ACO REACH Model
Summary of Quality Performance, Financial Performance, and Model Payments
Updated 11/22/2024

The Centers for Medicare & Medicaid Services (CMS) conducts routine and ongoing monitoring of the quality and financial performance of innovative payment and care delivery reform models. This document will be updated regularly to provide information on the quality and financial performance of the Accountable Care Organizations (ACOs) participating in the ACO REACH Model.

Although the Global and Professional Direct Contracting (GPDC) Model was updated and renamed the ACO REACH Model in performance year (PY) 2023, we reference PY 2022 data from the GPDC Model. Participating organizations in PY 2022 were referred to as Direct Contracting Entities (DCEs), whereas in PY 2023 and PY 2024 participants are referred to as REACH ACOs. However, to avoid confusion, and because many of these organizations participated in both periods, we will not distinguish between DCEs and ACOs and will instead refer to all participating organizations as REACH ACOs in this document.

Note that the data in this document are for model monitoring purposes and are not evaluation results.

1. Quality Performance

Summary: CMS is sharing performance data on the All-Condition Readmission (ACR), Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC), and Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU) measures for nine periods. For PY 2021 through PY 2023, Table 1 shows the final quality measure performance as used in the final settlement for each PY. For PY 2023, the table also provides data for all four quarters. Lastly, the table shows quality results for the first and second quarters of PY 2024. The ACO REACH Model focuses quality measurement on a small set of critically important quality measures, including CAHPS® (beneficiary experience of care surveys),[1] ACR, UAMCC, TFU (Standard and New Entrant REACH ACOs only), and Days at Home (High Needs Population REACH ACOs only).[2] However, in PY 2021 and PY 2022, only the ACR and UAMCC measures were treated as pay-for-performance measures. The remaining measures were pay-for-reporting. In PY 2023 and PY 2024, all of the claims-based quality measures are pay-for-performance. Because all claims-based measures have a 12-month performance period, CMS shares performance measure data based on 12-month rolling periods in any quarterly reporting.

- ACR data should be read as the "percent of initial hospital admissions that resulted in an unplanned readmission." Lower values for unplanned hospital readmissions indicate higher quality. For the PY 2024 Quarter 2 (Q2) reporting period, ending in June 2024, the average ACR score across all Standard and New Entrant ACO REACH Model participants (known as REACH ACOs) was 15.16% (i.e., 15.16% of hospital admissions resulted in an unplanned readmission for beneficiaries aligned to a REACH ACO). For reference, the average ACR score across all non-ACO REACH TINs (including, but not limited to, TINs participating in traditional Medicare, the Medicare Shared Savings Program, and Other Alternative Payment Models) was 15.17%. This difference is not statistically significant (i.e., ACO REACH Model participants did not score statistically better or worse on the ACR measure).
- UAMCC data should be read as the "number of unplanned hospital admissions per 100 person-years among beneficiaries with multiple chronic conditions." Lower values for unplanned hospital admissions indicate higher quality. For the PY 2024 Q2 reporting period, ending in June 2024, the average UAMCC score across all Standard and New Entrant REACH ACOs was 31.31 (i.e., there were, on average, 31.31 unplanned hospital admissions for every 100 person-years among beneficiaries with multiple chronic conditions aligned to a participant in the ACO REACH Model). For reference, the average UAMCC score across all non-ACO REACH

[1] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[2] For more information on the ACO REACH Model quality policy, please see the Quality Measurement Methodology paper available on our website (for PY 2025): https://www.cms.gov/files/document/aco-reach-quality-msr-meth-py25.pdf.

TINs (including, but not limited to, TINs participating in traditional Medicare, the Medicare Shared Savings Program, and Other Alternative Payment Models) was 33.97. **This difference is statistically significant** (i.e., ACO REACH Model participants scored statistically better on the UAMCC measure).

- TFU data should be read as the "percent of acute events related to one of six chronic conditions where follow-up care was received in a non-emergency outpatient setting within the time frame recommended by clinical practice guidelines." Higher follow-up rates indicate higher quality. For the PY 2024 Q2 reporting period, ending in June 2024, the average TFU score across all Standard and New Entrant REACH ACOs was 70.92% (i.e., the average rate of timely follow-up after an acute exacerbation was 70.92%). For reference, the average TFU score across all non-REACH ACO TINs (including, but not limited to, TINs participating in traditional Medicare, the Medicare Shared Savings Program, and Other Alternative Payment Models) was 68.71%. **This difference is statistically significant** (i.e., ACO REACH Model participants scored statistically better on the TFU measure).

Table 1. ACO REACH Quality Data December 2021 through June 2024

12-Month Period Ending:	Claims Processed as of:	REACH ACO[1] count	ACR[2]: All REACH ACO TINs[5]	ACR[2]: All Non-REACH ACO TINs[6]	UAMCC[3]: All REACH ACO TINs[5]	UAMCC[3]: All Non-REACH ACO TINs[6]	TFU[4]: All REACH ACO TINs[5]	TFU[4]: All Non-REACH ACO TINs[6]
PY 2021								
Dec 2021	Apr 2022	47	14.98%	14.96%	30.75	32.58	67.38%	67.93%
PY 2022								
Dec 2022	Apr 2023	91	15.28%	15.27%	**31.62**	33.73	68.31%	68.11%
PY 2023								
Dec 2023	Apr 2024	118	15.29%	15.32%	**31.84**	34.40	**71.80%**	69.91%
PY 2023								
Mar 2023	Jul 2023	118	15.24%	15.18%	**32.53**	34.20	68.95%	67.72%
Jun 2023	Oct 2023	118	15.30%	15.25%	**31.77**	33.79	69.37%	68.15%
Sep 2023	Nov 2023[7]	118	15.06%	15.04%	**31.03**	33.24	69.53%	68.29%
Dec 2023	Feb 2024	118	14.97%	14.99%	**31.69**	34.20	70.65%	69.10%
PY 2024								
Mar 2024	May 2024	101	15.13%	15.11%	**31.56**	34.18	**70.41%**	68.19%
Jun 2024	Aug 2024	101	15.16%	15.17%	**31.31**	33.97	**70.92%**	68.71%

1. REACH ACO = Participants in ACO REACH Model
2. Counts exclude High Needs Population ACOs given the small sample size and lack of comparability to a general reference population (like all non-REACH ACO TINs).
3. ACR = All-Condition Readmission; this data should be interpreted as "percent of initial hospital admissions that resulted in an unplanned readmission." Lower values are more favorable and indicate better performance.
4. UAMCC = Unplanned Admissions for Patients with Multiple Chronic Conditions; this data should be interpreted as the "number of unplanned hospital admissions per 100 person-years among beneficiaries with multiple chronic conditions." Lower values are more favorable and indicate better performance.
5. Timely Follow-Up After Acute Exacerbations of Chronic Conditions; this data should be interpreted as "percent of acute events related to one of six chronic conditions where follow-up care was received in a non-emergency outpatient setting within the time frame recommended by clinical practice guidelines." Higher values are more favorable and indicate better performance.
6. Bolded data represents differences that are statistically significant between REACH ACO TINs and non-REACH ACO TINs.
7. All Non-REACH ACO TINs = All non-REACH ACO TINs participating in traditional Medicare and the Medicare Shared Savings Program with at least 1,000 eligible beneficiaries.
8. Starting with the PY 2023 Q3 reporting period, the ACO REACH Model transitioned to a one-month claims runout to improve the timeliness of quarterly quality reporting for participants. The reduced runout has a limited impact on average performance scores across the quality measures for both non-REACH ACO TINs and REACH ACOs, however, it may impact how comparable results are to previous years. The final quality measure performance used for PY 2023 and PY 2024 final financial settlement is still based on a 3-month run-out.

This data is based on performance data collected for the purpose of quality measurement in the model and does not represent formal evaluation data.

2. Financial Performance

Summary: CMS is releasing summary statistics of ACOs' financial performance. Across the 115 ACOs[3] participating in the ACO REACH Model in PY 2024, the total number of aligned beneficiaries through the third quarter (Q3) of PY 2024 is approximately 2,403,721 beneficiaries. The total dollars under risk (i.e., the sum of the Performance Year Benchmark across all 115 PY 2024 ACOs), which is a cumulative year-to-date (YTD) figure from January 2024 through September 2024, is consistent with an average per-beneficiary-per-month (PBPM) benchmark of approximately $1,281. **Based on the first three quarters of 2024, all 115 ACOs combined for a roughly 5.5% reduction in Medicare spending compared to their combined PY benchmarks in PY 2024**. Combined with the capitation data (see below), this is analogous to a Medical Loss Ratio (MLR) of 94.2%.[4]

Average reduction in Medicare spending with just three quarters of experience in PY 2024 is likely unreliable in predicting final performance for the year for several reasons. First, spending is often lower in the first quarter than for the whole performance year due to the Part B deductible. Second, because no claims run-out is included in this report, it is highly likely that expenditures in the quarter are understated, causing an inflation in the snapshot savings estimate. While an estimated incurred-but-not-reported (IBNR) adjustment is applied to claims to account for the lack of claims runout, it is often unreliable early in the performance year.

It is important to caveat that this data is not final and is subject to change. For the 98 ACOs that elected 100% risk (the 'Global' option) in PY 2024, a discount of 3% is applied to PY benchmarks to ensure savings for CMS (discount has been applied in this data); **because of this, the reported reductions in expenditures are in addition to the savings against benchmark for CMS**.[5]

This data does not represent formal model evaluation data but is collected for purposes of monitoring the Model's financial methodology and performance.

Table 2. ACO REACH Financial Performance Data

Period Covered	Claims Runout Through Date	ACO Count	Avg. Aligned Beneficiaries Across All ACOs	Total Dollars Under Risk Across All ACOs (cumulative YTD)	Aggregate Reduction (increase) in Spending Compared to Benchmark[1]	Standard Deviation[1]
PY 2021						
Apr–Dec 2021	May, 2022	53	338,938	$3,514,813,246	1.7%	10.1%
PY 2022						
Jan–Dec 2022	March, 2023	99	1,728,087	$23,307,949,564	2.3%	7.2%
PY 2023						
Jan–Dec 2023	March, 2024	132	1,924,155	$27,533,061,850	3.6%	7.8%
PY 2024[2]						
Jan–Mar 2024, YTD	March, 2024	115	2,429,577	$9,316,107,099	14.8%[3]	9.3%
Jan–Jun 2024, YTD	June, 2024	115	2,413,568	$18,511,357,306.	6.9%[3]	8.6%
Jan–Sept 2024, YTD	September, 2024	115	2,403,721	$27,720,440,721	5.5%[3]	9.2%

1. Compared to benchmark across all ACOs participating in the performance year.
2. A policy choice was made for PY 2023 and onward to defer application of the Retrospective Trend Adjustment to Q3; consequently, benchmarks (and more prominently, savings) will be inflated as reflected in the Q1 and Q2 2024 snapshot. In prior years, the Retrospective Trend Adjustment (RTA) was applied beginning in Q1, whereas for PY 2023 and PY 2024, application has been deferred until Q3.
3. Q1, Q2, and Q3 savings estimates tend to be overstated due to seasonality (e.g. Part B deductible effect) and lack of claims run-out (which has more pronounced effect earlier in the year).

[3] Seven ACOs have terminated from the model since the ACO REACH PY 2024 Participant List was published in late January.

[4] MLR generally refers to the percent of health care premiums spent on medical claims. Because the ACO REACH Model exists within traditional Medicare and model participants are not functioning as payers, this terminology is generally not used in the context of ACO-based models like the ACO REACH Model. However, for comparison purposes, MLR may be considered analogous to the reduction in spending compared to the benchmark (5.5% - see Table 2, most recent data for PY 2024) combined with the percent of the benchmark comprised of capitation payments (2.9% - see Table 3, most recent data for PY 2024) and the percentage of those payments that is not spent on Medicare Covered Services (1 – 91.2% = 8.8% - see Table 3, most recent data for PY 2024). For PY 2024, MLR could be estimated to be 100% - 5.5% - (2.9% * 8.8%) = 94.2%.

[5] For a full explanation of the benchmark methodology, please see the Financial Operating Guide: Overview paper available on our website

3. Capitation

CMS is publishing available data on capitation in the ACO REACH Model. **From January to September of PY 2024, 2.9% of total services provided to aligned beneficiaries were impacted by capitation (i.e., 97.1% of all Medicare payments for services to aligned beneficiaries were not impacted by capitation).** Capitation in the ACO REACH Model functions differently than capitation in other health care contexts, such as Medicare Advantage (MA). In MA, CMS pays MA plans capitation payments covering the total cost of care, and MA plans assume responsibility for contracting a provider network and adjudicating and paying all claims that those providers bill to the plan. In the ACO REACH Model, capitation payments cover only a portion of total cost of care: Medicare Part A and Part B services rendered by health care providers participating in the Model who agree to participate in capitation. CMS retains responsibility for adjudicating all claims, including those covered by capitation, and for paying approved claims, as appropriate and in accordance with accompanying claims reduction arrangements. Beneficiaries maintain the freedom of choice to see any Medicare-enrolled provider or supplier. Capitation in the ACO REACH Model enables participating health care providers to forgo a portion of their fee-for-service (FFS) claim payments in exchange for receiving compensation from the ACO (e.g., share of savings) with the goal of better aligning financial incentives at the point of care.

There are two capitation options (called "capitation payment mechanisms") in the ACO REACH Model. Primary Care Capitation (PCC) is a payment mechanism in which participating primary care providers in the ACO REACH Model agree to forgo between 1–100% of FFS claims payments for a specific set of services rendered to aligned beneficiaries by participating health care providers (see Table B.6.3 in the Financial Operating Guide: Overview paper for a list of these services). Total Care Capitation (TCC) is a payment mechanism in which participating health care providers in an ACO agree to forgo 100% of FFS claims payments for services rendered to aligned beneficiaries.

Health care providers who are not participating in the ACO REACH Model do not have their claims payments adjusted in any way under the model, even when providing services to aligned beneficiaries. Further, health care providers who are participating in TCC or PCC do not have their claims payments adjusted in any way under the model when providing services to beneficiaries who are not aligned to their ACO.

Because capitation only affects participating health care providers, it generally impacts a small percentage of Medicare Covered Services provided to aligned beneficiaries. During PY 2024, all Participant Providers were required to have some portion of their eligible claims reduced via capitation, while Preferred Providers could choose whether to participate in capitation. Of the 115 ACOs in the model for PY 2024, 96 opted for PCC and 19 for TCC. Through the third quarter of PY 2024, **capitation impacted, on average, 2.9% of total cost of care** (i.e., 97.1% of all Medicare payments for services furnished to aligned beneficiaries were not impacted by capitation). Two policy changes from PY 2021 that may change the proportion of payments impacted by capitation are (1) all Participant Providers participating in an ACO were required to participate in capitation in PY 2022, PY 2023, and PY 2024; and (2) a higher minimum claims reduction amount for PCC was required in PY 2022, PY 2023, and PY 2024 (1–100% permitted in PY 2021 vs. 5–100% in PY 2022, 10–100% in PY 2023, and 20–100% in PY 2024).

The total amount of these claim reduction amounts due to TCC and PCC has historically hovered near 90% of total payments levels made to ACOs. In other words, the amount of fee-for-service payments withheld has historically been approximately 90% of the capitation dollars paid to ACOs, implying that approximately 90% of capitation dollars paid are spent on Medicare Covered Services while the remaining 10% may be spent on practice infrastructure and care innovation.

This figure – percent of capitation spent on Medicare Covered Services - tends to fluctuate during the Performance Year for a variety of reasons – i.e., change in capitation payment levels (due to alignment attrition, updated Withhold Percentage, and updated PBPM benchmark); seasonality-related considerations (e.g., services at beginning of PY contribute less to benchmark expenditures due to beneficiaries' Part B deductible); and updated incurred and paid expenditure totals with varying levels of claims run-out. We would expect the early PY 2024 estimate below to increase as greater performance year experience is accumulated.

This data is not final and is subject to change. Further, this data is not formal model evaluation data, but data collected for the purposes of monitoring the Model's financial methodology and performance.

Table 3. ACO REACH Capitation Data (PCC and TCC combined)

Period covered	ACO Count	Claims Runout Through Date	Aggregate % of Performance Year Benchmark paid via capitation	Preliminary % of capitation payments spent on Medicare Covered Services[1]
PY 2021				
Apr–Dec 2021	36	May 31, 2022	2.5%	90.8%
PY 2022				
Jan–Dec 2022	99	March 31, 2023	2.9%	95.5%
PY 2023				
Jan–Dec 2023, YTD	132	March 31, 2024	3.5%[2]	95.8%
PY 2024				
Jan–Mar 2024, YTD	115	October 31, 2024[3]	2.9%[2]	82.8%
Jan–Jun 2024, YTD	115	October 31, 2024[3]	2.9%[2]	90.5%
Jan–Sep 2024, YTD	115	October 31, 2024[3]	2.9%[2]	91.2%

1. Reflects the total amount of forgone FFS claim payment due to TCC and PCC as a proportion of total TCC and PCC payments made to ACOs; driven by many factors, such as level of capitation payment, level of claims run-out, and incidence of healthcare services furnished outside construct of Medicare fee schedule; prior quarters' data is updated to incorporate most recent estimates of accurate capitation levels.
2. To include the most up-to-date figures, the PY 2023 Capitation Data included in Table 3 includes S2 capitation payments calculated during PY3 Final Settlement which incorporates S2 benchmarks. PY 2024 Capitation Data uses the most up-to-date retrospectively updated capitation payments calculated in the PY4Q4 APA reports.
3. Note that an additional month of run-out (October 31 vs September 30) was incorporated in calculation of capitation figures compared to the benchmark savings results calculated in Table 2 above. The inclusion of additional months reduces the forecasting error of capitation payments relative to benchmark savings results.