

CMS Perspective:

ACO REACH Model PY 2023 Evaluation Report and Preliminary Results for PY 2024

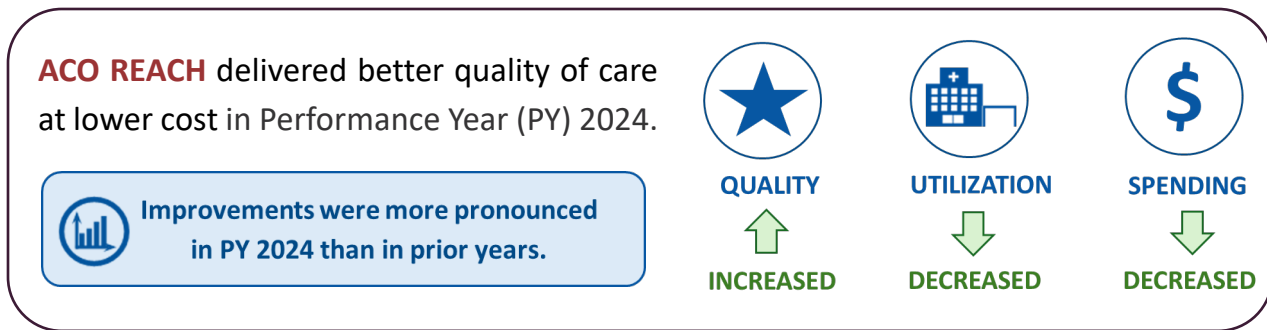
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For information on ACO REACH and to download the independent evaluation report discussed in this document, please visit

<https://www.cms.gov/priorities/innovation/innovation-models/aco-reach>



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Building on prior tests of accountable care arrangements, the Center for Medicare and Medicaid Innovation (Innovation Center) launched the ACO REACH Model to provide novel tools and resources that enable health care providers to work together to improve quality of care for people with Original Medicare. The model incorporates lessons learned from prior accountable care organization (ACO) models, which traditionally have shown reductions in spending while maintaining or modestly improving quality.

Building on the evaluation results released in the performance year (PY) 2023 evaluation report, this report provides an early look at ACO REACH Model results for PY 2024 in the context of future changes to the model design and in relation to the Innovation Center's new Long-term Enhanced ACO Design (LEAD) Model. These preliminary PY 2024 results demonstrate similar reductions in spending but provide stronger evidence of quality improvements.

Model overview

ACO REACH is an advanced ACO initiative to promote patient-centered care, lower costs, and align payment systems for Original Medicare beneficiaries through ACO risk-sharing and prospective payment. A range of entities participate in the model as one of the following ACO types:

- 1) *Standard ACOs*: Organizations and providers with experience serving Original Medicare beneficiaries, many have previously participated in accountable care models
- 2) *New Entrant ACOs*: Organizations and providers initially new to accountable care models in Original Medicare, many of which transition to Standard ACOs over time
- 3) *High Needs ACOs*: Organizations and providers that serve predominantly medically complex beneficiaries

Beneficiaries served by ACO REACH in Performance Year (PY) 2024

In PY 2024, the ACO REACH Model served over 2.5 million Original Medicare beneficiaries through 115 ACOs¹. The majority (97%) of these beneficiaries were seen by providers in one of the 97 Standard ACOs², with the remaining 3% aligned to either one of the four New Entrant ACOs³ or one of the 14 High Needs ACOs.⁴

By design, Standard and New Entrant ACOs served beneficiaries that were relatively healthier than beneficiaries aligned to High Needs ACOs. Beneficiaries in a Standard or New Entrant ACO had an average of 6.3 chronic conditions, whereas beneficiaries served by High Needs ACOs had an average of 12 chronic conditions.

ACO REACH Model Performance Year 2024

Standard ACOs

97 ACOs
2.4 million beneficiaries



Risk-based FFS contract experience
Account for 97% of aligned beneficiaries

New Entrant ACOs

4 ACOs
42,000 beneficiaries



Limited risk-based FFS experience
Most transition to Standard ACOs

High Needs ACOs

14 ACOs
33,000 beneficiaries



Serve beneficiaries with complex needs

Model impacts on Original Medicare spending, health services utilization, and quality of care⁵

In its first four performance years (PY 2021 – PY 2024), ACO REACH showed statistically significant improvements in utilization, quality, and spending across ACO types, with stronger effects in PY 2024 than in prior years. These findings are likely due in part to ACOs' reported efforts to improve care coordination, chronic care management, and transitions across care settings.

Overall, the model reduced PY 2024 gross spending by 2.2% (\$309 per beneficiary per year [PBPY], \$706.1 million) and cumulatively reduced gross spending by 1.0% (\$127 PBPY, or \$781.0 million). After accounting for the model's financial incentives and payments to other ACOs, net spending increased modestly by 0.2% in PY 2024 (\$24 PBPY, \$55.3 million) and 0.6% cumulatively (\$80 PBPY, \$492.5 million). As discussed below, although not statistically significant, Standard and New Entrant ACOs reduced net spending for PY 2024.

All three ACO types substantially improved quality and utilization measures in PY 2024, by even more than in PY 2023. Standard and High Needs ACOs reduced emergency department (ED) visits in both PYs, with larger

¹ While 122 ACOs participated at the start of PY 2024, 7 ACOs left the model in the first quarter. These analyses represent only 97 Standard ACOs, three New Entrant ACOs, and 13 High Need ACOs that could be rigorously analyzed.

² In PY 2024, there were 104 Standard ACOs that participated; however, seven of these ACOs terminated prior to the 3/31/24 liability deadline and therefore were not financially liable in PY 2024. These seven Standard ACOs were excluded from these analyses, leaving 97 Standard ACOs for analysis.

³ In PY 2023, there were 13 New Entrant ACOs. Four of these participants left the model after PY 2023 and five transitioned into Standard ACOs in PY 2024, leaving four New Entrant ACOs remaining in PY 2024. One of the four New Entrant ACOs was not included in evaluation analyses because it had insufficient baseline data.

⁴ One of the 14 High Needs ACOs that participated in PY 2024 was not included in the analysis because we could not reliably construct a comparison group for that ACO.

⁵ All evaluation results in this report are statistically significant at the $p < 0.10$ level unless otherwise noted.

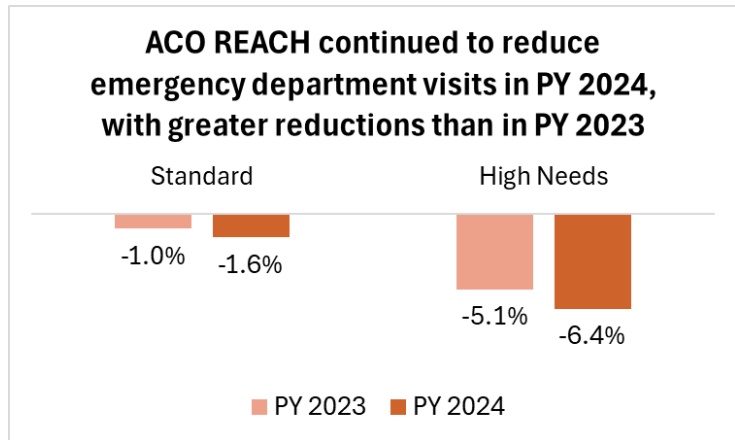
reductions observed in PY 2024. All three ACO types also continued to reduce hospitalizations for ambulatory care-sensitive conditions (ACSCs) and unplanned admissions for beneficiaries with multiple chronic conditions, suggesting that ACOs improved ambulatory care more broadly and not just for a subset of patients with more severe comorbidities.⁶ All three ACO types increased timely follow-up after acute exacerbations of chronic conditions.⁷ It is noteworthy that ACOs also improved their performance on quality measures that increase

spending through additional service use and those that were not tied to financial incentives,⁸ suggesting ACOs' quality improvements extended beyond what the model incentivized. For example, in PY 2024 Standard and New Entrant ACOs increased (2.9%) recommended diabetes care, such as hemoglobin A1c testing, eye exams, cholesterol screening, and medical attention for nephropathy.

These evaluation results were produced by comparing beneficiaries aligned to REACH ACOs to a blend of beneficiaries served by providers participating in accountable care initiatives (such as the Medicare Shared Savings Program) and those not in accountable care arrangements. This methodology is intended to reflect the broad range of beneficiaries residing within the same markets as ACO REACH beneficiaries. Some may consider this a high bar for measuring ACO REACH's impact, since beneficiaries in other accountable care arrangements may have experienced similar care improvements and cost reductions, thereby making it harder to see any model effects among the ACO REACH beneficiaries. To this point, we found more favorable spending results in PY 2023 when we compared ACO REACH beneficiaries to those not in accountable care initiatives.⁹ As accountable care initiatives expand, fewer beneficiaries remain outside these arrangements, and those who do tend to differ from Innovation Center model participants, reducing the appropriateness of this group as a comparator. Lastly, these results are also relative to ACOs' baseline performance, during which time many providers had already made substantial improvements in care delivery, making further improvements increasingly difficult to achieve. Thus, these favorable results are especially notable because many ACOs, particularly Standard ACOs, have participated in accountable care models for over a decade.

Standard and New Entrant ACOs

Standard and New Entrant ACOs participating in ACO REACH in PY 2024 reduced gross spending by 2.0% (\$275 per beneficiary per year [PBPY], \$622.9 million). Spending reductions were larger in PY 2024 than in PY 2023. For example, Standard ACOs (when examined separately) reduced gross spending in PY 2024 by 2.0% (\$274 PBPY, \$613.7 million) but only by 0.9% (\$109 PBPY, \$197.5 million) in PY 2023. In PY 2024, the gross spending reduction among ACOs that had ever participated as a New Entrant ACO (including those still active as New



⁶ The ACSC measure captures a broad range of chronic conditions inclusive of diabetes and heart failure as well as acute conditions such as pneumonia and urinary tract infections relative to the unplanned admissions measure, which focuses on a subset of beneficiaries with more severe combinations of these comorbidities (such as acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease or asthma, depression, heart failure, and stroke or transient ischemic attack).

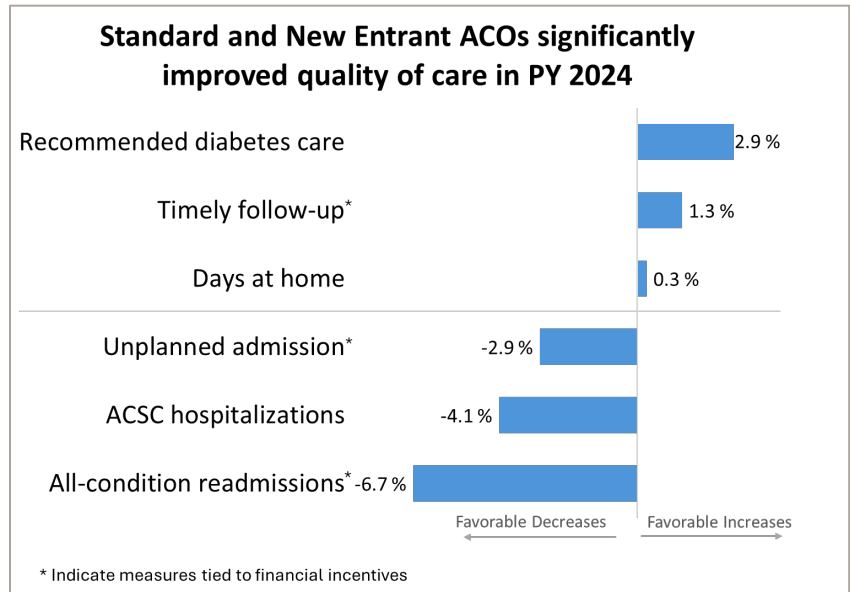
⁷ This means that beneficiaries with a chronic condition (such as hypertension or diabetes) who experienced an acute event (such as an ED visit or hospitalization) received follow-up care in the outpatient setting within seven to 30 days following discharge to align with clinical practice guidelines.

⁸ Measures such as timely follow-up after acute exacerbations of chronic conditions) and those not tied to payment (such as ACSC hospitalizations).

⁹ This alternative comparison group was less rigorous than the ones used to evaluate ACO REACH.

Entrant ACOs and those that transitioned to Standard ACOs in this year) was nearly twice that of ACOs that had always participated as Standard ACOs. Specifically, gross spending for ACOs with New Entrant experience decreased by 3.5% (\$488 PBPY), compared with a 1.9% reduction (\$255 PBPY) among ACOs that were always Standard ACO participants. After accounting for model incentive payments, Standard and New Entrant ACOs reduced net spending 0.1% (\$13 PBPY, \$29.7 million, not statistically significant) in PY 2024.

These gross spending reductions were driven by reductions in utilization across multiple settings, including ED visits and observational stays (1.6%), acute care hospitalizations (2.5%), acute care days (3.1%), skilled nursing facility days (3.8%), and home health episodes (3.4%) in PY 2024. These ACOs continued to improve quality of care across a range of measures (see graph on the right for these results), including many that were financially incentivized by the model. PY 2024 effects were larger than PY 2023 effects, which may reflect the cumulative effects of Standard and New Entrant ACOs’



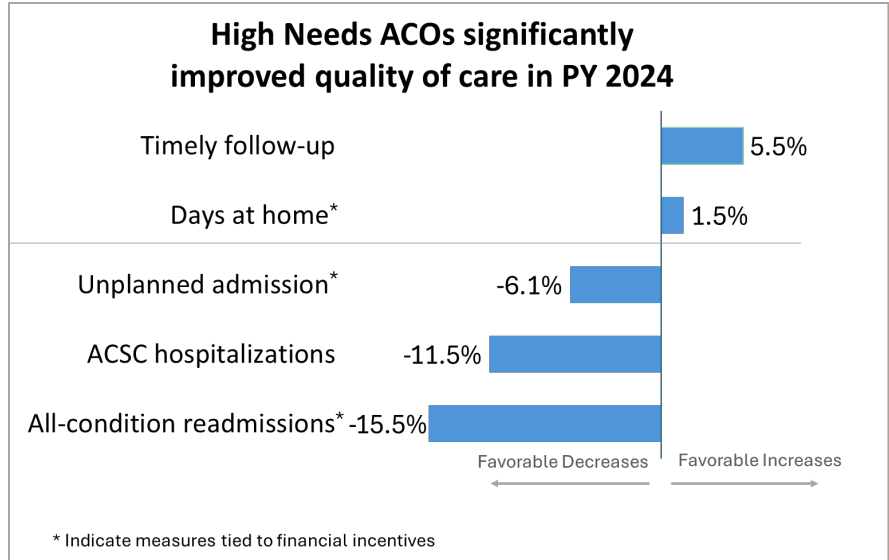
ongoing investments in care management and related infrastructure over the course of the model. Survey findings indicate that many ACOs either had standardized care management protocols (48%) or provided best practices (50%) to their providers to manage chronic conditions. Majorities of ACOs also reported having processes in place for real-time notification of hospital admissions (65%) and ED visits (56%). These patterns may also be influenced by differences in cohort tenure and participant mix.

High Needs ACOs

High Needs ACOs reduced gross spending by 8.9% (\$3,560 PBPY, \$83.2 million) in PY 2024. A comparably strong result was seen in PY 2022 when High Needs ACOs reduced gross spending by 7.3% (\$3,262 PBPY). Although High Needs ACOs had large gross spending reductions in PY 2024, net spending increased by 9.1% (\$3,643 PBPY, \$85.1 million) after accounting for incentive payments. However, this PY 2024 increase was smaller compared to the PY 2023 increase (14.5%, \$5,288 PBPY, \$85.2 million). Additionally, as noted below, these results do not yet account for pre-planned model design changes to transition High Needs ACOs’ benchmarking from being primarily driven by the ACO REACH rate book, which tend to increase shared savings payouts for already-efficient ACOs, to benchmarks that blend in historical baseline expenditures, which tend to reduce shared savings payouts.

Reductions in spending were driven by large reductions in utilization across multiple care settings. High Needs ACOs reduced ED visits and observational stays (6.4%), acute care hospitalizations (13.2%), acute care days (16.3%), and skilled nursing facility days (13.6%). High Needs ACOs also improved multiple claims-based utilization quality-of-care measures (see graph to the left for these results), with larger effects relative to

Standard and New Entrant ACOs. For example, High Needs ACOs increased the number of days at home by 1.5% relative to 0.3% among Standard and New Entrant ACOs. While these effect sizes may seem small, these results translate into fewer days these beneficiaries spent in institutional settings (such as hospitals or post-acute care facilities), which aligns with beneficiaries’ preferences and improves their quality of life.



Utilization reductions and quality of care improvements were larger in

PY 2024 than in PY 2023. These stronger PY 2024 effects may reflect, at least in part, High Needs ACOs’ intensive longitudinal care models for medically complex beneficiaries that include proactive monitoring, care management, and coordination across home, facility, acute, and post-acute settings. Survey findings indicate that almost all High Needs ACOs (12 of 14) use home-based medical care in some capacity. Of this group, most provide multiple services through home-based medical care, including routine primary care visits (12 of 12), transition from facilities to home and palliative hospice care (11 of 11, each), management of uncontrolled conditions (10 of 12), and delivery of acute services (9 of 12).

Discussion

ACO REACH participants continued to reduce gross spending and improve quality, with stronger impacts observed in PY 2024 than in prior years. This is notable given that many participants have prior experience in accountable care arrangements, which may make further improvements more incremental. These results may reflect, at least in part, the cumulative effects of ACO’s ongoing investments in care coordination and care delivery changes over time. Taken together, qualitative and survey findings suggest that many ACOs built on existing capabilities – such as strengthening primary care engagement and enhancing care management and care transitions – which may have supported observed improvements. Overall, these findings suggest that continued investments in care delivery are contributing to improvements over time.

It can be difficult for voluntary models like ACO REACH to reduce net spending while also attracting participants.¹⁰ Thus, it is noteworthy that net spending performance improved in PY 2024 relative to prior years, especially given that shared savings payments to REACH ACOs have historically been much larger than gross spending reductions. Also, for the first time in PY 2024 Standard and New Entrant ACOs reduced net spending (although the amounts were not statistically significant). Additionally, net spending increases among High Needs

¹⁰ The Innovation Center has the authority to require participation in a model test (e.g., mandatory) or incentivize participation without such a requirement (e.g., voluntary). Entities and providers that choose to participate in a voluntary model test tend to have lower baseline spending through pre-existing efficiencies relative to participants in mandatory models, which include a broader, and more representative mixture of health care providers.

ACOs, which care for a much smaller population and represent a smaller impact on CMS outlays overall, were lower in PY 2024 relative to PY 2023.

These net spending results do not reflect recent model benchmark design changes made in PY 2025 and PY 2026 to reduce shared savings payments to ACOs. Additionally, these results do not yet account for plans to transition New Entrant and High Need ACOs' benchmarking from being primarily driven by the ACO REACH rate book (providing larger shared savings payouts) to benchmarks that blend in historical baseline expenditures (reducing shared savings payouts)¹¹. CMS expects that these changes will maintain incentives for the remaining ACO participants to further reduce their spending while continuing to improve quality.

Although New Entrant and High Needs ACOs represented a smaller share of ACO REACH participants overall, they were particularly successful in reducing gross spending in PY 2024. New Entrant ACOs, which have less experience in Original Medicare value-based care arrangements, had more room for improvement compared to more established Standard ACOs that started making improvements during their prior participation in other accountable care models.

High Needs ACOs serve high-cost populations with a wide range of health care needs and who have the greatest need for coordinated, high-quality care. The elevated baseline spending among these populations provides opportunities to meaningfully reduce costs through targeted care improvements. However, their smaller number of aligned beneficiaries with poorer health status can make it difficult to set benchmarks prospectively. ACO REACH aimed to create pathways for providers specializing in caring for high-cost populations to participate in an ACO model.¹² The preliminary PY 2024 evaluation results suggest that High Needs ACOs can improve care at lower cost for some of the sickest beneficiaries in Original Medicare. The Innovation Center continues its work to identify the right financial structure to support these new ACO providers.

Building upon the promising gross savings and quality results from ACO REACH, the Innovation Center will launch the Long-term Enhanced ACO Design (LEAD)¹³ Model on January 1, 2027. LEAD seeks to support and empower a broader mix of health care providers newly entering accountable care arrangements (such as smaller, independent, rural, or higher-spending practices), and its unique risk adjustment and benchmarking features aims to improve quality of care for higher-needs beneficiaries and generate shared savings. As ACO REACH continues to generate valuable insights and lessons learned in the coming years, CMS will continue to apply them to LEAD and other Innovation Center accountable care models.

¹¹ In the early years of the ACO REACH model, financial benchmarks were composed of a higher blend of regional rates for New Entrant ACOs than for Standard ACOs (whose benchmarks use a blend of historical and regional rates); High Needs ACOs' benchmarks were completely composed of regional rates. Starting in PY 2025, the incentive structures for New Entrant and High Needs ACOs became more like Standard ACOs in that they gradually started using a higher blend of historical and regional rates. These gradual changes allowed entities new to Innovation Center models in Original Medicare to continue participating while slowly adjusting to model incentives.

¹² Indeed, many providers participating in High Needs ACOs previously participated in the [Independence at Home Demonstration](#).

¹³ Details about the [LEAD Model](#) can be found at the Innovation Center website.