. Calculate the Initial Quality Score 33
4.6.4 Step 4. Apply CI/SEP Multiplier 33
4.6.5 Step 5. The HEDR Adjustment Is Applied to Determine the Total Quality Score 34
4.6.6 Step 6. Total Quality Score Is Multiplied by the Quality Withhold to Determine a REACH ACO's Quality Withhold Earn Back 34

4.6.7 Step 6. *(PY 2024–PY 2026 only)* HPP Funds Are Distributed 34

5. Worked Examples of Quality Score Calculations 35

5.1 Worked Examples of the Final Earn-Back Rate Calculation for PY 2024–PY 2026 35

5.2 Worked Examples for PY 2025 35

5.2.1 High Needs Population ACO That Does NOT Meet CI/SEP Gateway Criteria.............. 35

Appendixes

A: Timelines for PY 2025 and PY 2024 A-1

B: Terminology List (selected) B-1

C: Sampling Methodology for the ACO REACH Consumer Assessment of Healthcare Providers and Systems (CAHPS) C-1

List of Acronyms

ACO	Accountable Care Organization
ACO REACH	Accountable Care Organization Realizing Equity, Access, and Community Health
ACR	Risk-Standardized All-Condition Readmission Measure
ADL	Activities of Daily Living
CAD	Coronary Artery Disease
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®
CCN	CMS Certification Number
CI/SEP	Continuous Improvement/Sustained Exceptional Performance
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
DAH	Days at Home for Patients with Complex, Chronic Conditions Measure
DCEs	Direct Contracting Entities, this terminology is only used when referring to PY 2021 and PY 2022 participants during those years
FFS	Medicare Fee-for-Service
GPDC	Global and Professional Direct Contracting
HEDR Adjustment	Health Equity Data Reporting Adjustment
HPP	High Performers Pool
ICD-10	International Classification of Diseases, Version 10
IP	Implementation Period
MIF	Measure Information Form
MIPS	Merit-Based Incentive Payment System
NGACO	Next Generation ACO
P4P	Pay-for-Performance
P4R	Pay-for-Reporting
PY	Performance Year
QPB	Quality Performance Benchmark
QMMR	Quality Measurement Methodology Report
REACH ACOs	Accountable Care Organizations participating in the ACO REACH Model in PY 2023 and subsequent years
RSAAR	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 Measure
TIN	Tax Identification Number
The Innovation Center	Center for Medicare & Medicaid Innovation
UAMCC	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions Measure
USCDI	United States Core Data for Interoperability

Overview

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 began on January 1, 2023, and runs through 2026. For completeness and context, this paper may refer to policies from Performance Year 2021 (PY 2021) and PY 2022 of the GPDC Model.

This Quality Measurement Methodology Report describes at a high level the quality approach for the duration of the model. It gives additional detail for PY 2025. It also 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 short summary of the ACO REACH Model and offers background on the quality strategy. **Section 2** gives a summary of the quality performance assessment process and how performance assessment will be applied in PY 2025 and other PYs of the ACO REACH model. **Section 3** has additional details on the design of the Quality Measures in use during PY 2025 of the ACO REACH Model. **Section 4** gives 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** offers worked examples of how the quality strategy is applied.

1. Model Background: Context for Quality Approach

1.1 Accountable Care Organization Realizing Equity, Access, and Community Health 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 redesign health care delivery system reform through the redesign of primary care. Through the ACO REACH Model, CMS aims to improve quality of care through better care coordination and reaching and connecting health care providers and beneficiaries, including those beneficiaries who are underserved.

CMS is leveraging 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 to 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. To measure this, the ACO REACH Model will include an assessment of quality during each PY using several Quality Measures.

The rest of **Section 1** briefly reviews several parts of the ACO REACH Model that affect 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]

1.2 Types of REACH ACOs

REACH ACOs can participate as one of three ACO types in PY 2025:

- **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.

[1] Financial specification papers, and FAQs are available at the bottom of the ACO REACH Model main page at https://www.cms.gov/priorities/innovation/innovation-models/aco-reach.

- **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 one used in the Programs of All-Inclusive Care for the Elderly.

CMS uses different Quality Performance Benchmarks (QPBs) for the High Needs Population ACOs and Standard and New Entrant ACOs. The benchmarking approach for claims-based measures is also different from the benchmarking approach for the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®). **Section 4.1** provides additional details on benchmarking.

1.3 Beneficiary Alignment

Eligible beneficiaries will be aligned to REACH ACOs via claims and voluntary alignment.[3] Before each PY starts, REACH ACOs have to meet minimum counts of beneficiary alignment (see **Table 1.1**). These minimum aligned beneficiary requirements impact the construction of QPBs, which vary by REACH ACO type and are discussed in **Section 4.1**. **Table 1.1** provides a summary of the minimum beneficiary alignment requirements by REACH ACO type. *These apply to all REACH ACOs regardless of when they began model participation.*

Table 1.1. Minimum Counts of Aligned Medicare FFS Beneficiaries Required by Year

REACH ACO Type	Minimum Aligned Medicare FFS Beneficiaries					
	PY 2021*	PY 2022	PY 2023	PY 2024	PY 2025	PY 2026
Standard	5,000	5,000	5,000	5,000	5,000	5,000
New Entrant	1,000	1,000	2,000	3,000	4,000	5,000
High Needs	250	250	500	750	1,000	1,250

* April–December 2021

ACO = Accountable care organization; FFS = Fee-for-service; PY = Performance year; REACH = Realizing Equity, Access, and Community Health

[2] Beneficiaries meet the High Needs criteria if they have one or more of the following: (1) Hierarchical Condition Category risk score ≥ 3.0 (for concurrent or prospective Aged and Disabled scores) or > 0.35 (for prospective End-Stage Renal Disease [ESRD] scores); (2) Hierarchical Condition Category 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; (4) signs of mobility impairment based on International Classification of Diseases, Version 10, Clinical Modification (ICD-10-CM) diagnosis codes, (5) qualified for and received skilled nursing and/or rehabilitation services in a SNF for a minimum of 45 days in the previous 12 months as determined by CMS, or (6) qualified for and received home health services for a minimum of 90 days in the previous 12 months as determined by CMS. More detailed information is available in the appendix of the ACO REACH Model PY 2024: Financial Operating Guide: Overview.

[3] Please see Appendix B: Beneficiary Alignment Procedures, found on page 34 of the ACO REACH Model PY 2024: 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. CMS expects REACH ACOs to meet goals for 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 assess quality performance during each PY using several Quality Measures. Performance on these measures will impact the PY Benchmark for Final Financial Settlement.[4] In PY 2025, 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 who are 66 years of age or 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—not in 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 (HTN), asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and diabetes. This measure will apply to **Standard and New Entrant ACOs** only. It was new to the model in PY 2022.

5. 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 also have questions about patient/caregiver experience with care delivered by a REACH ACO. The survey will 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 PY 2022. 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. These Quality Measures and timing are subject to change. Before each PY, CMS will provide quality guidance that informs REACH ACOs of any changes to the quality approach.

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[4] Materials that give 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.

Table 2.1. Summary Table of Quality Measures Used by Year

Measure	PY 2021	PY 2022	PY 2023	PY 2024	PY 2025	PY 2026	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

ACR = All-Condition Readmission; CAHPS = Consumer Assessment of Healthcare Providers and Systems; DAH = Days at Home; PY = Performance Year; REACH ACO = Realizing Equity, Access, and Community Health Accountable Care Organization; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

2.2 Quality Withhold

Table 2.2 shows how quality performance impacts Final Financial Settlement through the Quality Withhold for each model PY. In **PY 2024**, 2% of a REACH ACO's Financial Benchmark (the Quality Withhold) will be held "at risk."[5] A REACH ACO can earn part or all of it back, depending on how well it does 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
PY 2021*	5%	4%	1%
PY 2022	5%	4%	1%
PY 2023	2%	0%	2%
PY 2024	2%	0%	2%
PY 2025	2%	0%	2%
PY 2026	2%	0%	2%

* April–December 2021

PY = Performance year

[5] As shown in Table 2.2, the Quality Withhold was 5% in PY 2021 and PY 2022 and only 1% was tied to performance. Starting with PY 2023, CMS reduced the amount of the Quality Withhold to 2%, with the entire 2% being tied to performance.

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 PY 2024 and beyond, Quality Measures are equally weighted in how they affect the Initial Quality Score (see Section 2.3.1 for an explanation of the Initial Quality Score). Each measure determines one-quarter of the amount an ACO is eligible to earn back from their 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 ACOs[6]

PY	Quality Withhold	P4R	P4P
PY 2021	5%	▪ 4% = claims-based measures (ACR, UAMCC)	▪ 1% = Meet benchmark with either ACR or UAMCC
PY 2022	5%	▪ 2% = claims-based measures (ACR, UAMCC, TFU) ▪ 2% = CAHPS	▪ 1% = Meet benchmark with either ACR or UAMCC
PY 2023–PY 2026	2%	—	▪ 0.5% = ACR ▪ 0.5% = UAMCC ▪ 0.5% = TFU ▪ 0.5% = CAHPS

— = Not applicable.

ACR = All-Condition Readmission; CAHPS = Consumer Assessment of Healthcare Providers and Systems; DAH = Days at Home; P4R = Pay-for-Reporting; P4P = Pay-for-Performance; PY = Performance Year; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for patients with Multiple Chronic Conditions

Table 2.4. P4R and P4P Measures by PY: High Needs Population ACOs

PY	Quality Withhold	P4R	P4P
PY 2021	5%	▪ 4% = claims-based measures ▪ (ACR, UAMCC, DAH)	▪ 1% = Meet benchmark with either ▪ ACR or UAMCC
PY 2022	5%	▪ 2% = claims-based measures (ACR, UAMCC, DAH) ▪ 2% = CAHPS	▪ 1% = Meet benchmark with either ACR or UAMCC
PY 2023	2%	▪ 0.5% = CAHPS	▪ 0.5% = ACR ▪ 0.5% = UAMCC ▪ 0.5% = DAH
PY 2024–PY 2026	2%	—	▪ 0.5% = ACR ▪ 0.5% = UAMCC ▪ 0.5% = DAH ▪ 0.5% = CAHPS

— = Not applicable.

ACR = All-Condition Readmission; CAHPS = Consumer Assessment of Healthcare Providers and Systems; DAH = Days at Home; P4R = Pay-for-Reporting; P4P = Pay-for-Performance; PY = Performance Year; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for patients with Multiple Chronic Conditions

[6] 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.

CMS maintains the authority to revert measures from pay-for-performance (P4P) back to pay-for-reporting (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

To calculate a Total Quality Score (between 0% and 100% for each REACH ACO in each PY), 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 (see **Section 2.5.1**). CMS will then use the Total Quality Score to determine what portion of the 2% Quality Withhold the REACH ACO earns back when calculating its financial benchmark. For example, a Total Quality Score of 100% would result in a REACH ACO earning back the entire 2% Quality Withhold, while 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

In PY 2024 and beyond, there will be four Quality Measures, each worth 10 points, that CMS will use to calculate an ***Initial*** **Quality Score** for each REACH ACO. The Initial Quality Score is equal to the percentage of possible points (40) earned by the REACH ACO.

The Initial Quality Scores for **Standard and New Entrant ACOs** will be based on four P4P measures (ACR, UAMCC, TFU, and CAHPS).[7] Initial Quality Scores for **High Needs Population ACOs** will also be based on four P4P measures (ACR, UAMCC, DAH, and CAHPS).

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 to (1) determine the contribution to the Initial Quality Score of each P4P Quality Measure (out of 10 points); (2) assess the Exceptional Performance component of the CI/SEP criteria; and (3) determine which REACH ACOs are eligible for the High Performers Pool (HPP), which is discussed in **Section 2.4**. The benchmarks for Quality Measures for High Needs Population ACOs will be separate from the benchmarks for 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. **Section 4.1** has more detailed information about construction of the QPBs.

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

In PY 2025, all REACH ACOs will be 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 that is 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 have a multiplier of 0.5, cutting the Initial Quality Score in half. Aside from any HEDR adjustments (see **Section 2.3.4**), a REACH ACO with an Initial Quality Score of 80% that met the CI/SEP criteria would have a Total Quality Score of

[7] In PY 2021 and PY 2022, a REACH ACO's Total Quality Score was based on P4R and P4P. There are no P4R measures for PY 2025.

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%.

2.3.4 Overview of Adjustments to the Initial Quality Score (2 of 2): Health Equity Data Reporting 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 Health Equity Data Reporting (HEDR) Adjustment to determine the REACH ACO's Total Quality Score and final Quality Withhold Earn Back.

To monitor and evaluate the ACO REACH Model, starting in PY 2023, CMS began requiring all REACH ACOs to collect and submit certain beneficiary-reported demographic data for aligned beneficiaries with a minimum of 6 months of alignment during the PY. In PY 2024, CMS began requiring REACH ACOs to collect and submit data on social determinants of health (SDOH) reported by beneficiaries. The degree of completeness of reporting on this HEDR requirement will determine the HEDR Adjustment applied to each REACH ACO's Initial Quality Score.

Table 2.5 shows how the HEDR Adjustment might affect a REACH ACO's Initial Quality Score. CMS will not adjust an Initial Quality Score downward for the failure to report required data. Instead, REACH ACOs may earn an upward adjustment of up to five percentage points for reporting demographic data and an upward adjustment of up to five percentage points for reporting SDOH data, for a total bonus of up to 10 percentage points added to their Initial Quality Score. Please refer to **Table 2.5** for more details.

Table 2.5. Range of HEDR Adjustment Impact on Initial Quality Score by PY

PY	Demographic Data	SDOH Data
PY 2023	0 to 10 percentage point adjustment, based on proportion of aligned population for which data is reported	No impact (reporting optional)
PY 2024	0 to 5 percentage point adjustment, based on proportion of aligned population for which data is reported	0 to 5 percentage point adjustment, based on proportion of aligned population for which data is reported
PY 2025	0 to 5 percentage point adjustment, based on proportion of aligned population for which data is reported	0 to 5 percentage point adjustment, based on proportion of aligned population for which data is reported
PY 2026	0 to 5 percentage point adjustment, based on proportion of aligned population for which data is reported	0 to 5 percentage point adjustment, based on proportion of aligned population for which data is reported

HEDR = Health Equity Data Reporting; PY = Performance year; SDOH = Social determinants of health

Note: Effective Fall 2023, CMS revised the range of the HEDR Adjustment from a two-sided adjustment to upside only.

The HEDR Adjustment will be applied *after* the CI/SEP multiplier is applied (1.0 for REACH ACOs that meet the CI/SEP criteria or 0.5 for those that do not meet the CI/SEP criteria) to the Initial Quality Score. The resulting value is the Total Quality Score. Because the HEDR Adjustment will be applied after the CI/SEP multiplier, if a +10-percentage point HEDR Adjustment is achieved but the REACH ACO does not meet the CI/SEP criteria, the REACH ACO will still receive the full 10-percentage point adjustment (not 5 percentage points). 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.

Mathematically, 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-percentage point HEDR Adjustment will have a Total Quality Score of [80% x 1.0] + 4% = 84%.

Please note that beneficiary reporting of demographic and SDOH information is voluntary. REACH ACOs should not impose on the beneficiaries they serve any requirement to report such information or impose on their 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 about this requirement, including required data, data submission process and timing, and assessment of performance, is included in **Section 4.4**.

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

The Total Quality Score is calculated by taking the Initial Quality Score and applying the two adjustments described above, i.e., (1) the CI/SEP Multiplier and (2) the HEDR Adjustment.

To determine the Quality Withhold Earn Back, the Total Quality Score is multiplied by the 2% Quality Withhold. For example, a Total Quality Score of 100% would result in a REACH ACO earning back the entire 2% Quality Withhold, while a Total Quality Score of 50% would result in a REACH ACO earning back only half of the 2% Quality Withhold, or, in other words, 1% of their financial benchmark.

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%.

2.4 HPP

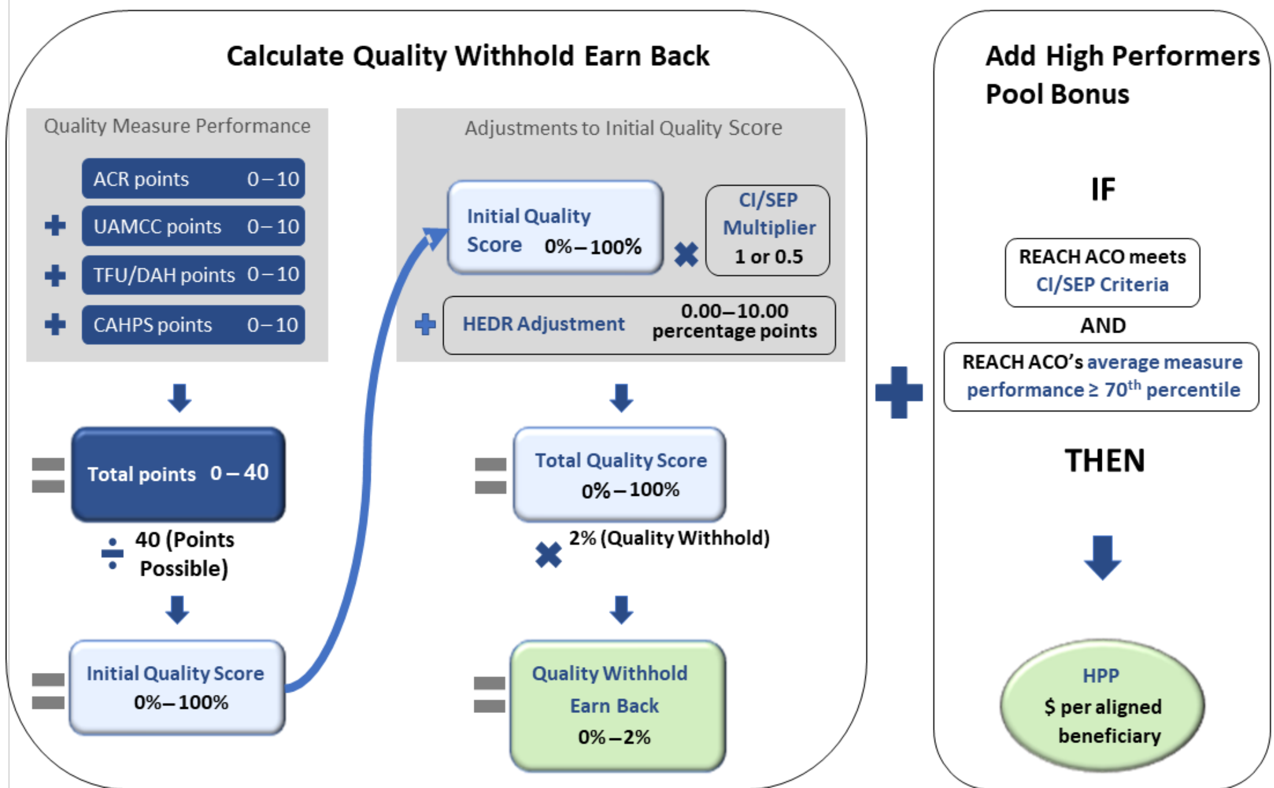
In **PY 2023–PY 2026**, REACH ACOs that meet the CI/SEP criteria and have an average percentile rank of 70% or more across all claims-based measures will be eligible to get additional funds from the HPP. The HPP provides an opportunity for a bonus payment based on quality performance or improvement. The HPP is funded by pooling the portions of the Quality Withhold that REACH ACOs that met the CI/SEP criteria did not earn back. For example, a REACH ACO that meets the CI/SEP criteria and reaches a Total Quality Score of 80% after factoring in the HEDR adjustment would earn back 80% of the 2% Quality Withhold, or 1.6% of the Financial Benchmark. The remaining Quality Withhold that was not earned back (0.4% of the REACH ACO's Financial Benchmark) would be put into 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. Because of this, the highest-performing REACH ACOs may earn back more than the total 2% Quality Withhold after Financial Settlement (for example, REACH ACOs that 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 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 calculates the Initial Quality Score. Second, the HEDR Adjustment 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 on the application of quality assessment to the Final Financial Settlement. See **Section 5** for worked examples.

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



ACR = All-Condition Readmission; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CI/SEP = Continuous Improvement/Sustained Exceptional Performance; DAH = Days at Home; HEDR = Health Equity Data Reporting; HPP = High Performers Pool; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

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

For PY 2025, CMS will measure quality of care for REACH ACOs using five measures (see **Table 2.1**). All REACH ACO types will use the ACR and UAMCC measures. Only High Needs Population REACH ACOs will use DAH, and only the Standard and New Entrant ACOs will use TFU. Measure Information Forms (MIFs) and Value Sets, which contain more detailed information for the four claims-based measures, are currently available in the 4i Knowledge Library. PY 2025 versions of these forms will be available in November 2024.

For PY 2025, the final Quality Measure scores will be based on a performance period that covers January 1, 2025, through December 31, 2025. Aligned beneficiaries with one or more alignment-eligible months during this performance period will be included in the Quality Measure calculations if they meet the Quality Measure inclusion criteria. The full 12-month performance period will be used for beneficiaries aligned at the beginning of the year.

3.1 ACR

3.1.1 ACR Summary

Description: Risk-adjusted percentage of hospitalizations of REACH ACO-assigned beneficiaries that result in an *unplanned* readmission to a hospital within 30 days following discharge from the index hospital admission.[8]

Measure Overview: ACR is an outcome measure calculated using 12 consecutive months of Medicare FFS claims data. The measure is a risk-standardized 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 CMS's Hospital-Wide (All-Condition) 30-Day Risk-Standardized Readmission Quality Measure.[9]

Rationale: Hospital readmissions are costly and often preventable.[10] They also disrupt 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 65 years of age or older at non-federal, short-stay acute care, or critical access hospitals.

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

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[8] An 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).

[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. doi:10.1056/NEJMsa0803563

[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.

1. Patient is enrolled in Medicare FFS.
2. Patient is actively aligned to a REACH ACO.
3. Patient is 65 years of age 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 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 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.
8. Admissions for non-claims-based-aligned patients who were voluntarily aligned after January 1, 2025.

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-quality care. Planned readmissions are identified using procedure and diagnosis codes.

3.2 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 or 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 CMS hospital RSAAR Quality Measure.

Rationale: Patients with multiple chronic conditions account for a significant proportion of Medicare beneficiaries; they experience high morbidity and costs associated with their diseases, and 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 diseases.[12,13,14,15,16,17] REACH ACO program goals are fully aligned with the objective of lowering patient risk of acute care admissions—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 66 years of age or older at the start of the measurement period with International Classification of Diseases, Version 10 (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) COPD 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 before 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 die or enter hospice during the measurement period are not excluded if they are continuously enrolled in Medicare Parts A and B until death or entering hospice (the 12-month requirement is relaxed for these beneficiaries).
3. Patients enrolled in hospice during the year before 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 providers associated with the attributed REACH ACOs during the measurement year and the year before the measurement year. Providers are linked to ACOs via Tax Identification Number (TIN) and National Provider ID combinations or CMS Certification Number (CCN) and National Provider ID combinations (see TIN and CCN definitions, Appendix B, Terminology List).
5. Patients not at risk for hospitalization at any time during the measurement year.
6. Non-claims-based-aligned patients who were voluntarily aligned after January 1, 2025.

Numerator Statement: Number of acute *unplanned* admissions per 100 person-years at risk for admission. Persons are considered at risk for admission if they are included in the denominator (as described above), alive, enrolled in

[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. doi:10.1377/hlthaff.2012.0393

[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. doi:10.1371/journal.pone.0075256

[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. doi:10.2337/diacare.22.12.2011

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-quality care. 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 REACH ACO.

3.3 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 spent at home or in community settings (in other words, not in acute care, such as inpatient hospital or emergent care settings, or post-acute settings, such as SNFs). The measure looks at 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. Another adjustment accounts for patients' risk of transitioning to a long-term nursing home supports community-based care, in alignment with 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 home differs substantially among older patients, which suggests that the quality of care and resulting days at home could be improved for the elderly population.[20,21]

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[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-Based Primary Care Interventions. Agency for Healthcare Research and Quality (US).

[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*. YNHHSC/CORE.

3.3.2 DAH Denominator and Numerator Information

Denominator Statement: Eligible beneficiaries aligned to participating REACH ACOs. Eligible beneficiaries must meet the following criteria:

1. Adult (18 years of age 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 to the start of the PY.
4. An average Hierarchical Condition Category composite risk score ≥ 2.0 in the year before the PY.

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

Denominator Exclusions: All patients meeting the denominator inclusion criteria are included, except for non-claims-based-aligned patients who were voluntarily aligned after January 1, 2025, who are excluded from the denominator.

Numerator Statement: The outcome measured for each eligible beneficiary is number of days spent "at home," adjusted for clinical and social risk factors, risk of death, and risk of transitioning to a long-term nursing home. DAH 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 in the measurement year when 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" (in other words, a patient will have no measured days in care if 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 lower quality of care; 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.

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, to encourage home- and community-based care in alignment with CMS' policy goals, this measure includes an adjustment that accounts for patients' risk of transitioning to a long-term nursing home.

3.4 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 for one of six conditions of interest, which can be attributed to providers participating in the model.

Measure Overview: This is a measure of provider follow-up for patients with chronic conditions who have experienced an acute exacerbation of hypertension, asthma, heart failure, CAD, COPD, or diabetes. Specifically, this measure examines follow-up that can be attributed to providers participating in the Innovation Center ACO REACH Model. Results of the measure are aggregated at the REACH ACO level. The Yale New Haven Health Services Corporation–Center for Outcomes Research & Evaluation respecified the TFU measure, which IMPAQ originally codified (Partnership for Quality Measurement #3455).

Rationale: Patients hospitalized or seen acutely in the emergency department and hospital outpatient departments for exacerbations of chronic conditions are at high risk of readmission and poorly coordinated care, which may increase health care spending, worsen health care outcomes, and result in poor quality of life. Evidence has shown that delivering clinically appropriate follow-up care and improving care coordination can improve health care outcomes, reduce readmissions, and reduce health care 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 health care. We expect the TFU measure will encourage model participants to improve care coordination and produce long-term savings for their health care systems.

3.4.2 TFU Denominator and Numerator Information

Denominator Statement: The count of the REACH ACO-level acute exacerbations that require either an emergency department visit, observation stay, or inpatient stay (in other words, the count of acute events) for any of the following eight condition cohorts: high-acuity CAD, high-acuity hypertension, asthma, HF, high-acuity diabetes, COPD, medium-acuity hypertension, and low-acuity CAD.

An acute encounter is assigned to one of the eight conditions if

- the primary diagnosis is a sufficient code for that condition or
- the primary diagnosis is a related code for that condition AND at least one additional diagnosis is a sufficient code for that condition.

For conditions with different levels of acuity, the encounter is then assigned to the highest-acuity condition for which a code is present.

If the acute encounter meets the criteria for more than one condition cohort, the encounter is assigned to the condition cohort with a higher follow-up priority in the following order: CAD, high-acuity diabetes, HF, asthma, high-acuity hypertension, medium-acuity hypertension, COPD, and low-acuity CAD.

If a beneficiary has an acute encounter that begins on the same or the following day of another acute encounter, the claims are considered part of one continuous acute event. If the acute encounters that make up an acute event are assigned to different condition cohorts, the acute event is assigned to the condition cohort that occurs last chronologically. Following this methodology, only one condition is recorded in the denominator per acute encounter.

Denominator Exclusions:

The measure excludes events with the following:

1. Subsequent acute events that occur 2 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 2 months for all the condition groups, except the low-acuity CAD group, which requires continuous enrollment of 3 months.
3. Acute events where the discharge status of the last claim is not "to community" (note: "Left against medical advice" is not considered a discharge to community).
4. Acute events for which the calendar year ends before the follow-up window ends (for example, 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.
6. Acute events for non-claims-based-aligned patients who were voluntarily aligned after January 1, 2025.
7. Acute events for patients who are participating in the Guiding an Improved Dementia Experience (GUIDE) Model.

Numerator Statement: The count of the REACH ACO-level denominator events (emergency room, observation hospital stays, or inpatient hospital stay) for acute exacerbations of hypertension, asthma, heart failure, 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. Heart failure: 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 time frame 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 (CPT) or Healthcare Common Procedure Coding System (HCPCS) 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 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. The questionnaire asks 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 is 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 adhere better to provider health care 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 that providers have given high-quality care;[25] furthermore, positive patient experience is associated with improved clinical outcomes[26,27] and reduced costs[28] in some settings. Thus, patient experience is a lever capable of not only providing our beneficiaries with a better experience—which itself is valuable—but also spurring long-term benefits in clinical outcomes, population health, and costs within the ACO REACH Model.

CMS measures patient experience by applying 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.

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 2024, CMS will publish information on REACH ACOs' CAHPS-related responsibilities and timelines in the **4i Knowledge Library** and on the **CMS ACO REACH website**. REACH ACOs will need to select and contract with their CAHPS vendor by July 2025. The **CMS ACO REACH Newsletter** will proactively notify REACH ACOs of all CAHPS information.

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

[23] Ratanawongsa, N., Karter, A. J., Parker, M. M., et al. (2013). Communication and medication refill adherence: The Diabetes Study of Northern California. *JAMA Internal Medicine, 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. *Social Science & Medicine, 68*(6), 1060-1068. doi:10.1016/j.socscimed.2008.12.033

[25] Cook, N., Hollar, L., Issac, E., Paul, L., Amofah, A., & Shi, L. (2015, December). Patient Experience in Health Center Medical Homes. *Journal of Community Health, 40*(6), 1155–1164 https://www.ncbi.nlm.nih.gov/pubmed/26026275

[26] Meterko, M., Wright, S., Lin, H., et al. (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., et al. (2011). Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *American Journal of Managed Care, 17*(1), 41–48.

[28] Anhang Price, R., Elliott, M. N., Zaslavsky, A. M., et al. (2014). Examining the role of patient experience surveys in measuring health care quality. *Medical Care Research and Review, 71*(5), 522–554. doi:10.1177/1077558714541480

The CAHPS for ACOs Survey uses mixed-mode data collection procedures. Sampled beneficiaries receive a pre-notification postcard via mail, 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. For additional information regarding CAHPS sampling methods, please refer to Appendix C.

3.5.3 CAHPS SSM Domains

The CAHPS measures are referred to as 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**.

Table 3.1. Experience of Care Summary Survey Measure Domains[29]

Summary Survey Measure	High Needs	Standard & New Entrants
Getting Timely Appointments, 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. Create a sample of beneficiaries from claims for primary care services among REACH ACO participating providers.
2. Send a survey to all sampled beneficiaries; follow up by telephone for nonresponse. This "mail with nonresponse telephone follow-up" survey methodology ensures enough responses to allow sufficient statistical precision to reliably distinguish between REACH ACOs.
3. Create the denominator from all beneficiaries who answered the survey questions.

Denominator Exclusions: The following beneficiaries are excluded from the CAHPS Measure:

1. Beneficiaries who received care in recent visits but are now deceased.
2. Beneficiaries who are less than 18 years of age.
3. Beneficiaries in institutions.

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

4. Beneficiaries receiving the hospice benefit.
5. Beneficiaries sampled for some other concurrent CAHPS surveys.
6. Beneficiaries residing outside the United States, Puerto Rico, or the Virgin Islands.
7. Beneficiaries who received less than two primary care service visits with a provider from the REACH ACO during the lookup period.
8. Beneficiaries who have a language or disability barrier that prevents them from completing the survey and do not have 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 enough beneficiaries with recent primary care visits for a reliable CAHPS Survey to be conducted.

Numerator Statement: We will assign values to survey questions included in each SSM; values will be based on patient responses and combined to calculate the SSMs. Each question 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 are collected, the scoring phase begins. We will use 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 the Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program except for Asian language, because we will not have an Asian-language survey. 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 whether another person helped the respondent complete the survey. For High Needs Populations, since no oversampling was done, we will not assign sampling weights. We will, however, investigate nonresponse to determine whether nonresponse-adjusted weights are necessary.

The patient-mix adjusters will remain the same each year. Using the CAHPS Macro, we will re-estimate the patient-mix adjuster coefficients each survey period.

3.6 Quality Measure Resources

Additional measure documentation will be made available each PY for further guidance and technical information. **Table 3.2** displays the forthcoming resources for REACH ACOs for PY 2025.

For detailed information on quality reports, please refer to Section 3 of the ACO REACH Reporting and Data Sharing Overview. This section provides a high-level summary of the list of reports and data feeds, along with the attributes of each report posted in the 4i Knowledge Library.

Table 3.2. Quality Measure Resources

Document	Measure Type	Description	Location
MIFs and Value Sets	Claims-based measures	▪ MIFs provide detailed descriptive information on each measure. ▪ Value sets contain corresponding lists of codes	▪ PY 2025 MIFs and Value Sets will be posted to 4i Knowledge Library in November 2024. ▪ PY 2021, PY 2022, PY ▪ 2023, and PY 2024 MIFs and Value Sets are currently available in 4i.
QPB Report	All P4P measures	▪ Basis for determining REACH ACO performance on P4P measures. ▪ Provides an overview of benchmark development and details benchmark threshold scores for each percentile.	▪ The PY 2025 QPB Report Release 1 CAHPS benchmarks will be released in March 2025. ▪ For the claims-based measures, provisional QPBs are included in each quarterly quality report.[30] ▪ The PY 2025 QPB Report Release 2 will contain final QPBs for the claims-based measures and will be released in June 2026.
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.	▪ Website: https://acoreachcahps.org ▪ Email: acoreachcahps@rti.org
PY 2021 and PY 2022 GPDC QMMRs	All REACH ACOs	▪ Guidance on the quality measurement and performance evaluation methodology for the DCEs participating in the GPDC Model. These documents focus on the quality measurement and reporting approach relevant for PY 2021 and PY 2022.	▪ PY 2021 GPDC QMMR ▪ PY 2022 GPDC QMMR
PY 2023 and PY 2024 ACO REACH QMMRs	All REACH ACOs	▪ Guidance on the quality measurement and performance evaluation methodology for the REACH ACOs participating in the ACO REACH Model. These documents focus on the quality measurement and reporting approach relevant for PY 2023 and PY 2024.	▪ PY 2023 ACO REACH QMMR ▪ PY 2024 ACO REACH QMMR

ACO = Accountable care organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; GPDC = Global and Professional Direct Contracting; MIF = Measure information form; P4P = Pay-for-Performance; PY = Performance year; QMMR = Quality Measurement Methodology Report; QPB = Quality Performance Benchmark

[30] Provisional QPBs in the QQRs are for informational purposes only. Final QPBs for PY 2025 will be released in June 2026 and will be based on claims data from the full calendar year of 2025.

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

4.1 Creation of QPBs

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 to (1) calculate the contribution to the Initial Quality Score of each P4P Quality Measure (out of 10 points); (2) assess the Exceptional Performance component of the CI/SEP criteria; and (3) determine eligibility for the HPP. There will be separate sets of QPBs for Standard and New Entrant ACOs combined, and for High Needs Population ACOs, and for each quality measure included in the ACO REACH Quality Strategy.

Starting in **PY 2023** through **PY 2026**, 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**.

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. CMS will use scores from both REACH ACOs and non–ACO REACH provider groups to create the QPB distributions for evaluating performance. CMS will use all available Medicare FFS data aggregated to individual TINs or CCNs to identify non–ACO REACH provider groups, like physicians, group practices, or hospitals.[31] It will also use the same rules used to align beneficiaries to REACH ACOs to align beneficiaries to non–ACO REACH provider groups. For High Needs Population ACOs, CMS will develop QPBs 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/New Entrant ACO QPBs, TINs and CCNs must have at least 1,000 aligned beneficiaries to be included in the QPB distribution. For the High Needs Population ACO Quality Benchmarks, TINs and CCNs must have at least 250 aligned beneficiaries who meet High Needs eligibility requirements. These requirements lessen potential concerns about differences between smaller TIN/CCN-level entities and REACH ACOs. These minimum aligned beneficiary counts for the QPBs are similar to minimum beneficiary thresholds for each REACH ACO type as applied in PY 2021 and PY 2022 (1,000+ beneficiaries for New Entrant ACOs and 250+ High Needs beneficiaries for High Needs Population ACOs).

4.1.2 CAHPS Benchmarks

4.1.2.1 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, CMS will pool entity-level data from this combined set of entities to create the SSM-specific QPB distribution and identify decile thresholds for scoring. CMS will then compare each Standard/New Entrant ACO's SSM scores to this set of decile thresholds.

For PY 2025, the Standard/New Entrant ACO CAHPS SSM-specific QPB distributions will be based on pooled data from MIPS, the Shared Savings Program from 2023, 2022, and 2021, and NGACO from 2021, combined with PY

[31] Note: The non–ACO REACH provider groups included in the QPB distribution could be participants in the Shared Savings Program or other Alternative Payment Models.

2024, PY 2023, and PY 2022 data for REACH ACOs. Before CAHPS data collection in PY 2025 begins, CMS will provide the PY 2025 CAHPS QPBs to participants. **Table 4.1** shows the data sources and performance years included in the Standard/New Entrant ACO CAHPS SSM benchmarks for PY 2023 through PY 2026. Three years of data from ACO REACH will be used for the QPBs for PY 2025 and PY 2026.

Table 4.1. Data Sources and Time Periods for ACO REACH CAHPS QPBs for Standard/New Entrant ACOs

Data Source	PY 2023 ACO REACH CAHPS Benchmark, Comprising Performance Scores from:	PY 2024 ACO REACH CAHPS Benchmark Comprising Performance Scores from:	PY 2025 ACO REACH CAHPS Benchmark, Comprising Performance Scores from:	PY 2026 ACO REACH CAHPS Benchmark Comprising Performance Scores from:
REACH ACOs	PY 2022	PY 2022 PY 2023	PY 2022 PY 2023 PY 2024	PY 2023 PY 2024 PY 2025
MIPS (includes ACOs from the Medicare Shared Savings Program; and the Next Generation ACO Model through 2021)	PY 2019 PY 2021	PY 2019 PY 2021 PY 2022	PY 2021 PY 2022 PY 2023	PY 2022 PY 2023 PY 2024

ACO = Accountable care organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; MIPS = Merit-Based Incentive Payment System; PY = Performance year; QPB = Quality Performance Benchmark; REACH = Realizing Equity, Access, and Community Health

4.1.2.2 CAHPS QPBs for High Needs Population ACOs

The QPBs used for scoring will be based on entity-level patient mix–adjusted data from the Medicare Shared Savings Program, NGACO, and MIPS for 2023, 2022, and 2021, combined with the PY 2024, PY 2023, and PY 2022 CAHPS scores for High Needs Population ACOs. **Table 4.2** shows the data sources and performance years included in the High Needs Population ACO CAHPS SSM benchmarks for PY 2025 through PY 2026. CMS will use 2 years of data from ACO REACH for the QPBs for PY 2024 and 3 years of data for PY 2025 and PY 2026.

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 calculates how many points a REACH ACO has earned for each measure. An ACO can earn up to 10 points on each measure. There are four measures for each ACO that make up a total of 40 points: three claims-based measures and the composite CAHPS measure, which combines all eight CAHPS SSMs.

A REACH ACO earns points for each measure based on how it performs compared to measure-specific QPBs. In PY 2024 and beyond, 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 toward the total number of points possible. Likewise, CAHPS requires a REACH ACO to meet a minimum number of surveyable beneficiaries before it can proceed with the survey (see **Appendix C**). Any ACO that does not meet these thresholds will be exempt from CAHPS. The total number of quality points possible for a REACH ACO that is exempt from CAHPS will be 30; that is, 10 points for each claims-based measure. REACH ACOs that are *not* exempt from the requirement to administer a CAHPS survey but do not administer the survey and/or do not transmit any data to CMS will earn zero points out of 10 for CAHPS.

Table 4.2. Data Sources and Time Periods for ACO REACH CAHPS QPBs for High Needs Population ACOs

Data Source	PY 2024 ACO REACH CAHPS Benchmark Comprising Performance Scores from:	PY 2025 ACO REACH CAHPS Benchmark Comprising Performance Scores from:	PY 2026 ACO REACH CAHPS Benchmark Comprising Performance Scores from:
REACH ACOs	PY 2022 PY 2023	PY 2022 PY 2023 PY 2024	PY 2023 PY 2024 PY 2025
MIPS (includes ACOs from the Medicare Shared Savings Program; and the Next Generation ACO Model through 2021)	PY 2019 PY 2021 PY 2022	PY 2021 PY 2022 PY 2023	PY 2022 PY 2023 PY 2024

ACO = Accountable care organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; PY = Performance year; QPB = Quality Performance Benchmark; REACH = Realizing Equity, Access, and Community Health

Note: CAHPS data from MIPS will be restricted to responses from beneficiaries who meet the High Needs criteria.

To figure out the Initial Quality Score, CMS will calculate the percentage of points earned from all measures divided by the total points possible (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 4.3 presents the distribution of points (out of 10) awarded for each claims-based quality measure. This is 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**). If a REACH ACO's quality score falls below the 30th percentile benchmark, CMS awards zero points for a measure. As shown in the table, REACH ACOs that meet the 30th percentile benchmark receives 7.5 points; the points awarded increase at 5 percentile increments until the 90th percentile, where the full 10 points are awarded for the measure.

Table 4-3. 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 Composite Score accounts for 10 points out of the total 40 possible points awarded based on quality measure performance used to determine a REACH ACO's Initial Quality Score. A REACH ACO's performance on the eight SSMs listed in **Section 3.5.3** determines how many of the 10 possible points for CAHPS it earns.

4.2.2.1 SSM Scoring Against Benchmarks

To arrive at the final number of points—out of 10—that a REACH ACO will be awarded for its CAHPS performance, CMS first needs to roll up a REACH ACO's performance on the separate SSMs into a single summary number referred to as the "CAHPS Composite Score."

A REACH ACO can earn 10 SSM points for each SSM, up to 80 total SSM points. To figure out the allocation of points, CMS compares the REACH ACO's SSM performance against a QPB distribution. **Table 4.4** shows the SSM points awarded at each benchmark threshold. As with the scoring system for claims-based measures, there are no SSM points awarded for SSM scores that fall below the 30th percentile benchmark.

Table 4.4. 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

CAHPS = Consumer Assessment of Healthcare Providers and Systems; SSM = Summary survey measure

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

The process of determining the 10 SSM points for each SSM for Standard/New Entrant ACOs is similar to the one for the claims-based measures. Each REACH ACO will receive between zero and 10 SSM points for each SSM. The proportion of 80 possible SSM points earned by the REACH ACO determines the final CAHPS Composite Score. This CAHPS Composite Score is multiplied by 10 to determine the number of CAHPS points earned out of 10 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 toward the numerator of the Initial Quality Score.

4.2.2.3 High Needs Population ACOs Scoring and Final CAHPS Composite Score Construction

CAHPS performance rates for High Needs Population ACOs are calculated using survey response data pooled from the current and prior performance year. In PY 2024, CMS began to use the same methodology for CAHPS scoring and final CAHPS Composite Score Construction for the High Needs Population ACOs as is used for the Standard and New Entrant ACOs. Using this method, each REACH ACO receives between zero and 10 SSM points for each SSM. The proportion of 80 possible SSM points earned by the REACH ACO determines the final CAHPS Composite Score. The CAHPS Composite Score is multiplied by 10 to determine the number of CAHPS points earned and is included in the ACO's Initial Quality Score calculation.

4.2.2.4 The Impact of Unscored SSMs on the CAHPS Composite Score

For a given Standard/New Entrant or High Needs Population 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 have 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 CI/SEP Criteria

In **PY 2023–PY 2026**, the CI/SEP criteria will determine the value of the CI/SEP multiplier applied to the Initial Quality Score.[32] Note: This step comes before the HEDR Adjustment is applied. 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, before factoring in the HEDR Adjustment, would be 1%.

In PY 2025, 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 compares performance in the current PY with the prior year. CMS will use the following steps used to determine whether a REACH ACO meets the CI/SEP criteria in PY 2025:

1. Continuous Improvement: CI/SEP points are awarded for each claims-based quality measure based on statistically significant change from PY 2024 to PY 2025:
    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 PY 2024 and PY 2025. In other words, if a REACH ACO has a statistically significant decline in UAMCC from PY 2024 to PY 2025 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 added up 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 (that is, the REACH ACO must show 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 zero.

4.3.1 Standardized Score Components

Standardized score components will be used as part of the evaluation of the continuous improvement for the CI/SEP criteria. The COVID-19 pandemic has shown that external events that influence utilization rates may also affect quality measure scores based on utilization, such as UAMCC and ACR. The shift to concurrent benchmarking is one step that addresses this concern but, by definition, the continuous improvement component of the CI/SEP

[32] In PY 2023, CI/SEP and HPP did not apply to PY 2023 starters. CI/SEP and HPP apply to all REACH ACOs from PY 2024 to PY 2026.

criteria compares quality measure performance from two periods. Thus, the determination of continuous improvement is based on standardized score components (except for 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). Usually, these components are 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 to determine continuous improvement.

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

- For a given measure, if the 95% confidence intervals from PY 2024 and PY 2025 overlap for a particular REACH ACO, the change for that REACH ACO is not considered statistically significant.
- UAMCC and ACR are reverse-scored measures (that is, higher scores indicate poorer performance) for:
  - Non-overlapping 95% confidence intervals with *lower* scores in PY 2025 indicate statistically significant improvement;
  - Non-overlapping 95% confidence intervals with *higher* scores in PY 2025 indicate statistically significant decline in performance.
- For DAH and TFU:
  - Non-overlapping 95% confidence intervals with *higher* scores in PY 2025 indicate statistically significant improvement;
  - Non-overlapping 95% confidence intervals with *lower* scores in PY 2025 indicate statistically significant decline in performance.

4.4 HEDR Adjustment

As noted in **Section 2.3.4**, for the purpose of monitoring and evaluating the ACO REACH Model, CMS began requiring all REACH ACOs in PY 2023 to collect and submit certain beneficiary-reported demographic data for

[33] Because the SEP 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.

[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.

aligned beneficiaries. In PY 2024, CMS began requiring REACH ACOs to collect and submit certain beneficiary-reported SDOH data. Performance on this HEDR requirement, based on reporting completeness, will result in a HEDR Adjustment applied to each REACH ACO's Initial Quality Score. The following subsections cover 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. For PY 2023 and beyond, CMS requires the reporting of demographic data elements from USCDI V2. Reporting of these data elements for aligned beneficiaries will contribute 0% to 5% of the to the potential upward HEDR Adjustment. **Table 4.5** includes all data elements included in the demographic component of the HEDR requirement. For additional details, please refer to the ACO REACH HEDR Implementation Guide, which can be accessed on 4i (only accessible to ACOs). REACH ACOs will be notified of updates to the HEDR Implementation Guide via the REACH ACO Newsletter.

Table 4.5. Data Elements for the Demographic Component of the HEDR Requirement

Data Element	Required for HEDR Adjustment Credit?	Source
Preferred language	No	USCDI V1 and V2
Beneficiary race	Yes	USCDI V1 and V2
Beneficiary ethnicity	Yes	USCDI V1 and V2
Sexual orientation	No	USCDI V2
Gender identity	No	USCDI V2

CMS = Centers for Medicare & Medicaid Services; HEDR = Health Equity Data Reporting; PY = Performance year; USCDI = United States Core Data for Interoperability.

Note: Effective November 2023, the table above reflects a clarification regarding optional and required fields under the ACO REACH model, for the life of the model.

SDOH data: CMS permits 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

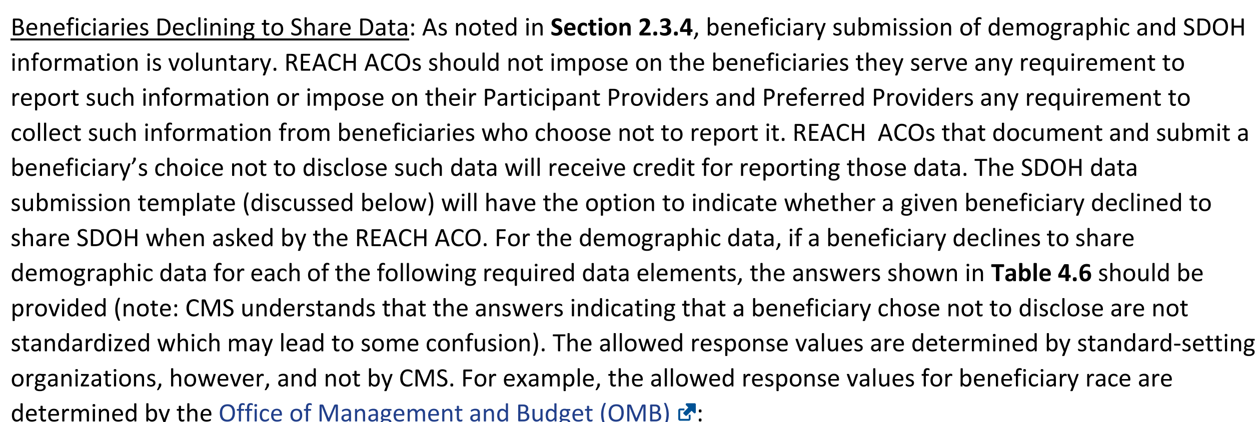
REACH ACOs and their contracted providers may choose to collect beneficiary-level SDOH data using one or all three of the SDOH screening tools. However, only one screening tool should be used to record responses from a given beneficiary. All responses collected from a single beneficiary must come from a single screening tool. While different screening tools may be used for different beneficiaries within a REACH ACO or a contracted provider's panel, REACH ACOs and their contracted providers cannot use questions from different screening tools to collect responses from a single beneficiary.

If any updates are made to the current demographic and SDOH templates, CMS will publish an updated version of this document with those changes, along with a revision to the HEDR Implementation Guidance and submission template.

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 PY 2023, the REACH ACO may submit the same data to receive credit for the HEDR requirement in PY 2024, PY 2025, and PY 2026. A REACH ACO that collected beneficiary-reported demographic data prior to participation in the ACO REACH Model may use those data so long as they can be mapped to valid values in the demographic and SDOH templates.

Due to the dynamic nature of SDOH data, CMS requires REACH ACOs to collect beneficiary-reported data on an annual basis to receive credit for reporting SDOH data. CMS will require REACH ACOs to include the date on which the SDOH data were collected when reporting to CMS. If a REACH ACO collects SDOH data from a given beneficiary in August of PY 2024, the REACH ACO may submit those data for credit toward the HEDR Adjustment in PY 2024. To receive credit toward the HEDR Adjustment for SDOH data in PY 2025, the REACH ACO must recollect SDOH data from the same beneficiary in PY 2025. Data submitted with a collection date outside of the PY will not count for credit toward 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. REACH ACOs should not impose on the beneficiaries they serve any requirement to report such information or impose on their 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 those 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 answers shown in **Table 4.6** 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 4.6. 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

ACO = accountable care organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; REACH = Realizing Equity, Access, and Community Health

4.4.2 HEDR Adjustment Scoring Methodology

REACH ACOs will be able to receive partial credit toward the HEDR Adjustment. CMS will calculate two HEDR Reporting Rates, one for the demographic data reported and the other for the SDOH data reported. These reporting rates will be calculated the same way, 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 which 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, 2025, will be pre-populated in the HEDR submission templates. ACOs will be 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 for PY 2025 that will be conducted in April 2026. If after the final eligibility checks, a beneficiary has less than 6 months of alignment as of October 1, 2025, the beneficiary will be excluded from both the calculations of the demographic and SDOH HEDR Reporting Rates. No beneficiaries will be added to either HEDR Reporting Rate based on final eligibility checks.

CMS' 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. To calculate the final HEDR Adjustment, each of the Reporting Rates will be multiplied by the maximum adjustment in **Table 2.5**. In PY 2025, this maximum adjustment remains 5 percentage points for demographic data and 5 percentage points for SDOH data. The final HEDR Adjustment will be the sum of an ACO's Demographic Reporting Rate multiplied by 5, plus their SDOH Reporting Rate multiplied by 5. For example, a REACH ACO with a Reporting Rate of 40% for demographic data and 20% for SDOH data in PY 2025 will receive a HEDR Adjustment of [40% * 5%] + [20% * 5%] = 3%. In other words, this ACO will have 3 percentage points added to their Total Quality Score as their HEDR Adjustment.

4.4.3 Data Submission

Format: For PY 2025, REACH ACOs must report demographic and SDOH data to CMS using CMS-provided Excel templates. Note: there are separate templates for demographic data and SDOH data submission. These templates are available to REACH ACOs via the 4Innovation System (4i) Knowledge Library: https://4innovation.cms.gov/secure/knowledge-management/view/1302.

For each beneficiary included in the demographic data submission template, all columns corresponding to required data elements listed in **Table 4.5** should be completed. Please 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 (Accountable Health Communities' Health-Related Social Needs Screening Tool, North Carolina SDOH Screening Tool, or National Association of Community Health Centers' Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences Screening Tool) should be populated, unless the beneficiary chooses not to disclose, which should be indicated in a relevant column. The following two required SDOH data elements must be completed for all beneficiaries regardless of which screening tool is used: (1) date the SDOH assessment was completed or declined, and (2) assessment declined (Yes or No).

Additionally, for future PYs, CMS may establish 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 once this functionality has been finalized.

Timing and Process: For PY 2025, SDOH data must be collected during the ACO REACH Model PY for beneficiaries with at least 6 months' experience in the PY. ACOs will submit completed data submission templates to CMS during pre-established submission windows for each PY. CMS will communicate the submission window to REACH ACOs once it is established for each PY.

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 PY, CMS will use only the most recently uploaded template. When submitting data for a given PY, REACH ACOs must submit a full replacement file that includes all available data on all aligned beneficiaries for the PY. CMS will provide a response file for each submitted template to identify which beneficiaries' data were successfully reported. If the data were not successfully reported, CMS will provide a response file with the source of any errors so that the REACH ACO may correct them in subsequent template submissions.

4.5 HPP

In PY 2025, 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]

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. The steps to determine whether a REACH ACO gets one of these bonus payments are below:

1. Determine HPP total fund amount ($): Sum of Quality Withholds not earned back by all REACH ACOs that meet the CI/SEP criteria.
2. Apply HPP eligibility criteria: CMS determines which REACH ACOs meet the HPP criteria. This includes those that (1) meet the CI/SEP criteria and (2) have an average percentile rank of at least 70% across all Quality Measures in PY 2025.
3. Count total number of HPP beneficiary-months: CMS adds the number of aligned beneficiary-months across each REACH ACO that meets the HPP criteria (this includes Standard and New Entrant ACOs and High Needs Population ACOs).
4. Determine HPP per beneficiary per month (PBPM) bonus rate ($): CMS divides the HPP total fund amount (from Step 1) by the total number of HPP beneficiary-months (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 PBPM bonus rate (from Step 4) multiplied by the REACH ACO's number of model eligible months across aligned 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 PY 2025 as an example. The steps are:

1. CMS develops QPBs for each P4P measure.
2. 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).
3. The Initial Quality Score is calculated as the percentage of points earned from all measures out of the total possible points (40).
4. CI/SEP criteria are assessed to determine the CI/SEP multiplier, either 1.0 or 0.5, used to adjust the Initial Quality Score. The Initial Quality Score of a REACH ACO that does not meet the CI/SEP criteria will be multiplied by 0.5; the modifier is 1.0 for a REACH ACO that meets the CI/SEP criteria, resulting in no change to the Initial Quality Score.

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

5. The Total Quality Score is adjusted based on the HEDR bonus. In PY 2025, the HEDR bonus is an adjustment between 0 and 10 percentage points added to the Total Quality Score. For PY 2025, the HEDR adjustment has two components: ACOs can earn up to 5 percentage points added to their Total Quality Score based on their demographic reporting, and up to an additional 5 percentage points based on their reporting of SDOH data. The HEDR adjustment is based on the sum of the demographic reporting rate multiplied by 5% plus the SDOH reporting rate multiplied by 5%. (See Section 4.4.2 for an example calculation). The Total Quality Score is capped at 100%.
6. After the CI/SEP and HEDR adjustments, CMS multiplies the final Total Quality Score by the 2% Quality Withhold to determine the Quality Withhold Earned Back.
7. 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 QPBs for Each P4P Measure

In **PY 2025**, all Quality Measures will be P4P for Standard and New Entrant ACOs and High Needs Population ACOs. To determine performance levels for each REACH ACO, CMS compares 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. Standard and New Entrant ACOs and High Needs Population ACOs will have separate QPBs for the claims-based measures and CAHPS.

Historically, CMS has released QPBs for claims-based measures in other models before the start of a given PY. However, because of observed and anticipated changes in utilization and outcomes resulting from COVID-19, CMS is taking a different approach for ACO REACH quality performance benchmarking for the claims-based measures used in the model. **For PY 2023 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 4.7 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 4.7** illustrates a hypothetical example. **These are NOT the final QPBs** 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.

Table 4.7. Hypothetical QPBs for ACR and UAMCC for Comparison with Standard and New Entrant ACO Measure Scores

Percentile	**30th**	**35th**	**40th**	**45th**	**50th**	**55th**	**60th**	**65th**	**70th**	**75th**	**80th**	**85th**	**90th**
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

ACR = All-condition readmission; QPB = Quality Performance Benchmark; TFU = Timely Follow-Up; UAMCC = All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

One benefit of the shift to using 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 (for example, April 1, 2024–March 31, 2025, for PY 2025 Q1). CMS will update the provisional QPBs 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 PY 2025 will be based, for the claims-based measures, on official QPBs calculated using data from calendar year 2025 and will be determined during final settlement in 2026.

For PY 2025, the Standard/New Entrant ACO CAHPS QPB distributions will be based on pooled data from 2023, 2022, and 2021 for MIPS, Shared Savings Program, and NGACOs combined with PY2024, PY 2023, and PY 2022 Data for Standard/New Entrant ACOs. CAHPS will be P4P for High Needs Population ACOs, with QPB distributions based on PY 2022, PY 2023, and PY 2024 High Needs Population ACO data combined with pooled data from 2023, 2022, and 2021 for MIPS, Shared Savings Program, and NGACOs restricted to responses from beneficiaries who meet the High Needs criteria.

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 or High Needs Population ACOs in PY 2025.

P4P Measures: Each Quality Measure will be worth 10 points. Standard and New Entrant ACOs and High Needs Population ACOs can earn up to 40 points based on four P4P measures. CMS will use the QPBs to determine the number of points each REACH ACO will earn for each P4P Quality Measure. 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 percentage of total possible points earned across all measures. There are four Quality Measures (CAHPS, ACR, UAMCC, and DAH/TFU). Each measure is worth 10 points, with 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 (in other words, 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 zero. 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 PY 2025, REACH ACOs may receive a bonus added to the Initial Quality Score for submitting beneficiary-reported demographic and SDOH data—between +0% and +5% based on the proportion of beneficiaries for whom demographic reporting is complete and between +0% and +5% based on the proportion of beneficiaries for whom SDOH 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 and SDOH 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 and SDOH 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 that REACH ACO completes reporting of demographic data on 90% of eligible beneficiaries and reporting of SDOH data on 80% of eligible beneficiaries, its Total Quality Score with the HEDR Adjustment will be 38% + 4.5% (for demographic data) + 4% (for SDOH data) = 46.5%.

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 **PY 2023–PY 2026**, CMS will calculate the Quality Withhold Earn Back 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. *(PY 2024–PY 2026 only)* HPP Funds Are Distributed

In PY 2023 and beyond, REACH ACOs are eligible for a PBPM bonus payment from the HPP funds if they meet the CI/SEP criteria and their average measure percentile rank is at least in 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 on the HPP.

5. Worked Examples of Quality Score Calculations

The following subsections provide worked examples of selected scenarios for PY 2025 and subsequent PYs.

5.1 Worked Examples of the Final Earn-Back Rate Calculation for PY 2024–PY 2026

From PY 2023 through PY 2026, 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 all REACH ACOs. 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 claims-based measure score rank of at least the 70th percentile will be eligible for a bonus payment from the HPP on a per-beneficiary basis.

5.2 Worked Examples for PY 2025

5.2.1 High Needs Population ACO That Does NOT Meet CI/SEP Gateway Criteria

Table 5.1 shows calculations for a hypothetical High Needs Population ACO that did not meet the CI/SEP Gateway, had a 50% demographic reporting rate for HEDR, and had a 50% SDOH reporting rate.

Table 5.1. Final Earn-Back Rate Calculation, PY 2025 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	9.25	10.0
3. P4P: DAH (High Needs Population ACOs Only)	8.5	10.0
4. P4P: TFU (Standard/New Entrant Only)	N/A	N/A
5. P4P: CAHPS	10.0	10.0
Total Points	35.25	40.0
<u>Initial Quality Score (0%–100%)</u> Points earned/points possible * 100	88.125%	
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	
Adjustments to Total Quality Score: <u>HEDR Adjustment</u> 0 to 10 percentage point bonus based on: ($\text{Reporting Rate}_{Demographic}$ * 5%) + ($\text{Reporting Rate}_{SDOH}$ * 5%) *Assuming a reporting rate of 50% of eligible beneficiaries for both SDOH and demographic HEDR data* *0.5 * 5 + 0.5 * 5*	5	
<u>Total Quality Score (0%–100%)</u> (Initial Quality Score * CI/SEP Multiplier) + HEDR *88.125 * 0.5 + 5*	49.063%	
Impact on Financial Settlement: <u>Quality Withhold Earned Back (0%–2%)</u> Total Quality Score * 2% Quality Withhold *49.063% * 2%*	0.981% of the financial benchmark	
Impact on Financial Settlement: <u>HPP Bonus</u> Must meet CI/SEP criteria AND have average quality measure performance ≥ 70th 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) 90.0 percentile or better performance on all eight SSMs for a full 10 points for each SSM and a total of 80 out of 80 possible CAHPS SSM points earned; (5) the REACH ACO had 628 aligned beneficiaries with at least 6 months of eligibility and reported complete demographic data on 50% (314) of them and complete SDOH data on the same proportion (50%); and (6) the REACH ACO did not meet the CI/SEP criteria and is also therefore not eligible for the HPP bonus.

5.2.2 Standard ACO That Meets CI/SEP Gateway Criteria

Table 5.2 shows calculations for a hypothetical Standard ACO that did meet the CI/SEP Gateway, had a 100% demographic reporting rate for HEDR, and had an 80% SDOH reporting rate.

Table 5.2. Final Earn-Back Rate Calculation, PY 2025 Example—Standard ACO Meets CI/SEP Gateway

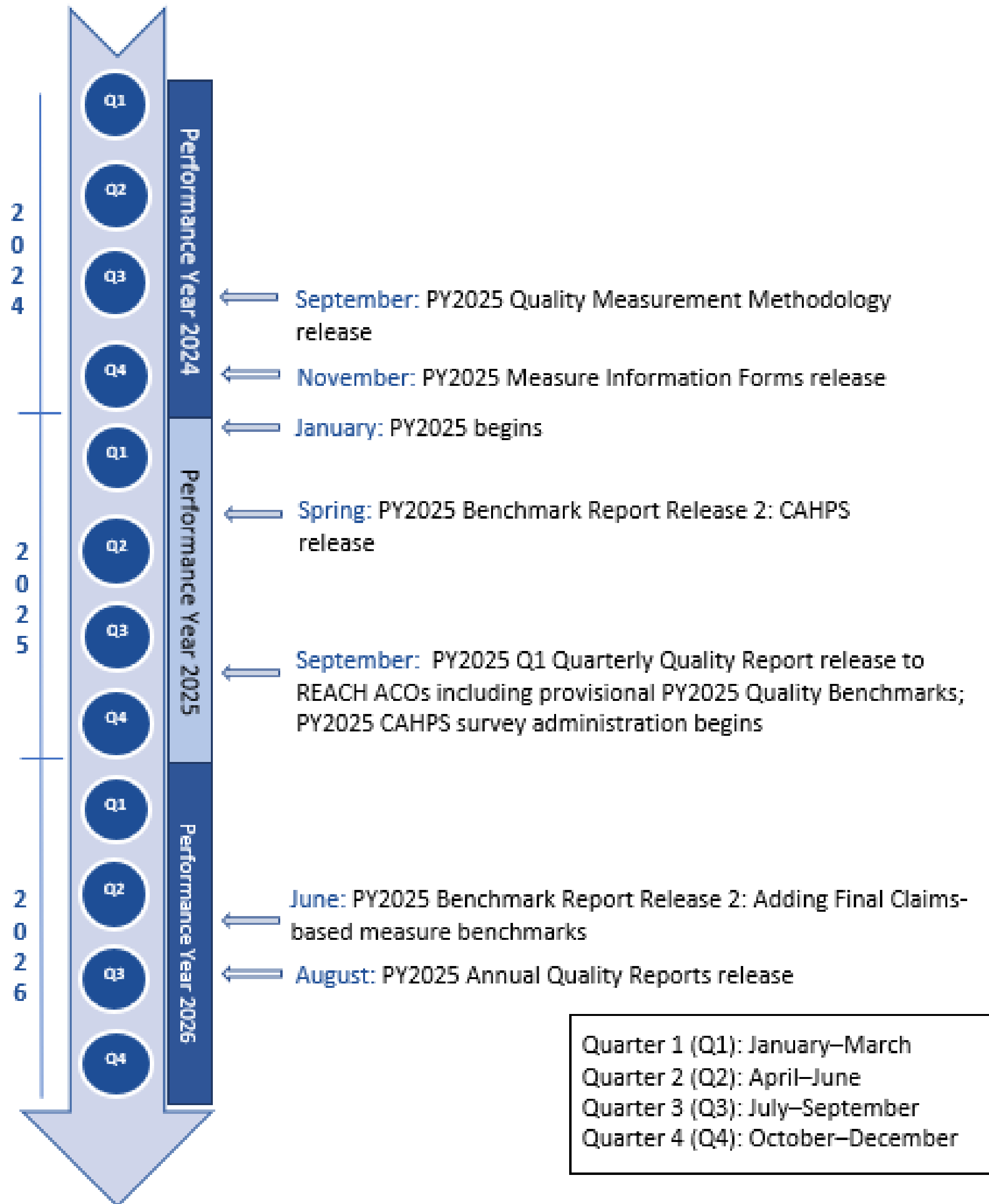
<table>
<tr><th colspan="2">Measure</th><th>Points Earned</th><th>Points Possible</th></tr>
<tr><td colspan="2">1. P4P: ACR</td><td>9.875</td><td>10.0</td></tr>
<tr><td colspan="2">2. P4P: UAMCC</td><td>9.625</td><td>10.0</td></tr>
<tr><td colspan="2">3. P4P: DAH (High Needs Population ACOs Only)</td><td>N/A</td><td>N/A</td></tr>
<tr><td colspan="2">4. P4P: TFU (Standard/New Entrant Only)</td><td>9</td><td>10.0</td></tr>
<tr><td colspan="2">5. P4P: CAHPS</td><td>8.031</td><td>10.0</td></tr>
<tr><td colspan="2">Total Points</td><td>36.531</td><td>40.0</td></tr>
<tr><td colspan="2"><u>Initial Quality Score (0%–100%)</u>
Points earned/points possible * 100</td><td colspan="2">91.328%</td></tr>
<tr><td rowspan="2">Adjustments to Total Quality Score</td><td><u>CI/SEP Gateway Multiplier</u>
1.0 if ACO met CI/SEP criteria;
0.5 if ACO did not meet CI/SEP criteria</td><td colspan="2">1.0</td></tr>
<tr><td><u>HEDR Adjustment</u>
0–10 percentage point bonus based on:
($\text{Reporting Rate}_{\text{Demographic}}$ * 5%) + ($\text{Reporting Rate}_{\text{SDOH}}$ * 5%)
Assuming a 100% demographic reporting rate and an 80% reporting rate for SDOH
1 * 5 + 0.8 * 5</td><td colspan="2">9</td></tr>
<tr><td colspan="2"><u>Total Quality Score (0%–100%)</u>
(Initial Quality Score * CI/SEP Multiplier) + HEDR
91.32 * 1.0 + 9</td><td colspan="2">100%</td></tr>
<tr><td rowspan="2">Impact on Financial Settlement</td><td><u>Quality Withhold Earned Back (0%–2%)</u>
Total Quality Score * 2% Quality Withhold
100% * 2%</td><td colspan="2">2% of the financial benchmark</td></tr>
<tr><td><u>HPP Bonus</u>
Must meet CI/SEP criteria AND have average quality measure performance ≥ 70th percentile</td><td colspan="2">+ $ per beneficiary</td></tr>
</table>

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 a total of 64.25 SSM points earned based on the eight CAHPS SSMs; (5) REACH ACO had 10,470 aligned beneficiaries with at least 6 months of eligibility, reported complete demographic data on 100% of them, and reported complete SDOH data on 80% (8,376) of them; and (6) 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.

Appendix A:
Timelines for PY 2025 and PY 2024

Figure A-1 shows key time points for the ACO REACH Quality Strategy for PY 2025.

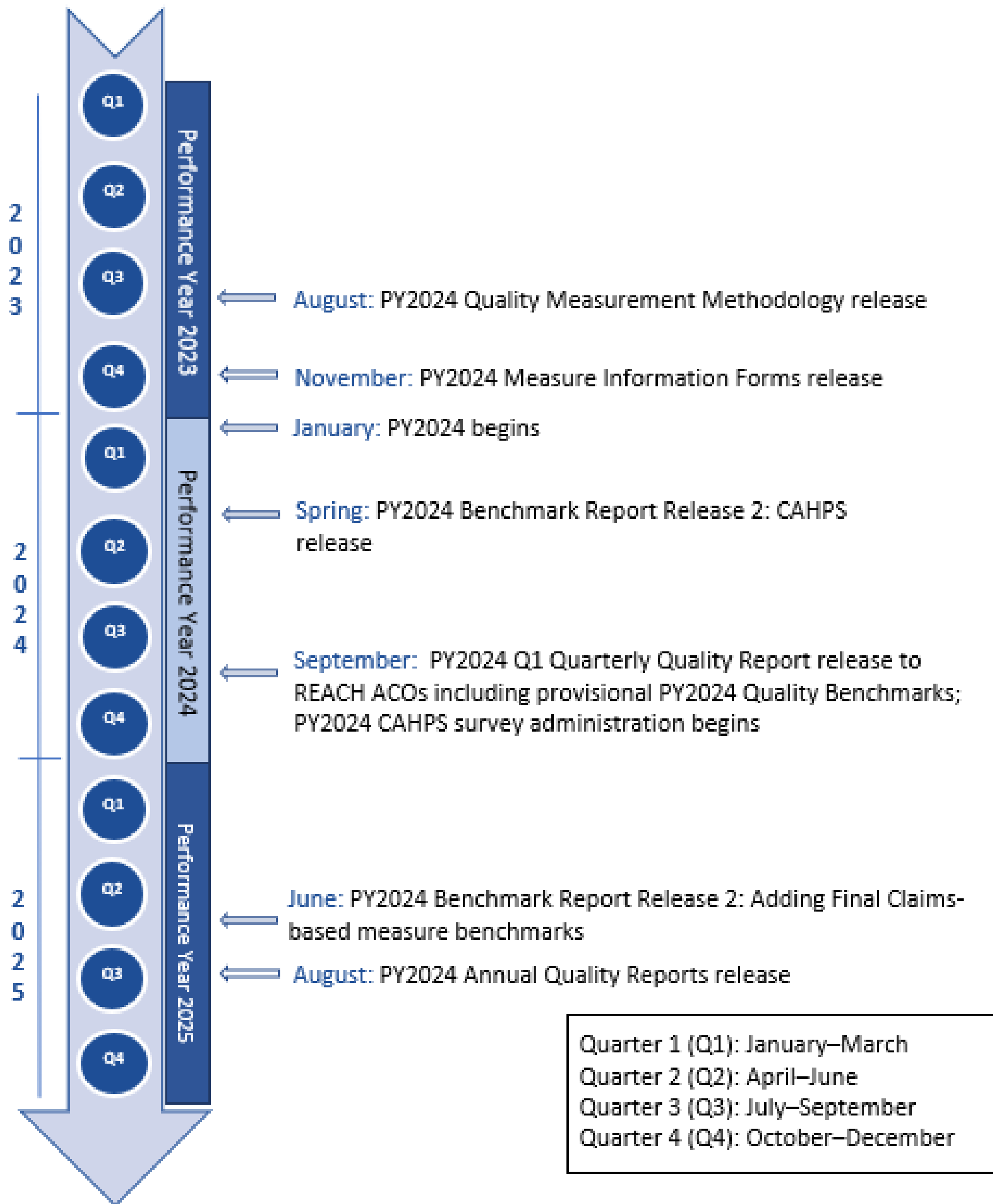
Figure A.1. Timeline of Quality Reporting and Performance Assessment Activities for PY 2025



CAHPS = Consumer Assessment of Healthcare Providers and Systems; PY = Performance year

Figure A-2 shows key time points for the ACO REACH Quality Strategy for PY 2024.

Figure A.2. Timeline of Quality Reporting and Performance Assessment Activities for PY 2024



CAHPS = Consumer Assessment of Healthcare Providers and Systems; PY = Performance year

Appendix B:
Terminology List (selected)

Term	Definition
Beneficiary	A person who has health care insurance coverage through the Medicare program.
Consumer Assessment of Healthcare Providers and Systems (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 to 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 of the 40 total possible points awarded for quality measure performance. The number of points a REACH ACO earns for CAHPS will be determined by their performance on the eight SSMs listed in Section 3.5.3 of this report.
CAHPS Summary Survey Measures (SSMs)	The ACO REACH CAHPS Survey will be based on the ACO CAHPS Survey and derive CAHPS SSMs for scoring, which will then be combined into a single CAHPS Composite Measure. The measures are referred to as SSMs because the survey includes multiple questions for most of the measures. Table 3.1 describes the SSMs included in the CAHPS Performance Score, and Appendix Tables C.2 and C.3 display the questions included in each SSM.
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 Performance Year (PY) 2024 through PY 2026. 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. Whether the REACH ACO earns this portion back will depend on its performance on a predetermined set of quality measures and CI/SEP. Specifically, this quality incentive will be structured as a Quality Withhold, in PY 2025 it is set at 2% of the value of the trended, regionally blended, risk-adjusted benchmark. The Quality Withhold will be recalculated for each PY. The REACH ACO will have the opportunity to earn back some or all the Quality Withhold, depending on the REACH ACO's performance on the quality measure set and CI/SEP. In PY 2021 and PY 2022, the Eligible Earn-Back Rate was 5% for all REACH ACOs. From PY 2023 through PY 2026, the Eligible Earn-Back Rate will be 2% or 1%; the rate will be based on the REACH ACO's performance on the CI/SEP criteria. In PY 2025, if the REACH ACO does not meet the CI/SEP criteria, the REACH ACO's Eligible Earn-Back Rate will be 1%.
Final Earn-Back Rate	Equals the Total Quality Score multiplied by the Eligible Earn-Back Rate.
Final Financial Settlement	Final Financial Settlement is conducted approximately 7 months after the PY ends for all ACOs. This settlement includes claims run-out through the end of the first quarter of the calendar year after the PY for expenditures incurred in the PY. Final Financial Settlement is based on risk adjusting the Performance Year Benchmark using the final risk scores for the PY and then comparing the Performance Year Benchmark with PY 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 PY 2023 and certain beneficiary-reported social determinants of health (SDOH) data starting in PY 2024 on aligned beneficiaries. Performance on this HEDR requirement will produce a 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 fee-for-service (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 before PY 2021 and PY 2022, 500 before PY 2023, 750 before PY 2024, 1,200 before PY 2025, and 1,400 before PY 2026.
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 either 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 PY compared to the prior PY, or may be based on performance against the Quality Measure benchmark, or a combination of both.
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 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 Care Model, or the Comprehensive Primary Care Plus Model.
Pay-for-Performance	Criteria for achieving payments to REACH ACOs are based on their performance relative to a quality benchmark or standard.
Pay-for-Reporting	Criteria for achieving payments to REACH ACOs are based on whether their reporting is complete and accurate.
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 a REACH ACO's performance.
Quality Measure	A numeric quantification of health care quality for a designated accountable health care entity, such as a 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" in 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. 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 (for example, 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.
Risk-Standardized Acute Admission Rate (RSAAR)	Lower RSAARs indicate better performance.
Risk-Standardized Readmission Rate (RSRR)	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 before each PY (PY 2021–PY 2026). 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 a 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.

Appendix C: Sampling Methodology for the ACO REACH Consumer Assessment of Healthcare Providers and Systems (CAHPS)

C.1 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 https://acoreachcahps.org/.[36] For **PY 2025**, REACH ACOs will need to select and contract with their CAHPS vendor by July 2024. The **CMS ACO REACH Newsletter** will continue to proactively notify REACH ACOs of all CAHPS information.

C.2 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 2024 that they will not need to contract with a CAHPS Survey vendor for PY 2025. 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 125 survey-eligible aligned beneficiaries, the survey cannot be conducted.

(continued)

[36] The website https://acoreachcahps.org became available as a resource February 2023.

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

High Needs ACOs	
All ACOs	▪ 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 37, all eligible beneficiaries will be surveyed. If there are fewer than 37 survey-eligible aligned beneficiaries, the survey cannot be conducted.

ACO = Accountable care organization; CAHPS = Consumer Assessment of Healthcare Providers and Systems; REACH = Realizing Equity, Access, and Community Health.

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	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

(continued)

Table C.2. Final Standard and New Entrant CAHPS Questions and SSMs (continued)

Item #	Full CAHPS Questions Text	SSM for Scored Items
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
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

(continued)

Table C.2. Final Standard and New Entrant CAHPS Questions and SSMs (continued)

Item #	Full CAHPS Questions Text	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 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)

(continued)

Table C.2. Final Standard and New Entrant CAHPS Questions and SSMs (continued)

Item #	Full CAHPS Questions Text	SSM for Scored Items
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
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

ADL = Activities of daily living; N/A = Not applicable (not a part of an SSM). SSMs marked with “Not scored” do not affect CAHPS PY 2025 scoring.

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

Item #	Full CAHPS Text	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

(continued)

Table C.3. Final High Needs Population CAHPS Questions and SSMs (continued)

Item #	Full CAHPS Text	SSM for Scored Items
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
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)

(continued)

Table C.3. Final High Needs Population CAHPS Questions and SSMs (continued)

Item #	Full CAHPS Text	Summary Survey Measure (SSM) for Scored Items
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
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)

(continued)

Table C.3. Final High Needs Population CAHPS Questions and SSMs (continued)

Item #	Full CAHPS Text	Summary Survey Measure (SSM) for Scored Items
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
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?	N/A
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

ADL = Activities of daily living; N/A = Not applicable (not a part of an SSM). SSMs marked with “Not scored” do not affect CAHPS PY 2025 scoring.