Preview of Findings from the Evaluation of ACO REACH Model for Performance Year 2023

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Introduction

The Centers for Medicare & Medicaid Services (CMS) launched the Global and Professional Direct Contracting (GPDC) Model in 2021 and subsequently renamed it the ACO REACH Model in 2023. ACO REACH is an advanced accountable care organization (ACO) initiative to promote patient-centered care, lower costs, and align payment systems for Medicare fee-for-service (FFS) beneficiaries through ACO risk-sharing and prospective payment. There are three types of ACOs in the model: Standard ACOs, New Entrant ACOs (new to traditional FFS Medicare that become Standard ACOs), and High Needs ACOs (serving predominantly medically complex beneficiaries). Full evaluation results are available through performance year (PY) 2022. Of the 132 ACOs that participated in ACO REACH in PY 2023, 84 continued from the GPDC Model, while 48 joined as new model participants. In PY 2023, ACOs provided services to over 2 million aligned beneficiaries. Half (52%) of these beneficiaries were new to the model in PY 2023.

Our mixed methods evaluation estimates ACO REACH's impact on Medicare FFS spending, health services utilization, and quality of care for beneficiaries aligned to the model through their providers. This document provides an early look at the preliminary results through PY 2023, and CMS anticipates releasing a full evaluation report later in calendar year 2025.

PY 2023 evaluation estimates were more favorable for Standard and New Entrant ACOs relative to prior years with statistically significant reductions in gross spending and stronger improvements in quality measures. Preliminary estimates show that High Needs ACOs had non-significant reductions in gross spending and statistically significant improvements in quality across PY 2022 and PY 2023. While PY 2022 estimates had shown larger reductions in gross spending, cumulative estimates for High Needs ACOs were highly sensitive to an overrepresentation of a new cohort of participants (most of whom were under shared ownership) that drove increased costs in PY 2023. Additionally, the current comparison group for High Needs ACOs may reflect providers serving healthier populations and we are currently exploring revisions to ensure the model is being assessed relative to a comparable set of beneficiaries with complex medical needs. Cumulatively, all ACO types increased net spending once accounting for CMS shared savings and losses and performance bonuses, although gross savings, quality, and utilization measure performance show signs of trending in a positive direction overall.

The impact of ACO REACH was estimated using a difference-in-differences statistical design, with a comparison group of beneficiaries from the same health care markets served by non-ACO REACH providers. Comparison group beneficiaries are balanced based on a variety of health conditions, demographic, and regional factors. The comparison group included FFS Medicare beneficiaries, including those served by providers in the Medicare Shared Savings Program (Shared Savings Program) ACOs and other alternative payment models (APMs)[1] (participation choices absent ACO REACH) as well as beneficiaries served by providers who were not participating in APMs during the study period.

Gross and Net Spending among Standard ACOs

The 105 Standard ACOs in PY 2023 served 1.96 million beneficiaries, representing 96% of all ACO REACH beneficiaries in PY 2023. Over time, the number of Standard ACOs has increased, in part due to the recategorization of some New Entrant and High Needs ACOs who met model requirements to participate as a Standard ACO. Standard ACOs reduced gross total spending in PY 2023 by $197.5 million in aggregate (0.9%), or $109 per beneficiary per year (PBPY), which is statistically significant at $p<0.01$. Reductions in total spending were driven by statistically significant ($p<0.1$) decreased spending on outpatient care (2.2%), acute care (1.2%), and post-acute care (PAC), such as skilled nursing facility (1.1%) and home health (1.7%). Reduced spending in PY 2023 reversed the previous increasing trend from the first two years of the model (0.8% increase in cumulative gross spending for PY 2021-PY 2022). When the total gross spending results for PY 2021–PY 2023 are combined, there are no statistically

[1] Other alternative payment models include could include Bundled Payments for Care Improvement, Comprehensive Care for Joint Replacement, Comprehensive Primary Care Plus, Primary Care First, End Stage Renal Disorder Treatment Choices, Financial Alignment Initiative, Independence at Home, Next Generation ACO, Kidney Care Choices, and the Oncology Care Model in the baseline or performance period.

significant changes for Standard ACOs relative to a blend of beneficiaries in other accountable care relationships and those not currently in accountable care.

Subgroup analyses also show variations in gross total spending results for specific types of ACOs or the beneficiaries they served. For example, ACOs that elected global (higher) risk-sharing and total cost of care capitation reduced spending ($65 PBPY, $p<0.1$) while ACOs that elected professional risk-sharing with primary care capitation increased spending ($70 PBPY, $p<0.05$) through PY 2023.[2] ACOs that were networks of individual practices reduced spending ($98 PBPY, $p<0.01$), while integrated delivery/hospital system ACOs increased spending ($91, PBPY, $p<0.01$) through PY 2023. There were also larger, statistically significant reductions in spending among specific beneficiary subgroups in PY 2023, including beneficiaries with eight or more chronic conditions ($588 PBPY, $p<0.01$), beneficiaries who were dually eligible for Medicare and Medicaid ($350 PBPY, $p<0.01$), and beneficiaries with a disability or end-stage renal disease ($261 PBPY, $p<0.01$).

After factoring in shared savings and losses or performance bonus payments for ACO REACH, cumulative (PY 2021-PY 2023) net spending increased by $1.1 billion ($p<0.01$); note that this estimate does not adjust for any shared savings or losses incurred for the comparison group. Cumulative net spending increases were smaller ($310 million, $p<0.01$) for Standard ACOs after accounting for shared savings and losses received by providers participating in the Shared Savings Program and the Next Generation ACO (NGACO) model.

One of the goals of testing this model, which differs from Shared Savings Program, is to understand whether advanced accountable care improves quality for beneficiaries and reduces spending for Medicare. The main research question to date explores whether this model test provides improvements to cost and quality beyond what would otherwise be available, inclusive of Shared Savings Program. The high prevalence of Standard ACO model participants with prior experience in other accountable care models (>50% during the baseline period) presents a challenge for evaluating the ACO REACH model outside of this historical value-based care context, particularly when ACOs may reinvest shared savings payments into infrastructure supports that may have longitudinal impacts on beneficiaries' experience of care. However, stakeholders and policymakers may be interested in understanding the effects of the model without a direct comparison to Shared Savings Program or other accountable care models. Sensitivity analyses removing beneficiaries served by other accountable care programs revealed larger, statistically significant reductions in total gross spending in PY 2023 (ranging from $192 to $408 PBPY or $348.8 million to $739.6 million).[3] Net spending under this scenario would range from reductions of $1 PBPY (reduction of $1.1 million) to increases of $1,215 PBPY (increase of $389.7 million) in PY 2023. While this updated range includes a scenario where Standard ACOs showed reductions on net spending in PY 2023 alone, we do not yet have cumulative estimates. The cumulative estimates would be impacted by the statistically significant increases in gross spending in PY 2022 that would likely still show unfavorable cumulative increases in net spending for Standard ACOs.

Gross and Net Spending among New Entrant ACOs[4]

New Entrant ACOs experienced more year-to-year shifts in participation than Standard ACOs, leading to more shifts in the beneficiary population over time.[5] New Entrant ACOs were much smaller than Standard ACOs, with an average of about 5,000 beneficiaries per ACO, for a total of approximately 67,900 beneficiaries (3% of all ACO REACH beneficiaries in PY 2023).

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[2] ACOs could choose between two risk-sharing options—Global (full risk) or Professional (lower risk)—against a benchmark based on historical and regional claims data. ACOs were also required to select an option for monthly capitation payments, used to reimburse providers for services or to invest in staff and services not covered under traditional FFS. Those that selected Global risk could choose either PCC—for primary care services delivered to aligned beneficiaries—or Total Care Capitation (TCC)—for all services delivered to aligned beneficiaries. The ACOs that selected Professional risk were required to elect PCC.

[3] Sensitivity analyses were conducted to compare care given to beneficiaries by ACO REACH providers relative to FFS beneficiaries seen by providers who had not participated in any ACO models during the study window. In one scenario, we removed beneficiaries served by providers participating in Shared Savings Program and other ACO models from the baseline and performance period for the comparison group only. Another scenario further removed beneficiaries served by ACO providers in the baseline period who later participated in the ACO REACH model.

[4] We estimated impacts for 12 of the 13 New Entrant ACOs in PY 2023; one ACO could not be evaluated due to inadequate baseline data.

[5] In PY 2023, six New Entrant ACOs entered the model. Through PY 2023, 15 of the 28 ACOs that entered the model as New Entrant ACOs transitioned to Standard ACOs.

New Entrant ACOs had higher reductions in total gross spending than Standard ACOs, with large statistically significant decreases in PY 2023 ($890 PBPY or 6.2%, and $36.8 million in aggregate, $p<0.01$) and cumulatively over PY 2021–PY 2023 ($433 PBPY or 3.2%, and $51.1 million in aggregate, $p<0.01$). Decreases in spending were driven by reductions in outpatient (4.8%) and acute care (6.6%) spending in PY 2023 ($p<0.05$).

Net spending for New Entrant ACOs increased cumulatively over PY 2021–PY 2023 by $43.2 million (2.7%) or $366 PBPY, after accounting for shared savings or losses and performance bonuses ($p<0.01$); note that this estimate does not adjust for any shared savings, performance-based payments paid or losses to the comparison group. Cumulative net spending increases were smaller ($30.6 million, $p<0.01$) after accounting for shared savings or losses received by providers participating in the Shared Savings Program and NGACO.

Similar to Standard ACOs, a large proportion of beneficiaries served by providers in New Entrant ACOs had prior experience in other accountable care initiatives (34%), as did beneficiaries seen by comparison group providers. Sensitivity analyses excluding beneficiaries served by other accountable care programs showed larger, statistically significant reductions in total gross spending in PY 2023 (ranging from $1,108 to $1,214 PBPY or $45.8 million to $50.0 million[6]). Net spending under this scenario would range from reductions of $99 PBPY (or $4.1 million) to $205 PBPY (or $8.5 million) in PY2023. While this updated range includes a scenario where New Entrant ACOs showed reductions on net spending in PY 2023 alone, cumulative estimates under this scenario may show less favorable results for net spending.

Gross and Net Spending among High Needs ACOs

Compared with Standard ACOs and New Entrant ACOs, beneficiaries aligned to High Needs ACO providers made up a much smaller percentage of the ACO REACH beneficiaries (1%) and had more complex medical needs. For example, a higher proportion of beneficiaries served by High Needs ACOs are dually eligible for Medicare and Medicaid (61%) relative to Standard ACOs (14%) and New Entrant ACOs (16%).[7] High Needs ACOs also have a high mortality rate within the aligned population (affecting one in five beneficiaries each year) with an average of only nine months of alignment for beneficiaries in this ACO type. To account for these factors, comparison group beneficiaries are selected based on the High Needs eligibility criteria and balanced based on a variety of health conditions, as well as additional demographic factors.

High Needs ACOs were the smallest of the ACO types, with an average of about 1,540 beneficiaries per ACO, for a total of approximately 21,600 beneficiaries in PY 2023 across 14 ACOs. The small number of High Needs ACOs and beneficiaries aligned to each ACO presented challenges to the evaluation, requiring modifications to the evaluation approach. As a result of the modifications, ACOs with larger sample sizes or specific practice patterns, for instance, may be heavily influencing the overall impact estimates for this ACO type without an ability to tease out these factors. Our evaluator also was limited in its ability to identify a comparison group with similar types of home-based and palliative care providers as those participating in the model. This is an important limitation because many beneficiaries in the model are homebound or home-limited and it may be difficult to observe differences and alignment patterns between beneficiaries seeking home-based care and other beneficiaries. As a result, the current comparison group may reflect providers serving healthier populations, as is evidenced by the larger proportion of beneficiaries served by the Shared Savings Program providers (25% in the comparison group relative to 11% of those served by model participants in the baseline period). Given that the Shared Savings Program providers tend to serve healthier patients, we are currently exploring revisions to the comparison group to ensure the model is being assessed relative to a comparable set of beneficiaries with complex medical needs. For example, original analyses for High Needs ACOs required additional methodological modifications to adjust for an imbalance in frailty

[6] Sensitivity analyses were conducted to compare care given to beneficiaries by ACO REACH providers relative to FFS beneficiaries seen by providers who had not participated in any ACO models during the study window. In one scenario, we removed beneficiaries served by providers participating in Shared Savings Program and other ACO models from the baseline and performance period for the comparison group. Another scenario further removed beneficiaries served by ACO providers in the baseline period who later participated in the ACO REACH model. Cumulative estimates will be available in the full evaluation report.

[7] Average annualized baseline spending for High Needs ACO was around $45,000 relative to $12,000 for beneficiaries in Standard ACOs and $13,000 for New Entrants.

between beneficiaries aligned to High Needs ACOs versus the comparison group. While the High Needs ACO impact estimates for spending in this document reflect this adjustment, the estimates for all other measures will be adjusted accordingly in the full evaluation report released later this year.

In summary, there are inherent difficulties in evaluating an intervention focused on serving high-cost and medically complex patients. For example, it is difficult to predict which patients will meet the High Needs ACO alignment criteria in a given performance year, and it is challenging to assess the counterfactual for how care would be delivered and by whom outside the model. Model design features intended to support the population served under the model, such as prospective plus voluntary alignment and the use of concurrent risk scores, are difficult to accommodate in typical evaluation designs. Alternative designs may be needed to fully capture the range of beneficiaries within the High Needs ACO type.

With these caveats in mind, preliminary estimates show there were non-significant reductions ($103 per beneficiary or 0.3%, and $2.3 million in aggregate) in total gross spending for High Needs ACOs across PY 2022 and PY 2023 relative to a blend of beneficiaries in other accountable care relationships and those not in accountable care.[8] Cumulative estimates were highly sensitive to the addition of a large, new cohort of participants (most of whom were under shared ownership) that entered the model in PY 2023. Prior statistically significant reductions in total gross spending in PY 2022 ($1,810 per beneficiary or 4.5%)[9] were overcome by non-significant increases in PY 2023 ($509 per beneficiary or 1.4%, and $8.2 million in aggregate). Participants from the cohort that entered the model in PY 2023 were shown to increase spending in PY 2023 ($1,265 per beneficiary or 3.6%, and $10.8 million in aggregate, $p<0.1$). We are investigating further if there are differences between the population of beneficiaries served by these providers and the comparison group.

Relative to a comparison group of beneficiaries served by a blend of providers participating in accountable care and those not in accountable care, net spending increased for High Needs ACOs. After accounting for shared savings or losses and performance bonuses, net spending increased for High Needs ACOs cumulatively across PY 2022-PY 2023 by $116.2 million in total or $5,310 per beneficiary, ($p<0.01$).[10] Cumulative estimates of net spending increases were smaller ($113.3 million, $p<0.01$) when accounting for shared savings and losses received by providers participating in the Shared Savings Program and NGACO.[11] We are continuing to perform sensitivity analyses to address potential, remaining differences between the intervention and comparison groups. Future analyses will also benefit from examining model design changes that occurred in subsequent performance years. High Needs ACOs in particular outlined changes in benchmarking beginning in PY 2025 as part of the original model design.

Sensitivity analyses removing beneficiaries served by other accountable care programs from analyses showed non-significant increases in total gross spending in PY 2023 (ranging from $102 to $129 per beneficiary or $1.6 million to $2.1 million[12]). Understanding the effect of removing these beneficiaries may be particularly important for High Needs given the imbalance in the comparison group between the proportion of beneficiaries served by Shared Savings Program providers relative to those served in the model. Net spending under this scenario would range from increases of $5,624 per beneficiary (or $90.6 million) to $5,651 per beneficiary (or $91.0 million) in PY2023.[13]

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[8] Initial impact estimates of the change in total gross spending for High Needs ACOs are preliminary and subject to revision a future evaluation report.

[9] PY 2022 estimates for total gross spending were updated to adjust for reweighting the comparison group on the High Needs frailty flag and showed more favorable reductions relative to previously published estimates.

[10] Note that this estimate does not adjust for any shared savings or performance-based payments paid to the comparison group.

[11] The cumulative estimate was primarily driven by PY 2023 where increases in net spending were $94.7 million (net spending increases in PY 2022 were $18.5 million).

[12] Sensitivity analyses were conducted to compare care given to beneficiaries by ACO REACH providers relative to FFS beneficiaries seen by providers who had not participated in any ACO models during the study window. In one scenario, we removed beneficiaries served by providers participating in Shared Savings Program and other ACO models from the baseline and performance period for the comparison group. Another scenario further removed beneficiaries served by ACO providers in the baseline period who later participated in the ACO REACH model. Cumulative estimates will be available in the full evaluation report. These analyses did not include one of the High Needs ACOs whose weighting-regression would not converge with the frailty adjustment.

[13] These analyses did not include one of the High Needs ACOs whose weighting-regression would not converge with the frailty adjustment.

Quality of Care Across ACO Types

All three ACO types significantly reduced emergency department visits and observation stays (Standard: 0.6%; New Entrant: 3.2%; High Needs: 6.3%, $p<0.05$) without any decline in quality.[14] Standard[15] and New Entrant[16] ACOs improved multiple claims-based quality measures related to lowering hospitalization rates with stronger effects in PY 2023 relative to prior years. Standard (1.0%) and New Entrants (3.2%) significantly ($p<0.01$) improved recommended diabetes care, possibly due to ACO's efforts to increase primary care touchpoints and slow disease progression through chronic disease management. High Needs ACOs, serving patients with serious illnesses, significantly ($p<0.05$) improved timely follow-up after acute exacerbations of chronic conditions (4.0%) and increased hospice utilization (7.0%) across PY 2022-PY 2023.

Summary

To date, the ACO REACH Model— which includes transformed risk-sharing arrangements, capitation to support investments in population health, and benefit enhancements to support delivery of care— has shown incremental improvements in quality and reductions in gross spending. There are scenarios under which the model has decreased Medicare net spending for specific ACO types in PY 2023, although cumulative estimates across ACO types continue to show increased net spending for the Medicare FFS program overall.

Total gross spending reductions for Standard and New Entrant ACOs in PY 2023 were more promising than previous years, providing signals that model impacts may be improving, although only New Entrant ACOs had statistically significant cumulative reductions. Under various scenarios there were reductions in total gross spending for High Needs ACOs, although these results may change with further analysis. For all ACO types, results from sensitivity analyses excluding beneficiaries served by the Shared Savings Program providers from the comparison group showed more favorable total gross spending reductions, representing a range of estimates relative to the cost of operating an ACO model in the context of the Shared Savings Program.

Unlike the first three model performance years when there were substantial shifts in the number of participants and composition of each ACO type, the evaluation study sample should be more stable going forward. Additionally, changes to the model design made after PY 2023 may reflect smaller incentive payments to participants. This, coupled with the potential to realize returns from investments in care delivery changes from participation in the model over time, may produce more favorable results for the model in the future.

[14] Impact estimates for utilization and quality measures for High Needs ACOs are preliminary and subject to change given ongoing methodological adjustments to increase the comparability between High Needs beneficiaries and the comparison group.
[15] Standard ACOs significantly ($p<0.1$) reduced hospitalizations for ambulatory care sensitive conditions (ACSC, by 3.3%), unplanned hospital admissions among beneficiaries with multiple chronic conditions (by 1.6%), while increasing the timely follow-up after acute exacerbations of chronic conditions (by 0.8%) and percent of days at home (by 0.1%) across PY 2021-PY 2023.
[16] New Entrant ACOs significantly ($p<0.1$) reduced hospitalizations for ACSC (by 4.7%) and improved percent of days at home (by 0.2%) across PY 2021-PY 2023.