ACO REACH Model
Summary of Quality Performance, Financial Performance, and Model Payments
Updated 6/06/2025

Consistent with Pillar 2 of the Centers for Medicare & Medicaid Services (CMS) Innovation Center's 2025 Strategy to Make America Healthy Again, Empower People to Achieve Their Health Goals, CMS is publishing the Quarterly Transparency Report to support patient decision making by providing preliminary data on provider performance in the ACO REACH Model.[1] 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 through PY 2025 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: 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 seven 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 2024, the table also provides data for all four quarters of the year. The ACO REACH Model focuses quality measurement on a small set of critically important quality measures, including CAHPS® (beneficiary experience of care surveys),[2] ACR, UAMCC, TFU (Standard and New Entrant REACH ACOs only), and Days at Home (High Needs Population REACH ACOs only).[3] 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 claims-based quality measures were 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 4 (Q4) reporting period, ending in December 2024, the average ACR score across all Standard and New Entrant ACO REACH Model participants (known as REACH ACOs) was 15.25% (i.e., 15.25% 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 Taxpayer Identification Numbers (TINs) (including TINs participating in traditional Medicare, the Medicare Shared Savings Program, and other Alternative Payment Models) was 15.28%. 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

[1] For more information, please refer to the CMS Innovation Center's 2025 Strategy to Make American Healthy Again webinar slides.
[2] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[3] For more information on the ACO REACH Model quality policy, please see the Quality Measurement Methodology paper available on our website (for PY 2025).

quality. For the PY 2024 Q4 reporting period, ending in December 2024, the average UAMCC score across all Standard and New Entrant REACH ACOs was 31.29 (i.e., there were, on average, 31.29 unplanned hospital admissions for every 100 person-years among beneficiaries with multiple chronic conditions aligned to a REACH ACO) . For reference, the average UAMCC score across all non-ACO REACH TINs (including TINs participating in traditional Medicare, the Medicare Shared Savings Program, and other Alternative Payment Models) was 34.30. **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 Q4 reporting period, ending in December 2024, the average TFU score across all Standard and New Entrant REACH ACOs was 77.28% (i.e., the average rate of timely follow-up after an acute exacerbation was 77.28%). 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 74.70%. **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 December 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 2024*	–	–	–	–	–	–	–	–
Mar 2024	May 2024[7]	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%
Sep 2024	Nov 2024	101	15.11%	15.13%	**30.85***	33.74	**76.37%***	74.15%
Dec 2024	Feb 2025[8]	101	15.25%	15.28%	**31.29***	34.30	**77.28%***	74.70%

* Denotes significant value.

[1] REACH ACOs = Participants in ACO REACH Model, referred to as REACH Accountable Care Organizations (REACH ACOs). 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).

[2] ACR = All-Condition Readmission; these 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.

[3] UAMCC = Unplanned Admissions for Patients with Multiple Chronic Conditions; these 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.

[4] Timely Follow-Up After Acute Exacerbations of Chronic Conditions; these 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.

[5] Bolded data represent differences that are statistically significant between REACH ACO TINs and non-REACH ACO TINs.

[6] 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.

[7] Starting with the PY 2023 Q3 reporting period, the ACO REACH Model transitioned to a one-month claims run-out 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.

[8] Note that the PY 2024 Q4 data is based on a one-month claims run-out as well. The final quality measure performance that will be used for PY 2024 final financial settlement will be based on a 3-month run-out.

These data are based on performance data collected for the purpose of quality measurement in the model and do not represent formal evaluation data.

2. Financial Performance

Summary: CMS is releasing summary statistics of ACOs' financial performance. Across the 100 ACOs[4] participating in the ACO REACH Model in PY 2025, the total number of aligned beneficiaries through the first quarter (Q1) of PY 2025 is approximately 2,193,975 beneficiaries. The total dollars under risk (i.e., the sum of the Performance Year Benchmark across all 100 PY 2025 ACOs), which is a cumulative year-to-date (YTD) figure from January 2025 through March 2025, is consistent with an average per-beneficiary-per-month (PBPM) benchmark of approximately $1,280. **Based on the first quarter of 2025, all 100 ACOs combined for a roughly 5.9% reduction in Medicare spending compared to their combined PY benchmarks in PY 2025**. Combined with the capitation data (see below), this is analogous to a Medical Loss Ratio (MLR) of 93.03%.[5]

Average reduction in Medicare spending with one-quarter of experience in PY 2025 may differ from final performance for the year for several reasons. First, spending is often lower in the first quarter than for the whole PY 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. Although an estimated incurred-but-not-reported (IBNR) adjustment is applied to claims to account for the lack of claims run-out, it is often unreliable early in the PY.

It is important to caveat that these data are not final and are subject to change. For the 87 ACOs that elected 100% risk (the "Global" option) in PY 2025, a discount of 3.5% is applied to PY benchmarks to ensure savings for CMS (discount has been applied in these data); **because of this, the reported reductions in expenditures are in addition to the savings against benchmark for CMS**.[6]

These data do not represent formal model evaluation data but are collected for purposes of monitoring the model's financial methodology and performance.

Table 2. ACO REACH Financial Performance Data

Period Covered	Claims Run-out 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	–	–	–	–	–	–
Jan–Dec 2024, YTD[2]	March, 2025	115	2,381,679	$36,651,952,047	4.33%	7.60%

[4] Three ACOs have terminated from the model since the ACO REACH PY 2025 Participant List was published in late January 2025.

[5] 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 (5.9% - see Table 2, most recent data for PY 2025) combined with the percent of the benchmark comprised of capitation payments (3.75% - see Table 3, most recent data for PY 2025) and the percentage of those payments that is not spent on Medicare Covered Services (1 – 71.5% = 28.5% - see Table 3, most recent data for PY 2025). For PY 2025, MLR could be estimated to be 100% - 5.9% - (3.75% * 28.5%) = 93.0%.

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

Period Covered	Claims Run-out 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 2025[3]	–	–	–	–	–	–
Jan–Mar 2025, YTD	March, 2025	100	2,193,975	$8,425,588,107	5.9%[4]	7.67%

[1] Compared to benchmark across all ACOs participating in the performance year.
[2] PY 2024 data updated from Preliminary Settlement, with full year data and claims runout through March 31, 2025. Final PY 2024 figures will be available in August 2025.
[3] 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 2025 snapshot. In prior years, the Retrospective Trend Adjustment (RTA) was applied beginning in Q1, whereas for PY 2023 through PY 2025, application has been deferred until Q3. In prior years, the trend has overestimated expenditures. For PY 2025, preliminary data indicate that the trend is currently below actual expenditures; however, this may change once complete data are available following the run-out period in 2027.
[4] 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. Capitation

CMS is publishing available data on capitation in the ACO REACH Model. **From January to March of PY 2025, 3.75% of total services provided to aligned beneficiaries were impacted by capitation (i.e., 96.25% 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 the 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 2025, 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 100 ACOs in the model for PY 2025, 85 opted for PCC and 15 for TCC. 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 through PY 2025; and (2) a higher minimum claims

reduction amount for PCC was required in these Performance Years (1–100% permitted in PY 2021 vs. 5–100% in PY 2022, 10–100% in PY 2023, 20–100% in PY 2024, and 100% in PY 2025).

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 FFS 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 PY 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 the 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 2025 estimate below to increase as greater PY experience is accumulated.

These data are not final and are subject to change. Further, these data are 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%	95.8%
PY 2024				
Jan–Dec 2024, YTD	115	March 31, 2025[3]	2.9%[2]	94.3%
PY 2025				
Jan–Mar 2025, YTD	100	March 31, 2025	3.75%[2]	71.51%

[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 runout, and incidence of health care services furnished outside construct of Medicare fee schedule; prior quarters' data are updated to incorporate most recent estimates of accurate capitation levels.

[2] To reflect the most up-to-date figures, PY 2024 Capitation Data included in Table 3 use capitation payments calculated for PY4 Preliminary Settlement, with full-year data and claims run-out through March 31, 2025. Final PY 2024 figures will be available in August 2025. PY 2025 Capitation Data uses the most up-to-date retrospectively updated capitation payments calculated in the PY5Q2 APA reports.

[3] Note that an additional three months of runout (March 31 vs. December 31) was incorporated in calculation of capitation figures compared to the benchmark savings result for PY 2024 calculated in Table 2. The inclusion of additional months reduces the forecasting error of capitation payments relative to benchmark savings results.