Overview: ACO REACH Model Quality Measurement Methodology

(Updated May 2023)

Under the ACO Realizing Equity, Access, and Community Health (REACH) Model, the Center for Medicare and Medicaid Innovation (Innovation Center) implemented significant updates to the quality methodology, including a reduction in the quality withhold, the introduction of the health data reporting adjustment, and the announcement of the Continuous Improvement/Sustainable Exceptional Performance (CI/SEP) criteria. The full quality measurement methodology paper is posted on the Innovation Center's website. This document has been updated to reflect that updated paper.

NAACOS is actively engaged in shaping the ACO REACH Model, providing advocacy to improve the model and education to prepare providers for participation. Please visit our ACO REACH Model website to learn more, and submit questions or feedback to us at ACOREACH@naacos.com.

Quality Measures

The Innovation Center will assess quality using four quality measures, none of which are reported by ACOs. Standard and New Entrant ACOs will report:

- Risk-Standardized All-Condition Readmission
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- Timely Follow-Up After Acute Exacerbations of Chronic Conditions
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey

For High Needs ACOs, the Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions, a measure that is still under development.

Measure Descriptions:

Risk-Standardized All-Condition Readmission: Measures how many hospital stays result in a readmission within 30 days after patient discharge. This is a claims measure.

All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions: Measures unplanned hospital admissions among Medicare fee-for-service beneficiaries 65 years of age and older with multiple chronic conditions. This is a claims measure.

CAHPS is based on the Clinician and Group CAHPS Survey and includes additional content relevant to patient/caregiver experience with care delivered by an ACO. The survey asks patients about their experiences with care at their most recent visit with an ambulatory care provider. It is applicable to any type of synchronous visit, regardless of whether the interaction occurred in person, by phone, or by video. ACOs must contract with a CMS-approved CAHPS Survey vendor for each reporting year to administer the CAHPS Survey.

Timely Follow-Up is defined as the percentage of acute events related to one of six chronic conditions where follow-up was received within the timeframe recommended by clinical practice guidelines in a non-emergency outpatient setting. Acute events are those that required either an emergency department visit or hospitalization. The six chronic conditions include hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and Type I/II diabetes mellitus. This is a claims measure.

Days at Home for Patients with Complex, Chronic Conditions: Measures the number of days that adults with complex, chronic disease spend at home and out of acute and post-acute care settings. This is a claims measure.

Quality Withhold

Beginning in 2023, 2 percent of an ACO's financial benchmark is at risk based on quality performance for each of four quality measures. If CMMI adds any new measures during the model, any such measures will be pay-for-reporting only for its first year of use and will not impact an ACO's quality score during that first year.

Quality Score

For each performance year, the Innovation Center will calculate a quality score for each ACO (the ACO's Total Quality Score), based on a ten-point scale for each quality measure. scale of 1–100 percent, which is then applied to the 2 percent quality withhold. For 2023 only, the CAHPS measure is pay-for-reporting only and will be included as a pay-for-performance measure beginning in 2024. For The Total Quality Score is the combination of an ACO's score on pay-for-reporting measures and its score on pay-for-performance measures.

For pay-for-reporting measures, an ACO gets a 100 percent score if it successfully reports the measure and a 0 percent score if it fails to completely report the measure. Because all but the CAHPS measure are claims measures, reporting is automatic. For the CAHPS measure, reporting requires the ACO's survey vendor to successfully report the survey results to the Innovation Center.

For each pay-for-performance measure, the Innovation Center will set a Quality Benchmark using TIN-level claims data from large physician practices and other non-ACO organizations. CMS will set a separate benchmark for each of the High Needs ACO measures. Each ACO will receive a quality score by comparing its score on a quality measure to the Quality Benchmark for that measure.

Standard and New Entrant ACOs

ACOs must report on all four applicable measures, which are the All-Condition Readmissions, Unplanned Admissions for Patients with Multiple Chronic Conditions, CAHPS, and Timely Follow-Up. The quality score is based on each of these four measures, with each measure tied to 0.5 percent of the 2 percent quality withhold.

High Needs ACOs

ACOs must report on all 4 applicable measures, which are which are the All-Condition Readmissions, Unplanned Admissions for Patients with Multiple Chronic Conditions, CAHPS, and Days at Home. The quality score is based on each of these four measures, with each measure tied to 0.5 percent of the 2 percent quality withhold.

Continuous Improvement/Sustained Exceptional Improvement (CI/SEP)
Beginning in 2023, the Innovation Center will implement the CI/SEP threshold, which determines whether an ACO can earn back up to 1 percent or the full 2 percent of the quality withhold. The threshold requirement only applies to claims-based measures.

The CI/SEP is a multiplier (of either 0.5 or 1.0) applied to an ACO's Initial Quality Score based on the ACO's total CI/SEP points earned (total CI/SEP scores range from -3 to plus 6). If the ACO meets the CI/SEP criteria, the Initial Quality Score is multiplied by 1.0; If it fails to do so, the Initial Quality Score is multiplied by 0.5.

To meet the CI/SEP threshold requirement, an ACO must:

1. Receive 1 point for at least 1 claims-based measure (either a CI point or a SEP point); AND
2. Have a total CI/SEP score equal or greater to zero.

Calculation of CI/SEP score
The CI score is based on statistically significant change in each (standardized) claims-based quality measure from one performance year to the next, using a 95% Confidence Interval. An ACO will earn:

- -1 point for declining performance
- 0 points for no change in performance
- +1 point for improving performance

The SIP score is calculated for each measure, based on whether the ACO meets or exceeds 70th percentile benchmark values in current and prior performance year. The ACO will earn +1 point for each measure sustained above the 70th percentile benchmark value.

Health Equity Data Reporting (HEDR) Adjustment
Beginning in 2023, the ACO REACH Model will include an adjustment to ACOs' quality scores based on the proportion of their aligned population for which it reports of health equity data. For 2023 and 2024, the adjustment is upside only and ACOs will not be penalized for incomplete HEDR. However, the model will move to a two-sided adjustment for 2025 and 2026, as follows:

Adjustment to Initial Quality Score (after CI/SEP multiplier)

	Demographic Data	*SDOH Data*	*TOTAL*
PY2023	0-10%	n/a	0-10%
PY2024	0-5%	0-5%	0-10%
PY2025	-5-5% (2023 benchmark)	0-5%	-5-10%
PY2026	-5-5% (2024 benchmark)	-5-5%	-10-10%

For reporting of demographic data, the ACOs only needs to collect beneficiary once for each aligned beneficiary (but will resubmit that data annually). The SDOH data must be collected and reported annually because this data is not static. Because ACOs cannot require beneficiaries to disclose this data, ACOs will receive reporting credit so long as they report the beneficiary's decision not to disclose.

The HEDR Adjustment will be applied after the application of the CI/SEP multiplier and is added to the ACO's initial quality score. For 2023 and 2024, the adjustment is calculated based on the proportion of

their aligned population for which it reports of health equity data, where the numerator is the number of the ACO's aligned beneficiaries for whom ACO successfully reports the data elements and the denominator is all of the ACO's beneficiaries. The calculation only includes beneficiaries with at least 6 months alignment during the Performance Year. This fraction is then multiplied by the applicable adjustment rate (10% for 2023, 5% for 2024). For 2025 and 2026, the adjustment is based on a comparison to a benchmark constructed from reporting data from two years prior.

High Performers Pool (HPP)

Beginning in 2023, the Innovation Center will create an HPP, funded by the portion of ACOs' quality withholds that are not earned back from ACOs that meet the CI/SEP threshold but do receive a 100 percent Total Quality Score. The Innovation Center will distribute these HPP funds to the highest performing ACOs, meaning those ACOs may earn back more than the 2 percent withhold. An ACO will earn a HPP bonus if it: (i) meets CI/SEP criteria; and (ii) has average measure performance of at least 70th percentile across all claims-based measures. The HPP will be distributed proportionally to eligible ACOs based on each qualifying ACO's overall number of beneficiary alignment-months in the performance year.