EVALUATION REPORT 3: EXECUTIVE SUMMARY

July 2026

Evaluation of the ACO REACH Model

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Key Findings

The ACO REACH Model is an advanced accountable care organization (ACO) initiative to promote patient-centered care, lower costs, and align payment systems for Original Medicare beneficiaries through ACO risk-sharing and prospective payment. In performance year (PY) 2023, the model showed stronger improvements in quality than prior years and lowered gross spending across all ACO types by 1% ($126 per beneficiary per year [PBPY]). Although net spending increased for all ACO types, the estimated increase was not statistically significant for New Entrant ACOs and was less than 1% for Standard ACOs. Across all ACO types, the model increased net spending by 0.8% ($102 PBPY; **Exhibit ES.1**). These promising 2023 results, coupled with more recent model design changes aimed at providing smaller incentive payments to participants, may give the model increased opportunity to reduce spending while improving quality. Future reports will determine if these results continue.

Participation increased as 48 new ACOs joined the model in PY 2023.

The model served over 2 million beneficiaries through 132 participating ACOs: 105 Standard ACOs, 13 New Entrant ACOs, and 14 High Needs ACOs. Half (52%) of aligned beneficiaries were new to the model in PY 2023.

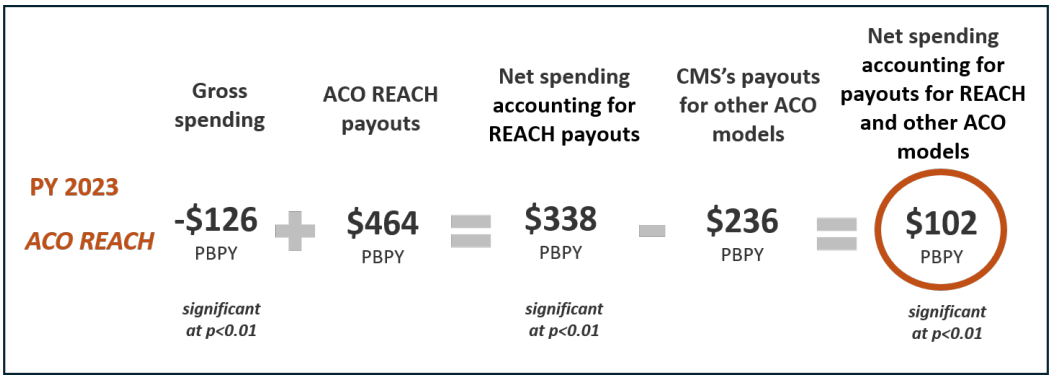
ACOs refined and built on existing care delivery activities to manage complex care needs.

Over 70% of ACOs reported prioritizing initiatives to reduce avoidable hospital utilization, increase primary care touchpoints, and manage care for patients with complex needs. Care strategies were implemented broadly, not only among beneficiaries aligned with REACH ACOs.

REACH ACOs reduced gross spending and improved quality more in PY 2023 than in prior years

All three ACO types reduced gross spending in PY 2023 relative to comparison groups of beneficiaries seen by a blend of providers participating in other accountable care relationships such as the Medicare Shared Savings Program (Shared Savings Program) and those without such experience.[1] After factoring in shared savings and incentive payments, net spending increased across all ACO types in PY 2023 relative to comparison groups, but findings for New Entrant ACOs were not statistically significant and increases for Standard ACOs were only marginally statistically significant at $p<0.1$. Future results, reflecting model design changes to reduce incentive payments, may be more favorable.[2] All ACO types reduced emergency department visits and observation stays, improved hospitalizations and/or post-acute care in PY 2023. All ACO types improved multiple quality measures, with larger improvements in PY 2023 relative to prior years.

Exhibit ES.1 Across all ACO Types, Net Spending Increased in PY 2023 Despite Reductions in Gross Spending



[1] Comparison groups comprised beneficiaries with similar characteristics that resided within the same health care markets as the ACO REACH beneficiaries during the same time period but were mainly seen by providers not participating in the model. These providers included those participating in the Shared Savings Program and other Innovation Center models as well as providers without such experience, comparable to ACO REACH providers prior to the start of the model.

[2] The original design of GPDC and ACO REACH phased New Entrant and High Need ACOs away from regional-only benchmark calculations into a blend of regional and historical expenditures for beneficiaries in the model starting in PY 2025. This coupled with model design changes for PY 2025 and PY 2026 should create lower shared savings payments to participants in future performance years, allowing for an opportunity for more favorable net spending results.

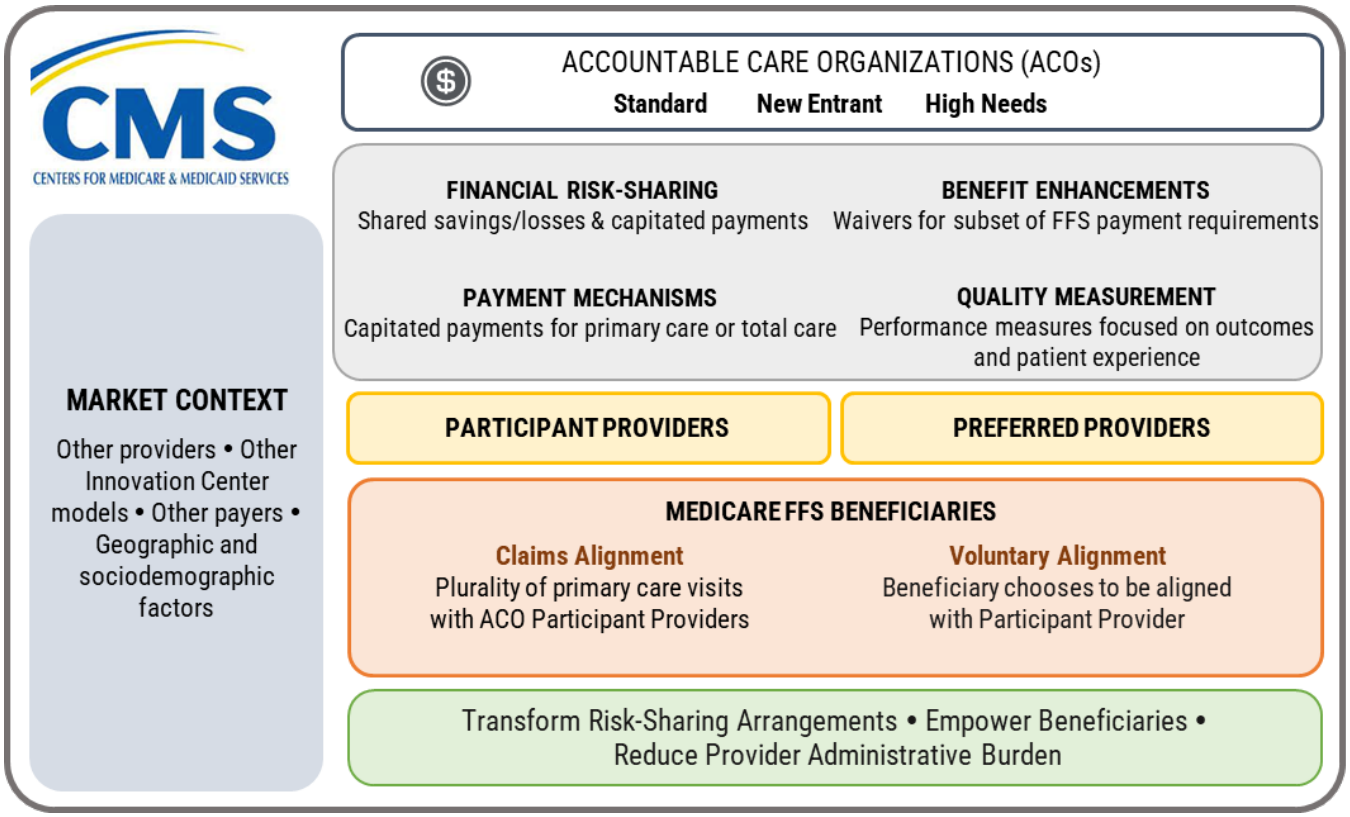
Executive Summary

Our mixed methods evaluation of the ACO REACH Model estimates its impact on spending, health services utilization, and quality of care for beneficiaries aligned to the model through their providers. The impact of ACO REACH was estimated using a difference-in-differences design, with a comparison group of beneficiaries from the same ACO markets served by non-ACO REACH providers. The comparison groups included Original Medicare beneficiaries served by providers in Shared Savings Program ACOs and other alternative payment models that would be alternatives absent the ACO REACH Model. To understand implementation progress and experience, we conducted a survey of ACO leaders and interviews with ACO leaders and providers.

Overview of the ACO REACH Model

In 2021, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) launched the Global and Professional Direct Contracting (GPDC) Model. The model is an advanced ACO initiative designed to shift risk-sharing from the fee-for-service (FFS) Medicare program (Original Medicare) to ACOs, legal entities organized by providers to voluntarily accept fiscal and quality accountability for the spending and quality of care for beneficiaries under their care. After GPDC's first two performance years, CMS redesigned the model and renamed it "ACO REACH," effective January 2023. ACO REACH builds on GPDC, placing greater emphasis on increasing provider leadership within ACOs and enhancing monitoring and transparency for the benefit of beneficiaries (**Exhibit ES.2**). In PY 2023, the first year of ACO REACH, the model served more beneficiaries and engaged more providers than during the previous two years of the GPDC Model.

Exhibit ES.2. Overview of ACO REACH Model



Scope and Reach of the Model

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. The model offered three categories of participation, based on prior experience and patient population (see text on right). Eighty percent of participating ACOs were Standard ACOs. Over time, the number of Standard ACOs has increased, in part due to the recategorization of some New Entrant and High Needs ACOs to meet model requirements. This steady transition has led to an increase in the average size of participating ACOs.

Model Requirements by ACO[3] Type in PY 2023[4]

Standard ACOs (n=105): Have experience serving Original Medicare beneficiaries in risk-based contracts; minimum of 5,000 aligned beneficiaries.

New Entrant ACOs (n=13):[5] Have limited experience serving Original Medicare beneficiaries; minimum of 2,000 aligned beneficiaries.

High Needs ACOs (n=14): Serve Original Medicare beneficiaries with complex needs; minimum of 500 aligned beneficiaries.

Organizational characteristics. The organizational characteristics of ACOs can influence the resources and capacities they bring to model implementation and their ability to help providers deliver value-based care. In PY 2023, ACOs were led and managed by a broad range of organizations. Health care providers (either health systems or physician practices) and management services organizations (MSOs)[6] each led more than one-third of participating ACOs. Even when they did not lead ACOs, MSOs were frequently partners or vendors to ACOs—about three-quarters of ACOs worked with an MSO in some capacity.

Provider networks. ACOs built their provider networks by contracting with practitioners and with facilities to be either Participant Providers (used in beneficiary alignment and quality measure scoring) or Preferred Providers (affiliated but not used for alignment or quality purposes). In total, ACOs had 133,288 providers in PY 2023; fewer than half were Participant Providers. As the largest ACO type, Standard ACOs accounted for 92% of Participant and Preferred Providers. New Entrant ACOs had the fewest providers and accounted for no more than 1,500 Participant and Preferred Providers in the model. Almost all safety net facilities in the model were Participant Providers, while ACOs typically included other facilities like hospitals and skilled nursing facilities (SNFs) as Preferred Providers. In PY 2023, the number of safety net facilities participating in the model more than doubled from the year before, reflecting a large increase in participation from federally qualified health centers (FQHCs).

[3] Accountable care organizations (ACOs) are health care providers and suppliers that enter arrangements with CMS to accept financial risks and rewards (shared savings) based on the cost and quality of care for their Medicare beneficiaries. In GPDC and ACO REACH, Participant Providers are individual practitioners, suppliers, or facilities participating in the model that contribute to beneficiary alignment and quality measure scoring. Preferred Providers are individual practitioners, suppliers, or facilities affiliated with an ACO that are not used in beneficiary alignment or quality measures scoring.

[4] For details on model requirements and features, see the ACO REACH Request for Applications, available at: https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa.

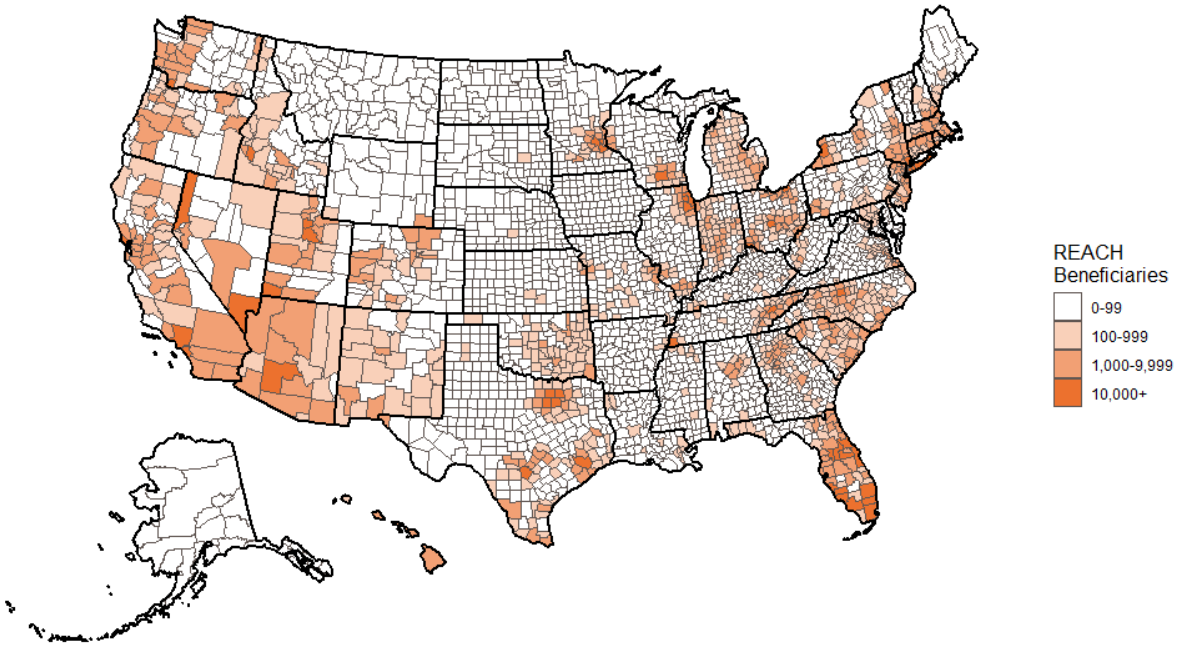
[5] We estimated impacts for 12 of the 13 New Entrant ACOs. One New Entrant ACO could not be evaluated due to an inadequate baseline.

[6] Also known as management companies, MSOs provided non-clinical administrative and operational services and supports to providers.

Beneficiaries. In PY 2023, ACOs provided services to over 2 million aligned beneficiaries residing in all 50 states.[7] Almost all beneficiaries (96%) were aligned to Standard ACOs. Half (52%) of these beneficiaries were new to the model in PY 2023.

Geographic reach of ACOs. As shown in **Exhibit ES.3,** the model's beneficiaries were generally more widespread in the Southeast, Southwest, and Mountain West. Forty-nine counties had more than 10,000 ACO beneficiaries.

Exhibit ES.3. County-Level ACO REACH Beneficiary Population Distribution



SOURCE: Medicare claims and enrollment data.
NOTE: Provider overlap is prohibited with the following statewide models—the Maryland Total Cost of Care Model and the Vermont All-Payer ACO Model. ACO REACH-aligned beneficiaries residing in Maryland and Vermont received care from ACO REACH providers in other states.

How ACOs Chose and Implemented Model Features

At the beginning of each performance year, ACOs elected specific model features, including risk-sharing approaches and payment mechanisms, beneficiary alignment approaches, and benefit enhancements.

Risk-sharing and payment mechanisms. As ACOs aimed to optimize their performance in each model performance year, they selected a combination of risk and payment options. 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. Over 80% of ACOs chose Global risk. 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

[7] The total number of aligned beneficiaries in PY 2023 was 2,046,054 beneficiaries. The ACO REACH intervention group (ACO REACH group) included 1,814,335 aligned beneficiaries and was defined as beneficiaries aligned to ACO REACH Participant Providers in PY 2023 and in the baseline period, excluding Prospective Plus voluntarily aligned beneficiaries.

covered under Original Medicare. Most ACOs selected both Global risk and PCC (59%), rather than the more comprehensive Global risk with TCC (23%) or the lower risk Professional option with PCC (18%). In interviews, many ACO leaders referred to their prior experience with full-risk contracts and their expectation that Global risk would maximize their shared savings under the model. Leaders of some ACOs that elected PCC explained that they considered PCC more appropriate for their organization due to the primary care focus of their providers.

Risk and payment options

Global risk: A higher risk-sharing arrangement - 100% savings/losses with two payment options (PCC or TCC).

Professional risk: A lower risk-sharing arrangement—50% savings/losses with one payment option (PCC).

Primary Care Capitation (PCC): A risk-adjusted monthly payment for primary care services provided by the ACO's participating providers.

Total Care Capitation (TCC): A risk-adjusted monthly payment for all covered services, including specialty care, provided by the ACO's participating providers.

The model afforded ACOs discretion in their downstream payment arrangements with providers. Nearly all ACOs (92%) distributed some amount of shared savings to participant practitioners. In interviews, some ACO leaders explained that they paid savings to providers based on performance, quality, and utilization measures. However, only 26% of ACOs shared losses. The majority of ACOs (70%) used a blend of payment arrangements with providers that included capitation, FFS, and quality-based payments, with arrangements often tailored to providers' experience with risk and cashflow needs. Payment structures varied, including recurring upfront payments or a combination of initial payments and deferred, performance-based bonuses. Incentive payments were typically contingent on provider performance on specified quality and outcome metrics, contributions to shared savings, or the provider's proportion of model-aligned beneficiaries.

Beneficiary Eligibility and Alignment. Most beneficiaries in Standard and High Needs ACOs were passively aligned with an ACO through claims. In interviews, ACO leaders noted challenges with voluntary alignment related to eligibility criteria, administrative burden, and delays in attribution. New Entrant ACOs aligned a higher proportion of beneficiaries using voluntary alignment, relative to Standard and High Needs ACOs.

Benefit Enhancements. CMS conditionally waived certain Medicare payment requirements to test whether additional benefit flexibilities could reduce costs and improve care coordination and patient outcomes. With the exception of High Needs ACOs, benefit enhancement uptake was generally low. While all ACOs submitted claims under the telehealth and SNF 3-day rule waivers, fewer utilized other flexibilities, including homebound home health (55%), concurrent care for beneficiaries electing Medicare hospice (38%), nurse practitioner services (20%), care management home visits (5%), or post-discharge home visits (4%).[8] ACOs cited administrative and operational challenges as barriers to their use, including building relationships with SNFs and home health agencies, establishing contracts with vendors and other providers, developing and implementing workflows, and educating providers. After adjusting for the numbers of beneficiaries aligned to each ACO, High Needs ACOs were more likely than Standard or New Entrant ACOs to submit claims related to the home health or concurrent care waivers. High Needs ACOs with the most claims submitted per 1,000 beneficiaries tended to focus on delivering care to beneficiaries in institutional and home health settings.

[8] For a description of each benefit enhancement waiver and eligibility criteria, please see the ACO REACH Request for Applications, available at: https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa

How ACOs Implemented the Model

ACO REACH allowed ACOs to tailor their approaches to improving care delivery. Over 70% of ACO leaders reported reducing avoidable hospital utilization and admissions, increasing primary care touchpoints, and implementing complex care management or population-specific care management as high priorities. Most ACOs took advantage of model participation to refine and build on pre-existing initiatives. In both interviews and the survey, ACO leaders reported that their strategies were not limited to ACO REACH beneficiaries; most commonly, ACOs provided similar services to Medicare Advantage beneficiaries.

Building and expanding health IT and data analytic infrastructure. In interviews, many ACO leaders and providers described supporting primary care and population health management through health IT and data analytics. To identify high-cost, high-risk beneficiaries, some ACOs relied on externally developed risk algorithms from vendors, while others conducted their own analytics or developed proprietary algorithms. In the survey, two-thirds of ACOs reported that by PY 2023, they could identify and target beneficiaries using predictive risk stratification. ACO leaders also emphasized the importance of accurate patient-level data and real-time tracking and notification of ED visits and inpatient admissions, discharges, and transfers.

Expanding care management. In the survey, 89% of ACOs reported that complex or population-specific care management was a high or medium priority; two-thirds of these ACOs reported adopting (19%) or expanding (47%) care management during participation in the model. ACOs also expanded their care teams. Many providers interviewed said that since joining ACO REACH they had greater access to staff across disciplines, including nurse care managers, clinical pharmacists, community health workers, social workers, and dietitians. To manage care for high-risk beneficiaries, including those with chronic conditions, ACOs supported increases in the frequency of primary care visits and connected patients to primary care. ACOs also used in-home interventions, including remote monitoring, to manage the care of high- and rising-risk beneficiaries.

Supporting care transitions and reducing post-acute care utilization. ACOs used multiple strategies to improve care transitions, most commonly medication reconciliation, telephone follow-up, and standardized post-discharge processes for timely follow-up. For 61% of ACOs, reducing post-acute care utilization was a high priority; in interviews, many ACO leaders noted that they began or expanded strategies to reduce post-acute care utilization because of their participation in the model. Common strategies included monitoring admissions and discharges by having dedicated staff to follow ACO beneficiaries and coordinate with SNF staff, partnering with select SNFs to improve quality more broadly, and focusing on process improvements to reduce length of stay and improve quality.

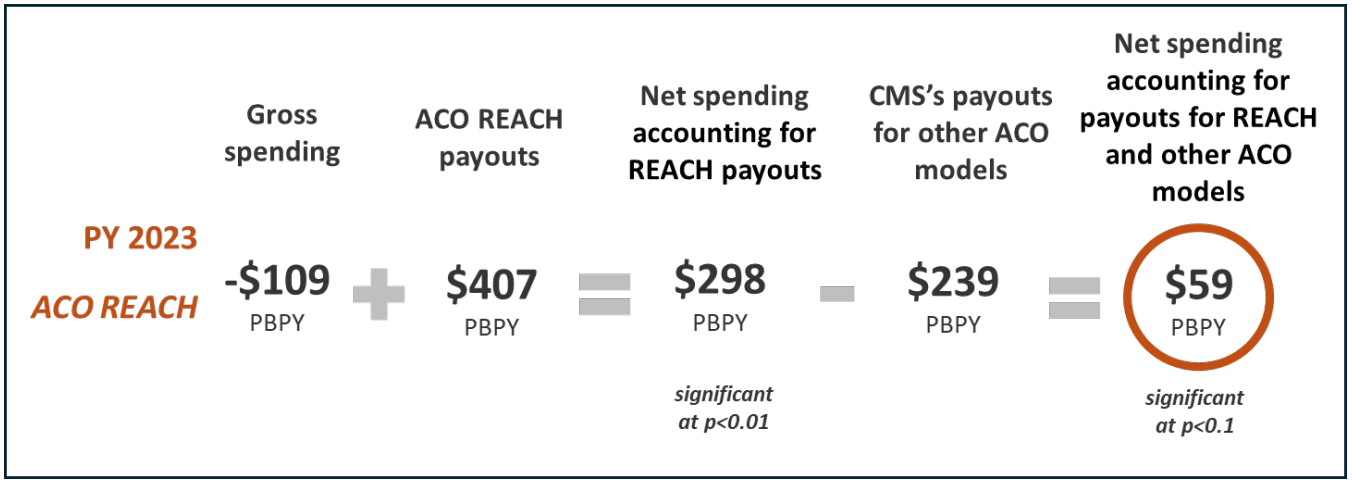
Engaging providers. ACOs offered different levels and types of support to providers and exerted varied degrees of control over providers' administrative and clinical operations. They used an array of strategies to engage providers in improving quality and reducing unnecessary utilization. Most ACOs reported financial bonuses as very important to engage providers; fewer said the same of financial penalties or nonfinancial incentives. ACOs also engaged providers through practice support and improvement activities. Supporting data analytics was an important strategy for ACOs. Most ACO leaders emphasized that building rapport with providers—through regular meetings, coaching, and one-on-one reviews of performance data—was also critical to increasing provider awareness of the objectives of value-based care. Further, ACOs offered training and education to their providers. Many ACO leaders and providers identified barriers, including limited provider bandwidth, the small proportion of aligned beneficiaries in providers' panels, and limited incentives for specialist engagement.

Standard ACOs: Impact on Medicare Outcomes

In PY 2023, Standard ACOs in ACO REACH showed a promising statistically significant reduction in total **gross spending** by $197.5 million in aggregate (0.9%), or $109 per beneficiary per year (PBPY), relative to their comparison groups (**Exhibit ES.3)**; the reduction reflected decreased spending for outpatient care, acute care, and PAC, as expected. Reduced spending in PY 2023 reversed a trend from the second year of the model, where gross spending had increased. The overall decrease in gross spending in PY 2023 reflected the experience of ACO cohorts that started in 2021 and the influx of 2023 participants, which had declines of 1.7% and 0.7%, respectively (the 2022 cohort also saw a decrease that was not statistically significant). Cumulatively across PY2021-PY2023, there was no statistically significant change in gross spending for Standard ACOs. Standard ACOs that elected the highest levels of financial accountability (Global TCC and Global PCC) statistically significantly reduced gross spending in PY 2023 (-1.9% and -0.8, respectively). ACOs structured as networks of individual practices also had a statistically significant reduction in gross spending (-1.3%) in PY 2023 and cumulatively as of PY 2023 (-0.8%), while ACOs structured as integrated delivery system (IDS)/hospital systems had a statistically significant cumulative increase in gross spending (0.8%). Those ACOs described as networks of individual practices reduced utilization of outpatient and acute care, and home health episodes, while IDS/hospital system ACOs increased utilization of ED visits and institutional PAC, relative to comparison groups.

Net spending for Medicare statistically significantly increased by $59 PBPY (0.5% or $107 million in total), after accounting for shared savings and performance bonus payments for ACO REACH ACOs and comparison groups (**Exhibit ES.4)**. Cumulatively, net spending among Standard ACOs statistically significantly increased by $83 PBPY (0.7% or $310.5 million in total) across PY 2021-PY 2023.

Exhibit ES.4. Net Medicare Spending Increased for Standard ACOs in PY 2023, Despite Decreases in Total Gross Medicare Spending in PY 2023



SOURCE: NORC analysis of Medicare FFS claims data and programmatic data.
NOTE: PBPY=per beneficiary per year. Impact estimates were relative to baseline years and a comparison group employing difference-in-differences regressions. PBPY shared savings and bonus payments reflected the number of beneficiaries included in evaluation analyses, which excluded Prospective Plus voluntarily-aligned beneficiaries.

Cumulatively, over the three years of GPDC and ACO REACH, Standard ACOs improved **quality of care** for five of the six measures evaluated (**Exhibit ES.5**).[9] For Standard ACOs, there were larger improvements in quality and larger declines in utilization in the first year of ACO REACH relative (PY 2023) to what was observed cumulatively.

Exhibit ES.5. Standard ACOs Improved Five Quality Measures and Decreased Utilization Across Settings in PY 2023 and Cumulatively as of PY 2023

Quality						
	All-Condition Readmissions^	**ACSC Hospitalizations**	**Unplanned Admissions for Patients With MCC^**	**Recommended Diabetes Care**	**Timely Follow-Up^**	**Days at Home**
Cumulatively as of PY 2023	-0.4%	-3.3%***	-1.6%***	+1.0%***	+0.8%***	+0.1%***
In PY 2023	-1.3%*	-4.7%***	-2.0%***	+1.3%***	+1.3%***	+0.2%***

Utilization					
	ED Visits and Observation Stays	**Acute Care Hospitalizations**	**Acute Care Length of Stay**	**SNF Days**	**Home Health Episodes**
Cumulatively as of PY 2023	-0.6%***	-0.5%**	-0.5%*	-0.7%*	-1.4%***
In PY 2023	-1.0%***	-1.4%***	-1.7%***	-1.1%*	-1.7%***

SOURCE: NORC analysis of Medicare fee-for-service (FFS) claims data and programmatic data.
NOTE: ACSC=ambulatory care-sensitive condition; ED=emergency department; MCC=multiple chronic conditions; SNF=skilled nursing facility. Quality measures reflect care that is either avoidable or recommended, while utilization measures reflect use of care where appropriateness could not be determined. Percent impact was relative to expected outcomes had the model not existed, estimated using difference-in-differences regressions. *p<0.10, **p<0.05, ***p<0.01. ^Measure included in quality performance calculations.

New Entrant ACOs: Impact on Medicare Outcomes

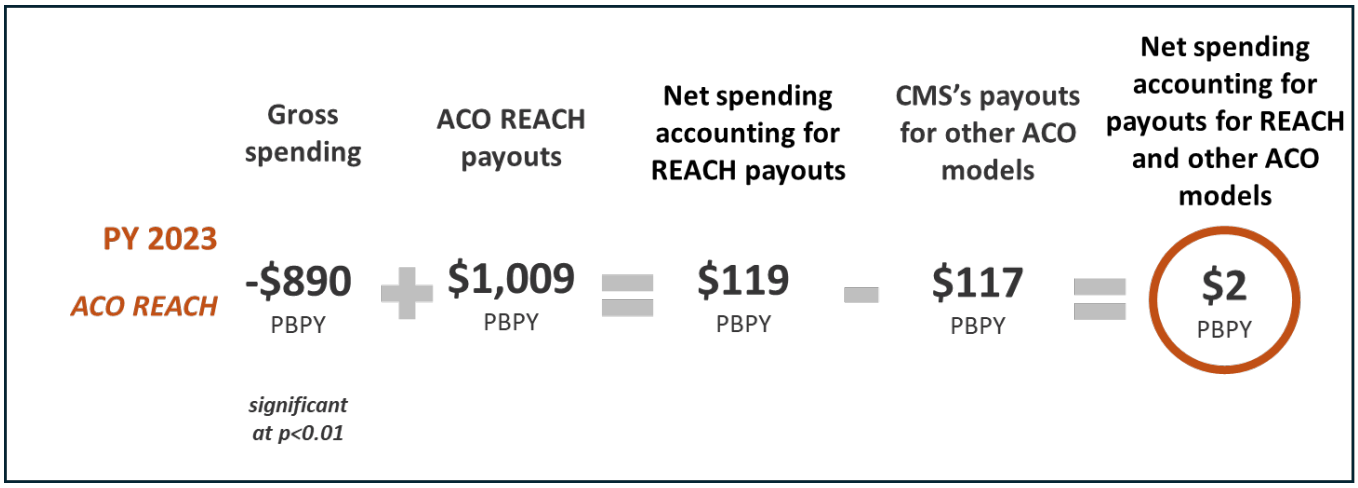
New Entrant ACOs experienced more year-to-year shifts in participation than Standard ACOs, leading to more variation in the beneficiary population over time. In PY 2023, six New Entrant ACOs entered the model. Through PY 2023, 15 of the 28 ACOs that entered the model as New Entrant ACOs transitioned to Standard ACOs. 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.

In general, impacts for New Entrant ACOs were larger per beneficiary than those observed for Standard ACOs. New Entrant ACOs experienced more favorable impacts on total **gross spending** than Standard ACOs, with large statistically significant decreases during ACO REACH in PY 2023 (by $890 PBPY or 6.2%, and $36.8 million in aggregate) as well as a cumulative decrease over the three years of GPDC and ACO REACH (by $433 PBPY or 3.2%, and $51.1 million in aggregate, **Exhibit ES.6**). Decreases in spending reflected utilization declines in ED visits and in acute care settings (**Exhibit ES.7**). Similar to Standard ACOs, **net spending** statistically significantly

[9] The six quality measures evaluated were: 1) ambulatory care-sensitive condition (ACSC) hospitalizations, 2) unplanned admissions for beneficiaries with multiple chronic conditions (MCC), 3) all-condition readmissions, 4) rate of receipt of recommended diabetes care, 5) rate of timely follow-up after acute exacerbations of chronic conditions, and 6) percent days at home. Four of the measures were included in the calculation of the model's financial incentives for PY 2023: unplanned admissions for beneficiaries with MCC, all-condition readmissions, rate of timely follow-up (Standard and New Entrant ACOs only), and percent days at home (High Needs ACOs only).

rose for New Entrant ACOs cumulatively as of PY 2023 by $259 PBPY (1.9%, $30.6 million in total), after accounting for shared savings and performance bonuses. However, net spending increases of $2 PBPY ($98,669 in aggregate) in PY 2023 were not statistically significant (**Exhibit ES.6**).

Exhibit ES.6. Despite Large Decreases in Total Gross Medicare Spending, New Entrant ACOs Slightly Increased Net Spending in PY 2023, although the Increase was not Statistically Significant



SOURCE: NORC analysis of Medicare FFS claims data and programmatic data.
NOTE: PBPY=per beneficiary per year. Impact estimates were relative to baseline years and a comparison group employing difference-in-differences regressions. PBPY shared savings and bonus payments reflected the number of beneficiaries included in evaluation analyses, which exclude Prospective Plus voluntarily-aligned beneficiaries.

New Entrant ACOs not only reduced gross spending but also statistically significantly improved quality of care for three of the six measures evaluated—greater adherence to diabetes care recommendations, more days at home, and fewer hospitalizations for ambulatory care-sensitive conditions (ACSCs) (**Exhibit ES.7**). For New Entrant ACOs, effects in PY 2023 were more favorable than cumulative effects, with larger improvements in quality outcomes and larger declines in utilization, including for acute care, in ACO REACH's first year.

Exhibit ES.7. New Entrant ACOs Improved Three Quality Measures and Decreased ED Visits in PY 2023 and Cumulatively as of PY 2023

Quality						
	All-Condition Readmissions^	**ACSC Hospitalizations**	**Unplanned Admissions for Patients With MCC^**	**Recommended Diabetes Care**	**Timely Follow-Up^**	**Days at Home**
Cumulatively as of PY 2023	-0.9%	-4.7%*	-2.2%	+3.2%***	+1.5%	+0.2%*
In PY 2023	-1.9%	-11.7%**	-1.0%	+2.1%	+2.1%	+0.6%**

Utilization					
	ED visits & observation stays	**Acute care hospitalizations**	**Acute care length of stay**	**SNF days**	**Home health episodes**
Cumulatively as of PY 2023	-3.2%***	-1.3%	-0.8%	-3.2%	-1.2%
In PY 2023	-3.6%**	-3.6%*	-4.5%*	-6.0%	-3.8%

SOURCE: NORC analysis of Medicare fee-for-service (FFS) claims data and programmatic data.
NOTE: ACSC=ambulatory care-sensitive conditions; ED=emergency department; MCC=multiple chronic conditions; SNF=skilled nursing facility. Quality measures reflect care that is either avoidable or recommended, while utilization measures reflect use of care where appropriateness could not be determined. Percent impact was relative to expected outcomes had the model not existed, estimated using difference-in-differences regressions. *p<0.10, **p<0.05, ***p<0.01. ^Measure included in quality performance calculations.

High Needs ACOs: Impact on Medicare Outcomes

As discussed in the Preview of Findings from the Evaluation of ACO REACH Model for PY 2023, evaluating the High Needs ACO type has presented a number of challenges. Revisions to the comparison groups for High Needs ACOs were made to address compositional changes in the providers and beneficiaries participating in the model in PY 2023.[10] These changes have updated impact estimates for both PY 2022 and PY 2023 relative to what has been previously publicly released.[11] Additionally, the small sample sizes and wide variability in the patient populations served by the High Needs ACOs can make it difficult for impact estimates to achieve statistical significance and instead the directionality and effect size of the impact estimates may be more useful to examine.

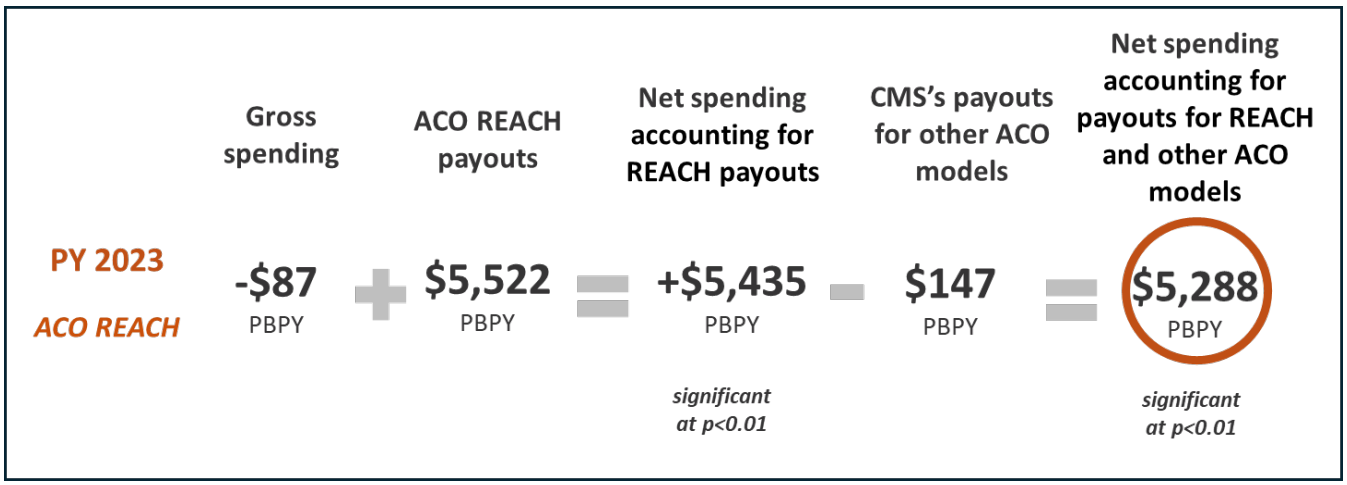
While High Needs ACOs reduced total spending in PY 2023, their comparison groups had similar reductions in spending that resulted in a non-statistically-significant relative decrease in total **gross spending** of -$87 PBPY (**Exhibit ES.8**) or -0.2% (-$1.4 million in aggregate).[12] However, in some versions of regression models tested to improve the comparison group, gross spending estimates were statistically significant with similar effect sizes as are reported above. Cumulatively, there were statistically significant reductions in total gross spending for High Needs ACOs, relative to the comparison groups (-$903 PBPY, -2.3% and -$19.6M aggregate).[13]

There were cohort effects for the High Needs ACOs, similar to Standard ACOs, with stronger reductions in total spending among the 2021 and 2023 cohorts relative to the 2022 cohort of participants. In PY 2022, the PY 2021 cohort (-10.0%, $-4,504 PBPY, p<0.01) was driving the statistically significant reduction in gross spending relative to the PY 2022 cohort (-2.7%, $-1,214 PBPY, not statistically significant).[14] In PY 2023, while none of the estimates were statistically significant, there were increase in spending observed among the PY 2022 cohort (4.4%) relative to reductions among the PY 2021 (-0.9%) and PY 2023 (-0.8%) cohorts (Appendix Exhibit L.2).[15]

[10] The refinements to the current comparison group focused on matching beneficiaries on more specific criteria used for determining high needs eligibility, which improved the comparability of the two groups. However, the updated comparison groups may still 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).
[11] Evaluation Report 2: Evaluation of the GPDC Model reported statistically significant gross spending reduction in PY 2022 of $1,397.76 PBPY (-3.5% or $8.1 million in aggregate). The Preview of Findings from the Evaluation of ACO REACH Model for Performance Year 2023 further refined the comparison groups used for assessing PY 2022 and PY 2023 impact estimates relative to methods used in Evaluation Report 2. The preview report listed statistically significant spending reductions of $1,810 PBPY (4.5%) in PY 2022 and non-statistically significant spending increases of $509 PBPY (1.4% or $8.2 million in aggregate) for PY 2023 with total cumulative spending non-statistically-significantly increasing by $103 PBPY (0.3%, $2.3 million in aggregate).
[12] These results were sensitive to model specifications such as the inclusion of specific baseline variables used to construct the comparison groups and control for covariates in regression models (e.g., whether a beneficiary resided in a long-term care facility in the prior 12 months).
[13] We found consistent parallel trend violations for the PY 2022 cohort across all regression models tested, suggesting that caution should be used in interpreting these results.
[14] The PY 2022 impact estimates by cohort are updated relative to what was reported in Annual Report 2: Evaluation of the GPDC Model where both cohorts of High Needs DCEs in PY2022 showed statistically significant and consistent declines (3.4% for the 2021 cohort and 3.7% for the 2022 cohort).
[15] The Preview of Findings from the Evaluation of ACO REACH Model for Performance Year 2023 reported differing cohort effects that appeared to show the PY 2023 cohort driving spending increases in PY 2023.

High Needs ACOs statistically significantly increased **net spending** by $5,288 PBPY (14.5%, $85 million total) in PY 2023 (**Exhibit ES.8**) and cumulatively ($96.0 million across PY 2022 and PY 2023).[16] These results reflect net spending through PY 2023, prior to pre-planned model design changes that may reflect smaller incentive payments to participants in future performance years. [17] Given this, and the relatively small sample sizes, high mortality rate, and few number of participants in High Needs ACOs, future analyses are needed to determine if these trends hold over time.

Exhibit ES.8. Total Net Medicare Spending Increased for High Needs ACOs in PY 2023 Despite Reductions in Total Gross Spending



SOURCE: NORC analysis of Medicare FFS claims data and programmatic data.
NOTE: PBPY=per beneficiary per year. Impact estimates were relative to baseline years and a comparison group. Cumulative estimates and shared savings/bonus payments reflected PY 2022 and PY 2023 only; impact estimation was not feasible for PY 2021. PBPY shared savings and bonus payments reflected the number of beneficiaries included in evaluation analyses, which excluded Prospective Plus voluntarily-aligned beneficiaries.

On quality, both cumulatively and in PY 2023, High Needs ACOs had a statistically significant improvement in one measure—an increase in timely follow-up after exacerbations of chronic conditions (**Exhibit ES.9**). Cumulatively, High Needs ACOs made a statistically significant improvement in days at home, though this improvement was marginal in size. In PY 2023, High Needs ACOs statistically significantly reduced hospitalizations for ACSC. On utilization, High Needs ACOs decreased ED visits both in 2023 and cumulatively. For post-acute care, inpatient rehabilitation facility/long-term care hospital (IRF/LTCH) days decreased in PY 2023, SNF days decreased cumulatively, and home health episodes decreased both in PY 2023 and cumulatively **(Exhibit ES.9).**

[16] The relatively small number of High Needs ACOs in the model's first year (PY 2021) meant that impacts could not be evaluated for that year. For High Needs ACOs, cumulative impact estimates reflect aggregation over two performance years (PY 2022 and PY 2023) rather than the three years used to estimate performance for the Standard and New Entrant ACOs.
[17] The original design of GPDC and ACO REACH phased New Entrant and High Need ACOs away from regional-only benchmark calculations into a blend of regional and historical expenditures for beneficiaries in the model starting in PY 2025. This coupled with model design changes for PY 2025 and PY 2026 should create lower shared savings payments to participants in future performance years.

Exhibit ES.9. High Needs ACOs Improved Timely Follow-Up and Decreased ED Visits and Post-Acute Care Utilization in PY 2023 and Cumulatively as of PY 2023

Quality					
	All-Condition Readmissions	ACSC Hospitalizations	Unplanned Admissions for Patients with MCC^	Timely Follow-Up	Days at Home^
Cumulatively as of PY 2023	-2.4%	-5.1%	-2.6%	+3.5%*	+0.4%***
In PY 2023	+1.0%	-7.1%*	-1.1%	+2.6%**	+0.1%

Utilization					
	ED Visits and Observation Stays	IRF and LTCH days	Total Hospice Days	SNF days	Home Health episodes
Cumulatively as of PY 2023	-5.7%***	-8.6%	2.0%	-6.5%**	-6.3%***
In PY 2023	-5.1%***	-13.4%**	0.7%	-1.5%	-7.2%***

SOURCE: NORC analysis of Medicare FFS claims data and programmatic data.
NOTE: ACSC=ambulatory care-sensitive condition; MCC=multiple chronic conditions; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; SNF=skilled nursing facility. Quality measures reflect care that is either avoidable or recommended, while utilization measures reflect use of care where appropriateness could not be determined. Recommended diabetes care was not measured for High Needs ACOs. Percent impact was relative to expected outcomes had the model not existed, estimated using difference-in-differences regressions. Cumulative estimates reflected PY 2022 and PY 2023 only; impact estimation was not feasible for PY 2021. *p<0.10, **p<0.05, ***p<0.01. ^Measure included in quality performance calculations.

Discussion

Over the first three years of the model, GPDC and then ACO REACH has demonstrated substantial growth and fluid participation, with a notable shift of New Entrant ACOs into Standard ACOs and an increase in the average size of ACOs. Standard ACOs now represent 80% of all ACOs and 96% of aligned beneficiaries. The model's growth is reflected in its nationwide presence throughout the U.S. with over 2 million aligned beneficiaries.

In its first performance year (PY 2023), the ACO REACH Model continued to improve quality of care and utilization, as seen in the prior two performance years under GPDC. These improvements are in line with ACOs' investments in analytic capacity to better understand the care needs of their populations and implementation of strategies to reduce avoidable hospital utilization and admissions, including a focus on complex and population-specific care management and on increasing primary care touchpoints. Both Standard and New Entrant ACOs had statistically significant reductions in total gross Medicare spending (Parts A & B) and High Needs ACOs had promising reductions that were statistically significant under some modeling scenarios. However, the model did not achieve reductions in net Medicare spending in the first three performance years.

The marked changes in impacts from GPDC to ACO REACH likely reflected four factors:

- Model changes to the benchmark implemented in PY 2023 that incentivized ACOs to serve more beneficiaries who were dually eligible or who were in under-resourced areas
- For ACOs continuing in the model, improvements over time in their ability to generate savings
- Exit from the model of ACOs that did not perform well
- Selective entry by the final cohort of ACOs in PY 2023

Given the notable significant fluctuations in evaluation estimates across the three performance years to date, as well as the model design changes in future performance years, future analyses are needed to determine these promising trends providing an opportunity for the model to improve quality without increasing spending.

Interested in Learning More?

The following resources are available to obtain a snapshot of key findings or to dive deep into the evaluation of ACO REACH's third performance year:

- **Findings at a Glance** | 2 pages

  Concise visual summary of key findings

- **In-Depth Report** | 87 pages

  Comprehensive evaluation findings and methodology