



## EVALUATION REPORT 3

July 2026

# Evaluation of the ACO REACH Model

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This project was funded by the Centers for Medicare & Medicaid Services under contract no. 75FCMC19D0092, Task Order 75FCMC21F0002. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. NORC at the University of Chicago assumes responsibility for the accuracy and completeness of the information contained in this report.

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We would also like to thank the **CMS Innovation Center** team for their review and feedback on draft materials and their support in finalizing this report and over the course of the evaluation to date.

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# List of Acronyms

ACO	Accountable care organization
ACSC	Ambulatory care sensitive condition
ADI	Area Deprivation Index
ADT	Admissions, discharges, transfers
APO	Advanced payment option
AWV	Annual wellness visit
CHW	Community health worker
CMS	Centers for Medicare & Medicaid Services
DID	Difference-in-differences
ED	Emergency department
EHR	Electronic health record
FFS	Fee-for-service
GPDC	Global and Professional Direct Contracting
HCC	Hierarchical condition category
HIE	Health information exchange
IDS	Integrated delivery system
IRF	Inpatient rehabilitation facility
IT	Information technology
MSO	Management services organization
LTCH	Long-term care hospital
NGACO	Next Generation Accountable Care Organization
PAC	Post-acute care
PCC	Primary Care Capitation
PCP	Primary care practitioner
PBPY	Per beneficiary per year
PY	Performance year
SDOH	Social determinants of health
SNF	Skilled nursing facility
TCC	Total Care Capitation

# Report Overview

This report covers the key findings from NORC at the University of Chicago's evaluation of the Accountable Care Organization (ACO) REACH Model's first performance year (PY 2023), as well as the two years of the preceding Global and Professional Direct Contracting (GPDC) Model.

The report is structured as follows:

**Chapter 1: Introduction.** This chapter provides an overview of the ACO REACH Model, model design and features, and an overview of NORC's evaluation.

**Chapter 2: Impact Analysis Methods.** This chapter summarizes NORC's approach to assessing the impact of ACO REACH using Medicare claims and program data.

**Chapter 3: What Was the Scope and Reach of the ACO REACH Model in PY 2023?** This chapter includes an overview of the scope and reach of the ACO REACH Model in PY 2023.

*Research question: What are the characteristics of ACOs? Do ACOs differ by organizational characteristics, capitation type, or risk level?*

**Chapter 4: How Did ACOs Respond to Model Features?** This chapter discusses how ACOs responded to model features, including financial and quality incentives and benefit enhancements.

*Research question: How did ACOs respond to financial and quality incentives and benefit enhancements?*

**Chapter 5: How Did ACOs Change Care Delivery?** This chapter examines how ACOs implemented the ACO REACH Model, including the activities the ACOs undertook and how this varied by ACO type.

*Research questions: What types of transformation activities did ACOs undertake? How did providers change their care delivery approaches in response to financial and quality incentives and benefit enhancements?*

**Chapter 6: Standard ACOs, Chapter 7: New Entrant ACOs, and Chapter 8: High Needs ACOs.** These chapters analyze the impact of ACOs on spending, utilization, and quality of care, by ACO type.

*Research questions: Did spending, utilization, or quality of care change under the model relative to a comparison group? Did any changes vary by ACO characteristics or beneficiary characteristics (Standard ACOs only)?*

**Chapter 9: Discussion.** This chapter summarizes the successes, challenges, and lessons learned from the first three performance years (PYs) of the model.

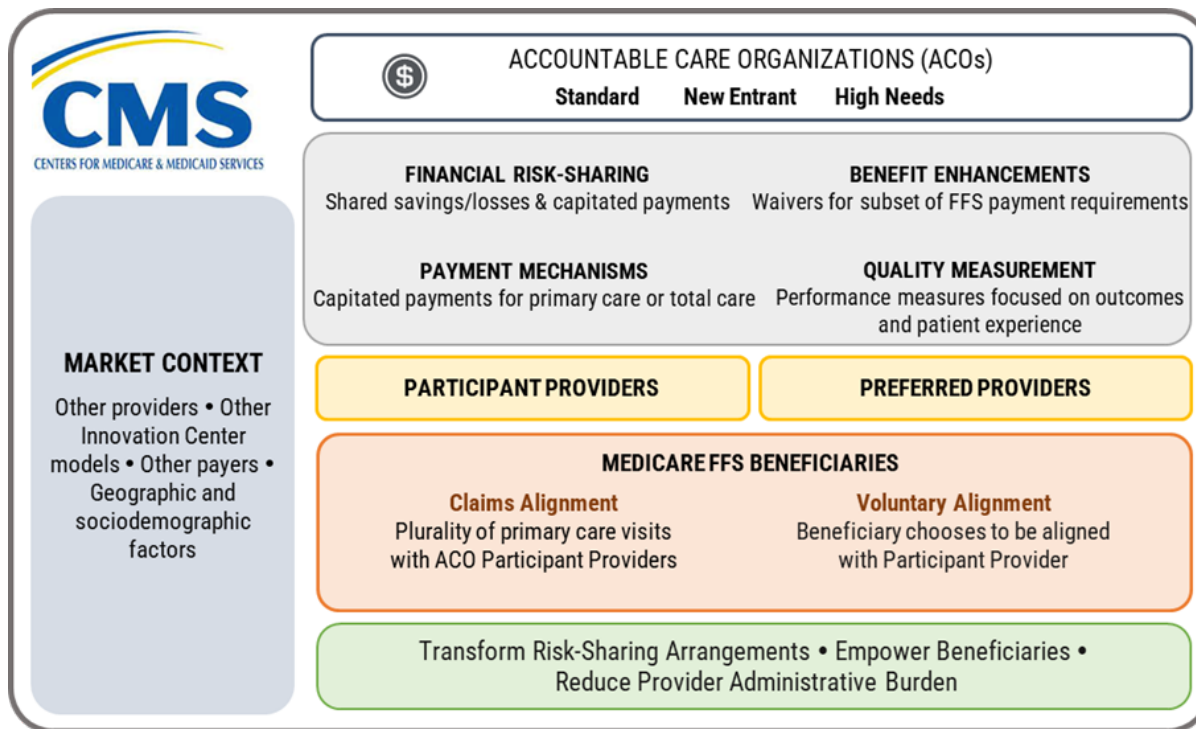
# Chapter 1: Introduction

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) has partnered with NORC at the University of Chicago to evaluate the ACO REACH Model, formerly known as the GPDC Model.<sup>1</sup> This chapter provides an overview of the model and the evaluation.

## 1.1 Overview of ACO REACH

The ACO REACH Model (**Exhibit 1.1**) is an advanced ACO initiative designed to shift Medicare risk-sharing from fee-for-service (FFS) Medicare (Original Medicare) to value-based accountable care.<sup>2</sup> The model seeks to improve the quality of care and health outcomes for Original Medicare beneficiaries by aligning financial incentives to promote effective and appropriate care, emphasizing beneficiary choice and care delivery for the complex, chronically, and seriously ill population.<sup>3</sup> The model includes organizations with a strong track record of taking risk in Medicare Advantage (MA) or Managed Medicaid, as well as entities not previously eligible for the Shared Savings Program or other ACO models because they serve a smaller number of aligned Medicare beneficiaries.

**Exhibit 1.1. Overview of ACO REACH Model**



<sup>1</sup> The Innovation Center launched the GPDC Model in April 2021. The GPDC Model was an advanced ACO initiative designed to shift Medicare risk-sharing from FFS to value-based accountable care. After GPDC’s first two performance years, CMS redesigned the model and renamed it the ACO REACH Model, effective January 2023.

<sup>2</sup> An ACO is made up of 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 provided to the Medicare beneficiaries aligned to them. Beginning in 2023, after the redesign, model participants were referred to as REACH ACOs instead of Direct Contracting Entities (DCEs).

<sup>3</sup> ACO REACH Model. CMS. Accessed November 17, 2025. <https://www.cms.gov/priorities/innovation/innovation-models/aco-reach>

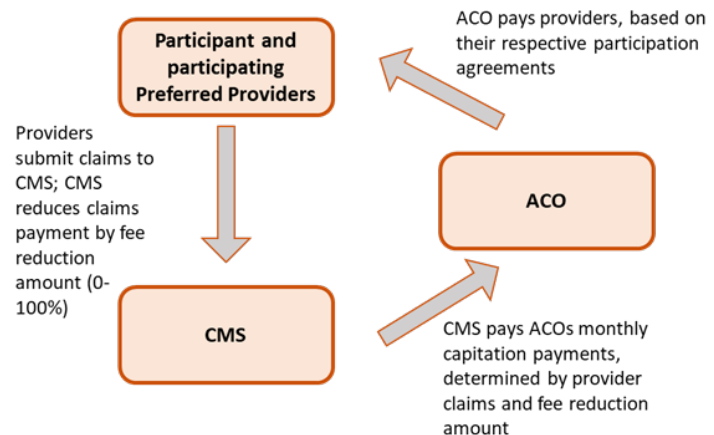
## 1.2 Model Design and Features

The ACO REACH Model includes three types of ACOs.<sup>4</sup> Standard ACOs generally have experience serving Original Medicare beneficiaries. New Entrant ACOs are entities that have not traditionally provided services to an Original Medicare population. High Needs ACOs serve Original Medicare beneficiaries with especially complex needs. See **Appendix C** for more information on the three ACO types.

### ***Financial Risk-Sharing and Payment Mechanisms***

ACOs select a combination of risk and payment options reflecting the extent to which they prefer to handle two-sided financial risk and capitation. ACOs have the choice of two risk-sharing options—Professional risk (a lower-risk option with 50% shared savings/losses) or Global risk (a full-risk option with 100% shared savings/losses) (**Exhibit 1.2**).<sup>5</sup> ACOs are also required to implement capitation payment mechanisms. ACOs that choose the Professional risk option must elect Primary Care Capitation (PCC) to receive monthly capitation payments for primary care services provided to aligned beneficiaries with the option to receive monthly payments for eligible non-primary care services with the advanced payment option (APO). ACOs choosing the Global risk option can select either PCC or Total Care Capitation (TCC), under which they receive monthly capitation payments for all services provided to aligned beneficiaries.

**Exhibit 1.2. Flow of Funds Among CMS, ACOs, and Providers**



Under the ACO REACH Model, Participant Providers (along with Preferred Providers that elected to participate in capitation) continue to submit claims to CMS for services delivered, and the CMS FFS claims processing system then reduces claims payment amounts for all applicable services.<sup>6</sup> CMS compensates the ACOs directly with capitation payments and shared savings, where applicable, and the ACO in turn pays their Participant Providers and Preferred Providers for services delivered based on their pre-arranged contracts with providers. This payment approach allows ACOs to pay providers for services using flexible arrangements or to invest in staff and

<sup>4</sup> ACO REACH Model. CMS. Accessed November 17, 2025. <https://www.cms.gov/priorities/innovation/innovation-models/aco-reach>

<sup>5</sup> Under the Global Option risk arrangement, the ACO assumes “full reward” for any savings and “full risk” for any losses; the ACO is eligible for a reward of up to 100% of any savings against a benchmark based on historical claims, but is also at risk for up to 100% of any losses. Under the Professional Option risk arrangement, the ACO assumes partial reward for any savings and partial risk for any losses; the ACO is eligible for a reward of up to only 50% of savings while being at risk for up to only 50% of any losses. The benchmark is determined through a baseline calculation, risk adjustment, trend and efficiency adjustments, and discounts and withholds. ACOs that meet or exceed these benchmarks are eligible for shared savings, while underperformance can result in penalties. For more information, see the [ACO REACH Model FY2024 Financial Operating Guide](#).

<sup>6</sup> Fee reductions are made using a series of specifications. In TCC, Participant Providers are required to take a 100% fee reduction, while Preferred Providers electing to participate in the capitation payments can choose a fee reduction of any amount up to 100%. In PCC, Participant Providers can choose a fee reduction between a specific range each PY; in PY 2023, Participant Providers could select a fee reduction from 10%–100%. Preferred Providers electing to participate can choose a fee reduction of any amount up to 100% for all PYs.

services not reimbursable under traditional FFS payment models. **Exhibit 1.2** provides an overview of the flow of funds and payments among CMS, ACOs, and providers, noting how PCC and TCC payments vary and the provisional and final settlement. **Appendix E.1** provides more information on risk and payment options, as well as the flow of funds between CMS, ACOs, and providers.

## Quality Measures

CMS assesses ACO quality through claims-based quality measures, as well as performance on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. Each ACO type is evaluated on three claims-based measures, with some differences by ACO type: risk-standardized all-condition readmissions within 30 days of discharge, all-cause unplanned admissions for patients with multiple chronic conditions (MCC), timely follow-up after hospitalization (for Standard and New Entrant ACOs), and days at home for adults with complex, chronic disease (High Needs ACOs).<sup>8</sup>

Beginning in PY 2023, REACH ACOs shifted from pay-for-reporting to pay-for-performance measures. Performance on these measures affects the performance year benchmark used to calculate the final settlement. In both Global and Professional risk, CMS holds a portion of the performance year benchmark determined by the ACO's performance. ACOs can earn back some or all of this quality withhold.

### High Performers Pool

Starting in PY 2023, CMS introduced the High Performers Pool (HPP) to support exceptional performance and continuous quality improvement.

Under the HPP, ACOs qualify for a shared savings **bonus** if they meet or exceed the Continuous Improvement/Sustained Exceptional Improvement criteria<sup>7</sup> and their average measure performance is greater than or equal to the 70<sup>th</sup> percentile.

## Beneficiary Alignment

Beneficiary alignment in the ACO REACH Model refers to the process of identifying which Medicare beneficiaries are assigned to a specific ACO for care management and coordination. Beneficiaries are aligned to the model through their primary care practitioner (PCP) using either claims-based or voluntary alignment. Under claims-based alignment, beneficiaries are assigned based on their historical Medicare claims—specifically the provider from whom they receive most of their primary care. Under voluntary alignment, beneficiaries actively choose an ACO REACH provider as their primary practitioner through Medicare.gov or by completing a CMS-approved form.

<sup>7</sup> RFI International. *ACO REACH Model PY 2025 Quality Measurement Methodology*; 2025. <https://www.cms.gov/files/document/py25-reach-qual-meas-meth-report.pdf>

<sup>8</sup> ACO REACH Model Request for Applications. Published online February 24, 2022. <https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa>

## Benefit Enhancements and Beneficiary Engagement Incentives

The ACO REACH Model offers benefit enhancements, which are conditional waivers of certain Medicare payment rules that offer increased flexibility that may lower costs while also improving beneficiary outcomes and care coordination. The model also includes beneficiary engagement incentives to encourage beneficiaries to participate more actively in their own care. For more information on the benefit enhancements and beneficiary engagement incentives available to ACOs in the model in PY 2023, see **Appendix E.2**.

### 1.3 Overview of the Evaluation

NORC's mixed-methods evaluation of the ACO REACH Model assesses participants' implementation experiences and the model's impact on cost, utilization, and quality outcomes. Findings in this report reflect analyses of multiple primary and secondary data sources, including:

- Program data from PY 2021–2023, including model documentation (for example, ACO applications) and data provided by the implementation and monitoring contractor
- Semi-structured interviews with ACO leaders and providers conducted in 2023 and 2024
- A Pulse Check Survey of ACO leaders, fielded in 2023
- Medicare FFS claims and administrative data<sup>9</sup>
- CAHPS data for GPDC/ACO REACH ACOs in PY 2022 and PY 2023, Merit-Based Incentive Payment System (MIPS) CAHPS data in PY 2022 and PY 2023, and CAHPS data for Original Medicare beneficiaries not in any type of alternative payment models (APM) in PY 2022 and PY 2023

To assess ACOs' implementation approaches and experiences, we conducted thematic analyses of interview transcripts, descriptive analyses of survey responses, and content analyses of ACO applications and materials submitted to CMS (see **Appendices B and F** for more information). We also conducted descriptive analyses of program data on providers and beneficiaries, as well as claims-based outcomes for Medicare spending, utilization, and quality of care. To estimate the model's impact on claims-based outcomes, we used a quasi-experimental difference-in-differences (DID) approach. This method compares changes in outcomes for beneficiaries aligned to ACO REACH providers with those for a comparison group of Original Medicare beneficiaries in the same markets aligned to providers not in ACO REACH (see **Chapter 2** for more information). We conducted descriptive analyses of CAHPS data to compare beneficiary experience scores across GPDC/ACO REACH ACO-aligned beneficiaries, Original Medicare beneficiaries in SSP ACOs, and Original Medicare beneficiaries who were not in any type of APM (see **Appendix I.6** for more information).

<sup>9</sup> Claims data used in our analysis reflect both the baseline (ranging from 2018–2022, depending on when an ACO entered the model) and all performance years (PY 2021–PY 2023) in our evaluation.

#### Benefit Enhancements (PY 2023)

- Skilled Nursing Facility (SNF) 3-Day Rule Waiver
- Telehealth
- Post-Discharge Home Visits
- Care Management Home Visits
- Home Health Homebound Waiver
- Concurrent Care for Beneficiaries that Elect Medicare
- Hospice
- Nurse Practitioner Services and Physician Assistant Services (*new in PY 2023*)

#### Beneficiary Engagement Incentives (PY 2023)

- Rewards for chronic disease management
- Cost-sharing support for Part B services

## Chapter 2: Impact Analysis Methods

In this chapter, we summarize our approach to assessing the impact of ACO REACH using Medicare claims and program data. Our analysis considers model impacts both for the most recent performance year (PY 2023) and cumulatively over the first three years of the model (as of PY 2023) to answer the research questions described in the [report overview section](#). As described in prior evaluation reports, we could not evaluate the High Needs ACOs for PY 2021 due to the small numbers of both model participants and beneficiaries in this group in the first year. As a result, the cumulative impacts for the High Needs ACOs are aggregated across PY 2022 and PY 2023 only. Additionally, revisions were made to the comparison groups for High Needs ACOs to address compositional changes in the providers and beneficiaries participating in the model in PY 2023. Relative to estimates that were previously publicly released, the changes made to the comparison groups for High Needs ACO led to updated impact estimates for both PY 2022 and PY 2023.<sup>10</sup> We present more detail on this at the end of this chapter, and [Appendix I](#) includes more details on the methods.

### 2.1 Estimating the Causal Impact of ACO REACH

We used a DID design to examine impacts of ACO REACH participation on claims-based spending, utilization, and quality of care outcomes for beneficiaries aligned to the model relative to their expected outcomes in the absence of the model. The DID approach assumes that, had the model not existed, the changes over time in outcomes for both the comparison groups and ACO REACH beneficiaries would have followed similar or parallel trends over time.

#### The DID design captures the effects of the ACO REACH Model by comparing:

- Change over time in a given outcome for the ACO REACH group between the baseline and performance periods
- TO**
- Change over time in the same outcome for a comparison group

**Baseline Years.** We defined the baseline period for the DID analysis as three years prior to an ACO's start in the model ([Exhibit 2.1](#)).

<sup>10</sup> [Evaluation Report 2: Evaluation of the GPDC Model](#) reported a statistically significant gross spending reduction in PY 2022 for High Needs ACOs 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](#) refined the comparison group used for assessing PY 2022 and PY 2023 impact estimates relative to methods used in Evaluation Report 2. The Preview 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%) for PY 2023. Cumulatively across PY 2022 and PY 2023, there was a non-significant reduction in total spending by \$103 PBPY (0.3%). Following the publication of the Preview, additional refinements were made to the comparison groups to further improve their comparability to the treatment group. Findings in this report reflect updated impact estimates after incorporating all refinements to the comparison groups.

**Exhibit 2.1. Evaluation Baseline and Performance Years by Cohort**

	2018	2019	2020	2021	2022	2023	2024	2025	2026
<b>2021 Cohort</b>	Baseline Years			PY 2021	PY 2022	PY 2023	PY 2024	PY 2025	PY 2026
<b>2022 Cohort</b>		Baseline Years			PY 2022	PY 2023	PY 2024	PY 2025	PY 2026
<b>2023 Cohort</b>			Baseline Years			PY 2023	PY 2024	PY 2025	PY 2026

We applied **entropy weights** to comparison group beneficiaries in PY 2023 and baseline periods, as well as to the treatment group in the baseline period, to weight all groups to be similar to the treatment group beneficiaries in PY 2023. This ensured that we were capturing the experiences of voluntarily aligned beneficiaries in our comparison groups and baseline data.

**Defining the ACO REACH (Treatment) Group and Comparison Groups.** We defined the ACO REACH (treatment) group as beneficiaries aligned to ACO REACH Participant Providers in PY 2023 and in the baseline period. We excluded Prospective Plus voluntarily aligned beneficiaries from the ACO REACH group because their alignment process was not replicable in either the comparison group or the ACO REACH group for the baseline period (see **Appendix I.1** for more information).

Additional beneficiaries were excluded due to missing data. Our evaluation’s ACO REACH analytic sample comprised 92.7%, 60.9%, and 76.2% of total beneficiaries aligned by the model team to the Standard, New Entrant, and High Needs ACOs in PY 2023, respectively.<sup>11</sup>

The comparison groups comprised beneficiaries in ACO REACH market areas who were aligned to providers that were unaffiliated with the model at any time during the entire performance period. Comparators could have been in Original Medicare alone or in other APMs such as the Medicare Shared Savings Program. Other APMs, particularly the Medicare Shared Savings Program, reflect the alternatives available to ACO REACH beneficiaries had this model not been implemented. For the analyses of High Needs ACOs, we matched ACO REACH beneficiaries with up to 10 comparison beneficiaries who met the same combination of high needs eligibility criteria. Finally, we used entropy balancing to balance the treatment and comparison groups on observed, individual-level demographic characteristics and disease burden, as well as on area-level community and market characteristics. We weighted the baseline years individually to the treatment group in the performance year. See **Appendix H.1** for more information on the variables we used in the entropy balancing and regression adjustment.

Because stakeholders and policymakers may be interested in understanding the effects of the model without a direct comparison to beneficiaries in other Medicare accountable care models, for Standard and New Entrant ACOs, we conducted a supplemental analysis of impacts on spending relative to an *alternative comparison group* comprising Original Medicare beneficiaries and those in non-ACO payment model initiatives, including other

<sup>11</sup> A greater proportion of New Entrant (23%) and High Needs (16%) ACO beneficiaries, relative to Standard ACOs (3%), were excluded from the evaluation due to Prospective Plus voluntary alignment. Additionally, one New Entrant ACO was excluded from the evaluation due to inadequate baseline data (n=7,913), and one High Needs ACO was excluded from the evaluation due to non-convergence of entropy balancing weights (n=359). See **Appendix Exhibit I.7** for more information on the reasons for exclusion and numbers of beneficiaries affected for each ACO type.

primary care and episodic models. See **Appendices I.1 and I.4** for more information on the methodology we used to evaluate spending relative to an *alternative comparison group* and **Appendices J.5 and K.5** for results.<sup>12</sup>

**Estimation of Model-Level Impacts.** For Standard and New Entrant ACOs, we estimated impacts for each ACO using ACO-specific DID models and then aggregated the ACO-specific estimates into a single model-level estimate. We then weighted each estimate by the proportion of the model’s beneficiaries aligned to the given ACO out of the total number of beneficiaries aligned to that ACO’s type (Standard or New Entrant).

Again, for High Needs ACOs, we did not estimate impacts for each ACO individually because of small sample sizes and wide variability in the patient populations served by the High Needs ACOs. Small sample sizes and variability in patient populations can make it difficult for impact estimates to reach statistical significance. For High Needs ACOs, assessing the directionality of the impact estimates and their effect sizes may be more meaningful than focusing on statistical significance alone to understand impacts. We pooled all ACOs within a cohort and estimated the impacts separately for each cohort. We then calculated model-level estimates by weighting the cohort-specific impact estimates by the proportion of aligned beneficiaries.

For all ACO types, when reporting estimates covering multiple years, we report the number of “ACO-years,” or the total count of individual estimates (one for each ACO in each performance year) that contribute to the overall estimate.

**Estimation of Impacts for ACO and Beneficiary Subgroups (Standard ACOs Only).** We used the DID design to examine variations in model impacts in PY 2023 for subgroups within Standard ACOs defined by ACO- and beneficiary-level characteristics. ACO-level characteristics comprised organizational structure and risk/capitation election. Beneficiary-level characteristics included dual eligibility, burden of chronic conditions, and disability and/or end-stage renal disease (ESRD) as the original reason for Medicare eligibility, as well as area-level social need (as measured by the Area Deprivation Index [ADI]). See **Appendix I.4** for more information on the methodology we used to evaluate subgroup impacts, and **Appendices J.7, J.9, and J.11** for the results of these analyses.

## 2.2 Outcome Measures

We assessed 33 outcomes to measure the model’s impact on spending, utilization, and quality of care, using Medicare FFS claims data (**Exhibit 2.2**). Regarding total spending, the total gross spending measure represents what Medicare actually paid by including beneficiary-level capitated payments under the ACO REACH Model. The total net spending measure represents gross spending plus CMS’ ACO incentive payments in the form of shared savings and the HPP bonus to highest performing ACOs. Capitated payments were included in total spending but not in spending categories, precluding direct comparisons between the two sets of results. We conducted impact analyses for 25 measures; for the remaining 8 measures, more than 25% of ACOs violated the parallel trends assumption noted earlier, undermining the validity of the impact analysis. See **Appendices J.6 and J.8** for descriptive trends for these eight measures for the intervention group. In general, in ACO-level

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<sup>12</sup> The other shared savings initiatives include Comprehensive Primary Care Plus (CPC+), Making Care Primary (MCP), Independence at Home (IAH), Financial Alignment Initiative (FAI), and Value in Opioid Use Treatment Demonstration (VIT). Episodic models include Comprehensive Care for Joint Replacement (CJR), Bundled Payments for Care Improvement-Advanced (BPCI-A), Oncology Care Model (OCM), Enhancing Oncology Model (EOM), and End-Stage Renal Disease (ESRD) Treatment Choices (ETC).

analyses of Standard and New Entrant ACOs, if an ACO failed the parallel trends test, then the DID estimate for that ACO needs to be interpreted with caution.

**Exhibit 2.2. Claims-Based Outcome Measures Spanned Varied Care Settings**

	Ambulatory Care Settings	Acute Care Settings	Other Care Settings
<b>Total Spending</b>	<b>Total Gross Spending</b> <b>Total Net Spending</b>		
<b>Spending Categories</b>	<ul style="list-style-type: none"> <li>Professional services</li> <li>Specialty care visits</li> <li>Outpatient facility</li> <li>Primary care visits <i>(descriptive trends only)</i></li> </ul>	<ul style="list-style-type: none"> <li>Acute care facility</li> </ul>	<ul style="list-style-type: none"> <li>Skilled nursing facility</li> <li>IRF and LTCH</li> <li>Home health</li> <li>Hospice</li> </ul>
<i>Spending categories measures estimate resource use and do not account for capitated payments to ACOs</i>			
<b>Utilization</b>	<ul style="list-style-type: none"> <li><b>ED visits including observation stays*</b></li> <li>PCP services <i>(descriptive trends only)</i></li> <li>Urgent care visits (new for PY 2023; <i>descriptive trends only</i>)</li> <li>Urgent care visits excluding for COVID (new for PY 2023; <i>descriptive trends only</i>)</li> </ul>	<ul style="list-style-type: none"> <li><b>Acute care hospitalizations*</b></li> <li>Acute care length of stay</li> </ul>	<ul style="list-style-type: none"> <li>Skilled nursing facility days</li> <li>IRF and LTCH days</li> <li>Home health episodes</li> <li>Continuous hospice days prior to death</li> <li>Total hospice days (new for PY 2023)</li> </ul>
<b>Quality of Care</b>	<ul style="list-style-type: none"> <li>Hospitalizations for ACSCs</li> <li>Recommended care for diabetes</li> <li>Unplanned hospital admissions among beneficiaries with MCC</li> <li>Annual wellness visits <i>(descriptive trends only)</i></li> <li>Chronic care management in beneficiaries with MCC <i>(descriptive trends only)</i></li> </ul>	<ul style="list-style-type: none"> <li>All-condition readmissions</li> <li>Timely follow-up after acute exacerbations of chronic conditions</li> </ul>	<ul style="list-style-type: none"> <li>Days at home</li> <li><b>Low value care (new for PY 2023*; <i>descriptive trends only</i>)</b></li> <li>Mortality <i>(descriptive trends only)</i></li> <li>Advance care plan <i>(descriptive trends only)</i></li> </ul>

**NOTE:** Measures noted in orange (\*) were included in subgroup impact analyses by beneficiary characteristics. ACSC=ambulatory care sensitive condition; ED=emergency department; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; MCC=multiple chronic conditions; PCP=primary care practitioner. Quality measures reflect care that is either avoidable or recommended, while utilization measures reflect the use of care where the appropriateness cannot be determined.

## 2.3 Hypotheses

Our hypotheses for the model’s impacts on Standard and New Entrant ACOs (**Exhibit 2.3**) were informed by the findings presented in our First and Second Evaluation Reports, as well as by the literature on Medicare payment reform models and previous ACO evaluations. In our presentation of impacts, we show the hypothesized direction of change alongside the impact estimates for each measure.

**Exhibit 2.3. Hypothesized Impact of ACO REACH on Spending, Utilization, and Quality of Care for Standard and New Entrant ACOs**

Outcome	Hypotheses
<p><b>Total Spending: Gross and Net</b></p>	<p>Neither Standard nor New Entrant ACOs achieved significant gross spending reductions in the first two years of the model, likely due to the fact that it takes time to implement changes that translate into savings. In the third year of the model, we expected to begin seeing reductions in gross spending due to a combination of factors, such as: 1) the expansion of value-based care to new populations; 2) “learning” on the part of ACOs that continued participating in the model; and 3) selective attrition or exit of low-performing ACOs.</p> <p>The model was expected to reduce net spending as well. Whether such a reduction would be realized would depend on how the benchmarks were set and the relative magnitudes of model incentive payments through shared savings (or losses) and HPP bonuses across individual ACOs.</p> <p><b>ACO Characteristics</b></p> <ul style="list-style-type: none"> <li>• We expected ACOs that joined the model in the first or second cohorts to achieve greater reductions in gross spending, having honed their approaches to delivering accountable care and managing risk/capitation over time.</li> <li>• We expected ACOs that elected higher risk/capitation to show greater reductions in gross spending given their apparent higher expectation of outperforming benchmark targets and the suggestion that they saw more financial support for their accountable care efforts.</li> <li>• ACOs’ organizational structures reflect their internal economics, which in turn influences provider recruitment, their choice of model features, and their implementation approaches. We expected election of lower-risk (Professional track) and smaller reductions in gross spending among IDS/hospital system ACOs, given their overarching incentive structures designed to increase hospital-based inpatient and outpatient care as a means of increasing overall revenue. Correspondingly, we expected ACOs that were individual or medical group practices to see larger gross spending reductions in the absence of incentives to increase hospital-based care.</li> </ul> <p><b>Beneficiary Characteristics</b></p> <p>We expected gross spending to increase in PY 2023 for beneficiary subpopulations with greater clinical and social risk factors (for example, beneficiaries residing in under-resourced areas) because these beneficiaries were likely seeing improved access to care due to the model (and thus heightened utilization) to address previously unmet health care needs.</p>

Outcome	Hypotheses
<p><b>Utilization and Spending: Ambulatory Care, Acute Care, and Post-Acute Care</b></p>	<p>Reducing utilization and spending in specific care settings may take time given the potential lag in realizing improvements from care coordination and disease management—including ACO strategies such as shifting beneficiaries toward less resource-intensive care settings.<sup>13</sup></p> <p><b>ACO Characteristics</b></p> <ul style="list-style-type: none"> <li>Individual or medical group practice ACOs may have had greater capacity to reduce utilization and associated spending in ED and acute care settings compared with IDS/hospital system ACOs, given the aforementioned internal economics of these different organizational structures. ACOs with more experience and thus a higher risk tolerance may also have had greater capacity to achieve reductions in these areas.</li> </ul> <p><b>Beneficiary Characteristics</b></p> <ul style="list-style-type: none"> <li>As with total spending, we expected health care utilization to increase for beneficiaries in subgroups with more clinical and social risk.</li> </ul>
<p><b>Utilization and Spending: Home Health and Hospice</b></p>	<p>We were uncertain whether Standard and New Entrant ACOs would increase or decrease home health and hospice use depending on the ACOs’ and their providers’ prior use of these services and care delivery strategy. For example, some ACOs may have provided in-home services instead of referring patients to home health services.</p> <p><b>ACO Characteristics</b></p> <ul style="list-style-type: none"> <li>We expected mixed findings for home health and hospice services, to reflect differences in organizational structure, risk tolerance, and experience.<sup>14</sup></li> </ul> <p><b>Beneficiary Characteristics</b></p> <ul style="list-style-type: none"> <li>We did not analyze home health and hospice outcomes by beneficiary characteristics.</li> </ul>
<p><b>Quality of Care</b></p>	<p>We expected improvements in quality of care over time, particularly for outcomes tied to the model’s financial incentives. Specifically, we expected:</p> <ul style="list-style-type: none"> <li>Increases in use of recommended diabetes care and timely follow-up after exacerbation of chronic conditions, as well as decreases in ACSC hospitalizations and unplanned hospitalizations for beneficiaries with MCC.</li> <li>An increase in the percentage of days at home and a decrease in all-condition readmissions, given the additional time needed to realize gains in improved care coordination and disease management.</li> </ul> <p><b>ACO Characteristics</b></p> <ul style="list-style-type: none"> <li>Similar to spending and utilization outcomes, we expected quality of care improvements to be greater for ACOs electing higher risk/capitation, and ACOs that were individual or medical group practices.</li> </ul>

<sup>13</sup> This approach was evident in the first two years of the model, for example, in that Standard ACOs experienced unfavorable increases in specialty care spending, and both Standard and New Entrant ACOs increased acute care spending (ACOs that were IDS/hospital systems in particular experienced increases in acute care utilization). We expected the ACO REACH Model to begin reducing setting-specific (avoidable) utilization and spending for acute care hospitalizations, acute care lengths of stay, SNF lengths of stay, inpatient rehabilitation facility (IRF) and long-term care hospital (LTCH) days, and emergency department (ED) visits in PY 2023 for Standard and New Entrant ACOs, relative to the comparison group.

<sup>14</sup> While differences in ACO organizational structure, risk tolerance, and experience could plausibly shape how ACOs substitute services, manage end-of-life care, or respond to model incentives, we did not have clear *a priori* expectations for how impacts on home health and hospice services would vary along these dimensions. For example, IDS/hospital system ACOs may have the capacity to deliver in-home services internally, but whether and how they deploy those resources may depend on organizational priorities, providers’ approaches to care delivery, and beneficiary needs.

For High Needs ACOs, our expectations for impacts were similar to those laid out in **Exhibit 2.3**, but with key differences reflecting the greater medical complexity of their aligned beneficiaries. **Exhibit 2.4** lists our hypotheses for High Needs ACOs, noting where expectations specific to their performance differ from those for the Standard and New Entrant ACOs.

In considering the hypotheses described in **Exhibit 2.4**, the reader should bear in mind not only that there are organizational differences across High Needs ACOs, but also that the third cohort of High Needs ACOs is notably larger and differs in other respects from prior cohorts. For example, the third cohort included four larger High Needs ACOs led by the same serious illness management services organization (MSO) that was implementing the same care model and portfolio of services across all four. Beneficiaries in the third cohort also differed from those in the other cohorts in that they were less medically complex, but saw higher instances of frailty. These differences suggest that the mechanisms through which the model influences outcomes may vary across cohorts, and that evaluative hypotheses may not apply uniformly to all High Needs ACOs.

**Exhibit 2.4. Hypothesized Impact of ACO REACH on Spending, Utilization, and Quality of Care for High Needs ACOs**

Domain	Hypotheses
<b>Total Spending: Gross and Net</b>	We expected High Needs ACOs to reduce spending and (given their beneficiaries’ higher baseline utilization and spending) potentially achieve larger reductions relative to Standard and New Entrant ACOs. This expectation was informed by evidence from comparable models serving seriously ill populations, such as the Medicare Care Choices Model (MCCM) <sup>15</sup> and Comprehensive ESRD Care (CEC) Model, <sup>16</sup> which demonstrated the potential to lower intensive service use. We hypothesized that reductions would result from earlier identification and management of serious illness, more intensive services delivered in the home to avoid hospital and facility admissions, and improved end-of-life care to reduce the use of higher-cost settings.
<b>Utilization and Spending: Ambulatory Care, Acute Care, and Post-Acute Care</b>	We expected acute and post-acute care utilization and associated spending to decline as ACOs increased proactive management and in-home supports. Ambulatory care use could increase if more services were delivered in community or home settings. We also expected utilization patterns to vary across ACOs depending on their care delivery strategies and patient mix.
<b>Utilization and Spending: Home Health and Hospice</b>	For High Needs ACOs as well, we anticipated that impacts on home health and hospice utilization could shift upward or downward, influenced by their providers’ historical service use, the complexity of the patient population, and the strategies employed to coordinate intensive care needs. For the seriously ill population, spending on home health could have increased if home-based primary care was used. Hospice care could have increased if ACOs promoted hospice elections. Increased hospice use could have yielded lower acute care spending at the end of life, although hospice used concurrently with curative and high-intensity treatments or much lengthier hospital stays could offset savings.

<sup>15</sup> Mathematica. *Annual Report 4: Evaluation of the Medicare Care Choices Model*. Mathematica; 2022. <https://www.cms.gov/priorities/innovation/data-and-reports/2022/mccm-fourth-annrpt>

<sup>16</sup> Lewin Group, Inc. *Fifth Annual Evaluation Report: Comprehensive End-Stage Renal Disease Care (CEC) Model*. Lewin Group, Inc.; 2022. <https://www.cms.gov/priorities/innovation/data-and-reports/2022/cec-annrpt-py5>

Domain	Hypotheses
<b>Quality of Care</b>	<p>As with Standard and New Entrant ACOs, we expected High Needs ACOs to improve quality of care, particularly outcomes tied to the model’s financial incentives (for example, timely follow-up after exacerbation of chronic conditions and decreases in ACSC hospitalizations). However, it may be difficult for providers within the ACOs to be able to make improvements on these measures given the severity of illness for most beneficiaries enrolled in High Needs ACOs. We might expect beneficiaries aligned to High Needs ACO providers to see larger increases in timely follow-up within the clinically recommended timeframe after an acute event (ED visit or hospitalization) relative to both comparison beneficiaries and those enrolled in other ACO types, if the relatively small size of their patient populations allowed for more individualized care for their beneficiaries.</p>

## Chapter 3: What Was the Scope and Reach of the ACO REACH Model in PY 2023?

### Key Findings

#### ACOs Participating in PY 2023

- **Participation.** A total of 132 ACOs participated in the ACO REACH Model in PY 2023, including 84 ACOs that transitioned from the GPDC Model. The majority (80%) were Standard ACOs.
- **Participation dynamics.** Model participation remained fluid, with ACOs entering, switching ACO types, or exiting in each PY. The number of Standard ACOs has grown over time. In PY 2023, ACOs entering the model cited opportunities to advance value-based care and provide services and supports for providers. ACOs exiting the model cited operational and data challenges and financial losses.
- **Leadership and partnership models.** In PY 2023, two-thirds of ACOs were led by either a management services organization (MSO)<sup>17</sup> or health care providers (for example, health systems or physician practices). MSOs also played a significant supporting role, with an estimated 75% of ACOs working with an MSO in some capacity—as vendors, partners, or administrative support entities.
- **Geographic reach.** ACOs in PY 2023 served beneficiaries residing in all 50 states, with a higher prevalence in both the Southwest and Mountain West, as compared with other regions.

#### ACO Provider Networks in PY 2023

- **Broad provider participation.** In PY 2023, ACOs included a total of 133,288 providers (Participant and Preferred). While Participant Providers are used for beneficiary alignment and contribute to ACO quality scoring, Preferred Providers outnumbered Participant Providers among Standard and High Needs ACOs, driven by a small number of ACOs with very large numbers of Preferred Providers.
- **Network composition varies by ACO type.** Across ACO types, Participant Provider networks were predominantly composed of PCPs. High Needs ACOs relied more heavily on advanced practice providers, such as nurse practitioners and physician assistants, as compared to Standard and New Entrant ACOs. In Preferred Provider networks, Standard ACOs focused on specialty care, while New Entrant and High Needs ACOs further supplemented their primary care networks.
- **Growth in safety net facility participation.** The number of safety net facilities—including federally qualified health centers (FQHCs), rural health centers (RHCs), and critical access hospitals (CAHs)—more than doubled, from 420 in PY 2022 to 871 in PY 2023. The proportion of ACOs with at least one safety net facility in their provider networks also increased, from one-quarter in PY 2022 to nearly one-third in PY 2023.

#### Characteristics of ACO REACH-Aligned Beneficiaries in PY 2023

- **Broad beneficiary alignment.** In PY 2023, more than 2 million beneficiaries were aligned to REACH ACOs, with most (96%) aligned to Standard ACOs. Notably, half of the aligned beneficiaries were new to the model in PY 2023, reflecting ongoing expansion and turnover in the aligned population.
- **Variation in beneficiary characteristics by ACO type.** Standard and New Entrant ACOs served similar populations, with only minor differences in health care coverage (such as Part D coverage and Medicaid dual eligibility), rurality, and area-level social need. As expected, the beneficiaries aligned to High Needs ACOs were on average more medically complex.

<sup>17</sup> Management services organizations provide non-clinical administrative and operational services and supports to providers. They are also sometimes referred to as management companies.

The characteristics of participating ACOs—including their organizational characteristics, their provider networks, and the profiles of their aligned Medicare beneficiary populations—can influence both implementation experience and model performance. As such, understanding the types of organizations that participated in ACO REACH and whom they served is essential to interpreting model outcomes. This chapter presents key descriptive findings on ACOs, providers, and beneficiaries in PY 2023. We also examine variations by ACO type and organizational characteristics, drawing on multiple data sources and analytic methods, as detailed in **Appendix B**. These findings provide important context for understanding ACOs' decisions and implementation approaches, which are explored in subsequent chapters.

## 3.1 ACOs

In this section, we describe the 132 ACOs that participated in ACO REACH in PY 2023, including their motivations, experiences, and organizational characteristics.

### **ACO Participation in PY 2023**

**Of the 132 ACOs, 84 continued from the GPDC Model, while 48 were new model participants in PY 2023.** The majority (80%) were Standard ACOs, and the remaining 20% were either New Entrant or High Needs ACOs.

**Exhibit 3.1** shows the movement of ACOs between types over time before and during PY 2023. The chart tracks how many ACOs remain in each type, move to another type, or exit over time.

Over time, the number of Standard ACOs has grown, partly because new Standard ACOs have joined the model and partly because, as expected, some New Entrant and High Needs ACOs have been reclassified as Standard ACOs.<sup>20</sup> As a result, participating ACOs in PY 2023 are serving larger populations than they did in prior years, with their average size increasing from 6,745 total aligned beneficiaries in PY 2021 to 15,500 total aligned beneficiaries in PY 2023.<sup>21</sup> Larger beneficiary populations may help ACOs because they can spread fixed costs

### **Model Requirements by ACO Type in PY 2023**

**Standard ACOs:** Have prior experience in risk-based FFS contracts; minimum of 5,000 aligned beneficiaries

**New Entrant ACOs:** Have limited prior experience with risk-based FFS contracts; minimum of 2,000 aligned beneficiaries<sup>18</sup>

**High Needs ACOs:** Serve beneficiaries with complex needs; minimum of 500 aligned beneficiaries<sup>19</sup>

<sup>18</sup> The minimum number of aligned beneficiaries for New Entrant ACOs will increase incrementally from 2,000 in PY 2023 to 5,000 in PY 2026; the minimum for High Needs ACOs will increase incrementally from 500 in PY 2023 to 1,250 in PY 2026.

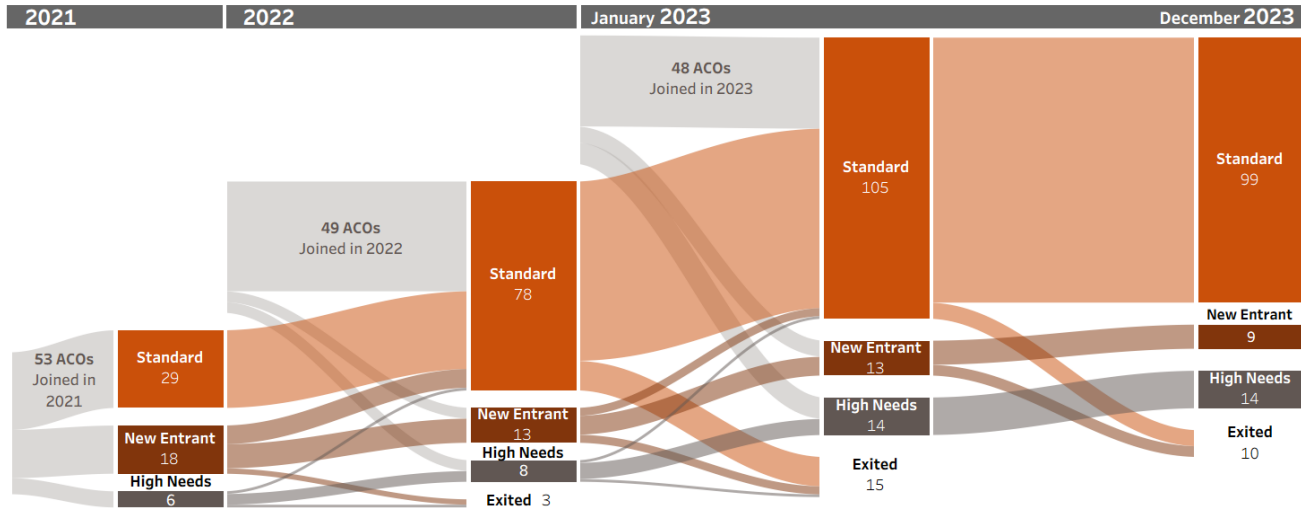
<sup>19</sup> Beneficiaries must meet one of the following High Needs criteria to be aligned to a High Needs ACO: 1) Hierarchical Condition Category risk score  $\geq 3.0$  (for concurrent or prospective Aged and Disabled scores) or  $> 0.35$  (for prospective end-stage renal disease [ESRD] scores); 2) Hierarchical Condition Category risk score  $\geq 2.0$  and  $< 3.0$  (for concurrent or prospective Aged and Disabled scores) or  $\geq 0.24$  and  $< 0.35$  (for prospective ESRD scores) with two or more unplanned admissions in the last year; 3) signs of frailty based on hospital bed or transfer equipment use; 4) signs of mobility impairment based on International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) diagnosis codes; 5) qualified for and received skilled nursing and/or rehabilitation services in a skilled nursing facility (SNF) for a minimum of 45 days in the previous 12 months as determined by CMS; or 6) qualified for and received home health services for a minimum of 90 days in the previous 12 months as determined by CMS.

<sup>20</sup> At the beginning of each PY, CMS reclassified eligible New Entrant ACOs after these ACOs met model requirements to operate as a Standard ACO. These requirements included the ACO reaching the threshold for the minimum number of aligned beneficiaries or their providers having sufficient experience with value-based care to no longer qualify as a New Entrant ACO.

<sup>21</sup> Using the final financial reconciliation data, NORC found that the average number of aligned beneficiaries for all ACOs was slightly higher in PY 2022 (18,475 total aligned beneficiaries) than in PY 2023 (15,500 total aligned beneficiaries). This can be attributed in part to the addition of eight High Needs ACOs and other smaller ACOs in PY 2023 that bring the overall average number of aligned patients down because these ACOs serve smaller numbers of beneficiaries relative to other ACOs in the model.

across a larger patient panel and thus reduce resource utilization per beneficiary. Additionally, about 8% of ACOs that participated in PY 2023 exited the model by the end of the year.

**Exhibit 3.1. Model Participation Was Fluid Across and Within PYs—In PY 2023, ACOs Joined and Exited the Model**



SOURCE: PY 2023 Financial Results (n=132).

In both interviews and surveys, ACOs referenced motivating factors for joining the ACO REACH Model. The 48 ACOs that joined in PY 2023 were motivated by their experience with value-based care and the new opportunities ACO REACH presented. Illustrative topics covered in our interviews with the 2023 cohort included the following:

- Some ACOs discussed the opportunity to provide care for communities in under-resourced areas and to expand upon pre-existing initiatives under the model.
- Some Standard ACO leaders with value-based care experience referenced their participation in ACO REACH as part of a strategic expansion of their value-based care portfolio. A few ACO leaders also described the Innovation Center’s broader efforts to boost provider participation in value-based care.<sup>22</sup>

**Reasons for Exiting the Model in PY 2023**

We conducted interviews with 8 of the 10 ACOs that exited the model in PY 2023. In these interviews, these ACOs referenced challenges with enrollment and implementation requirements, financial losses that they attributed to the model, data issues and financial uncertainties, and unexpected differences between ACO REACH and other ACO models in which they had previously participated. See **Appendix B.3** for more information on the ACOs that exited the model in PY 2023.

<sup>22</sup> CMS. CMS Innovation Center Strategy Refresh. <https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper>

- A few ACOs referenced their previous successes in value-based care initiatives and models (such as Medicare Shared Savings Program or the Next Generation ACO [NGACO] Model), suggesting that participation in ACO REACH was a “step up” and continuation of their value-based care and broader business strategies.
- A few Standard ACOs emphasized their population health management experience under Medicaid value-based care models.
- A few ACOs highlighted opportunities to engage and support providers by broadening the range of services delivered and access to data to improve care, as well as by investing in care teams and care delivery improvements.

### Factors Motivating Participation in ACO REACH in PY 2023

**In the survey, 41% of ACOs reported delivering value-based care to medically underserved beneficiaries<sup>23</sup> as their primary motivation, with ACOs joining the model in 2023 particularly likely to cite it as a top motivator.**

*“We’re dealing with this population of patients who are truly falling through the cracks of our system...we have an opportunity to really change that trajectory.” – New Entrant ACO Leader*

**A quarter of surveyed ACOs ranked expanding their value-based payment portfolio as their top motivator for joining the model.**

*“[Lead organization] owns and operates ACOs. We have several [Medicare Shared Savings Program] ACOs, and we have—we’re involved, I should say, in two ACO REACH entities. One, we own and operate that started this year.” – Standard ACO Leaders*

*“By 2030, everyone was going to be in a value-based care program, so we got to figure this out at some point.” – High Needs ACO Leader*

**When applying to the model, 94% of participating ACOs reported that the ACO, a partner, or their providers had MA experience,<sup>24</sup> while 73% reported Medicare ACO experience.**

*“We live and die by actually being able to be successful in these programs... From an economic viability standpoint, we literally cannot exist in a traditional fee-for-service environment.” – Standard ACO Leader*

**SOURCE:** Based on responses to Pulse Check Survey question 1. “Which of the following best describes your ACO’s main motivations for participating in ACO REACH?” (Total ACOs, n=132); NORC analysis of interviews with ACO leaders in PY 2023 and PY 2024 (n=66).

## ACO Leadership and Structure

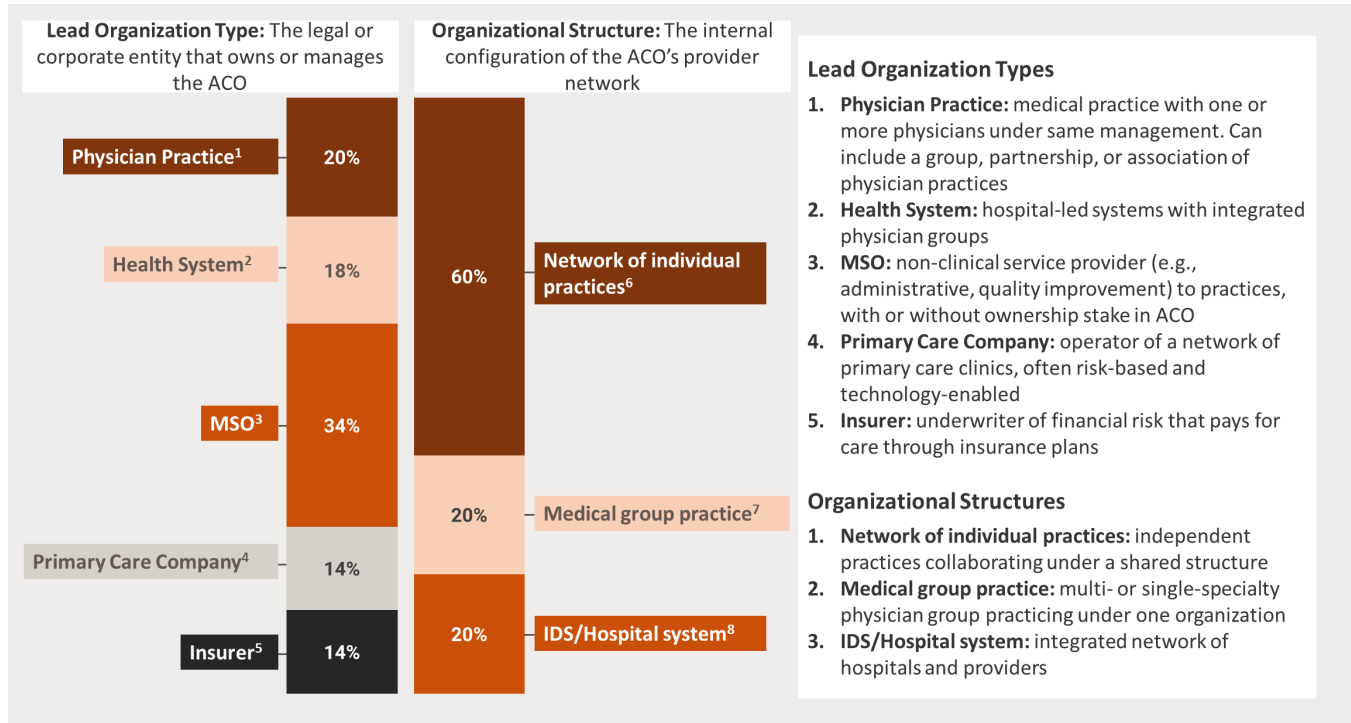
Understanding the organizations that lead ACOs and the structure of these ACOs highlights the resources and capacities that drive ACOs’ accountable care strategies and enhance their ability to support providers in delivering value-based care. **Exhibit 3.2** provides an overview of two key organizational characteristics (types of lead organizations and organizational structure) and the percentages of ACOs that fall into each category.

<sup>23</sup> Based on response to an item from Pulse Check Survey Q1: “To deliver value-based care to underserved Medicare beneficiaries.”

<sup>24</sup> Percentage of ACOs with MA experience excludes 6 ACOs that received a modified version of the application and did not provide information about involvement in MA.

Over half of ACOs (62%) were led by non-provider organizations, including MSOs, insurers, and primary care companies.<sup>25</sup> In PY 2023, different organizations played a key role in leading and managing the ACOs, with no single type of organization predominating. Health care providers (either health systems or physician practices) and MSOs each led more than one-third of participating ACOs, whereas insurers or primary care companies led one-quarter. For more information on these organizations and how they are defined, see **Appendix B.1**.

**Exhibit 3.2. Management Services Organizations Led More Than One-Third of REACH ACOs in PY 2023**



**SOURCE:** PY 2023 financial results (n=132); model applications and additional documentation (n=132); 2023 ACO REACH Pulse Check Survey (n=132).

In addition to leading ACOs, MSOs featured prominently as key vendors and partners to ACOs. MSO leadership of ACOs in the model grew significantly from PY 2022 to PY 2023. Of the ACOs that entered the model in PY 2023, nearly half were led by MSOs, nearly double the share of MSO-led ACOs that continued from PY 2022 (the GPDC Model). The MSOs that led ACOs often served as convening organizations for networks of providers, while all MSOs provided administrative and technical services that supported crucial accountable care functions. Approximately three-quarters of all ACOs active in PY 2023 were led by or partnered or contracted with an MSO. While MSOs typically have limited influence over direct patient care, they are well-positioned to support accountable care delivery by introducing and expanding infrastructure, technical capabilities, and administrative support to their participating provider networks. As ACO leaders and partners, they participated in the model’s risk arrangements and could receive shared savings.

<sup>25</sup> Primary care companies are organizations that operate a network of primary care clinics under one standard model of care, such as Oak Street Health, One Medical, or VillageMD.

ACOs led by MSOs, physician practices, or insurers were structured as loose networks of otherwise unaffiliated practices. In interviews, leaders described these ACOs as groups or partnerships of independent physician practices that either had a controlling interest in the ACO or were contracted by the lead organization.

ACOs led by health systems were organized around system-affiliated (and often -employed) providers and centralized care management teams. ACOs led by primary care companies were often organized around medical group practices with shared administrative and clinical supports and, to a lesser extent, as networks of individual practices.

### ***Partners and Vendors***

ACOs used partnerships and vendors to enhance their administrative capacities and to extend services and supports to providers. Care management, population analytics, administrative functions, and financial analytics were the most common services that ACOs secured through vendors and partners.<sup>26</sup> The types of vendors and partners discussed in these interviews included:



**Analytic and health IT** for population health management, patient panels, care gap screening, and clinical decision support tools



**Actuarial and financial** for financial modeling, risk management, and budget support



**Venture capital** for funding



**MSOs** for various supports and services (for example, administrative, clinical, population health management)



**Condition-specific clinical services**, including heart health and geriatric services for high-acuity beneficiaries



**Durable medical equipment, transportation services, and social work** to provide additional services and supports for high-risk and high-need beneficiaries

A few ACOs mentioned established relationships with vendors through their MA plans or the Medicare Shared Savings Program.

### ***What Was the Geographic Reach of the ACOs?***

**In PY 2023, aligned ACO beneficiaries resided in all 50 states.**<sup>27</sup> Exhibit 3.3 shows the geographic distribution of aligned ACO beneficiaries at the county level. The ACOs' beneficiary populations were distributed in clusters, typically in alignment with overall Medicare beneficiaries' geographic distribution, but were also spread across particular regions—like the Southeast, including Florida and the Carolinas; the Southwest; and the Mountain West—and states such as Oklahoma. Forty-nine counties had more than 10,000 aligned beneficiaries, and 42.8% of all aligned beneficiaries resided in these counties. The highest total residing in any county was 43,357 aligned beneficiaries. Appendix I.7 includes both a summary table of the beneficiary population's PY 2023 distribution

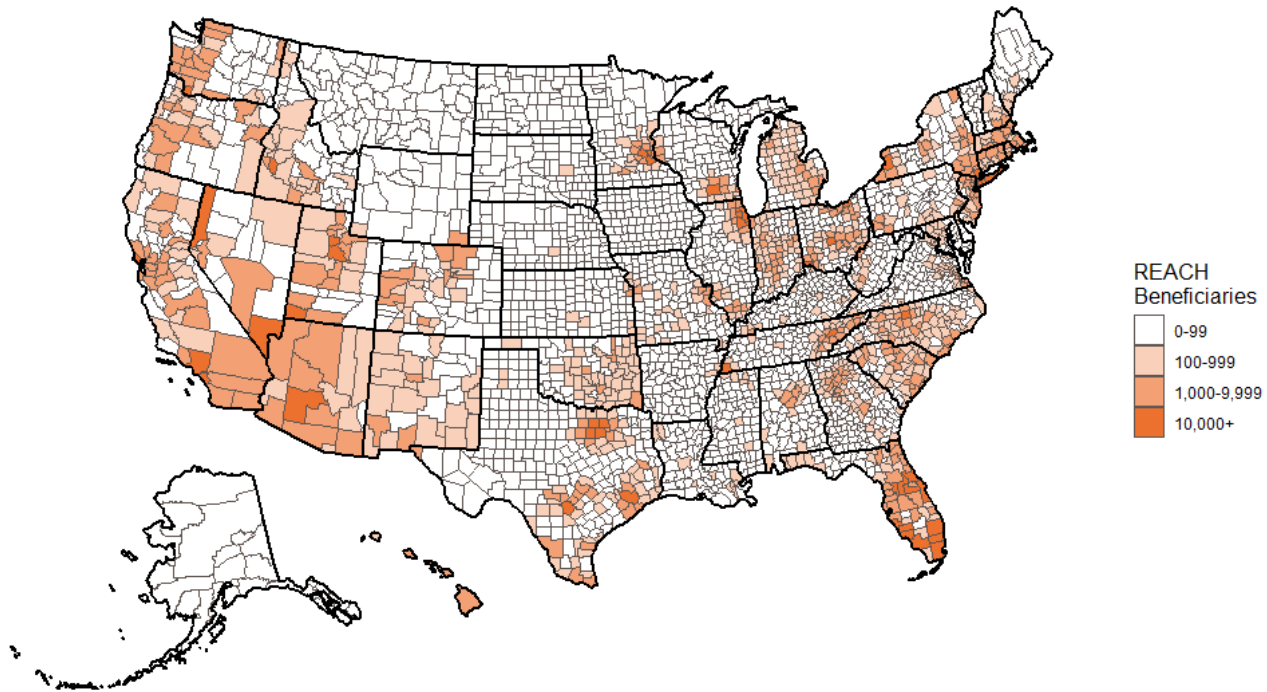
<sup>26</sup> When applying to ACO REACH, the ACOs starting in 2023 were asked to share information on their current partnerships and vendor relationships. Out of 48, 41 ACOs submitted information. Similar information is not available for the 2021 and 2022 cohorts.

<sup>27</sup> There were also ACO REACH-aligned beneficiaries in Washington, DC; Puerto Rico; Guam; the U.S. Virgin Islands; and the Northern Mariana Islands.

across counties and a map detailing the model's FFS market penetration (or the proportion of Original Medicare beneficiaries aligned to an ACO in the model).

### Exhibit 3.3. In PY 2023, 49 Counties Had 10,000 or More Aligned ACO Beneficiaries

#### County-Level ACO REACH Beneficiary Population Distribution



**SOURCE:** Medicare claims and enrollment data.

**NOTE:** Provider overlap is prohibited with the following statewide models: Maryland Total Cost of Care Model and Vermont All-Payer ACO Model. ACO REACH-aligned beneficiaries residing in Maryland and Vermont received care from ACO REACH providers in other states. For more information, see Appendix Exhibit I.37.

## 3.2 Provider Networks

ACOs built their provider networks by contracting with two types of providers: Participant Providers and Preferred Providers. Providers include individual practitioners, suppliers, and facilities. Beneficiaries were aligned to the ACO REACH Model through Participant Providers, whose performance is included in ACOs' quality measure scoring. Participant Providers, mainly PCPs and specialists, delivered the plurality of primary care services to aligned beneficiaries. Additionally, ACOs have the option of contracting with Preferred Providers. Although such providers are not used to align beneficiaries to the model or in the ACO's quality measure scoring, ACOs may engage Preferred Providers to establish formal relationships with specialty care and other providers not included in their Participant Provider list to expand their reach. In interviews, a few ACO leaders talked about how they used Preferred Provider arrangements to acknowledge existing relationships and referral patterns or to control costs for specific provider types. One leader for a High Needs ACO described their strategy

as “[focusing] on services [their] population use a lot of...building out the relationships and care coordination efforts with those organizations over the first two years here.”

**In total, ACOs had 133,309 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.

**ACOs typically included facilities such as SNFs and hospitals among their Preferred Providers.** High Needs ACOs had a notably high average number of Preferred facilities. Four High Needs ACOs managed by the same MSO and focused on hospice and home health made up 85% of all High Needs Preferred Providers. Each of these four ACOs had around 900 home health agencies and 400 hospices in their Preferred networks. **Exhibit 3.4** illustrates the total and average numbers of Participant and Preferred Providers, including practitioners and facilities by ACO type.

- Participant Provider:** Individual practitioner, supplier, or facility participating in the model; used in beneficiary alignment and quality measure scoring
- Preferred Provider:** Individual practitioner, supplier, or facility participating in the model; *not* used in beneficiary alignment or quality measure scoring
- Practitioner:** An individual physician, clinic or group practice, or network of practices that delivers care
- Facility:** A facility or institutional provider such as hospital, SNF, hospice or home health agency participating in the model

**While all ACOs included Participant practitioners as required, they were less inclined to include Preferred practitioners, with 40% having none.** In PY 2023, the average number of ACOs’ Participant practitioners remained consistent, while the average number of Preferred practitioners grew, compared with prior years. This increase varied across ACOs, with the rise in average number of Preferred practitioners largely from one ACO in the 2022 cohort that added nearly 20,000 practitioners in PY 2023. See **Appendix Exhibits D.1 and D.2** for more detail on Participant and Preferred Provider network size for PY 2023 and changes from PY 2022 to PY 2023.

**Exhibit 3.4. Standard ACOs Accounted for the Vast Majority of Participant and Preferred Providers in PY 2023**

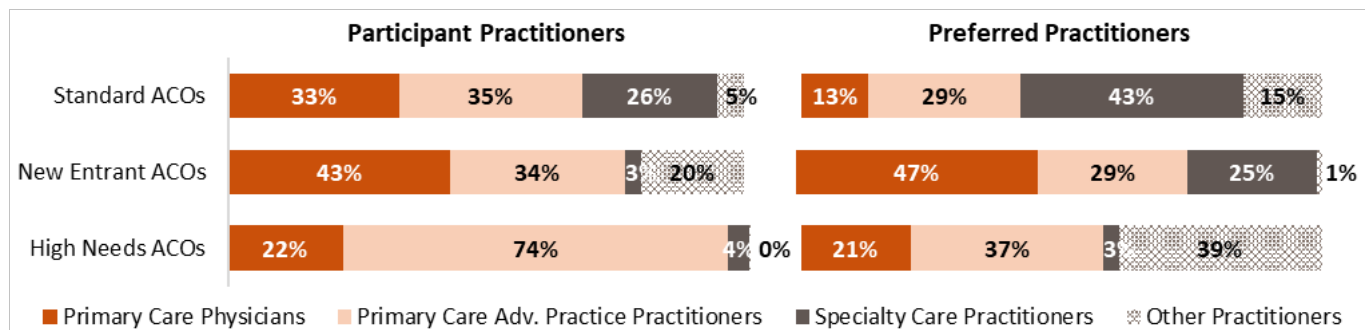
	Standard	New Entrant	High Needs	All ACOs
<b>Participant Providers, N</b>	<b>58,147</b>	<b>1,248</b>	<b>2,218</b>	<b>61,613</b>
<b>Practitioners, median (range)</b>	235 (23-4,408)	53 (11-253)	115 (43-409)	213 (11-4,408)
<b>Facilities, median (range)</b>	0 (0-185)	0 (0-5)	0 (0-3)	0 (0-185)
<b>Preferred Providers, N</b>	<b>65,128</b>	<b>239</b>	<b>6,329</b>	<b>71,696</b>
<b>Practitioners, median (range)</b>	10 (0-19,712)	0 (0-56)	2 (0-206)	3 (0-19,712)
<b>Facilities, median (range)</b>	19 (0-1,726)	0 (0-31)	92 (0-1,320)	17 (0-1,726)

**SOURCE:** NORC analysis of PY 2023 ACO REACH provider data (received from the model’s implementation and monitoring contractor; n=132 ACOs).

**NOTE:** ACO=Accountable Care Organization. N=number of providers, including practitioners and facilities, in each group. Practitioners include individual practitioners who may be employed directly by a health system or practice participating in the model; physician groups/practices; networks of individual physician practices or other practitioners; and independent or solo practitioners. Facilities include acute hospitals, critical access hospitals, federally qualified health centers, home health agencies, hospice facilities, long-term care hospitals, rehabilitation facilities, rural health centers, skilled nursing facilities, and facilities classified as other.

**ACOs tailored their provider networks to meet their beneficiary population’s needs.** Variations in the composition of Participant and Preferred Provider networks across ACO types illustrate this customization. For example, High Needs ACOs included a notably higher proportion (74%) of advanced practice providers, such as nurse practitioners and physician assistants, among their Participant Providers, compared with Standard and New Entrant ACOs (**Exhibit 3.5**). These ACOs also maintained a balanced mix of practitioner types among their Preferred Providers, including a high proportion of “other” behavioral health and social service providers concentrated in four ACOs. By contrast, New Entrant ACOs had the highest proportion of PCPs among both Participant and Preferred practitioners (43% and 47%, respectively). Standard ACOs generally featured a mix of primary and specialty care practitioners across both their Participant and Preferred Providers. Specialty care practitioners in ACO networks represented a broad range of disciplines, including cardiology, emergency medicine, surgery, internal medicine, pulmonology, and orthopedics. Additional details are provided in the chapters dedicated to each ACO type.

**Exhibit 3.5. Primary Care Advanced Practice Providers Made Up the Majority of High Needs ACOs’ Participant Practitioners**



**SOURCE:** NORC analysis of PY 2023 ACO REACH provider data (received from model’s implementation and monitoring contractor; n=132 ACOs).

**NOTE:** ACO=Accountable Care Organization; Primary Care Adv. Practice Practitioner=primary care advanced practice practitioner. Practitioners of unknown provider type are not shown. Totals by ACO type may not add up to 100% because of rounding. Primary care advanced practice practitioners include nurse practitioners, physician assistants, certified clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.

**In building their networks, ACOs considered providers' experience and mutual commitment to value-based care essential for achieving success.** In interviews, many ACO leaders reported that prior relationships and experience with risk-sharing or value-based care were important considerations when selecting providers. Pre-existing relationships made it easier for ACOs to identify experienced providers. For instance, providers with Medicare ACO experience tended to be in ACOs led by health systems and in physician practice-led and insurer-led ACOs organized as medical group practices, while those in ACOs organized as networks of independent practices across leadership structures had the least Medicare ACO experience. ACOs also sought participation from practitioners with demonstrated interest in value-based care, even without prior experience in value-based care.

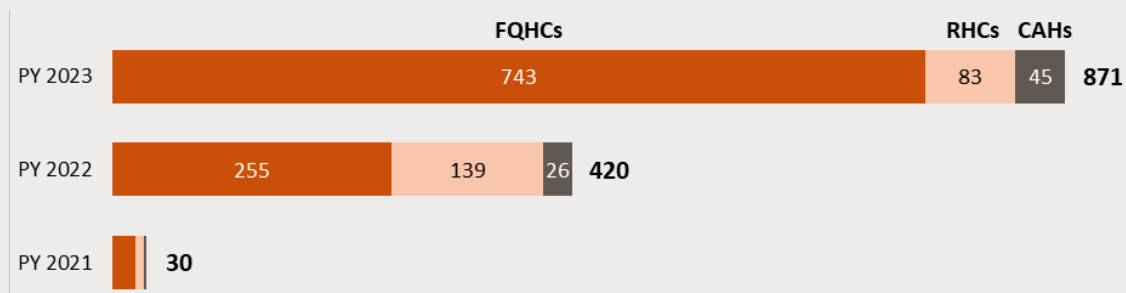
### Safety Net Facilities in ACO REACH

In PY 2023, participation by safety net providers—including FQHCs, RHCs, and CAHs—more than doubled.<sup>28</sup> However, this growth was concentrated in only a few ACOs. Previously, about one-quarter of ACOs included any safety net facilities in their network; in PY 2023, this rose to nearly one-third. Standard ACOs accounted for almost all safety net participation. Only four New Entrant ACOs included safety net facilities in their networks, each with five or fewer of these facilities. No High Needs ACOs had safety net facilities in their networks.

FQHCs have been the most common type of safety net facility, and their participation grew significantly each year. Five Standard ACOs had extensive FQHC networks, some spanning multiple states, accounting for 71% of all FQHCs participating in the model. Two in the 2023 cohort each had more than 150 sites.

Despite this growth, in interviews, a few ACO leaders reported challenges recruiting and retaining FQHCs. Barriers included administrative complexities related to reimbursement due to FQHC reporting requirements under the prospective payment system and the fact that ACO beneficiaries comprised a small portion of their overall patient population.

**Exhibit 3.6. Number of Participant and Preferred Safety Net Facilities in ACO REACH More Than Doubled in PY 2023**



**SOURCE:** NORC analysis of PY 2021 (n=53 ACOs), PY 2022 (n=99 ACOs), and PY 2023 (n=132 ACOs) ACO REACH provider data (received from model’s implementation and monitoring contractor).

**NOTE:** PY 2021 facility counts: 21 federally qualified health centers (FQHCs), 7 rural health centers (RHCs), and 2 critical access hospitals (CAHs).

<sup>28</sup> For the purposes of this analysis, safety net providers include only facilities designated as FQHCs, CAHs, or RHCs based on their CMS Certification Number (CCN).

### 3.3 Beneficiaries

The size and composition of ACOs' aligned beneficiary populations influenced the scope and scale of their accountable care efforts. **Appendix I.2** presents descriptive statistics on aligned beneficiaries in PY 2023.

In PY 2023, 2,046,054 beneficiaries were aligned to ACOs, with nearly all (96%) aligned to Standard ACOs. Notably, half (52%) of these beneficiaries were new to the model in PY 2023, while 40% continued from PY 2022.<sup>29</sup> Combined, ACOs led by MSOs and health systems served half of the beneficiary population (27% and 25%, respectively). Insurer-led ACOs served 20% of beneficiaries, physician practices served 17% of beneficiaries, and primary care companies served 11% of beneficiaries. Health system- and insurer-led ACOs had around 8,000 to 10,000 more beneficiaries on average than other ACOs. **Appendix I.2** includes an overview of the characteristics of beneficiaries by ACO type.

In the PY 2023 ACO REACH intervention group,<sup>30</sup> Standard and New Entrant ACOs served similar populations, with minor differences in health care coverage and case mix (including the percentages of beneficiaries previously enrolled in MA, disabled [with or without ESRD], with any Part D coverage, and receiving the Part D Low-Income Drug Subsidy), rurality, and HPSAs.<sup>31</sup> New Entrant ACOs saw slightly higher average percentages of dually eligible beneficiaries (16.4% compared to 14.9%). Clinical characteristics across Standard ACO and New Entrant ACO intervention groups

#### Beneficiaries' Awareness of the ACO REACH Model

Regardless of how they were aligned, beneficiaries interviewed in PY 2023 were unfamiliar with the ACO REACH Model. After hearing how ACOs deliver care, beneficiaries reacted favorably to the concept, its potential to lower costs or improve quality of care, and the ability to see their provider of choice. Beneficiaries voiced concerns around coordination among Medicare, Medicaid, and the Veteran's Administration, as well as potentially higher care costs and poor care coordination between providers. See **Appendix B.4** for more information on the beneficiary interviews conducted in PY 2023.

were largely similar; however, on average, more New Entrant ACO beneficiaries were diagnosed with behavioral health conditions (33.9% compared to 30.2%) and chronic kidney conditions (23.6% compared to 21.1%). On average, more Standard ACO beneficiaries lived in rural ZIP codes (5.4% compared to 3.1%), and more New Entrant ACO beneficiaries resided in areas with higher social need (and an ADI score of 1–25).

Beneficiaries in the High Needs ACOs' intervention group were more likely to be dually eligible (57.4%) and have disability and/or ESRD as the original reason for Medicare eligibility (32.7% compared to 15.3% of beneficiaries in the Standard ACOs' intervention group and 16.3% of beneficiaries in the New Entrant ACOs' intervention group). As of PY 2023, the cumulative proportion of dually eligible beneficiaries in Standard ACOs' intervention group increased (up to 14.3% from 13.9%). This increase is in part due to the high proportion of dually eligible beneficiaries among the ACOs that entered the model in PY 2023. In contrast, the proportion of dually eligible

<sup>29</sup> Of the 2,046,060 beneficiaries in the model in PY 2023, 177,322 (8.7%) were previously aligned to the model in PY 2021, 812,878 (39.7%) continued from PY 2022, and 1,055,860 (51.6%) were new to the model in PY 2023.

<sup>30</sup> The ACO REACH intervention group (ACO REACH group) was defined as beneficiaries aligned to ACO REACH Participant Providers in PY 2023 and in the baseline period, excluding Prospective Plus voluntarily aligned beneficiaries.

<sup>31</sup> Health Professional Shortage Areas (HPSAs) identify areas or populations that have a shortage of health professionals relative to the population and the health care needs of that population.

beneficiaries aligned to High Needs ACOs was smaller in PY 2023 compared to PY 2022 (down to 60.1% from 67.6%).

Half of the High Needs ACOs that started in PY 2023 were provider collaboratives focused on providing home-based palliative or primary care and were led by an MSO focused on serious illness. These four High Needs ACOs accounted for 41% of all beneficiaries aligned to High Needs ACOs in PY 2023 and may have been larger contributors to the proportional decrease in the number of dually eligible beneficiaries in the intervention group aligned to High Needs ACOs.

As a population, High Needs ACO beneficiaries were more medically complex, averaging just over 12 chronic conditions, compared with just over 6 chronic conditions in Standard and New Entrant ACOs. In contrast, the average proportion of the population living below the poverty line in the areas where aligned beneficiaries resided was similar for all ACO types, ranging from 11% to 13%.

### 3.4 Conclusion

Participation in the ACO REACH Model remained dynamic in PY 2023, with continued growth in the number and size of participating ACOs. The transition of New Entrant ACOs into Standard ACOs persisted, contributing to an increase in the average ACO size and broader geographic reach; beneficiaries were aligned to ACOs in every state across the country. Motivations for joining the model varied, but many ACOs cited the opportunity to strategically expand their value-based care portfolios and build on their prior successes in other APMs outside of the ACO REACH Model. At the same time, ACOs that exited the model often pointed to operational, data, and financial challenges.

Organizational leadership and structure varied across ACOs, with MSOs, health systems, and physician practices playing prominent leadership roles. MSOs were especially influential, serving as lead entities, partners, or vendors for approximately three-quarters of ACOs. ACOs leveraged partnerships and vendors to support care delivery, analytics, and administrative functions, often drawing on prior experience in MA or other ACO models.

In the third year of the model, ACOs continued to build and refine their provider networks. Most focused on strengthening primary care through Participant Providers, while leveraging Preferred Provider networks to establish relationships with specialty care and facilities. In building their provider networks, ACOs considered previous value-based care and risk-sharing experience and existing relationships with providers. Notably, participation of safety net facilities increased in PY 2023, driven by a nearly threefold rise in the number of FQHCs, though challenges with recruitment and retention of FQHCs remained.

Standard ACOs comprised 80% of all participating ACOs and accounted for 96% of all aligned beneficiaries. Beneficiary populations varied by ACO type, with High Needs ACOs serving more medically complex and dually eligible individuals. These distinctions provide important context for understanding model implementation strategies and outcomes, discussed in subsequent chapters. **Chapters 6–8** provide more information on characteristics within each ACO type.

## Chapter 4: How Did ACOs Respond to Model Features?

### Key Findings

#### Risk, Payment, and Projecting Financial Performance

- Risk option selection.** Most ACOs selected the Global (full-risk) option with PCC (n=78), compared to the more comprehensive Global risk with TCC (n=30) or the lower-risk Professional risk option with PCC (n=24). ACO leaders reported that prior ACO experience with risk-based contracts influenced their choice. Health system-led ACOs were more likely to choose Professional risk and PCC, citing risk aversion and limited experience with risk-based contracts.
- Use of shared savings and capitation.** ACO leaders reported using their shared savings and capitated payments to invest in infrastructure, new initiatives, and existing programs.
- Provider payment and incentives.** Most ACOs (64%) paid their providers at least partially through capitation, though financial arrangements were flexible and tailored to providers' experience with risk experience and their preferences. ACOs also offered additional payments and bonuses, often tied to performance on quality and cost metrics. Both ACO leaders and providers appreciated the prospective nature of capitation payments. While only about one-quarter of ACOs (26%) reported formally sharing downside risk with practitioners—such as requiring providers to absorb a portion of shared losses under the model—many practitioners still faced financial accountability through other means. For example, 57% of ACOs said payments tied to quality thresholds were very important for provider engagement, and 30% reported the same of performance-based financial penalties.

#### Beneficiary Alignment

- Claims vs. voluntary alignment.** Most beneficiaries in the model were passively aligned with an ACO through claims. New Entrant ACOs aligned a greater proportion of beneficiaries through voluntary alignment (58%) relative to Standard (8%) and High Needs (10%) ACOs.
- Challenges.** Some ACO leaders expressed concern with being held accountable for the costs and quality of care delivered to beneficiaries who no longer received care from their aligned providers. In interviews, ACO leaders noted that eligibility criteria, administrative burden, and delays in attribution limited the usefulness of voluntary alignment.

#### Benefit Enhancements

- Low uptake of benefit enhancements.** Overall uptake of benefit enhancements that waived certain Medicare payment requirements was low, with administrative complexity cited as a key barrier. The most used benefit enhancements were the 3-day SNF rule waiver and telehealth benefit enhancements; all ACOs submitted claims for these benefit enhancements.
- Higher benefit enhancement use among High Needs ACOs.** High Needs ACOs submitted more claims per 1,000 beneficiaries for the SNF 3-day rule and home health homebound waivers than did either Standard or New Entrant ACOs, suggesting that these benefit enhancements may have been particularly useful for high needs beneficiaries with more complex needs.

In this chapter, we discuss ACOs’ responses to and experience with the model features, including risk-sharing approaches and payment mechanisms, beneficiary alignment approach, and benefit enhancements. Findings draw on program data, interviews with ACO leaders and providers, and the survey of ACO leaders.<sup>32</sup> **Appendix B** provides more information on data sources and analytic methods.

## 4.1 Risk and Payment Options for ACOs

Each performance year, ACOs select a combination of risk and payment options. Because ACOs aimed to optimize their performance in each year of the model, model elections determined 1) the level of risk that ACOs assumed under the model, 2) the services eligible for monthly capitation payments, and 3) their final financial settlement at the end of each performance year. The choices gave ACOs greater flexibility and control over their cash flows and opportunities to invest in the infrastructure and staff needed to improve population health. They also allowed ACOs the flexibility to use financial incentives and other mechanisms to engage their providers.

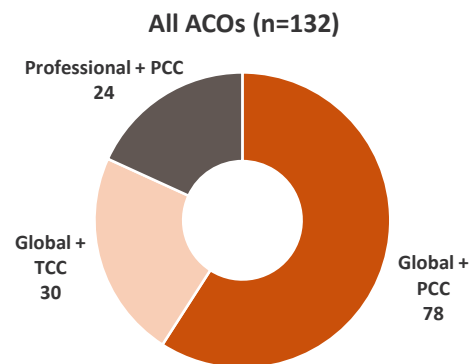
### ***ACOs’ Decisions on Risk-Sharing and Payment Mechanisms***

Most ACOs chose the Global (or full-risk) option with PCC, rather than the more comprehensive Global risk with TCC or the lower-risk Professional risk option with PCC (**Exhibit 4.1**). Many ACOs cited their experience with full-risk contracts, the primary care focus, and the potential to maximize shared savings under the model as factors in their choice of risk-sharing and payment mechanism.

**For some ACOs, prior experience with risk-based contracts influenced their decisions on risk and payment options.** Some ACOs that chose Global risk explained that their business model involved operating under full risk and that they or their providers had extensive experience with downside risk across Medicare, MA, and commercial health plans.

Leaders of some ACOs that elected PCC explained that they considered it a better choice for them due to their providers’ focus on primary care. Over 80% of ACOs opting for PCC continued with the highest enhanced rate option (7%).<sup>33</sup> These trends were consistent across performance years and cohorts. By contrast, those choosing TCC highlighted their multidisciplinary networks and whole-person approach to care. The health system-led ACOs were more likely to choose Professional risk and PCC due to their risk aversion and lack of experience with risk-based contracts. A few health system ACO leaders explained that ACO REACH was their first risk-based contract, and they felt they were not mature or large enough for full risk or capitation. However, a few did

**Exhibit 4.1. Most ACOs Elected Global Risk and Primary Care Capitation**



**SOURCE:** PY 2023 Financial Results (n=132).

<sup>32</sup> The report identifies themes by the number of ACOs with an interviewee who reported about the topic at hand: a few (2–3 ACOs, 5% of ACOs interviewed), some (4–7 ACOs, 6–10% of ACOs interviewed), many (8–32 ACOs, 12–48% of ACOs interviewed), most (33 or more ACOs, >50% of ACOs interviewed).

<sup>33</sup> For PCC payments, an ACO receives both a base amount to cover primary care services and an optional enhanced amount that is then recouped by CMS during financial settlement. ACOs can request an enhanced amount that is no more than the difference between 7% of the PY benchmark and the estimated base amount with 100% claims reduction for all participant providers.

choose TCC and Global risk and explained that they aimed to influence total health care costs and leverage their relationships with specialists.

#### Return on Investments in Model and Risk

*“This is a significant investment. The potential upside was looked at to see how [to] get at least some return on that investment...and it was determined the global option. At the time, much smaller ACOs, as a New Entrant, the risk was limited. I think there was steerage toward the global option to provide those potential funds, assuming there was performance that came with it.”*

– New Entrant ACO Leader

*“What it’s allowed us to do is, we’re making a lot more aggressive investments in clinical programs and patient care opportunities because the ACO REACH has more upside, we’re able to invest more. We’re doing a lot more for our patients in the last two or three years in ACO REACH than we were able to do in the MSSP.”*

– Standard ACO Provider

Many ACO leaders reported using capitated payments to invest in infrastructure, health information technology (IT), population health, clinical services, provider incentives, and initiatives to address needs such as food, housing, and transportation. A few ACO leaders indicated that capitation provided stable, up-front cash flow that allowed them to invest in practices and hire additional staff. Both ACO leaders and providers said the flexible funding structure under ACO REACH allowed for the development of new roles and multidisciplinary care teams, which would not have been possible under FFS. A few ACO leaders noted that the enhanced amount from their PCC payments was used for various efforts, including incentives to practices for certain types of behavior or services. These included annual wellness visits (AWVs), primary care, and care management. However, one Standard ACO expressed concerns about repaying enhanced rate funds.

## Payments to Providers

After ACOs receive monthly capitated payments from CMS under the model, they distribute them to providers based on negotiated agreements. Participant Providers must forgo FFS payments from CMS and instead receive them directly from their ACO for their aligned beneficiaries.<sup>34</sup>

**ACOs used a blend of capitation, FFS, and incentives to enhance providers’ experience with risk and cash flow needs.** On the evaluation’s survey, 71% of ACO leaders reported using some combination of these payment methods, with 27% using all three.<sup>35</sup> In interviews, some ACO leaders mentioned that they paid providers up front with recurring payments, while others paid one initial payment and withheld the rest for performance-based bonuses tied to quality measures or shared savings. Many ACOs that elected PCC paid providers the base amount from their PCC payments, sometimes supplemented by the enhanced amount or shared savings. A few ACO leaders mentioned paying providers the normal FFS rate, with an additional care coordination fee or payment for closing gaps in care. Some ACOs offered multiple payment options to appeal to providers’ preferences.

<sup>34</sup> ACO REACH Model Request for Applications. Published online February 24, 2022.

<https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa>

<sup>35</sup> Based on responses to Pulse Check Survey question 14. “Does your ACO use any of the following methods to pay Participant Providers?” See **Appendix F** for more information. Respondents who skipped the entire series of questions on payment methods were excluded from this count.

For many ACOs, payments to providers remained unchanged under the model, with employed providers receiving the same salaries and contracted providers the same rates across all models. As the leadership of two Standard ACOs explained, these ACOs operated under one *“incentive compensation model that intended to line up with all of the things [they’re] at risk for in the ACO and in [their] other value-based arrangements.”* One ACO leader noted that, because capitated payments constitute a big change in cash flow, especially for independent and rural providers, they initially limited their Participant Providers to employed providers to test the change to capitated payment without significantly affecting cash flows. Several ACOs with prior experience with MA plans highlighted that this background facilitated a smoother introduction to full capitation under the model.

The ACOs provided additional payments and bonuses based on provider performance in quality and outcome metrics such as follow-up post-discharge, AWWs, transitional care management visits, admission rates, chronic care management, population health outcomes, beneficiary experience, medical loss ratio, and relative value units. Most ACOs based financial incentives for providers’ performance on specific quality and outcome metrics, contributions to shared savings, or the proportion of aligned beneficiaries to whom each provider delivered care under the model. There were also frequent incentives for AWWs, which led to higher completion rates in some cases, according to ACO leaders.

Both ACO leaders and providers valued the prospective nature of capitation payments. On the survey, half of ACO leaders (49%) said that up-front payments were very important for engaging Participant Providers. Capitated payments allowed ACOs to make aggressive investments in areas such as clinical programs, beneficiary care, and practice improvements, reducing the need for external capital. The payments provided financial coverage for services that typically do not have a billable revenue code under Medicare. These included longer or more frequent visits for high needs beneficiaries, additional time in the hospital to stabilize patients before transitioning to a SNF, or treating a patient with heart failure on a hospital outpatient basis for a few hours rather than admitting them. As one ACO leader noted, *“Now it actually makes financial sense to do the right thing.”*

Providers used up-front funds to hire new staff, cover operational costs, enhance infrastructure, manage population health, and support patients by addressing other needs (for example, food, housing, transportation) or offering services such as home health or behavioral health visits. However, some ACO leaders and providers noted that the combination of the predominance of FFS payment and low proportions of ACO-aligned beneficiaries in provider panels created competing priorities, reluctance to take on risk, and frustrations due to lack of payment predictability and oversight.

### Population Adjustment to Broaden ACOs’ Market Reach

In PY 2023, CMS introduced an upward Population Adjustment to support ACOs serving in under-resourced areas. ACO leaders found the adjustment useful for expanding their networks to providers and beneficiaries in higher-need markets such as those with many dually eligible individuals and safety net settings. However, some ACOs expressed concern about the adjustment’s ability to capture beneficiary-level variations in risk within ZIP codes and across regions. Specifically, ACOs noted that the adjustment did not effectively account for risk variation among patients in:

- Urban areas with substantial differences within ZIP codes
- Safety net settings with providers serving many dually eligible beneficiaries in lower-need ZIP codes
- Areas with historically limited or inconsistent risk documentation

ACO leaders perceived mixed impacts on cost from the adjustment, with both positive and negative effects noted within their markets.

## ***Shared Savings and Losses and Final Settlements***

After each performance year, CMS informs ACOs of any savings or losses owed during the final settlement. ACOs used various approaches to sharing savings and losses with providers, and some ACO leaders explained that practice leaders decided how risk and savings would be split among providers.

**Shared savings were distributed to providers based on performance, quality, and utilization measures.** Some ACOs described imposing penalties or withholding savings for poorly performing providers, while others distributed savings regardless of individual performance. In interviews, providers understood that participation affected compensation, although many lacked clarity about how savings were distributed.

**ACOs shared financial losses with providers on a limited basis.** Survey data show that most ACOs (92%) shared savings with Participant practitioners, but only one-quarter (26%) shared losses.<sup>36</sup> In interviews, many ACO leaders described easing providers into the model by initially sharing only savings under upside-only risk arrangements and gradually introducing downside risk. This included formal loss-sharing arrangements—such as contractual agreements specifying provider accountability for a portion of ACO losses—or in a few cases, other financial consequences when ACOs experienced losses, such as withheld bonuses. While capitation (used by 64% of ACOs) and performance-based penalties (cited as very important for provider engagement by 30% of ACOs) may increase providers' financial accountability, it is unclear whether ACOs consistently viewed these mechanisms as forms of downside risk. ACOs were more likely to share savings than losses with facilities, with 27% of ACOs reporting sharing savings and only 7% sharing losses with Participant facilities.<sup>37</sup>

## ***Projecting Financial Performance Under the Model***

ACOs used financial modeling to determine returns on investment and opportunities for financial growth under different risk-sharing and payment options. Predictive modeling has been critical for ongoing financial projections, influencing decisions on model-related investments and participation. In interviews, a few ACOs reported conducting financial modeling in-house, while others used actuarial firms.

**A few ACOs noted that retrospective trend adjustments were a major barrier to predicting financial performance.** The adjustments modify ACOs' benchmarks at the end of the year based on differences between projected and actual growth trends, making it hard for ACOs to reliably predict end-of-year performance. ACOs noted that, in other CMS models, lookbacks and adjustments take place during the performance year.

**Data lags and varying data quality affected ACOs' ability to estimate their financial performance in the final settlement.** A few ACOs explained that delays in claims runout and final reconciliation meant that they lacked information about their financial performance until midway through the next year. One ACO explained that the data available for ACO REACH benchmarking and cost analyses were less extensive than in the Medicare Shared Savings Program.

The inability to accurately project financial performance affected ACOs' decisions about model-related investments and initiatives. In interviews, some ACO leaders described needing to invest up front to meet

<sup>36</sup> Participant practitioners include individual practitioners who may be employed directly by a health system or practice participating in the model, physician groups/practices, networks of individual physician practices or other practitioners, and independent or solo practitioners.

<sup>37</sup> Participant facilities include acute care hospitals, SNFs, home health agencies, LTCHs, or IRFs.

infrastructure needs required for value-based care—such as health IT, data systems, and care management staff—without guaranteed returns, which complicated budget projections. One ACO noted that the costs of model-related investments, along with the risk they were taking on, required them to raise capital to continue in the model. Another ACO highlighted that, while they believe in value-based care, the current economics have not been beneficial as the activities and initiatives aiming to reduce utilization and decrease total cost of care (for example, complex care management programs) were not fully funded by capitation and payments.

## 4.2 Beneficiary Eligibility and Alignment

In the ACO REACH Model, beneficiary alignment occurs through claims-based attribution or voluntary alignment. Claims-based alignment uses past claims data to identify beneficiaries receiving the plurality of primary care services from ACO Participant Providers. Beneficiaries may voluntarily align through Medicare.gov or by completing a CMS form, designating an ACO REACH Participant Provider as their primary practitioner or main source of care.<sup>38</sup> In PY 2023, large majorities of beneficiaries in Standard and High Needs ACOs were aligned via claims-based attribution (92% and 90%, respectively), while New Entrant ACOs relied more heavily on voluntary alignment, with over half of their beneficiaries voluntarily aligned in both PY 2022 and PY 2023.

**ACO leaders reported challenges with claims-based attribution, particularly when beneficiaries stopped seeing the provider through whom they were aligned.** Some ACO leaders also expressed concern that having

### Challenges with Claims-Based Attribution

*“When patients say they don’t want to be in the program...there’s no way to realign them. They’re going somewhere else, maybe some other place, and yet that doctor at [ACO name] is still at risk.”*

—ACO Leader

*“One of the biggest struggles is a lot of the patients we’re at risk for, we can’t find. They’ve been seen by their PCP once or twice, and they just don’t see any other brick and mortar establishment. There are no PCP codes...so under the plurality of care, they did claims-based align to this program, but we have no idea where they are.”*

—ACO Leader

only an annual opportunity to update their provider lists was insufficient to manage provider turnover, which can affect attribution accuracy and accountability. High Needs ACOs faced additional challenges with the timing around claims-based alignment due to higher beneficiary mortality rates.<sup>39</sup> One High Needs ACO leader noted a “roughly 30-35% year-over-year turnover due to death” and emphasized the importance of voluntary alignment as a mechanism for patients to be aligned more quickly.

**While voluntary alignment offered ACOs a valuable mechanism for engaging beneficiaries more proactively, ACO leaders also identified several challenges that limited its effectiveness.** These

challenges included strict eligibility criteria, administrative burden, and delays in attribution. For example, one High Needs ACO reported that only 40% of the beneficiaries they included on their voluntary alignment submission list met the CMS high needs eligibility criteria, possibly due to incorrect claims documentation, resulting in a limited number of beneficiaries being approved. Another issue for High Needs ACOs was their inability to discuss voluntary alignment with beneficiaries during home visits. This policy limitation significantly hindered early alignment efforts,

<sup>38</sup> Beneficiaries may align to a Participant Provider through Medicare.gov (previously known as electronic voluntary alignment [EVA]), or Signed Attestation-Based Voluntary Alignment (SVA, previously known as paper-based voluntary alignment [PVA]). For SVA, beneficiaries receive a Voluntary Alignment Form, a CMS-specific template that beneficiaries complete and return to the ACO.

<sup>39</sup> The mortality rate for High Needs ACOs was 203.8 deaths per 1,000 beneficiaries in PY 2023, compared to 34.1 in Standard ACOs and 37.8 in New Entrant ACOs.

especially for a population that is often very ill and difficult to reach through other means like regular mail. Other challenges cited were the administrative and time burdens of receiving and sharing beneficiary lists with CMS.

### 4.3 Benefit Enhancements

CMS conditionally waives certain Medicare payment requirements for participating ACOs through benefit enhancements designed to support care management and promote high-value services. An analysis of benefit enhancement claims identifies ACOs' most used waivers and differences by ACO type. **Appendix E.2** provides a summary of total claims submitted for each waiver by ACO type and organizational structure.<sup>40</sup>

**Overall uptake of benefit enhancement was low, except among High Needs ACOs.** All ACOs submitted claims for the telehealth and SNF 3-day rule waivers,<sup>41</sup> with telehealth claims (489,900 claims) submitted more than four times as often as SNF 3-day rule claims (118,427 claims). Fewer ACOs submitted claims for other waivers, including the home health homebound (55%), concurrent care for Medicare hospice (38%), nurse practitioner services (20%), care management home visit (5%), or post-discharge home visit (4%) waivers.<sup>42</sup> After adjusting for the number of aligned beneficiaries, High Needs ACOs were more likely to submit claims related to the home health homebound and concurrent care waivers.<sup>43</sup> High Needs ACOs most frequently submitted claims for the SNF 3-day rule and home health homebound waivers. This pattern suggests that these benefit enhancements may have been particularly useful for high needs beneficiaries with more complex needs.

**Administrative complexity was a key barrier to broader use of benefit enhancements.** In interviews, ACO leaders acknowledged the value of the waivers but described challenges related to relationship building (for example, with SNFs and home health agencies), contract development, workflow integration, and provider education. Some ACO leaders indicated plans to adopt waivers in future performance years. ACO leaders who reported effective use of waivers, particularly the SNF 3-day rule waiver, typically had existing SNF provider networks and prior experience in similar models. In contrast, ACOs without existing networks noted the need to invest time and resources in developing partnerships before waiver use could be operationalized.

### 4.4 Conclusion

In PY 2023, ACOs leveraged the flexibility of ACO REACH's risk-sharing and payment options to support care transformation and financial sustainability. Most ACOs chose the Global (full-risk) option, citing prior experience with risk-based contracts and a strategic focus on maximizing shared savings. PCC was the predominant payment mechanism, reflecting ACOs' emphasis on primary care. Capitated payments enabled investments in infrastructure, care teams, and services. While most ACOs paid their providers at least partially through

<sup>40</sup> ACO REACH Model Request for Applications. Published online February 24, 2022.

<https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa>

<sup>41</sup> Counts in this report reflect all PY 2023 claims for telehealth and SNF 3-day rule waiver services from participating ACOs. Claims from entities not listed in CMS' official ACO REACH participant file were excluded. See **Appendix E.2** for more information.

<sup>42</sup> The claims denial rates for benefit enhancements varied across ACOs. The home health homebound waiver had the lowest rate of denied claims, while the concurrent care for Medicare hospice waiver had the highest rate of denied claims. The rate for each benefit enhancement waiver in order of lowest to highest rate of denied claims (as a percentage of overall submitted claims) was as follows: 0.47% for home health waiver (252/53,869); 0.64% for care management home visit waiver (1/156); 4.56% for telehealth waiver (22,580/495,357); 8.62% for post-discharge home visit waiver (5/58); 9.25% for SNF 3-day rule waiver (1,377/14,889); 24.17% for nurse practitioner services rule waiver (51/211); and 35.92% for concurrent care waiver (9,708/27,029).

<sup>43</sup> Estimates are adjusted for the number of beneficiaries aligned to each ACO. See **Appendix E.2** for more information. (Fisher test results for claims per 1,000 beneficiaries submitted by ACO type: home health, p-value=4.166e-07; concurrent care, p-value=3.193e-07).

capitation, financial arrangements varied and were tailored according to providers' experience with risk experience and preferences.

ACOs also used performance-based payments and bonuses to influence provider behavior around quality and cost. While most ACOs shared savings with providers, only a minority shared downside risk, often citing the need to ease providers into value-based arrangements. ACO leaders and providers appreciated the prospective nature of capitation payments, although some noted challenges with cash flow predictability and the limited influence of ACO REACH payments on providers with predominantly Original Medicare patient panels.

Most beneficiaries in the model were aligned through claims-based attribution. New Entrant ACOs achieved higher rates of voluntary alignment, while strict eligibility criteria (particularly for High Needs ACOs), administrative burden, and delays in attribution limited its effectiveness. High Needs ACOs also faced higher beneficiary turnover due to mortality and were constrained by policies that limited their ability to discuss voluntary alignment with beneficiaries during home visits.

Use of benefit enhancements was limited, with ACO leaders citing the administrative burdens that they entailed. However, High Needs ACOs may have relied on benefit enhancements to address PAC utilization, submitting claims for the SNF 3-day rule and home health homebound waivers more often than the Standard or New Entrant ACOs.

## Chapter 5: How Did ACOs Change Care Delivery?

### Key Findings

#### Care Transformation Priorities

- **Reducing avoidable utilization.** ACOs prioritized initiatives aimed at reducing avoidable utilization, including complex and population-specific care management and increasing primary care touchpoints. Most built on existing initiatives and viewed model participation as an opportunity to refine and focus their strategies. Care strategies were often implemented broadly, extending beyond beneficiaries formally aligned with ACO REACH providers.
- **Investments in health IT infrastructure.** ACOs emphasized the importance of patient-level data for predicting risk and real-time data to monitor ED visits and hospital admissions, discharges, and transfers (ADT). These capabilities were viewed as critical to supporting care transformation goals.
- **Expansion of care management programs.** Nearly 60% of surveyed ACO leaders reported that participation in ACO REACH encouraged the adoption or expansion of complex care or population-specific care management programs. ACOs expanded multidisciplinary care teams in various ways, including using centralized teams at the ACO level and teams within practices. Care management efforts focused on increasing primary care touchpoints and improving the quality and comprehensiveness of patient connections to primary care—particularly for individuals with chronic conditions. High Needs ACOs delivered care primarily in patients' homes or in long-term care and assisted living facilities, while other ACOs also used home-based services to manage care for high-risk patients.
- **Improving care transitions and reducing PAC utilization.** ACOs implemented a range of strategies to support care transitions, with medication reconciliation, telephone follow-up, and standardized post-discharge processes being the most common. Over 60% of ACO leaders we surveyed identified reducing PAC utilization as a high priority. In interviews, many ACO leaders discussed strategies initiated or expanded under ACO REACH, such as assigning staff to monitor admissions and discharges, coordinating with SNF staff, partnering with select SNFs to improve quality, and implementing process improvements to reduce lengths of stay and improve quality.

#### Provider Engagement

- **Models of provider engagement.** ACOs used different approaches to engage providers in the model. Over half (55%) of ACOs acted as enablers to enhance providers' capacity for value-based care. About 38% were direct care providers that owned care delivery assets and controlled where and how providers delivered care. A small group (8%) served as conveners, bringing together independent providers and offering administrative and model support.
- **Use of financial incentives.** ACOs employed positive financial incentives—such as performance-based and up-front payments—to encourage provider participation and alignment with accountable care goals.
- **Practice support and improvement activities.** Common strategies to engage providers included offering data analytics to support clinical decision-making and care coordination, building rapport through regular meetings and coaching, centralizing population health support staff, and offering training and education.

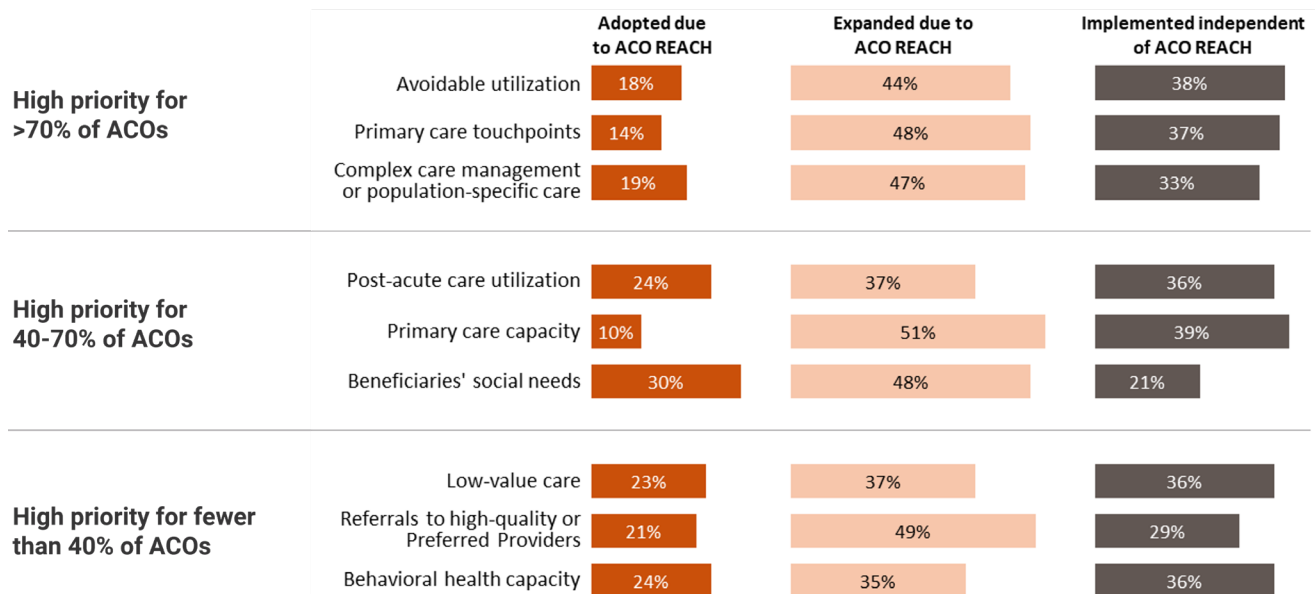
The ACO REACH Model’s financial incentives are designed to allow for variation in implementation approaches. This chapter describes how ACOs invested in infrastructure to improve quality of care, reduce utilization and spending, and engage providers in efforts to achieve the model’s goals. Our analysis is based on interviews with ACO leaders and providers from the 2021, 2022, and 2023 cohorts;<sup>44</sup> data from the 2023 Pulse Check Survey of ACO Leaders; and materials that the ACOs submitted to CMS. See **Appendices B and F** for more detail on the evaluation’s qualitative and survey data collection, respectively.

## 5.1 ACO Initiatives and Focus Areas

**ACO leaders emphasized that model participation allowed them to devote more resources and time to specific value-based care activities already of interest, prioritizing strategies to address avoidable utilization, including complex care management and increasing primary care touchpoints.** These priorities were in line with the model’s quality measures related to hospitalizations and readmissions.

ACO leaders described their efforts under REACH as part of an evolution of existing care models and improvements in population health management practices; most ACOs did not report having made significant operational changes due to the model. Interviews and survey findings suggest that ACOs mainly expanded or scaled work already in place or implemented strategies independently of the model, with few adopting new efforts solely due to ACO REACH (**Exhibit 5.1**).

**Exhibit 5.1. ACOs Largely Expanded Ongoing Work**



**SOURCE:** 2023 ACO REACH Pulse Check Survey (Total ACOs, n=132).

**NOTE:** Based on responses to Pulse Check Survey questions 3A and 3C. Question 3A asked “Now we would like to know about different strategies that your ACO may or may not be currently focused on in this performance year. For each of the items listed later in the text, please select the response option that most accurately reflects the perspective of your ACO.” Question 3C asked “For each strategy, please select the response that best reflects your ACO’s approach.” Question 3C was only asked of those ACOs that rated each item of Q3A as a high or medium priority. The ACOs that did not receive 3C due to skip logic were not included. See **Appendix F** for more information.

<sup>44</sup> Interviews with leaders and providers from ACOs that entered the model in 2021 and 2022 cohorts were conducted in 2023. Interviews with leaders and providers from ACOs that entered the model in 2023 were conducted in 2024.

**In both interviews and the survey, ACO leaders reported that their strategies were not limited to ACO REACH patients.** Most commonly, ACOs provided similar services to MA beneficiaries, while fewer reported extending these services to other Medicare, Medicaid, or commercial populations.<sup>45</sup> ACOs were generally least likely to offer these services to uninsured patients. However, IDS or hospital-based Standard ACOs were significantly more likely than other ACO types to implement certain strategies among the uninsured.<sup>46</sup>

ACO leaders described aligning workflows across full-risk MA contracts and ACO REACH to improve efficiency. This alignment also provided flexibility to fund services that may not be reimbursed under FFS. Some ACO leaders noted that many initiatives benefiting ACO REACH beneficiaries overlapped with other value-based models, enabling organizations to leverage efforts across programs like MA risk-bearing contracts, the Medicare Shared Savings Program, and Primary Care First.

### Performance on Quality Measures Affected the Performance Year Benchmark for ACOs' Final Financial Settlements

- Risk-Standardized All-Cause Readmissions Within 30 Days of Discharge
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- Timely Follow-Up After Hospitalization (Standard and New Entrant ACOs)
- Days at Home for Adults with Complex Chronic Disease (High Needs ACOs)

## ***Building Health IT and Data Analytic Infrastructure to Support Population Health Management and Primary Care***

**In interviews, most ACO leaders described relying on data analytics and health IT infrastructure to support population health management.** Accurate patient-level data and timely notifications were essential for identifying high-risk patients and guiding care delivery. One ACO leader noted, *"This is a model where you're very dependent upon information flow."*

By PY 2023, two-thirds of ACOs reported having a comprehensive ability to identify and target beneficiaries using predictive risk stratification.<sup>47</sup> 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. ACOs used several data sources for predictive risk modeling. Some focused on recent and historical utilization, such as ED visit or hospitalization claims, costs, and clinical complexity (for example, hierarchical condition categories [HCCs] and comorbid conditions). A few ACOs considered area-level variables such as Area Deprivation Index scores at the ZIP Code level and demographic variables such as age. Many ACOs further segmented higher risk patient populations for targeted interventions like higher touch care or care management.<sup>48</sup>

<sup>45</sup> Based on aggregated responses for different populations across all strategies in Pulse Check Survey question 3B: "For which patient populations is your organization implementing this strategy?" (N varies by item). ACOs that did not receive the question due to skip logic were not included. See **Appendix F** for more information.

<sup>46</sup> These strategies included behavioral health capacity investments, complex care management, initiatives to reduce avoidable inpatient and ED utilization, initiatives to reduce PAC utilization, initiatives to address social needs, and increasing primary care touchpoints.

<sup>47</sup> Based on responses to Pulse Check Survey question 21: "For beneficiaries attributed to the ACO, to what extent is a system in place for predictive risk stratification?" (n=132). See **Appendix F** for more information.

<sup>48</sup> On the Pulse Check Survey, roughly three-quarters of ACOs (73%) reported segmenting high-risk beneficiaries into subgroups based on common needs. Based on responses to Pulse Check Survey question 22: "Do you segment high-risk beneficiaries into subgroups based on common needs (for example, frailty, mental illness, similar combinations of chronic conditions)?" (n=132). See **Appendix F** for more information.

ACO leaders also emphasized the importance of accurate patient-level data for real-time tracking and notification of ED visits and inpatient ADT to inform care teams. Acquiring real-time data was a significant challenge. Some ACOs operating in multiple states navigated variations in hospitals' systems and health information exchanges (HIEs) when acquiring ADT data, negotiating with multiple state vendors and filling data gaps, especially in rural areas.

### ***Expanding Care Management Programs***

**Comprehensive care management was a central focus for ACOs under the model.** 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%) this strategy due to their participation in the model (**Exhibit 5.1**).<sup>49</sup> Standard ACOs were most likely to have comprehensive chronic care management programs in place (65%, compared with 46% of New Entrant ACOs and 36% of High Needs ACOs). Across all types, ACOs most commonly offered care management for patients with recent hospitalizations or ED visits (85%) and those with specific chronic conditions (84%), with some variation by ACO type (**Exhibit 5.2**). Just over two-thirds of ACOs offered care management programs for patients at rising risk.<sup>50</sup>

In interviews, many ACO leaders, particularly from Standard ACOs, described how participation in ACO REACH prompted them to strengthen existing care management programs. One ACO leader explained, for example, how they redesigned an existing navigation program with provider feedback, moving from a centralized, telephonic model to being more engaged in the practices. Another leader from a Standard ACO that previously participated in the Medicare Shared Savings Program noted that, with the "*more refined information from a beneficiary level*," they began focusing on connecting patients with their PCP to reduce inpatient and ED use.

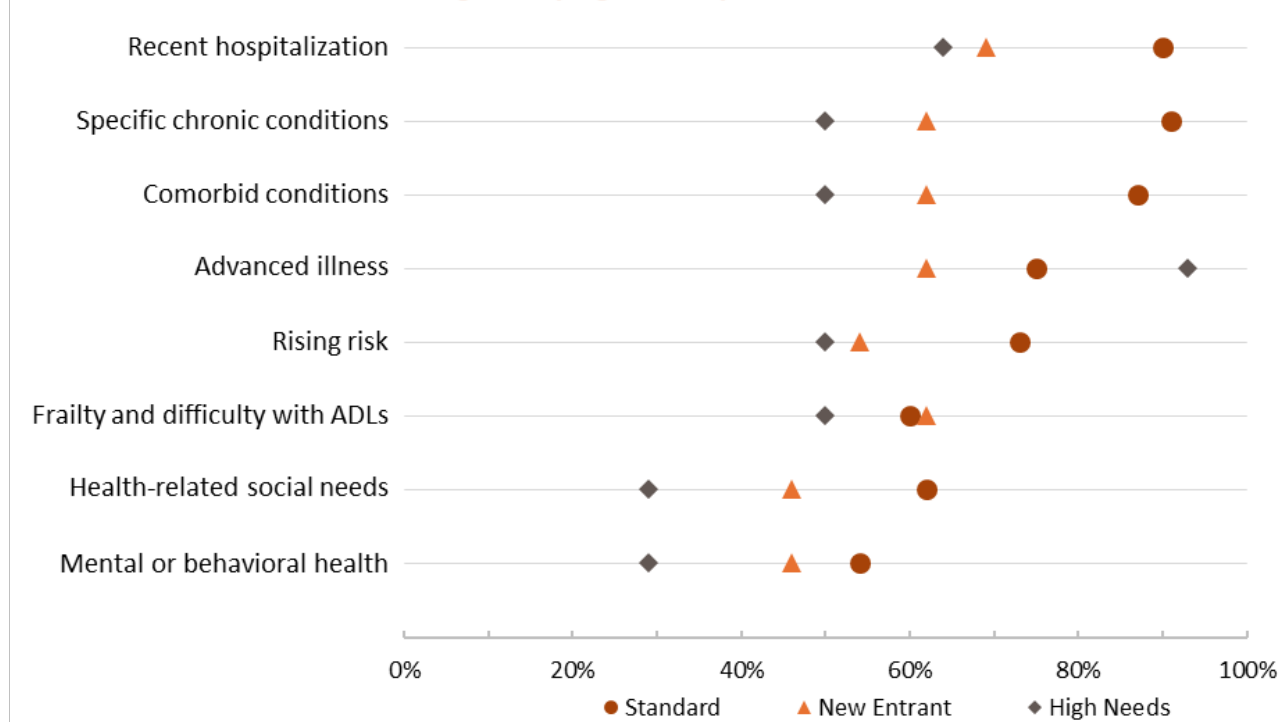
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<sup>49</sup> Based on responses to Pulse Check Survey question 3C: "For each strategy, please select the responses that best reflects your ACO's approach: complex care management or population-specific care management programs" (n=118). ACOs that did not receive the question due to skip logic were not included. See **Appendix F** for more information.

<sup>50</sup> Rising risk patients are those with moderate utilization and spending, forecast to become more costly in the future.

**Exhibit 5.2. Standard ACOs Most Commonly Offered Care Management Programs for Patients with Recent Hospitalizations or ED Visits, While High Needs ACOs Most Commonly Offered Programs for Patients with Advanced Illness**

**Percent of ACOs that offer care management programs for patients with each condition**



**SOURCE:** Based on responses to Pulse Check Survey question 23: “Does the ACO offer care management programs to patients that meet any of the following conditions?” (N=132). See **Appendix F** for more information.

**NOTE:** Rising risk=patients with moderate utilization and spending forecast to become more costly in the future; ADLs=activities of daily living.

**Most ACO leaders interviewed described expanding care teams to better manage patient populations.**

Individual ACOs and practices implemented different approaches to multidisciplinary care teams, ranging from centralized, ACO-level care teams to embedded, practice-based care teams. Providers reported gaining access to new types of professionals and strengthening relationships with care teams since joining in the model. One provider from a Standard ACO noted that the added support from care teams “is great when [providers] are overloaded and can’t be in many places at the same time.” They also expressed appreciation for the additional staff, stating, “I love the fact that I have additional people to help with certain things.”

**ACO leaders discussed efforts to increase primary care touchpoints.**

Many ACOs described how administrative and data analytics staff developed targeted reports for providers to identify high-risk patients to inform engagement efforts. In the survey, most ACOs reported pushing notifications or flagging beneficiaries for providers based on risk factors, such as those with a recent hospitalization or ED visit (82%), specific clinical conditions or combinations of chronic conditions (77%), or certain risk scores (65%). Most ACOs described working with providers to prioritize patients with chronic diseases like diabetes, chronic kidney disease, and hypertension for tailored interventions and more frequent visits. For example, providers described a specific focus on increasing visits and monitoring for patients with poorly controlled blood A1C levels.

Many ACOs sought not only to increase the number of primary care touchpoints, but also to enhance their quality and comprehensiveness. ACOs described how providers could build stronger connections with their patients and offer more proactive, high-value care like screenings, medication management, and follow-up after hospitalizations or specialist visits. To support these improvements, many ACOs invested in practices' infrastructure, giving them access to tools they had not used prior to joining the model. Examples included embedding clinical programming into electronic health records (EHRs) based on practice feedback, implementing care management tools at the practice level, conducting chart reviews, and providing access to proprietary software to monitor performance.

ACOs also supplied data and reports to inform care delivery before or after appointments. Some providers reported benefiting from actionable analytics, such as EHR flags or gap-in-care alerts. Three-quarters or more of ACOs flagged beneficiaries with care gaps, including those due for AWVs (80%) or preventive care screenings (74%). One provider explained that having these supports *"makes the AWV visit much more efficient and comprehensive."*

### Many ACOs used in-home interventions to engage and manage care for high- and rising-risk beneficiaries.

High Needs ACOs provided care primarily in patients' homes or in long-term care and assisted living facilities, while other ACOs offered home-based services for select patients. Interventions included virtual and in-person programs for those with at-home care needs or difficulty traveling to primary care offices. Multidisciplinary teams, such as PCPs, case managers, and CHWs, provided care, patient education, and needs assessments for the highest risk patients. In some cases, ACOs provided in-home primary care and post-discharge visits, along with supportive services like phlebotomy, vaccines, intravenous (IV) hydration, and medication management. Many ACOs also introduced remote patient monitoring and home blood pressure monitoring programs to promote patient education and awareness.

### Expanded Care Teams Allowed ACOs and Providers to Manage Patient Care Comprehensively

- **Nurse care managers** were embedded in primary care practices to help with referrals, follow-up with patients after discharge from the hospital, and monitor patients at high risk for readmission.
- **Clinical pharmacists** conducted medication reconciliation and proactive outreach to patients to discuss medications and management.
- **Community health workers (CHWs)** conducted home visits, educated patients, and offered resource navigation.
- **Social workers** addressed psychosocial needs and connected patients to financial assistance.
- **Dietitians** provided education on Type 2 diabetes and dietary changes.
- **Care coordinators** scheduled and sent reminders for appointments and identified and contacted patients overdue for AWVs.

### Scores for Patient Experiences of Care Were Similar Across Beneficiaries in ACO REACH, MIPS, and Original Medicare

Across most CAHPS survey measures, a descriptive analysis found that average scores for ACO REACH beneficiaries pooled across PY 2022–PY 2023 were similar to those of MIPS and Original Medicare beneficiaries. For example, average scores for overall provider rating were 91.4 in REACH ACOs, 92.1 in MIPS, and 90.5 in Original Medicare beneficiaries. Average scores for beneficiaries to get timely care, appointments, and information from their providers were 83.8 in REACH ACOs, 83.8 in MIPS and 81.5 in Original Medicare beneficiaries.

## Supporting Care Transitions

**ACOs managed their beneficiaries' transitions across care settings to mitigate risk, reduce readmissions, and ensure continuity of care.**

Leaders from a few ACOs described engaging patients during hospital stays through PCPs, care managers, and nurse navigators to coordinate care. Many ACOs used ADT systems to alert PCPs when patients presented at an ED or hospital. After discharge, ACOs commonly followed up with patients within a given timeframe (for example, 48 to 72 hours) to schedule follow-up appointments, reconcile medications, and review and update care plans.

### ACOs Increased Access to Primary Care to Decrease Unnecessary ED Visits

- **Expanded hours** (including weekends and evening), same-day appointments, and urgent care
- **Increased access to practitioners** with nurse triage lines, emergency lines to physicians, and direct lines to care managers
- **Extended care**, such as x-rays and IV therapies

Some ACOs also had longer-term (30 to 120 days) care transition management and wraparound programs following hospitalization or rehabilitation stays based on pre- and post-discharge risk assessment. Most often, ACOs provided medication reconciliation, conducted telephone follow-up within 72 hours, and implemented standardized processes to ensure timely follow-up with primary or specialty care for all or most beneficiaries undergoing a care transition to reduce the risk of readmission.<sup>51</sup> Fewer ACOs relied on beneficiary navigators, offered care management during hospitalization, or conducted in-home follow-up within 72 hours after discharge.

### ACOs' Data Helped Identify Patients to Engage through Care Management and More Frequent Primary Care Visits

*"I think that [ACO] has really helped us be more aware of who the most complex patients are that might need more attention and making sure we see those patients on a every three-month basis. Identifying people who often use the ER [emergency room] and how we can mitigate trying to avoid that, is something that I think that real-time data—[ACO] has improved."*

– Standard ACO Provider

*"We see our patients, some on average of...12 months a year. Some of them we see as frequently as 18 times a year...We, as an organization, particularly in these risk-bearing models, we overinvest in primary care with the strong conviction that...you more than save on that expenditure in avoided emergency room trips and hospitalizations and other things."*

–High Needs ACO Leader

<sup>51</sup> Based on responses to Pulse Check Survey question 20: "What share of your ACO-attributed hospitalized beneficiaries undergoing a care transition to home or post-acute care facility receive the following services to reduce the risk of admission?" (n=132). See **Appendix F** for more information.

## ***Working with Skilled Nursing Facilities to Reduce Post-Acute Care Utilization***

A majority of ACOs (61%) reported initiatives to reduce PAC as a high priority in the survey.<sup>52</sup> In interviews, many ACOs explained that participation in ACO REACH prompted them to initiate or expand strategies aimed at reducing PAC utilization. Common approaches included assigning dedicated staff to monitor admissions and discharges, coordinating with SNF staff, partnering with select SNFs to improve quality and focus on process improvements to reduce length of stay and improve quality.

### **Many ACOs Reported Using Vendors to Support Care Management and Coordination**

Vendors provided platforms for secure messaging and data sharing, case management tools, and other similar coordination technologies. To assist with care coordination and clinical decision-making, vendors also supported predictive analytics, risk stratification, and analyses of gaps in care.

ACOs with prior value-based care experience typically had PAC workflows and SNF relationships in place, enabling them to manage utilization more effectively early on. In contrast, ACOs without such experience spent time building these processes and partnerships during the model, which may have delayed impact.

### **Despite Challenges, Some FQHCs Implemented Initiatives to Reduce Utilization**

Some ACOs described challenges incorporating FQHCs into their existing business models and care management structure. Two main barriers were: 1) differing federal regulations and expectations around scope of practice and billing and 2) the small share of FQHCs' patient populations that were aligned with the ACO. Like independent primary care practices, FQHCs varied widely in data capabilities and capacity.

FQHC providers from several ACOs highlighted initiatives to reduce utilization, including:

- Expanding access to care through same-day walk-in appointments for sick patients aimed at reducing ED visits and increasing access hours
- Creating an internal task force to review high-risk patients and develop protocols to improve primary care access and reduce ED use
- Sharing information on timely follow-ups, hospital readmissions, and unplanned admissions with ACO and provider staff, including chief medical officers, billing and finance administrators, and care coordinators and managers

## ***Collecting Data on and Addressing Beneficiaries' Needs Such as Food, Housing, and Transportation***

Model requirements emphasized collecting beneficiary-level data on patients' non-medical needs such as food, housing, and transportation.<sup>53</sup> In the survey, 94% of ACOs reported collecting these data, with most starting after joining the model; only 28% had collected such information beforehand, and 6% of ACOs did not

<sup>52</sup> Based on responses to Pulse Check Survey question 3A: "Now we would like to know about different strategies that your ACO may or may not be currently focused on in this performance year. For each of the items listed below, please select the response option that most accurately reflects the perspective of your ACO." (n=132). See **Appendix F** for more information.

<sup>53</sup> As part of the Data Reporting requirement, CMS adjusts a portion of REACH ACO's Quality Withhold Earn Back based on ACOs' collection and reporting of beneficiary-level data on social needs.

collect it in PY 2023.<sup>54</sup> ACOs used different approaches. Some encouraged patients to self-report needs through electronic or paper-based questionnaires, while others had provider staff gather information during intake or had care team members administer screeners.

Challenges were common. Over three-quarters of ACOs reported issues: data collection systems not being fully set up, the lack of standardized data collection instruments, inconsistencies in data collection and storage across the ACO, and patient reluctance were at least somewhat of a challenge for collecting these data.<sup>55</sup> Fewer reported time constraints, provider reluctance, and data reliability as challenges. In interviews, ACO leaders noted that some beneficiaries did not complete questionnaires due to privacy concerns or perceived intrusiveness, while providers struggled with administrative burden and limited EHR adaptability.

To address these challenges, ACOs implemented strategies such as requiring structured formats, developing standardized tools, and creating new data pipelines to integrate data across the ACO.<sup>56</sup> In interviews, ACO leaders and providers also described leveraging existing workflows around AWWs, expanding demographic questionnaires, and enhancing EHR capabilities. Additional efforts included provider training and incentives for staff responsible for completing assessments.

As a result, some ACOs (particularly Standard ACOs) used these data to monitor and address unmet needs. Approaches included deploying CHWs or social workers to connect beneficiaries with services and partnering with community-based organizations to address transportation and food insecurity, such as through Meals on Wheels.

#### **ACOs Designed and Implemented Plans to Identify and Address Differences in Health Outcomes**

**To identify communities for intervention, ACOs selected individuals based on one or more geographic measures or person-level demographic characteristics.** The majority of ACOs defined populations of focus by where beneficiaries lived and used additional person-level data to specify target populations. A small subset proposed ACO-wide interventions for all beneficiaries meeting certain criteria—such as documented chronic diseases like diabetes or documented non-medical needs like food insecurity, transportation barriers, or Medicaid dual eligibility.

**Most ACOs proposed multi-component interventions focused on variations in access to care and optimal service utilization.** Several ACOs focused on variation in access to preventive care screening and referrals—most often cancer prevention (for example, colorectal screenings, mammograms)—or addressing non-medical needs (for example, food insecurity, transportation challenges). Others targeted access to outpatient care or chronic disease management (for example, AWWs, vaccinations, and effective control of conditions such as diabetes or hypertension). Several ACOs also targeted patterns of acute care use—such as high ED utilization or hospitalizations—that suggested constrained access.

**The scale of interventions varied widely, ranging from single practice to statewide efforts.** Some ACOs focused efforts across the ACO, with other qualifiers (for example, diagnostic or socioeconomic criterion), while others focused on smaller geographic areas (for example, particular counties or ZIP codes).

<sup>54</sup> Based on responses to Pulse Check Survey question 4A: "Which of the following best describes your ACO's collection of SDOH data?" (n=132). See **Appendix F** for more information.

<sup>55</sup> Based on responses to Pulse Check Survey question 4B: "To what extent is each of the following a challenge that your ACO faces in collecting SDOH data?" (n=132). See **Appendix F** for more information.

<sup>56</sup> Based on responses to Pulse Check Survey question 4C: "Is your ACO using any of the following strategies to address the challenges of collecting SDOH data?" Question 4C was asked only of those ACOs that report currently collecting SDOH data (n=124). See **Appendix F** for more information.

## 5.2 ACO Efforts to Engage Providers in Value-Based Care

We identified three general approaches that describe how ACOs engage providers, representing points along a spectrum defined by the types and levels of support offered. These approaches also reflect the varying degrees of control that ACOs exercised over providers' administrative and clinical operations.<sup>57</sup> Listed from the greatest support to the greatest independence for providers:

- **Directly controlling where and how care is delivered.** In PY 2023, 38% of ACOs owned or were led by organizations that had direct control of the settings, processes, staff, and technology that providers used to deliver care. Nearly half of all these ACOs were led by health systems (44%),<sup>58</sup> but other lead organizations included physician practices and primary care companies that tended to employ their Participant Providers and broader care teams, giving them greater control over workflows and technology to support population health.

- **Enabling population health management and effective care delivery by offering infrastructure, staff, and resources to build providers' capacity.** The enabler role was the most common role for participating ACOs (55% of PY 2023 ACOs), particularly those led by MSOs (91% of all MSO-led ACOs

functioned as enablers). These ACOs offered services such as embedded care management staff, proprietary analytic software, follow-up processes, and referral management. While more than half of the ACOs that focused on enabling providers were led by MSOs (57%), every other lead organization type—including physician practices, insurers, primary care companies, and health systems—led at least a few ACOs that adopted this approach.

### ACO Functional Roles with Providers

**Direct Care Provider.** ACO owns care delivery assets and directly manages where and how care is delivered, including staff, technology, settings, and processes. ACO typically employs providers and directly influences model implementation.

**Enabler.** ACO supplies infrastructure, tools, and staff to build providers' capacity to manage population health, care management support, analytics platforms, and vendor access.

**Convener.** ACO brings together independent providers or groups to reduce overhead and enable participation at scale. While providers retain clinical and operational autonomy, the ACO may offer administrative support, such as claims processing, compliance assistance, and shared services, to streamline model implementation.

For more information on functional roles, see **Appendix B.1**.

<sup>57</sup> To categorize ACOs, we synthesized and triangulated information from the Pulse Check Survey, ACO and Provider interviews, model documentation (applications, ownership templates, organization charts), and publicly available information (ACO and lead organization websites).

<sup>58</sup> While nearly all health system-led ACOs (91%) were categorized as direct owners of care delivery (or direct care providers), a few exceptions included coalitions or groups of hospital and health systems that operated with some level of independence under the ACO and the ACO's lead organization.

- **Convening independent providers under one organizational umbrella.** Only 8% of ACO REACH participants in PY 2023 focused exclusively on a convener role, and these ACOs were led by a variety of organizations, including insurers, physician practices, MSOs, and one primary care company. Notably, no health system-led ACOs focused primarily on convening. These convening ACOs supported providers in value-based payment arrangements by offering centralized administrative, non-clinical support (such as filing, claims reimbursement, and model-related activities such as waiver implementation and data sharing) that could increase economies of scale and help reduce providers' overhead costs. This approach preserves providers' clinical autonomy.

**ACOs primarily used positive financial incentives to engage Participant Providers in achieving ACO REACH or broader accountable care goals.** Financial bonuses tied to performance were considered very important by 83% of ACOs, compared with financial penalties (30%) or non-financial awards or recognition (34%). Nearly half (49%) viewed up-front payments as very important. Enablers were more likely than direct care providers to report that financial incentives were very important, whether bonuses (89% vs. 74%) or up-front payments (60% vs. 36%).<sup>59</sup> This reflects their distinct role: as external entities, enablers must actively engage providers through financial supports and incentives because they lack direct control over care delivery. Direct care providers, by contrast, can more easily integrate the model's objectives into day-to-day practice.

**Beyond financial arrangements, ACOs used a range of practice supports and improvement activities to engage providers.** In interviews and survey responses, ACO leaders highlighted strategies such as data analytic support, regular in-person meetings with practice leaders, and one-on-one coaching (**Exhibit 5.3**). Direct care providers reported infrastructure investments, including centralized population health support staff (92%), embedded staff (70%), and workflow optimization (72%), as very important tools for provider engagement. Conveners were least likely to provide staff or make infrastructure investments.<sup>60</sup>

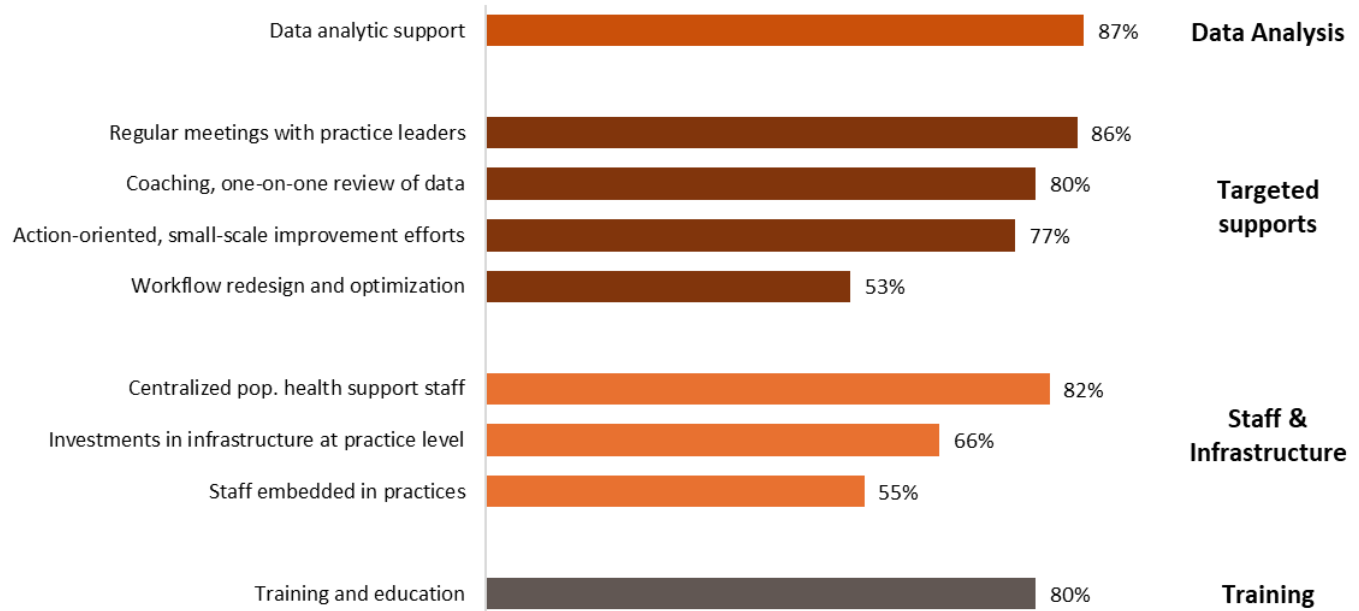
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<sup>59</sup> Based on aggregation of responses to 2023 Pulse Check Survey question 12 and 2022 Pulse Check Survey question 15A: "How important are each of the following incentives to your ACO's efforts to engage Participant Providers?" (n=132). See **Appendix F** for more information.

<sup>60</sup> Based on aggregation of responses to 2023 Pulse Check Survey question 10 and 2022 Pulse Check Survey question 13A: "How important are each of the following practice support and improvement activities to your ACO's efforts to engage Participant Providers?" (n=132). See **Appendix F** for more information.

**Exhibit 5.3. ACOs Most Frequently Identified Data Analytic Support, Regular Meetings with Practice Leaders, and Centralized Population Health Support Staff as Very Important for Provider Engagement**

Percentage of ACOs who identified practice supports and improvement activities as "very important" for provider engagement



SOURCE: 2023 ACO REACH Pulse Check Survey (Total ACOs, n=132) and 2022 GPDC Pulse Check Survey (Total ACOs, n=95).

NOTE: Based on combined responses to Q10 and Q11 from the 2023 Pulse Check Survey and Q13A from the 2022 Pulse Check Survey. Responses were collected and combined across years. From the 2023 survey, Q10 asked: "How important are each of the following practice support and improvement activities to your ACO's efforts to engage Participant Providers?" Q11 asked: "How important are each of the following information-sharing activities to your ACO's efforts to engage Participant Providers?" Q13A from the 2022 survey asked: "As part of the DCE's efforts to engage Participant Providers, how important is each of the following practice support and improvement activities?" See Appendix F for more information.

**Data analytic support was one of the most important strategies ACOs used to engage providers.** Eighty-seven percent of ACOs said this support was very important, and this was true for conveners, enablers, and direct care providers. A similar share (89%) of ACOs—particularly direct care providers and enablers—endorsed the importance of specific data supports that aided clinical decision-making and care coordination, such as ED visit notifications and inpatient ADT alerts.<sup>61</sup> Many ACOs also provided analytic support through clinical programming built into EHRs, care gap reports, and clinical decision support tools (see Section 5.1). One provider at a Standard ACO explained that the data are "really helpful to be able to real-time capitalize on taking good care of the patients who need us." Others noted this type of support helped them work more efficiently "and make space" for participation in the model.

**Most ACO leaders emphasized that building rapport with providers through regular meetings, coaching, and one-on-one reviews of performance data was critical to provider buy-in.** Survey findings suggest that most ACOs found that feedback reports on cost, quality, or utilization were very important for engagement, whether

<sup>61</sup> Based on aggregation of responses to 2023 Pulse Check Survey Question 11 and 2022 Pulse Check Survey Question 14A: "How important are each of the following information sharing activities for engaging your ACO's Participant Providers?" (n=132). See Appendix F for more information.

they functioned as conveners, enablers, or direct care providers.<sup>62</sup> Providers echoed this in interviews. One provider from a Standard ACO serving as a convener noted that seeing the data *“reinforc[ed] my thinking that primary and secondary prevention are worth doing,”* while another from an ACO serving as an enabler noted that *“physicians really respond well to that kind of visualization of how [we compare to the rest of the ACO] ... and how we’re addressing things that are being reported to CMS.”* Many providers said that regular meetings with ACO leaders helped them understand how their practice compared to others in the ACO. Some ACO leaders stressed that maintaining a regular cadence—not one-off meetings—was essential for engagement. As a leader from an ACO serving as an enabler put it, while these meetings required significant resources, it was crucial to *“look them in the eyes, and in many cases, break bread with them.”* Regular interaction reinforced that the ACO and providers were joint decision-makers and collaborators.

**ACOs also provided training and education opportunities to bolster provider engagement.** Most ACO leaders spent time up front educating providers about what to expect from participation in the model, the reasons behind transformation activities, and how these relate to their day-to-day operations. Through the trainings, providers developed a better understanding of population health measurement, accountable care, and operational elements of participation. One provider from a Standard ACO serving as an enabler emphasized the importance of provider education, noting that it increases awareness about doing *“the right thing”* and targeting the *“right spot”* and emphasized that *“everybody being on the same page is huge.”*

**Despite financial incentives and other engagement strategies, many ACO leaders and providers identified persistent barriers to provider engagement.** In the survey, fewer than half of ACOs rated as “very effective” the practice supports (39%), information-sharing activities (35%), and financial and non-financial incentives (48% and 12%, respectively) they used to engage providers.<sup>63</sup> ACOs serving in an enabling role were more likely than others to view information-sharing and financial incentives as very effective.

Interviews revealed additional challenges. Some ACOs struggled to secure buy-in around value-based care, particularly among specialists who were less familiar with the model’s impact on care compared with PCPs. As one provider from a Standard ACO that directly provides care noted, *“it’s been a little bit of growing pains because [specialists] just have a totally different mindset when it comes to caring for patients.”* Engagement required a foundational understanding of the model, yet some providers had limited knowledge of ACO REACH.

Providers also faced time constraints that limited participation in training and education due to heavy patient caseloads. One ACO leader explained, *“the core challenge [was] that it [was] very hard to engage [providers] in things that are not just deeply embedded in their standard operating procedures.”* While ACOs attempted to integrate the model into existing workflows, providers still felt a burden with participation. Some remained disengaged due to a reluctance to assume financial risk or because they had only a small number of ACO REACH beneficiaries in their panels.

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<sup>62</sup> Based on aggregation of responses to 2023 Pulse Check Survey Question 11 and 2022 Pulse Check Survey Question 14A: “How important are each of the following information sharing activities for engaging your ACO’s Participant Providers?” (n=132). See **Appendix F** for more information.

<sup>63</sup> Based on responses to Pulse Check Survey question 13: “Thinking about all the practice supports, information-sharing activities, and financial and non-financial incentives your ACO has been using for provider engagement, how effective would you say these activities have been for your ACO in engaging Participant Providers?” (n=132). See **Appendix F** for more information.

## 5.3 Conclusion

ACO REACH participation allowed ACOs to focus more intentionally on strategies for reducing avoidable utilization, particularly through complex and population-specific care management and increased primary care touchpoints. Most ACOs built on existing initiatives, using the model as an opportunity to refine and scale their efforts. Investments in infrastructure, especially health IT systems and patient-level data for risk stratification and real-time monitoring, were central to supporting improvements in care delivery. ACOs expanded multidisciplinary care teams and implemented a range of care management approaches across the continuum of care, particularly for patients with chronic conditions and recent hospitalizations, including in-home services and enhanced support for care transitions. Many ACOs reported offering similar services to patients outside of ACO REACH, particularly those in MA. ACOs also used financial incentives and practice supports to build provider capacity and foster participation in value-based care but continued to encounter barriers to engagement. Overall, findings suggest that, in keeping with the model's goal of improving quality of care, participation in ACO REACH supported ACOs in advancing existing strategies and adapting care delivery to meet the needs of complex patient populations.

## Chapter 6: Standard ACOs—Impact of the Model on Medicare Spending, Utilization, and Quality of Care

### Key Findings

#### Impacts on Total Gross and Net Medicare Spending

- **Gross spending.** Cumulatively over the first three years of the model (spanning the GPDC and ACO REACH phases), Standard ACOs did not significantly change gross spending for Medicare Parts A and B relative to their comparison groups. However, in PY 2023, Standard ACOs significantly reduced gross Medicare spending by \$197.5 million, or 0.9% (\$109 per beneficiary per year [PBPY]).
  - **By risk and capitation elections.** Consistent with expectations, cumulatively as of PY 2023, Standard ACOs that elected the highest level of risk and capitation (Global TCC) saw a statistically significant 0.5% reduction in gross spending (\$65 PBPY). In contrast, ACOs electing Professional PCC/PCC+APO (the lowest risk category) increased spending by 0.6% (\$70 PBPY).
  - **By organizational structure.** As of PY 2023, gross spending decreased by 0.8% (\$98 PBPY) for Standard ACOs made up of networks of individual practices, but increased by 0.8% (\$91 PBPY) for Standard ACOs that were IDS/hospital systems.
  - **By beneficiary characteristics.** Spending reductions were larger for beneficiaries living in under-resourced areas, with a greater burden of chronic conditions, with a disability or ESRD as their original reason for Medicare eligibility, and who were dually eligible for Medicare and Medicaid.
- **Net spending.** Financial incentives paid to REACH ACOs totaled \$738.5 million in PY 2023, which exceeded reductions in gross spending (relative to comparison groups), resulting in statistically significant increases in net Medicare spending for Standard ACOs of \$106.5 million, or 0.5% (\$59 PBPY). Cumulative net spending as of PY 2023 was higher than the comparison group by \$310.5 million, or 0.7% (\$83 PBPY).

#### Impacts on Utilization and Spending Categories

- **Utilization.** Both cumulatively and in PY 2023, Standard ACOs reduced acute care hospitalizations (by 0.5% and 1.4%, respectively) and lengths of stay (0.5% and 1.7%), ED visits (0.6% and 1.0%), SNF lengths of stay (0.7% and 1.1%), and home health episodes (1.4% and 1.7%) relative to the comparison groups. Reductions in PY 2023 were larger than cumulative reductions. There was little variation in utilization impacts by beneficiary subgroups.
  - **By organizational structure.** Standard ACOs that were networks of individual practices decreased utilization of home health (by 2.5%), ED (1.0%), and acute care settings (1.5% for length of stay and 1.3% for hospitalizations), while ACOs that were IDS/hospital systems saw relative increases in ED (0.5%) and PAC (3.6%) utilization. Changes in utilization were consistent with findings for total gross spending by ACO organizational structure.
- **Spending categories.** Both cumulatively and in PY 2023, spending decreased in outpatient settings (by 1.1% and 2.2%, respectively), home health (1.4% and 1.7%), and SNFs (0.7% and 1.1%) for Standard ACOs relative to the comparison groups. Spending on professional services and specialty care continued to increase in PY 2023 and cumulatively.

## Key Findings

### Impacts on Quality Measures

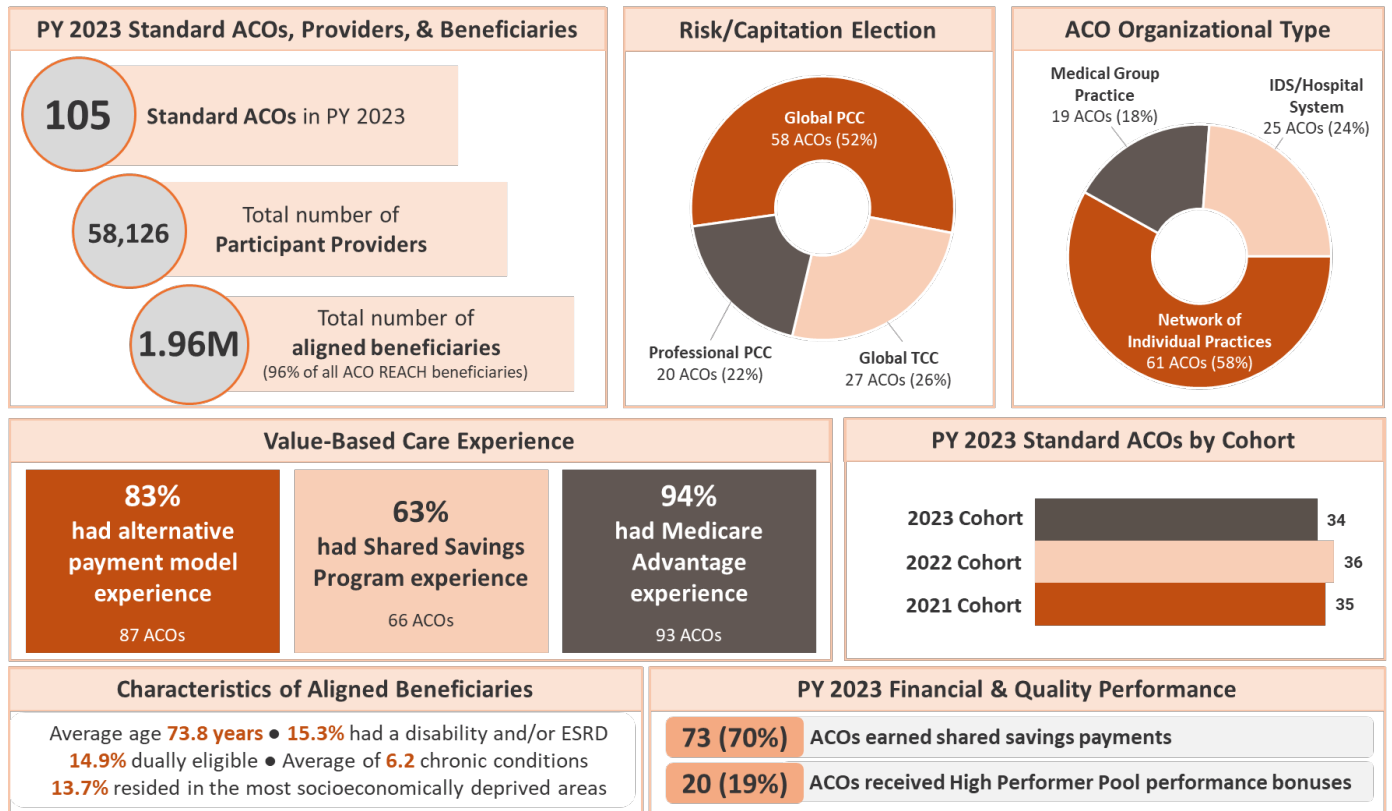
- Both cumulatively and in PY 2023, Standard ACOs improved quality of care across several measures, with significant reductions in ambulatory care sensitive condition (ACSC) hospitalizations (by 3.3% and 4.7%, respectively) and in unplanned admissions for patients with MCC (1.6% and 2.0%) relative to the comparison groups. There were significant increases in recommended diabetes care (1.0% and 1.3%), timely follow-up after exacerbations of chronic conditions (0.8% and 1.3%), and days at home (0.1% and 0.2%). All ACO-level subgroups, as defined by risk and capitation and by organizational structure, demonstrated improved quality.

As noted in **Chapter 3**, 80% of the ACOs participating in PY 2023 were Standard ACOs, and they accounted for the vast majority (96%) of aligned beneficiaries. In this chapter, we present findings on the impact of Standard ACOs on spending, utilization, and quality of care. The chapter opens with an overview of the participating Standard ACOs and their characteristics, followed by findings on impact which are presented for the model overall, by ACO characteristics, and by beneficiary characteristics. Detailed tables of results can be found in **Appendix J**.

## 6.1 Snapshot of Standard ACOs

The 105 Standard ACOs in PY 2023 (**Exhibit 6.1**) served 1.96 million beneficiaries, representing 96% of all ACO REACH beneficiaries in PY 2023. As mentioned in **Chapter 3**, about half of the aligned beneficiaries were new to the model in PY 2023. In addition, about 15% of aligned beneficiaries were eligible for Medicare through disability or ESRD, and 15% were dually eligible for Medicaid. As **Exhibit 6.1** shows, about three-quarters of Standard ACOs elected Global risk, and many elected PCC as well. Standard ACOs saw significant value-based care experience, including in MA and the Medicare Shared Savings Program. A majority earned shared savings payments in PY 2023.

**Exhibit 6.1. Standard ACOs Snapshot—Model Elections, Performance, and Organizational and Beneficiary Characteristics**



**SOURCE:** PY 2023 financial results; model applications and additional documentation; 2023 ACO REACH Pulse Check Survey; NORC analysis of PY 2023 Alignment Data (received from model’s implementation and monitoring contractor); and NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** IDS=integrated delivery system; PCC=Primary Care Capitation; TCC=Total Care Capitation. Percentage of Standard ACOs with Medicare Advantage experience excludes six (6) ACOs that did not have MA experience data because they completed a modified version of the model application. The number of Standard ACOs in the 2021 cohort increased from PY 2021 to PY 2022 due to recategorization of New Entrant and High Needs ACOs.

**Standard ACOs in PY 2023 exhibited different organizational structures and leadership models.** Most were built around networks of individual practices and were led by MSOs, insurers, or physician practices with a controlling interest.

- **MSOs and Insurers:** Nearly half (49%) of all Standard ACOs were led by MSOs and insurers. These lead MSOs and insurers focused on aggregating independent practices to achieve quality care and shared savings, often operating with a strategy for growth. As one ACO leader noted, they preferred to sign up providers with the potential to expand significantly. Financial support, often from private or capital investments, played a crucial role in enabling ACOs to invest in MSO activities or other provider services.

- Health Systems:** Just under a quarter (22%) of Standard ACOs were led by health systems, and nearly all health system-led ACOs were Standard ACOs (96%), due in part to the large number of beneficiaries aligned to them. These ACOs were among the largest, with an average of about 22,000 aligned beneficiaries. In interviews, leaders of health system-led ACOs referenced their own internal board structures, employed providers (including primary care and specialists), and centralized care management structure with population health managers and physician groups. Unlike other Standard ACOs, health system-led ACOs tended to choose Professional rather than Global risk.
- Physician Practice and Primary Care Companies:** The remaining Standard ACOs (29%) encompassed a variety of structures, including multispecialty group practices, primary care company-led networks implementing one standard care model across multiple ACOs, medical group practices partnering with unaffiliated physician groups, and other arrangements.

Overall, ACOs' varied organizational structures showed flexibility in how ACOs participated in the model and shaped their capacity and resources to deliver value-based care, highlighting the different ways ACOs organized to meet their goals.

## 6.2 Total Gross and Net Medicare Spending

This section presents impact findings on gross and net spending for Standard ACOs. Impact estimates for gross spending are presented overall as well as for subgroups defined by ACO and beneficiary characteristics.

### *Impacts on Gross Medicare Spending*

**Gross spending**<sup>65</sup> for Medicare Parts A and B, which includes CMS' payments for beneficiary capitation, significantly decreased by 0.9% (\$109 PBPY) in PY 2023 relative to the comparison groups (**Exhibit 6.2**), reflecting decreases in the 2021 and 2023 cohorts (declines of 1.7% and 0.7%, respectively; **Appendix Exhibit J.2**). The larger spending reduction for the 2021 cohort reflected the exit of poor performing ACOs and improvements by ACOs continuing in the redesigned model. However, the

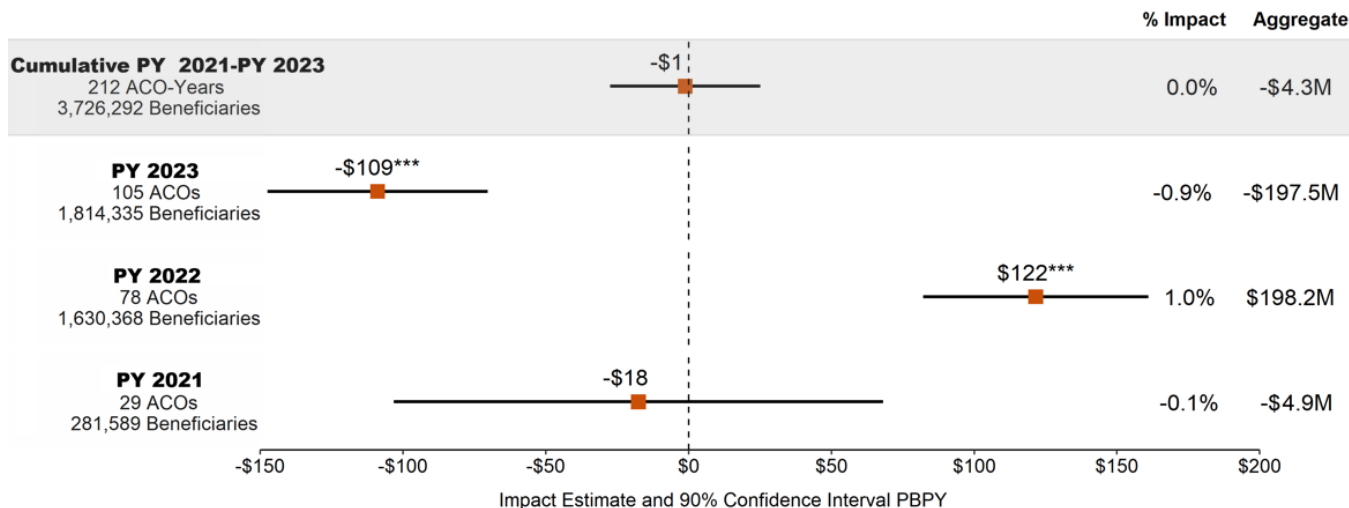
immediate reduction in spending seen in the 2023 cohort was unexpected and counter to our hypothesis of ACOs needing time and experience to achieve savings. Although there was a decrease in gross spending in PY 2023, there was no change in gross spending cumulatively over the first three years of the model. This was due to a 1.0% increase in spending in PY 2022. Cumulatively through the first two years, there was a 0.8% increase in spending, of which approximately 80% was driven by Integrated Delivery System (IDS)/hospital system ACOs that entered the model in PY 2022 after previously deferring participation.

Gross spending for Standard ACOs **decreased by a larger amount** relative to the alternative comparison group (that excluded beneficiaries in accountable care) both in PY2023 (3.2% (or \$408 PBPY) and cumulatively (2.3% (or \$291 PBPY). See Appendix Exhibit J.6 for more details.<sup>64</sup>

<sup>64</sup> These results should be interpreted with caution due to differences in the treatment group's specification between the baseline and performance periods. Specifically, the ACO REACH group in the PY included all aligned beneficiaries (of its Participant Providers), whereas in the baseline period, only a subset of aligned beneficiaries were included—namely, those in Original Medicare or non-ACO APMs. In contrast, the alternative comparison group maintained consistent composition across both periods, which may affect the comparability of results.

<sup>65</sup> In PY 2023, statistical significance aside, 66 of 105 Standard ACOs (62.9%) decreased gross spending, and 39 ACOs (37.1%) increased gross spending (see Appendix J.6).

**Exhibit 6.2. Cumulatively as of PY 2023, the ACO REACH Model Did Not Change Gross Medicare Spending for Standard ACOs, Despite a Significant Decrease in PY 2023**



SOURCE: NORC analysis of Medicare FFS claims and enrollment data and ACO REACH programmatic data.

NOTE: Model impact was estimated relative to the comparison groups and baseline years using a difference-in-differences (DID) model. "Impact (%)" was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) (PY) had the model not existed and had the beneficiaries' outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). "Aggregate" was the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year.

\*\*\*p<0.01.

**Standard ACOs: Impact on Total Gross Spending in ACO and Beneficiary Subgroups**

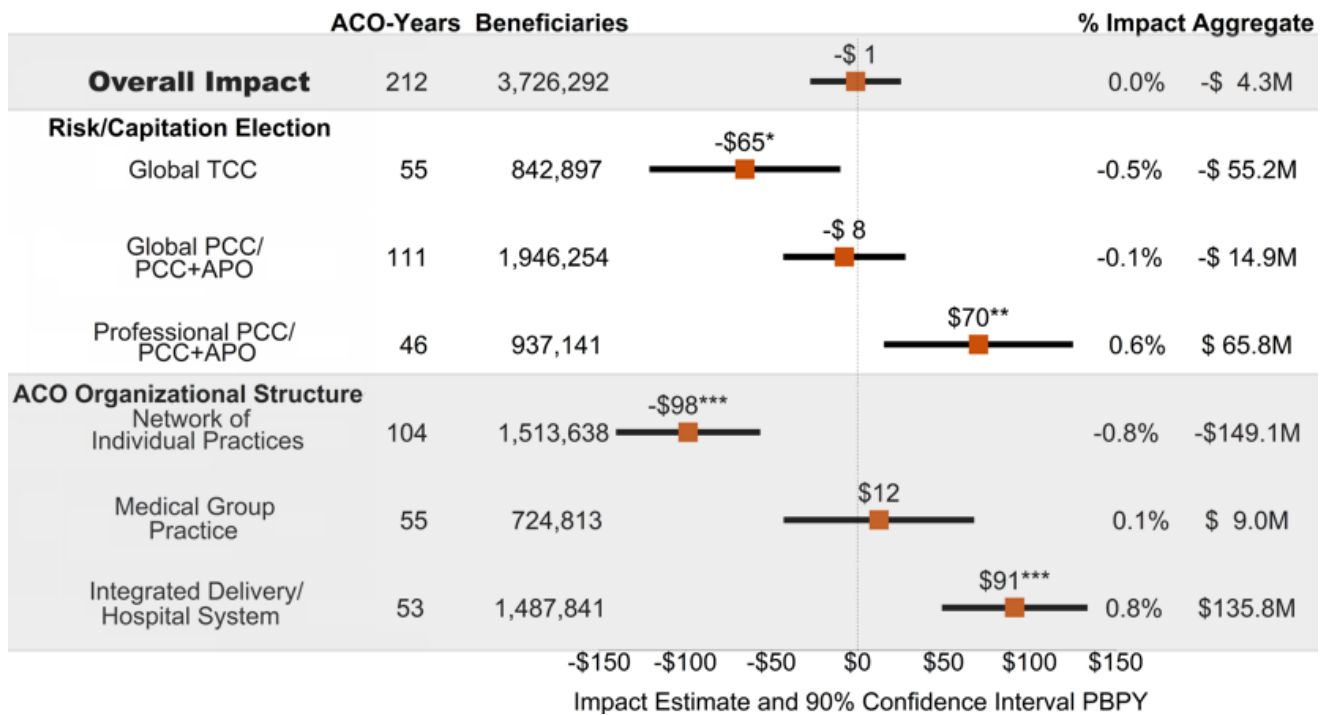
**Risk/Capitation Elections**

As of PY 2023, Standard ACOs that elected the highest levels of financial accountability (Global TCC) significantly reduced gross spending, consistent with our hypothesis. Standard ACOs electing the lowest risk option (Professional PCC) significantly increased gross spending. In previous years, Standard ACOs saw significant increases in gross spending regardless of risk/capitation. Separate results by risk level and capitation level are shown in **Appendix J.7**.

**ACO Organizational Structure**

As of PY 2023, IDS/hospital system ACOs saw an increase in gross spending, as in previous years. Those that were networks of individual practices had a significant decrease in gross spending. The difference in spending impacts between the two ACO subgroups is explained by differences in their relative impacts on utilization measures. ACOs organized as networks of individual practices reduced utilization of acute care, SNF, and home health, while IDS/hospital system ACOs increased utilization of acute care and institutional PAC relative to the comparison groups. IDS/hospital system ACOs may have been less supported to reduce utilization of hospital-based care, a main revenue source for those entities. Additional results by ACO lead organization and ACO functional role are shown in **Appendix J.7**.

**Exhibit 6.3. Cumulatively as of PY 2023, Standard ACOs That Elected Higher Risk/Capitation and Individual Practice ACOs Decreased Gross Medicare Spending**



**NOTE:** Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). “Aggregate” was the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year.

\*p<0.1, \*\*p<0.05, \*\*\*p<0.01.

**Beneficiary Characteristics**

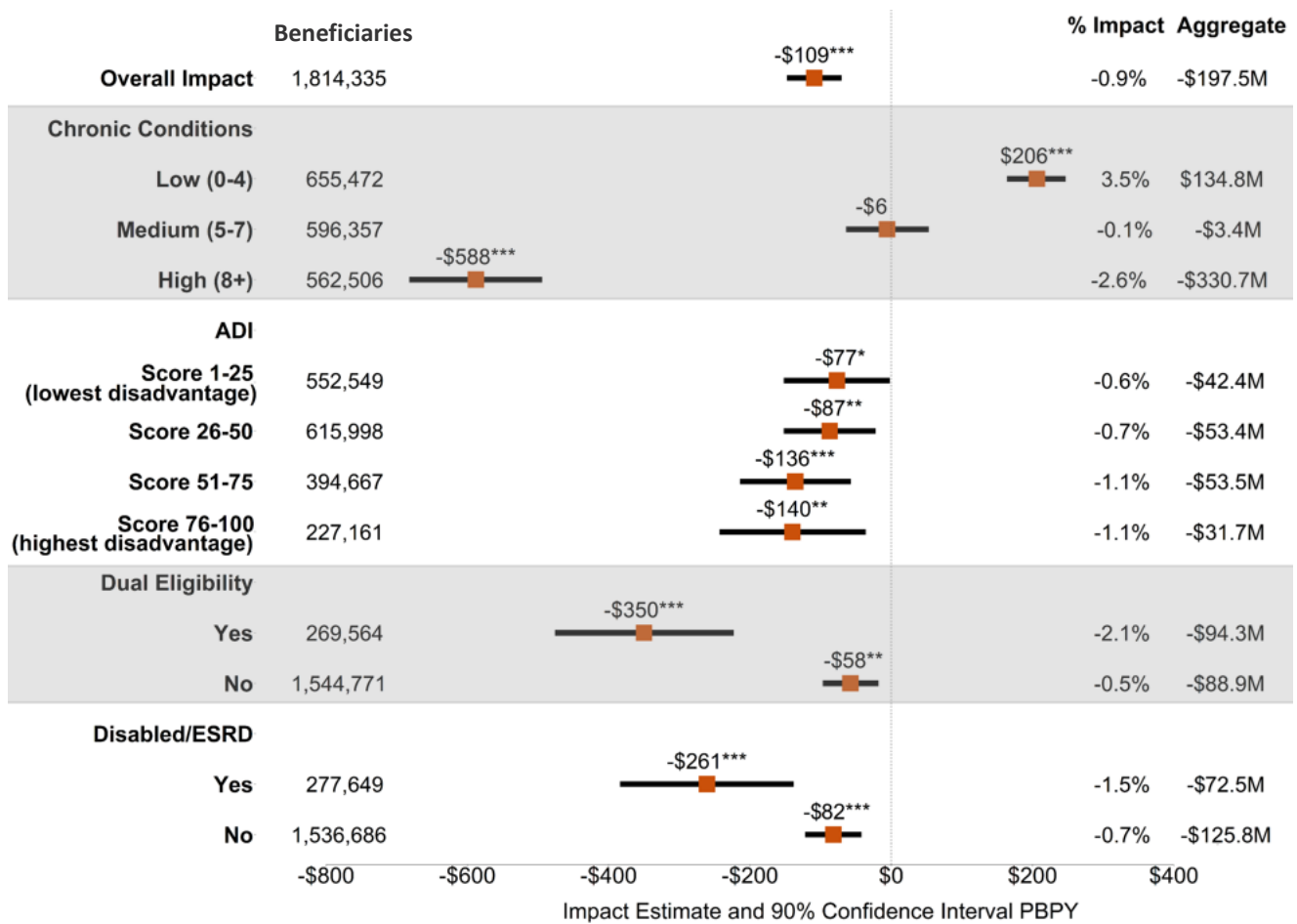
*PY 2023 is the first year of the model in which ACOs addressed beneficiary subpopulations, so we show results in PY 2023, not cumulatively.*

We expected gross spending initially to increase for beneficiaries with greater clinical and social risk factors as they receive greater access to care, but many findings were contrary to expectations. We found larger and significant reductions in spending for:

- Beneficiaries with 8+ chronic conditions
- Beneficiaries living in more under-resourced areas
- Beneficiaries with a disability/ESRD
- Dually eligible beneficiaries

Gross spending increased significantly for beneficiaries with the fewest chronic conditions.

**Exhibit 6.4. In PY 2023, Dually Eligible Beneficiaries and Those with More Chronic Conditions Saw Largest Spending Reductions**



NOTE: ADI=Area Deprivation Index. Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). “Aggregate” was the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year. \*p<0.1, \*\*p<0.05, \*\*\*p<0.01.

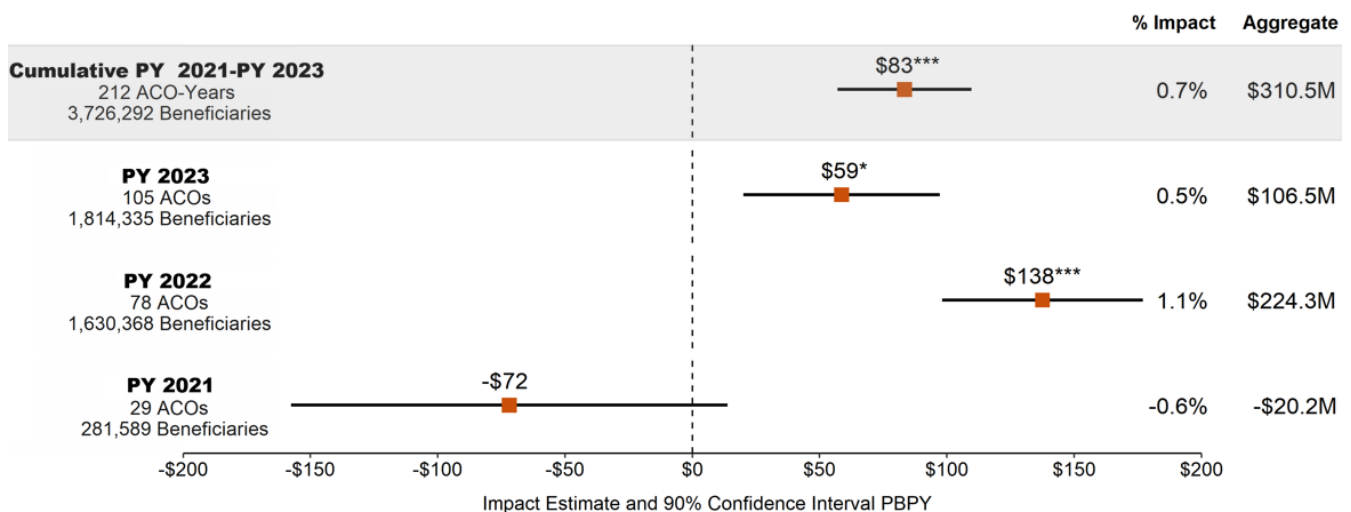
### Impacts on Net Medicare Spending

In PY 2023, CMS payouts to Standard ACOs totaled \$738.5 million, with \$693.7 million (94.0%) paid out via shared savings payments and the remaining \$44.8 million (6.0%) paid out as performance bonuses to 20 Standard ACOs that met the HPP requirements. Payouts were based on beneficiary alignment-months in PY 2023, the first year that performance bonuses were paid out via the HPP. Only ACOs that participated in both PY 2022 and PY 2023 were eligible to receive the HPP payouts.

Because a large proportion of ACO REACH providers (40%) participated in another ACO model before ACO REACH began (the baseline period), it is assumed that these providers would have continued to do so if the ACO

REACH did not exist. Therefore, the comparison groups include a similar proportion of beneficiaries in other ACO models (in both the baseline and performance periods) to approximate what would have happened had the model not occurred. Given that providers in other ACO initiatives, such as the Medicare Shared Savings Program, receive financial incentive payments similar to providers in the ACO REACH Model, we updated evaluation methods for net spending calculations in PY 2023 to account for these payouts by incorporating estimates of the share of those payouts attributable to beneficiaries in the analysis. This allows for an equivalent adjustment of CMS incentive payments across both the intervention and comparison groups in the net spending calculations, which is in line with methods used in the difference-in-difference analyses<sup>66</sup>. These updated methods improve upon prior calculations used to evaluate the GPDC model, which only accounted for financial incentives related to the model. Results for PY 2023 using this prior method are available in the technical appendix to enable comparisons with the methodology used in prior evaluation reports (**Appendix J.3**). After factoring in payouts for both ACO REACH and other CMS ACO initiatives, cumulative net spending increases were small but statistically significant for Standard ACOs (\$310.5 million, or 0.7%), as shown in **Exhibit 6.5** (results by cohort shown in **Appendix Exhibit J.4**).

**Exhibit 6.5. After Factoring in Payouts to REACH ACOs and the Comparison Groups, Net Medicare Spending Increased for Standard ACOs in PY 2023 and Cumulatively as of PY 2023**



**SOURCE:** NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** Model impact was estimated relative to the comparison groups and baseline years using a DID model. Both payouts to REACH ACOs and to the comparison groups were included. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). “Aggregate” is the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year. \*p<0.1, \*\*\*p<0.01.

<sup>66</sup> Difference-in-difference regression methods examine two groups: the intervention group (beneficiaries in the ACO REACH model) and the comparison group. These methods track both groups before ACO REACH (baseline period) and during ACO REACH (intervention period). The updated net spending calculations account for CMS incentive payments for both groups across both time periods.

## 6.3 Utilization and Spending Categories

This section presents impact findings on utilization and spending categories for Standard ACOs. We first present results for ambulatory, acute, and PAC utilization and spending, then for hospice and home health utilization and spending. Impact estimates for utilization are presented overall, as well as for subgroups defined by ACO and beneficiary characteristics.

Examination of baseline spending categories provides a window into the care settings where Standard ACOs had the largest proportion of spending, suggesting areas where participating providers can have improved care delivery to reduce total spending. For example, the largest proportion of baseline total spending for Standard ACOs occurred in the acute care, professional services, and outpatient settings (**Appendix Exhibit J.16**).

### ***Impacts on Ambulatory Care, Acute Care, and Post-Acute Care Utilization and Spending***

Standard ACOs reduced spending and utilization of services across many care settings; however, there were some exceptions.

- In PY 2023 and cumulatively as of PY 2023, there were statistically significant reductions in **ambulatory care settings (ED visits including observations stays and outpatient facility spending)** for Standard ACOs relative to the comparison groups (**Exhibit 6.6**), as expected. The results contrast with findings as of PY 2022 (**Appendix Exhibit J.17**) that showed no change in ED visits and outpatient spending. Contrary to expectations but consistent with findings from PY 2022, spending on professional services and specialty care continued to increase in PY 2023 and cumulatively as of PY 2023.
- In PY 2023, there were significant reductions in **acute care settings (hospitalizations, length of stay, and spending)**, consistent with expectations and in contrast to significant increases seen as of PY 2022 (**Appendix Exhibit J.17**). The decreases in PY 2023 influenced significant decreases in the cumulative estimates for both hospitalizations and length of stay.
- In PY 2023 and cumulatively, there were significant reductions in **PAC settings (SNF length of stay and SNF spending)** for Standard ACOs relative to the comparison groups, as expected. The decreases in PY 2023 drove the significant effect seen cumulatively, as these measures did not meaningfully change as of PY 2022 (**Appendix Exhibit J.17**).

#### **Trends in utilization of other ambulatory services for Standard ACO beneficiaries during PY 2023 (Appendix Exhibit J.19):**

- PCP services increased, after remaining flat in the baseline period.
- Urgent care visits increased above baseline levels.

Reductions in utilization of ambulatory, acute, and PAC were consistent with Standard ACOs' stated priorities on the 2023 Pulse Check Survey. All but one Standard ACO reported that initiatives to reduce avoidable inpatient or ED utilization were a high or medium priority for the performance year. Additionally, most Standard ACOs (90%) reported that initiatives to reduce PAC utilization were at least a medium priority. Over half of ACOs (60%) surveyed reported having comprehensive care management programs in place for high-need, high-cost beneficiaries. Increased spending on professional services is consistent with ACO efforts to increase primary care touchpoints for higher risk patients, including those with chronic conditions and previous hospitalizations.

**Exhibit 6.6. Cumulatively and in PY 2023, Standard ACOs Experienced Significant Reductions in Ambulatory, Acute, and Post-Acute Spending and Utilization; Spending Increased for Professional Services and Specialty Care**

Measure (Hypothesized Direction of Change)	In PY 2023 105 ACOs; 1,814,335 Beneficiaries				Cumulatively As of PY 2023 212 ACO-Years; 3,726,292 Beneficiaries			
	% Impact	Impact Estimate (90% CI)	BYs to PY(s)		% Impact	Impact Estimate (90% CI)	BYs to PY(s)	
			ACO REACH	Comp.			ACO REACH	Comp.
<b>Ambulatory</b>								
ED visits including observation stays (↓)	-1.0	-4.21*** (-5.68, -2.73)	↑	↑	-0.6	-2.49*** (-3.51, -1.47)	↑	↑
Spending on outpatient facilities (↓)	-2.2	-\$46*** (-\$57, -\$35)	↑	↑	-1.1	-\$22*** (-\$30, -\$15)	↑	↑
Spending on professional services (↓)	0.6	\$21*** (\$10, \$33)	↑	↑	0.8	\$27*** (\$20, \$35)	↑	↑
Spending on specialty care office visits (↓)	1.4	\$3*** (\$2, \$3)	↓	↓	1.4	\$3*** (\$2, \$3)	↑	↑
<b>Acute Care</b>								
Acute care LOS (↓)	-1.7	-22.93*** (-30.65, -15.20)	↓	↓	-0.5	-6.38* (-11.79, -0.98)	↓	↓
Acute care hospitalizations (↓)	-1.4	-2.94*** (-3.87, -2.01)	↓	↓	-0.5	-0.94** (-1.58, -0.30)	↓	↓
Spending on acute care setting (↓)	-1.2	-\$40*** (-\$60, -\$21)	↓	↓	0.01	\$0.2 (-\$13, \$14)	↓	↓
<b>Post-Acute Care</b>								
IRF and LTCH days (↓)	0.1	0.29 (-3.40, 3.99)	↑	↑	0.7	1.64 (-0.91, 4.18)	↑	↑
Spending on IRF and LTCH (↓)	0.2	\$1 (-\$6, \$8)	↑	↑	0.8	\$3 (-\$2, \$8)	↑	↑
SNF days (↓)	-1.1	-16.73* (-31.27, -2.19)	↓	↓	-0.7	-10.27* (-20.48, -0.07)	↓	↓
Spending on SNF (↓)	-1.1	-\$10* (-\$19, -\$2)	↓	↓	-0.7	-\$6* (-\$13, \$0)	↓	↓

**SOURCE:** NORC analysis of Medicare claims and enrollment data.

**NOTE:** ED=emergency department; LOS=length of stay; IRF=inpatient rehabilitation facility; LTCH=long-term care hospital; SNF=skilled nursing facility. Estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY) for spending outcomes and per 1,000 beneficiaries per year (BPY) for other outcomes. Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in PY(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year. Arrows in the “Measure” column represent the hypothesized direction of change. Impact estimates that are statistically significant *and* align with the hypothesized direction are shown in orange font.

\*p<0.1, \*\*p<0.05, \*\*\*p<0.01.

### Impacts on Hospice and Home Health Utilization and Spending

Hospice spending declined over time for both Standard ACOs and the comparison groups, but by a larger magnitude for the former. Consequently, in PY 2023, Standard ACOs experienced a significant decrease in **hospice spending** relative to the comparison groups (**Exhibit 6.7**). The spending decrease reflected significant decreases in total hospice days in PY 2023. However, there were no significant changes in hospice spending or total hospice days cumulatively. The cumulative decrease in continuous hospice days prior to death was driven by PY 2022 effects that were non-significant in PY 2023 (**Appendix Exhibit J.18**).

While these findings suggest that end-of-life care patterns for beneficiaries in Standard ACOs may differ from the beneficiaries in comparison groups, the evaluation does not point to a single explanatory mechanism. On the survey, 75% of Standard ACOs reported offering care management programs to patients with advanced illnesses that require palliative, hospice, or end-of-life care, though they did not indicate how these services are billed. These programs may influence how and when beneficiaries transition into hospice without necessarily generating Medicare hospice benefit claims.

There were significant decreases in both **home health episodes and corresponding spending** both in PY 2023 and cumulatively, consistent with the results observed as of PY 2022 (**Appendix Exhibit J.18**). We did not have clear expectations as to how ACOs would impact these outcomes because ACOs varied in their historical use of home health services and in their care delivery strategies. As described in Chapters 4 and 5, many ACOs expanded in-home and care management supports—often delivered as non-billable services—which may substitute for or complement traditional Medicare home health without necessarily generating Medicare home health claims. In future reports, we will continue to examine home health, including ACOs' approaches and associated spending and utilization.<sup>67</sup>

**Exhibit 6.7. Hospice and Home Health Utilization and Spending for Standard ACOs Decreased in PY 2023**

Measure (Hypothesized Direction of Change)	In PY 2023 <i>105 ACOs; 1,814,335 Beneficiaries</i>				Cumulatively As of PY 2023 <i>212 ACO-Years; 3,726,292 Beneficiaries</i>			
	% Impact	Impact Estimate (90% CI)	BYs to PY(s)		% Impact	Impact Estimate (90% CI)	BYs to PY(s)	
			ACO REACH	Comp.			ACO REACH	Comp.
<b>Hospice</b>								
Continuous hospice days prior to death (↑) or (↓)	-1.2	-0.31 (-0.72, 0.11)	↑	↑	-2.5	-0.61*** (-0.90, -0.33)	↑	↑
Total hospice days (↑) or (↓)	-2.5	-0.07*** (-0.10, -0.03)	↓	↑	-0.9	-0.02 (-0.05, 0.002)	↓	↓

<sup>67</sup>While the ACO REACH model offers unique waivers related to home health and concurrent hospice election, Standard ACOs submitted a moderate number of claims for the concurrent care for beneficiaries that elect Medicare hospice and the Home Health Homebound waivers relative to High Needs ACOs. In PY2023, Standard ACOs submitted an average of 8.62 and 24.24 claims per 1,000 beneficiaries for the concurrent care for beneficiaries that elect Medicare hospice and the Home Health Homebound waiver, respectively. High Needs ACOs submitted much higher numbers of claims for both waiver types (319.63 and 113.23 claims per beneficiaries, respectively), while New Entrant ACOs submitted fewer claims for both waiver types (1.79 and 1.46 claims per beneficiaries, respectively). See **Appendix Exhibit E.9** for more details. However, the use of benefit enhancements and other flexibilities in the model represents only one of multiple factors that may influence utilization and spending patterns. See Section 4.3 for additional discussion on benefit enhancements.

Measure (Hypothesized Direction of Change)	In PY 2023 <i>105 ACOs; 1,814,335 Beneficiaries</i>				Cumulatively As of PY 2023 <i>212 ACO-Years; 3,726,292 Beneficiaries</i>			
	% Impact	Impact Estimate (90% CI)	BYs to PY(s)		% Impact	Impact Estimate (90% CI)	BYs to PY(s)	
			ACO REACH	Comp.			ACO REACH	Comp.
Spending on hospice (↑) or (↓)	-2.5	-\$12*** (-\$17, -\$6)	↓	↓	-0.4	-\$2 (-\$6, \$2)	↓	↓
<b>Home Health</b>								
Home health episodes (↑) or (↓)	-1.7	-5.65*** (-7.47, -3.82)	↓	↓	-1.4	-4.49*** (-5.75, -3.22)	↓	↓
Spending on home health (↑) or (↓)	-1.7	-\$10*** (-\$14, -\$7)	↓	↓	-1.4	-\$8*** (-\$11, -\$6)	↓	↓

SOURCE: NORC analysis of Medicare claims and enrollment data.

NOTE: Estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY) for spending and “continuous hospice days prior to death” outcomes, and per 1,000 beneficiaries per year (BPY) for all other outcomes. Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Arrows in the “Measure” column represent the hypothesized direction of change. The number of beneficiaries for “continuous hospice days prior to death” is 61,900 in PY 2023 and 131,200 as of PY 2023, as the measure was assessed only among beneficiaries who died. Impact estimates that are statistically significant *and* align with the hypothesized direction are shown in orange font.

\*\*\*p<0.01.

### Standard ACOs: Impact on Utilization in ACO and Beneficiary Subgroups

#### ACO Organizational Structure

- Across PY 2021–PY 2023, Standard ACOs structured as IDS/hospital systems saw increases in ED visits and days in PAC settings, which may have explained the increases in total gross spending for this ACO structure (see **Appendix J.9** for additional results on this ACO-level characteristic and for results by ACO lead organization and ACO functional role). It is possible that IDS/hospital system ACOs have more difficulty reducing outpatient and acute care given the overarching incentive structures of health systems and hospitals, which may be associated with higher utilization in these settings.
- Standard ACOs structured as medical group practices or networks of individual practices saw decreases in home health and ED utilization.
- ACOs structured as networks of individual practices also saw decreases in acute care hospitalizations and length of stay. These results, coupled with other results, likely explain how these ACOs were able to reduce total gross spending. They may have had greater incentive to keep patients out of the hospital because they were not reliant on revenue from inpatient stays.

**Exhibit 6.8. As of PY 2023, IDS/Hospital System ACOs Increased ED and PAC Utilization**

	Network of Individual Practices (n=104)	Medical Group Practice (n=55)	Integrated Delivery/Hospital System (n=53)
ED visits incl observation stays	-1.0***	-2.3***	0.5**
Acute care LOS	-1.5***	-0.2	0.5
Acute care hospitalizations	-1.3***	-0.5	0.5
IRF and LTCH days	-1.0	-1.0	3.6***
SNF days	-0.9	-0.5	-0.4
Continuous hospice days prior to death	-1.0	-2.8*	-3.6***
Home health episodes	-2.5***	-1.1**	-0.2

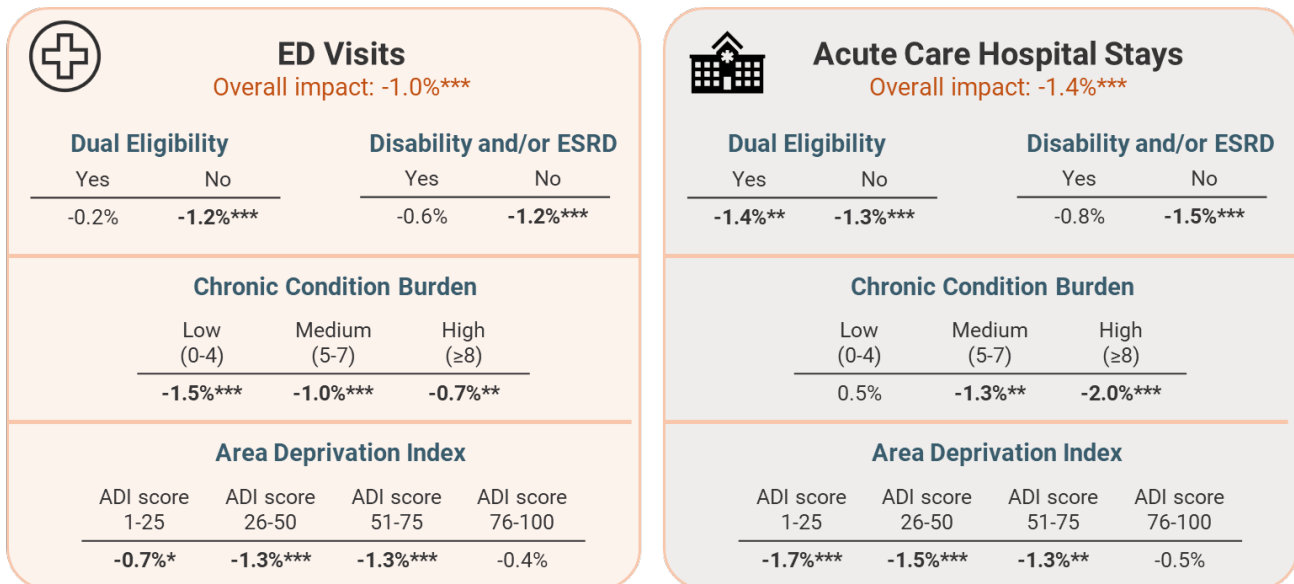
**NOTE:** Numbers in each cell denote % impacts.  
 \*p<0.1, \*\*p<0.05, \*\*\*p<0.01.

### Beneficiary Characteristics

Given the model design features focusing on medically underserved beneficiaries that began with ACO REACH, we assessed impact in beneficiary subgroups in **PY 2023**. We examined estimates for a range of subgroups for **ED visits** and **acute care hospital stays**, which may have been affected by the model from ACO’s focus on primary care and on population health management.

The magnitude of impacts on ED visits and acute care hospital stays in beneficiary subgroups were **generally similar to the overall impact**. Beneficiaries without dual eligibility, without disability and/or ESRD, and with fewer chronic conditions experienced **greater reductions in ED visits** than their counterparts, consistent with our hypotheses. For **acute care hospital stays**, similarly greater reductions were also seen for beneficiaries without disability and/or ESRD and beneficiaries residing in less disadvantaged areas. However, beneficiaries with the most chronic conditions had **larger decreases in acute care hospital stays** than those with fewer conditions. ACOs’ complex care management programs focused on these patients at higher risk of hospitalization, providing more frequent touchpoints, including more frequent visits with PCPs and outreach from nurse care managers, social workers, pharmacists, and other members of the care team who identified and addressed patients’ needs.

**Exhibit 6.9. Greater Reductions in ED Visits and Hospital Stays for Beneficiaries without Dual Eligibility, Disability, or Social Risk, in PY 2023**



**NOTE:** Lower ADI scores represent less disadvantaged census block groups, and higher ADI scores represent more disadvantaged block groups.

\*p<0.1, \*\*p<0.05, \*\*\*p<0.01.

## 6.4 Quality of Care

Standard ACOs improved quality of care across multiple outcomes, as expected (**Exhibit 6.10**). In PY 2023 and cumulatively, there were reductions in **ACSC hospitalizations and unplanned admissions** for patients with MCC for Standard ACO beneficiaries relative to the comparison groups. Additionally, the use of **recommended diabetes care** increased for ACO beneficiaries relative to the comparison groups, along with **timelier follow-up** after acute exacerbations of chronic conditions, and more healthy **days at home**. The improvements continued the trends seen as of PY 2022 (**Appendix Exhibit J.25**).

For Standard ACOs, observed quality impacts reflected **increasing trends in advanced care planning (ACP), AWVs, and chronic care management activities for beneficiaries with MCCs** (**Appendix Exhibit J.26**).

We observed **no declines in quality of care for any risk/capitation election or organizational structure subgroups** (**Appendix Exhibits J.27 and J.28**).

The findings reflect Standard ACOs’ focus on decreasing avoidable inpatient utilization (87% said this was a high priority in 2023), increasing primary care touchpoints (80%), and implementing complex care management and population-specific care management programs (79%). Two-thirds of Standard ACOs have established robust processes to support patients with high-need, high-cost conditions. Additionally, at least three-quarters offered care management programs for patients with the following: a recent hospitalization or ED visit; a specific chronic condition, including diabetes and ESRD; a comorbid condition; or advanced illness. For more information on ACOs’ use of care management and care coordination strategies, see **Chapter 5** and Pulse Check Survey results in **Appendix F**.

**Exhibit 6.10. Quality of Care Improved Across Multiple Outcomes for Standard ACOs, Both in PY 2023 and Cumulatively as of PY 2023**

Measure (Hypothesized Direction of Change)	In PY 2023 105 ACOs				Cumulatively As of PY 2023 212 ACO-Years			
	% Impact	Impact Estimate (90% CI)	BYs to PY(s)		% Impact	Impact Estimate (90% CI)	BYs to PY(s)	
			ACO REACH	Comp.			ACO REACH	Comp.
ACSC hospitalizations (↓)	-4.7	-0.95*** (-1.17, -0.73)	↓	↓	-3.3	-0.63*** (-0.78, -0.48)	↓	↓
Unplanned admission (patients with MCC)^ (↓)	-2.0	-4.46*** (-5.95, -2.96)	↓	↓	-1.6	-3.63*** (-4.70, -2.57)	↓	↓
All-condition readmissions^ (↓)	-1.3	-1.79* (-3.40, -0.18)	↓	↑	-0.4	-0.58 (-1.75, 0.59)	↑	↑
Recommended diabetes care (↑)	1.3	5.81*** (4.22, 7.40)	↑	↑	1.0	4.12*** (3.06, 5.19)	↑	↑
Timely follow-up^ (↑)	1.3	10.56*** (7.60, 13.52)	↑	↑	0.8	6.22*** (4.05, 8.38)	↑	↓
Days at home (per BPY) (↑)	0.2	0.17*** (0.12, 0.21)	↓	↓	0.1	0.10*** (0.07, 0.13)	↓	↓

**SOURCE:** NORC analysis of Medicare claims and enrollment data.

**NOTE:** ACSC=ambulatory care sensitive conditions; MCC=multiple chronic conditions. Estimates and 90% confidence interval (CI) are presented per beneficiary per year (BPY) for “days at home” outcome, and per 1,000 beneficiaries per year (BPY) for all other outcomes. Model impact was estimated relative to the comparison groups and baseline years using a difference-in-differences (DID) model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Arrows in the “Measure” column represent the hypothesized direction of change. Beneficiary sample sizes for each quality of care outcome may reflect different denominators, noted in **Appendix Exhibit J.25**. \*p<0.1, \*\*\*p<0.01. ^Measure included in quality performance calculations. Impact estimates that are statistically significant *and* align with the hypothesized direction are shown in orange font.

## 6.5 Conclusion

Over the first three years of the model, there was no significant change in total gross Medicare spending for Standard ACOs relative to comparison groups from within the same ACO markets. A notable reduction in spending under ACO REACH in PY 2023 was offset by an increase in PY 2022 under GPDC. The ACOs that opted for higher levels of risk and capitation, as well as those made up of networks of individual practices, achieved greater spending reductions. Additionally, we observed more substantial reductions in total gross spending in PY 2023 for beneficiaries in under-resourced areas, those with MCC, those who were dually eligible, and those eligible for Medicare due to disability and ESRD. ACOs focused on these beneficiaries through complex and population-specific care management programs, providing a higher touch model of care, including more frequent visits with PCPs and outreach from nurse care managers, social workers, pharmacists, and other members of the care team who identified and addressed patients' needs.

As of PY 2023, Standard ACOs saw a modest yet statistically significant increase in net Medicare spending. Relative to the comparison groups, the shared savings and performance bonus payments to ACOs for meeting benchmark targets and quality improvements exceeded their reductions in total gross spending. For all years, we saw a smaller increase in net spending relative to the comparison groups, after factoring in payouts made to both REACH ACOs as well as to beneficiaries seen by providers in other ACO models. For example, it is worth noting that net spending increased in PY 2023 by a smaller amount (\$59,  $p < 0.1$ ) than it did in PY 2022 (\$138,  $p < 0.01$ ) when shared savings payments were accounted for in the comparison group.

Standard ACOs decreased utilization and spending across ambulatory care, acute, and PAC settings, as expected. The exception was a continued increase in spending on professional services and specialty visits, consistent with prior years. Decreases in utilization were particularly evident among ACOs that were networks of individual practices. However, unlike total gross spending, there were minimal differences in utilization outcomes by beneficiary subgroups.

For Standard ACOs, there were no negative impacts on the quality of care for aligned beneficiaries. Many quality of care measures improved, both overall and for ACO subgroups defined by risk and capitation levels and organizational structure. Standard ACOs improved ACSC hospitalizations, unplanned hospitalizations for beneficiaries with MCC, recommended diabetes care, timely follow-up after exacerbation of chronic conditions, and days at home relative to the comparison groups. These improvements were anticipated given the model's financial incentives tied to quality of care outcomes. However, they may also reflect ACOs' increased emphasis on care management and coordination strategies aimed at improving patient outcomes.

Among ACO subgroups, the more risk-tolerant ACOs showed greater reductions in ACSC hospitalizations compared to their more risk-averse counterparts, as expected. However, decreases in unplanned admissions among patients with MCC were observed across all risk and capitation levels. Regarding quality of care by ACO organizational structure, smaller (individual or medical practices) ACOs generally outperformed larger (IDS/hospital systems) ACOs in improvements related to ACSC hospitalizations, unplanned admissions among patients with MCC, timely follow-up, and days at home—again, consistent with expectations.

Overall, while these findings indicate that the model was more financially favorable for Standard ACOs than for the Medicare program as of PY 2023, it is notable that a large number of Standard ACOs met their spending and quality improvement targets.

## Chapter 7: **New Entrant ACOs**—Impact of the Model on Medicare Spending, Utilization, and Quality of Care

### Key Findings

#### Impacts on Total Gross and Net Medicare Spending

- **Gross spending.** In PY 2023, New Entrant ACOs significantly reduced gross Medicare spending by \$36.8 million, or 6.2% (\$890 PPBY) relative to the comparison groups. Cumulatively over the first three years of the model, New Entrant ACOs significantly decreased gross spending for Medicare Parts A and B by \$51.1 million, or 3.2% (\$433 PPBY) relative to their comparison groups.
- **Net spending.** Financial incentives paid to REACH ACOs totaled \$41.7 million in PY 2023, which exceeded reductions in gross spending, resulting in non-statistically significant increases in net Medicare spending for New Entrant ACOs of \$0.1 million or 0.0% (\$2 PPBY). Cumulative net spending as of PY 2023 statistically significantly increased relative to comparison groups by \$30.6 million, or 1.9% (\$259 PPBY).

#### Impacts on Utilization and Spending Categories

- **Utilization.** Cumulatively over the first three years of the model, New Entrant ACOs continued to reduce ED visits (by 3.2%) and hospice use (by 10.6%). In PY 2023, New Entrant ACOs saw significant reductions in acute care hospitalizations (by 3.6%) and lengths of stay (by 4.5%) for the first time.
- **Spending categories.** Both cumulatively and in PY 2023, New Entrant ACOs decreased spending on outpatient services (by 2.9% and 4.8%, respectively) and acute care (by 3.0% and 6.6%, respectively). In PY 2023, New Entrant ACOs also decreased hospice spending for the first time (by 10.5%). Cumulatively as of PY 2023, New Entrant ACOs also decreased spending in specialty care (by 1.6%), consistent with prior years but in contrast to Standard ACOs, which increased specialty spending.
- Impacts on utilization and spending categories for New Entrant ACOs were generally larger than those seen for Standard ACOs.

#### Impacts on Quality Measures

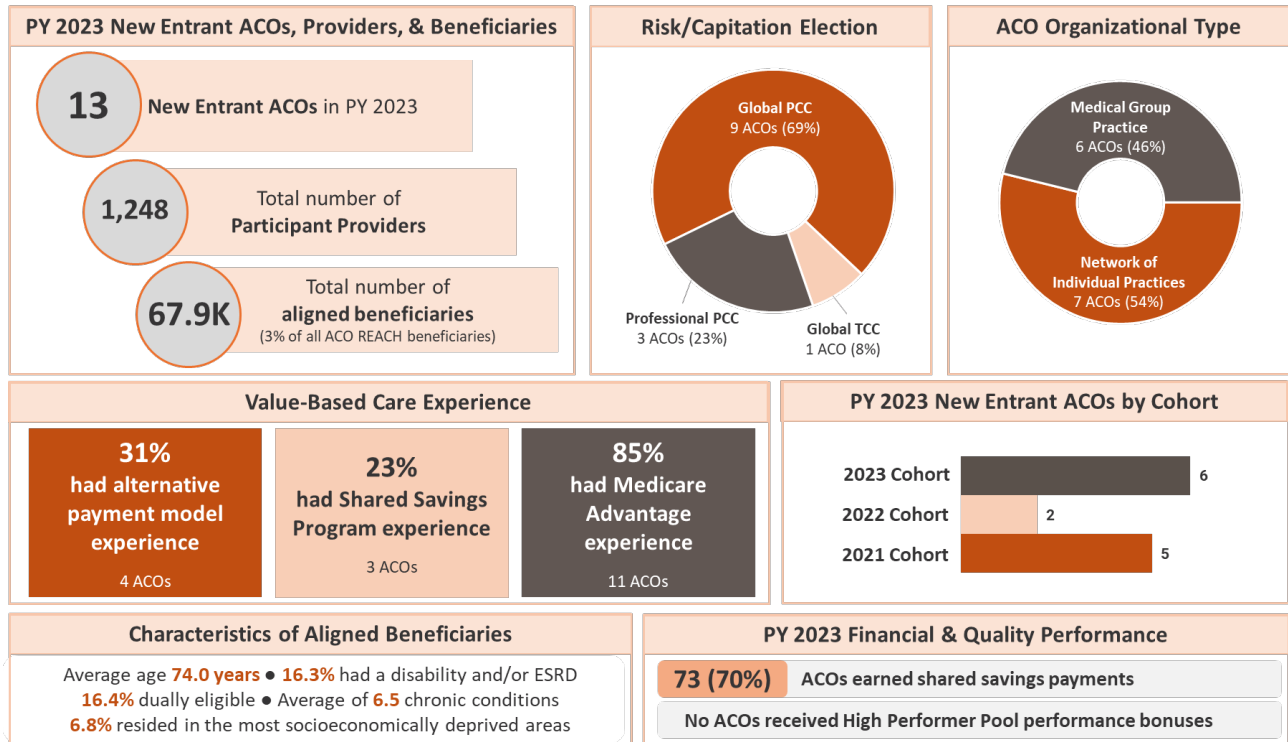
- New Entrant ACOs improved quality, both cumulatively and in PY 2023, with increases in percent of days at home (impacts of 0.2% and 0.6%, respectively) and decreases in ACSC hospitalizations (by 4.7% and 11.7%, respectively). Use of diabetes-recommended care also increased cumulatively through the first three years of the model (by 3.2%).

In this chapter, we present findings about the impact of New Entrant ACOs on spending, utilization, and quality outcomes. Unlike for Standard ACOs, we did not conduct subgroup analyses by ACO characteristics or beneficiary characteristics for New Entrant ACOs because of the decline in the number of New Entrant ACOs participating in ACO REACH as New Entrant ACOs transitioned to Standard ACOs (see **Exhibit 3.1**). See **Appendix K** for complete results, including cohort-level impacts.

## 7.1 Snapshot of New Entrant ACOs

Most of the 13 New Entrant ACOs in PY 2023 (**Exhibit 7.1**) elected Global PCC. Only 31% of the PY 2023 New Entrant ACOs had prior experience with APMs, although 85% had experience with MA.<sup>68</sup> 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).

**Exhibit 7.1. New Entrant ACOs Snapshot—Model Elections, Performance, and Organizational and Beneficiary Characteristics**



**SOURCES:** PY 2023 financial results; model applications and additional documentation; 2023 ACO REACH Pulse Check Survey; NORC analysis of PY 2023 Alignment Data (received from model’s implementation and monitoring contractor); and NORC analysis of Medicare claims, enrollment, and ACO REACH Model data. One New Entrant ACO was excluded from impact analyses due to insufficient baseline data.

**New Entrant ACOs in PY 2023 were organized around networks of individual practices or medical group practices, with no IDS/hospital systems.** Most were led by primary care companies, MSOs, and physician practices.

- **Primary Care Companies:** Nearly half of the 13 New Entrant ACOs were led by companies that operate networks of primary care clinics. These companies used a consistent care model across different ACOs and states. One such ACO operated entirely remotely, providing home-based care for complex patients.
- **Physician Practices:** Three ACOs were led by physician practices. These practices operated within a single state, as a network of primary care practices, a large independent physician association, or a part of one.

<sup>68</sup> Prior APM experience and MA experience occurred at various levels across the ACOs, including for the ACO itself as a model participant or as part of another ACO, for the ACO’s Participant Providers, for lead or parent organizations, and/or for members of ACO leadership teams.

- **MSOs and Insurers:** Three ACOs were led by MSOs and one by an insurer. These organizations viewed the ACO REACH Model as a chance to improve provider management and financial reporting. One MSO, which also manages four Standard ACOs in addition to managing one New Entrant ACO in 2023, was created specifically for the model and worked with providers eligible for the New Entrant track. Another MSO collaborated with SNFs and home health organizations to improve care coordination.

New Entrant ACOs generally had less experience with value-based care than did Standard ACOs. However, four New Entrant ACOs were led by organizations that also managed Standard ACOs, suggesting that these New Entrant ACOs' lead organizations had more experience within the ACO space historically. These New Entrant ACOs aimed to develop and administer primary care-centered, outcome-based contracts with regional and national payers.

## 7.2 Total Gross and Net Medicare Spending

This section presents impact findings on gross and net spending for New Entrant ACOs. We estimated impacts for 12 of 13 New Entrant ACOs in PY 2023; impacts for one ACO could not be evaluated because its providers did not deliver care to a sufficient number of Original Medicare beneficiaries at baseline.

### *Impacts on Gross Medicare Spending*

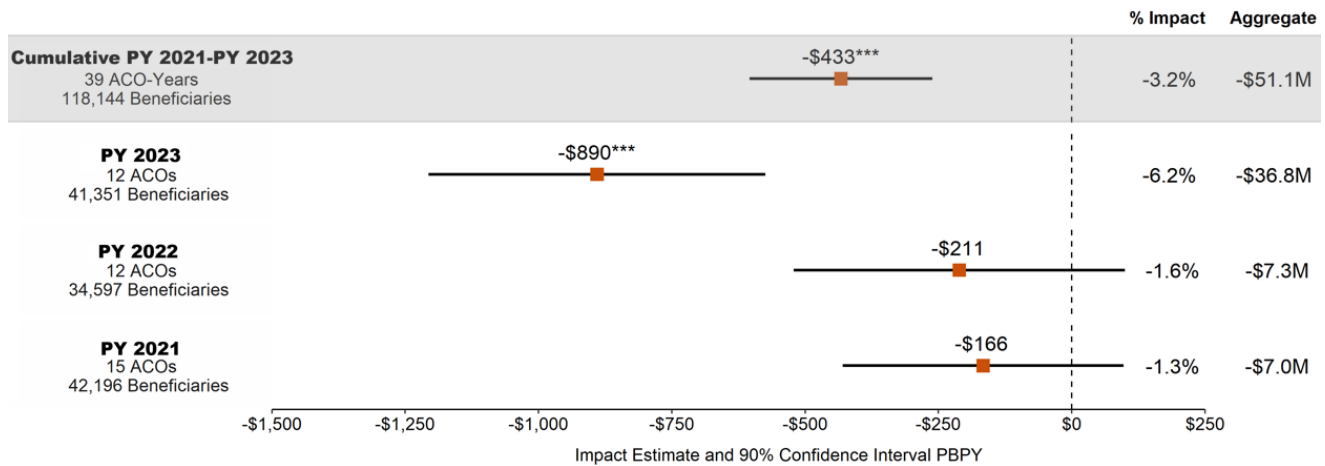
In PY 2023, New Entrant ACOs reduced **gross Medicare spending** relative to the comparison groups by 6.2% (\$890 PBPY; **Exhibit 7.2**)<sup>70</sup>. For New Entrant ACOs, this reduction was statistically significant for the first time and much larger than in prior performance years. The decrease in PY 2023 reflected significant decreases for the 2021 cohort (9.2%) and the 2022 cohort (4.9%; see **Appendix Exhibit K.2**), consistent with our hypotheses that earlier cohorts will begin to see spending reductions due to their time and experience in the model. The significant decrease in PY 2023 also contributed to a significant reduction cumulatively (3.2%, or \$433 PBPY).

Gross spending for New Entrant ACOs **decreased by a larger amount** relative to the alternative comparison group (that excluded beneficiaries in accountable care) both in PY 2023 and cumulatively (**Appendix Exhibit K.6**)<sup>69</sup>.

<sup>69</sup> These results should be interpreted with caution due to differences in the treatment group's specification between the baseline and performance periods. Specifically, the ACO REACH group in the PY included all aligned beneficiaries (of its Participant Providers), whereas in the baseline period, only a subset of aligned beneficiaries were included—namely, those in Original Medicare or non-ACO APMs. In contrast, the alternative comparison group maintained consistent composition across both periods, which may affect the comparability of results.

<sup>70</sup> In PY 2023, statistical significance aside, 9 of 12 New Entrant ACOs (75%) decreased gross spending, and 3 (25%) increased gross spending (Appendix K.6).

**Exhibit 7.2. Cumulatively as of PY 2023, New Entrant ACOs Significantly Decreased Gross Medicare Spending Relative to the Comparison Groups**



**SOURCE:** NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) (PY) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). “Aggregate” was the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year. Not all New Entrant ACOs could be evaluated because of availability of baseline data.

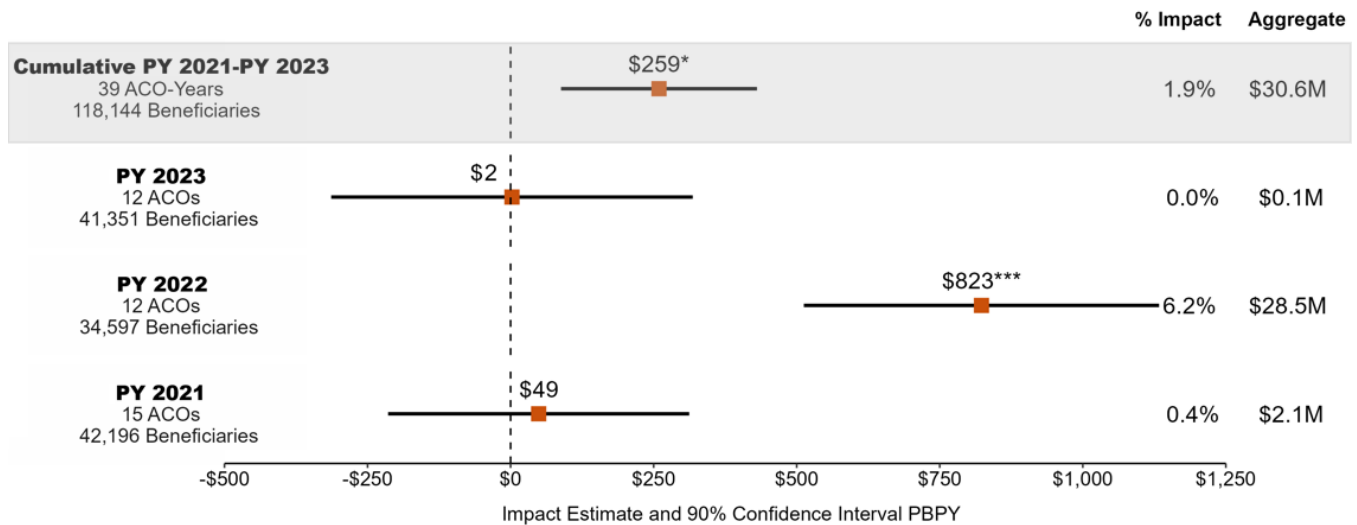
\*\*\*p<0.01.

**Impacts on Net Medicare Spending**

In PY 2023, CMS payouts to New Entrant ACOs totaled \$41.7 million, and no New Entrant ACOs received performance bonuses paid out via the HPP. Because a large proportion of ACO REACH providers (34%) participated in another ACO model before ACO REACH began (the baseline period), it is assumed that these providers would have continued to do so if the ACO REACH did not exist. Therefore, the comparison groups include a similar proportion of beneficiaries in other ACO models (in both the baseline and performance periods) to approximate what would have happened had the model not occurred. Given that providers in other ACO initiatives, such as the Medicare Shared Savings Program, receive financial incentive payments similar to providers in the ACO REACH Model, we updated evaluation methods for net spending calculations in PY 2023 to account for these payouts by incorporating estimates of the share of those payouts attributable to beneficiaries in the analysis. This allows for an equivalent adjustment of CMS incentive payments across both the intervention and comparison groups in the net spending calculations, which is in line with methods used in the difference-in-difference analyses. These updated methods improve upon prior calculations used to evaluate the GPDC model, which only accounted for financial incentives related to the model. Results for PY 2023 using this prior method are available in the technical appendix to enable comparisons with the methodology used in prior evaluation reports (**Appendix K.3**).

Impact estimates for net spending after factoring in CMS’ shared savings payouts for ACO REACH and other CMS ACO initiatives are shown in **Exhibit 7.3**. Cumulatively, the net spending increase was smaller but still significant (\$30.6 million, or 1.9%). In PY 2023, the net spending change was non-significant but there was a significant increase of 6.0% for the 2021 cohort and a significant decrease of 9.1% for the 2022 cohort (results by ACO cohort presented in **Appendix Exhibit K.5**).

**Exhibit 7.3. After Factoring in Payouts to REACH ACOs and the Comparison Groups, Net Medicare Spending Increased for New Entrant ACOs Cumulatively as of PY 2023 but not in PY 2023**



**SOURCE:** NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) (PY) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). “Aggregate” was the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year. Not all New Entrant ACOs could be evaluated because of availability of baseline data.

\*p<0.10, \*\*\*p<0.01.

### 7.3 Utilization and Spending Categories

This section presents impact findings on utilization and spending categories for New Entrant ACOs. Similarly to Standard ACOs, acute care, professional services, and outpatient facilities made up the majority of total spending for New Entrant ACOs (**Appendix Exhibit K.9**) in the baseline period. Although baseline spending among High Needs ACOs also centered on acute care and professional services, baseline spending on professional services was substantially higher among New Entrant ACOs relative to High Needs ACOs. These categories represented opportunities for ACOs to further reduce spending in these areas.

#### **Impacts on Ambulatory Care, Acute Care, and Post-Acute Care Utilization and Spending**

In PY 2023 and cumulatively as of PY 2023, there were significant reductions in **ambulatory care (ED visits including observation stays and outpatient spending)** for New Entrant ACOs relative to the comparison groups (**Exhibit 7.4**).<sup>71</sup> Consistent with prior years (**Appendix Exhibit K.10**), New Entrant ACOs saw a significant decrease in **specialty care spending** cumulatively.

<sup>71</sup> While trends in ED visits fluctuated across performance years and cohorts, with some time periods showing an increase in ED visits for both groups, overall trends in ED visits declined for both New Entrant ACOs and their comparison groups.

In PY 2023 and cumulatively as of PY 2023, there were also significant reductions in **acute care spending**. The results may reflect the significant decreases in acute care hospitalizations and lengths of stay seen in PY 2023 for the first time for New Entrant ACOs. There were no significant differences seen in PAC utilization or spending—impact estimates showed reductions in PY 2023, but none were statistically significant.

Reductions in utilization may reflect New Entrant ACOs’ stated focus on initiatives to reduce avoidable inpatient and ED utilization and PAC utilization. In the 2023 Pulse Check Survey, all New Entrant ACOs said each was at least a medium priority.

**Trends in utilization of other ambulatory services for New Entrant ACO beneficiaries (Appendix Exhibit K.12):**

- Spending on primary care office visits and PCP services remained relatively steady over time.
- Urgent care visits increased over the baseline period but decreased in PY 2023 to the level seen in BY3. When excluding COVID-related visits, urgent care visits decreased slightly over the baseline period but increased in PY 2023.

**Exhibit 7.4. Cumulatively and in PY 2023, New Entrant ACOs Experienced Significant Reductions in Ambulatory Utilization and Spending and for the First Time in PY 2023, Significant Reductions in Acute Care Utilization**

Measure (Hypothesized Direction of Change)	In PY 2023 12 ACOs; 41,351 Beneficiaries				Cumulatively As of PY 2023 39 ACO-Years; 118,144 Beneficiaries			
	% Impact	Impact Estimate (90% CI)	BYs to PY(s)		% Impact	Impact Estimate (90% CI)	BYs to PY(s)	
			ACO REACH	Comp.			ACO REACH	Comp.
<b>Ambulatory</b>								
ED visits including observation stays (↓)	-3.6	-15.06** (-25.17, -4.96)	↑	↑	-3.2	-12.66*** (-18.55, -6.77)	↓	↓
Spending on outpatient facilities (↓)	-4.8	-\$95** (-\$165, -\$25)	↑	↑	-2.9	-\$53** (-\$91, -\$15)	↑	↑
Spending on professional services (↓)	-1.4	-\$53 (-\$138, \$32)	↑	↑	-0.7	-\$24 (-\$71, \$23)	↑	↑
Spending on specialty care office visits (↓)	-1.6	-\$3 (-\$7, \$0)	↓	↓	-1.6	-\$3** (-\$5, -\$1)	↑	↑
<b>Acute Care</b>								
Acute care LOS (↓)	-4.5	-63.53* (-120.74, -6.32)	↓	↓	-0.8	-11.18 (-42.40, 20.04)	↓	↓
Acute care hospitalizations (↓)	-3.6	-7.73* (-14.42, -1.04)	↓	↓	-1.3	-2.64 (-6.41, 1.13)	↓	↓
Spending on acute care setting (↓)	-6.6	-\$262*** (-\$414, -\$109)	↓	↑	-3.0	-\$107** (-\$188, -\$26)	↓	↓
<b>Post-Acute Care</b>								
IRF and LTCH days (↓)	-10.3	-26.23 (-83.45, 31.00)	↓	↑	0.6	1.20 (-21.68, 24.07)	↓	↓
Spending on IRF and LTCH (↓)	-12.7	-\$62 (-\$180, \$57)	↑	↑	2.3	\$10 (-\$49, \$69)	↑	↑
SNF days (↓)	-6.0	-95.60 (-199.71, 8.51)	↓	↓	-3.2	-50.40 (-109.51, 8.72)	↓	↓
Spending on SNF (↓)	-5.2	-\$57 (-\$129, \$15)	↓	↑	-3.1	-\$31 (-\$69, \$7)	↓	↑

SOURCE: NORC analysis of Medicare claims and enrollment data.

**NOTE:** ED=emergency department; IRF=inpatient rehabilitation facility; LOS=length of stay; LTCH=long-term care hospital; SNF=skilled nursing facility. Estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY) for spending outcomes, or per 1,000 beneficiaries per year (BPY) for other outcomes. Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in PY(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year. Arrows in the “Measure” column represent the hypothesized direction of change. Impact estimates that are statistically significant *and* align with the hypothesized direction are shown in orange font.

\*p<0.1, \*\*p<0.05, p<0.01\*\*\*.

## ***Impacts on Hospice and Home Health Utilization and Spending***

Hospice spending declined over time for both New Entrant ACOs and the comparison groups, but by a larger magnitude for the former. Therefore, for the first time in PY 2023, New Entrant ACOs saw a significant decrease in **hospice spending** relative to the comparison groups (**Exhibit 7.5**). As with Standard ACOs, the spending decrease may have reflected significant decreases in total hospice days both in PY 2023 and cumulatively. In addition, we observed a significant cumulative decrease in **continuous hospice days prior to death**, consistent with PY 2022 (**Appendix Exhibit K.11**).

These findings suggest that New Entrant ACOs’ care patterns for beneficiaries nearing the end of life may differ from those of the comparison groups, though the evaluation does not point to a single explanatory mechanism. Survey data indicate that 62% of New Entrant ACOs offer care management programs for patients with advanced illness, which may influence how and when beneficiaries transition into hospice without necessarily generating Medicare hospice benefit claims. Many ACOs—including New Entrant ACOs—have begun placing greater emphasis on advance care planning (ACP) and serious-illness care discussions as part of their broader care management and primary care strategies, including through activities embedded in AWWs. We do not yet have sufficient information to determine what factors may be driving differences in end-of-life care patterns among New Entrant ACOs; future reports will explore these dynamics in greater depth, including how organizational approaches to serious-illness and end-of-life care may relate to hospice utilization and spending.

In contrast, there were no significant changes in home health utilization or spending cumulatively as of PY 2023 for New Entrant ACOs. These results differ from the results for Standard ACOs, where there were significant decreases in home health episodes and corresponding spending in PY 2023 and cumulatively. We did not have clear expectations related to how the ACOs would impact these outcomes, as ACOs may provide similar types of services through other forms of in-home care without billing home health. New Entrant ACOs submitted far fewer claims under home health-related waivers such as the Home Health Homebound waiver, than Standard and High Needs ACOs, though the use of benefit enhancements and other flexibilities in the model represents only one of multiple factors that may influence utilization and spending patterns.<sup>72</sup> Given the administrative capacity and resources required to operationalize these waivers, the lower submission rates among smaller New Entrant ACOs are understandable.

<sup>72</sup> In PY2023, New Entrant ACOs submitted an average of 1.79 and 1.46 claims per 1,000 beneficiaries for the concurrent care for beneficiaries that elect Medicare hospice and the Home Health Homebound waiver, respectively. Standard and High Needs ACOs submitted much higher numbers of claims for both waiver types (Standard ACOs submitted 8.62 and 24.24 claims per beneficiaries, respectively; High Needs submitted 319.63 and 113.23 claims per 1,000 beneficiaries, respectively). See **Appendix Exhibit E.9** for more details. Future reports will include additional details around the barriers and facilitators for these waivers.

In addition, underlying market conditions may help explain why home health utilization did not change meaningfully for New Entrant ACOs. Prior research suggests that post-acute care use, including home health, varies substantially across markets and is influenced by factors such as Medicare Advantage penetration and existing ACO presence, which can shape provider practice patterns and baseline levels of home health use.<sup>73</sup> Because New Entrant ACOs tend to operate in smaller or newer markets with different post-acute care dynamics, it is possible that their surrounding markets already exhibited relatively lower home health utilization or different patterns of post-acute care substitution. We will explore these contextual factors in future reports to more fully understand the drivers of these observed differences.

**Exhibit 7.5. Hospice and Home Health Utilization and Spending for New Entrant ACOs Decreased in PY 2023 and Cumulatively as of PY 2023**

Measure (Hypothesized Direction of Change)	In PY 2023 12 ACOs; 41,351 Beneficiaries				Cumulatively As of PY 2023 39 ACO-Years; 118,144 Beneficiaries			
	% Impact	Impact Estimate (90% CI)	BYs to PY(s)		% Impact	Impact Estimate (90% CI)	BYs to PY(s)	
			ACO REACH	Comp.			ACO REACH	Comp.
<b>Hospice</b>								
Continuous hospice days prior to death (↑) or (↓)	-7.6	-1.99 (-5.73, 1.76)	↓	↓	-10.6	-3.23** (-5.67, -0.79)	↓	↑
Total hospice days (↑) or (↓)	-13.7	-0.40** (-0.69, -0.12)	↓	↓	-4.1	-0.12 (-0.29, 0.04)	↓	↓
Spending on hospice (↑) or (↓)	-10.5	-\$58* (-\$110, -\$7)	↓	↓	-4.4	-\$24 (-\$52, \$4)	↓	↓
<b>Home Health</b>								
Home health episodes (↑) or (↓)	-3.8	-11.82 (-24.89, 1.25)	↓	↓	-1.2	-3.73 (-10.89, 3.42)	↓	↓
Spending on home health (↑) or (↓)	-3.5	-\$23 (-\$51, \$5)	↓	↓	-1.6	-\$11 (-\$25, \$4)	↓	↓

**SOURCE:** NORC analysis of Medicare claims and enrollment data.

**NOTE:** Estimates and 90% confidence intervals (CI) are presented per beneficiary per year (PBPY) for spending and “continuous hospice days prior to death” outcomes, and per 1,000 beneficiaries per year (BPY) for all other outcomes. Model impact was estimated relative to the comparison groups and baseline years using a DID model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in the performance year(s) (PY) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year. The number of beneficiaries for “continuous hospice days prior to death” was 1,564 in PY 2023 and 4,433 as of PY 2023, as the measure was assessed only for beneficiaries who died. Arrows in the “Measure” column represent the hypothesized direction of change. Impact estimates that are statistically significant *and* align with the hypothesized direction are shown in orange font. \*p<0.1, \*\*p<0.05.

<sup>73</sup> See, for example: Geng F, Lake D, Meyers DJ, et al. Increased Medicare Advantage Penetration Is Associated With Lower Postacute Care Use For Traditional Medicare Patients. *Health Aff (Millwood)*. 2023;42(4):488-497. doi:10.1377/hlthaff.2022.00994.

## 7.4 Quality of Care

As expected, New Entrant ACOs improved quality of care, with reductions in **ACSC hospitalizations** and an increase in **days at home**, relative to the comparison groups, both in PY 2023 and cumulatively (**Exhibit 7.6**). New Entrant ACOs also saw increases in **recommended diabetes care** cumulatively, as hypothesized. Although the model did not impact all-condition readmissions, both New Entrant ACOs and the comparison groups showed unexpected increases in all-condition readmissions in PY 2023 and cumulatively. In addition, contrary to expectations, both groups showed decreases in days at home in PY 2023. Almost all New Entrant ACOs reported that provider engagement via coaching, one-on-one review of performance quality and/or cost data, or providing real-time data on ED and inpatient ADTs was very important and may have been useful care delivery strategies for improving quality of care outcomes.

**Descriptive trends analysis shows constant or improving quality of care for New Entrant ACO beneficiaries in PY 2023 on several measures (Appendix Exhibit K.14):**

- Advanced care plans and AWVs stayed relatively constant over the baseline period and increased in PY 2023.
- Chronic care management among beneficiaries with MCC increased over the baseline period but decreased during PY 2023.

**Exhibit 7.6. Quality of Care Improved Across Multiple Outcomes for New Entrant ACOs Both in PY 2023 and Cumulatively as of PY 2023**

Measure (Hypothesized Direction of Change)	In PY 2023 12 ACOs				Cumulatively As of PY 2023 39 ACO-Years			
	% Impact	Impact Estimate (90% CI)	BYs to PY(s)		% Impact	Impact Estimate (90% CI)	BYs to PY(s)	
			ACO REACH	Comp.			ACO REACH	Comp.
ACSC hospitalizations (↓)	-11.7	-2.57** (-4.31, -0.84)	↓	↓	-4.7	-0.97* (-1.90, -0.03)	↓	↓
Unplanned admission (patients with MCC)^ (↓)	-1.0	-2.25 (-12.66, 8.16)	↓	↓	-2.2	-4.98 (-11.32, 1.37)	↓	↓
All-condition readmissions^ (↓)	-1.9	-2.65 (-14.17, 8.88)	↑	↑	-0.9	-1.46 (-8.44, 5.53)	↑	↑
Recommended diabetes care (↑)	2.1	8.17 (-2.55, 18.88)	↑	↑	3.2	11.73*** (5.84, 17.62)	↑	↑
Timely follow-up^ (↑)	2.1	16.92 (-3.72, 37.56)	↑	↓	1.5	11.88 (-0.40, 24.15)	↑	↓
Days at home (per BPY) (↑)	0.6	0.55** (0.20, 0.90)	↓	↓	0.2	0.22* (0.03, 0.40)	↑	↓

**SOURCE:** NORC analysis of Medicare claims and enrollment data.

**NOTE:** ACSC=ambulatory care sensitive conditions; MCC=multiple chronic conditions. Estimates and 90% confidence interval (CI) are presented per beneficiary per year (PBPY) for “days at home” outcome, and per 1,000 beneficiaries per year (BPY) for all other outcomes. Model impact was estimated relative to the comparison groups and baseline years using a difference-in-differences (DID) model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in performance year(s) (PY) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Arrows in the “Measure” column represent the hypothesized direction of change. Beneficiary sample sizes for each quality of care outcome reflected different denominators, noted in **Appendix Exhibit K.13**. Impact estimates that are statistically significant *and* align with the hypothesized direction are shown in orange font. \*p<0.1, \*\*p<0.05, p<0.01\*\*\*. ^Measure included in quality performance calculations.

## 7.5 Conclusion

Over three years of the model, New Entrant ACOs significantly reduced total gross Medicare spending, relative to comparison groups from within the same ACO markets, with a notable decrease in gross spending in PY 2023 under ACO REACH. However, net spending for New Entrant ACOs remained higher than the comparison group, resulting in increased cumulative net spending, although the increase in PY 2023 was very small and not statistically significant.

New Entrant ACOs achieved reductions in ED and hospice utilization, as well as decreased spending in outpatient, specialty care, and acute care settings. They also improved quality of care, as seen in increased adherence to diabetes care recommendations, more days at home, and fewer ACSC hospitalizations. The outcomes were generally similar to those for Standard ACOs, except for total gross spending changes, where Standard ACOs showed no cumulative changes. Overall, the per-beneficiary impacts for New Entrant ACOs were larger than those observed for Standard ACOs, suggesting potential benefits of accountable care implementation by these new organizations for their Original Medicare beneficiaries.

Similar to (but to a lesser extent than) Standard ACOs, New Entrant ACOs improved multiple quality of care measures. These improvements in quality of care measures were expected, as the outcomes are tied to the model's financial incentives.

## Chapter 8: High Needs ACOs—Impact of the Model on Medicare Spending, Utilization, and Quality of Care

### Key Findings

#### High Needs ACOs in PY 2023

- Eight High Needs ACOs joined the model in PY 2023, bringing the total to 14. A single MSO managed four of the new ACOs, and they all used an identical model of care.
- The eight ACOs in the 2023 cohort accounted for more than half of all beneficiaries aligned to High Needs ACOs in PY 2023.
- The beneficiaries aligned to these eight new High Needs ACOs were more likely to meet the frailty eligibility criteria for High Needs than were those in earlier cohorts.

#### Impacts on Total Gross and Net Medicare Spending

- **Gross spending.** Cumulatively across PY 2022–PY 2023, High Needs ACOs showed a significant reduction in total gross Medicare spending relative to their comparison groups, while a reduction in PY 2023 was non-significant. High Needs ACOs that entered in PY 2021 achieved a significant 4.9% reduction (\$1,935 PBPY) by PY 2023, largely driven by a 10.0% decrease in PY 2022, while later cohorts did not show significant changes in spending in either PY (although the PY 2023 cohort showed reductions and the PY 2022 cohort had increased spending in PY 2023).
- **Net spending.** Financial incentives paid to REACH ACOs totaled to \$89 million in PY 2023, which exceeded reductions in gross spending resulting in significant increases in net Medicare spending for High Needs ACOs of \$85.2 million or 14.5% (\$5,288 PBPY). Cumulative net spending as of PY 2023 increased by \$96.0 million, or 11.4% (\$4,426 PBPY), relative to comparison groups spending.

#### Impacts on Utilization and Quality

- In PY 2023, High Needs ACOs significantly reduced ED visits (5.1%) and IRF and LTCH lengths of stay (13.4%). Significant cumulative decreases in both ED visits (5.7%) and SNF days (6.5%) were also observed across PY 2022–PY 2023.
- In PY 2023, most quality of care measures for High Needs ACOs showed improvements in the expected directions even though many of the estimates did not reach statistical significance. Timely follow-up after chronic condition exacerbation significantly improved both in PY 2023 (2.6%) and cumulatively across PY 2022–PY 2023 (3.5%). ACSC hospitalizations significantly decreased in PY 2023 (7.1%). Cumulatively, days at home also significantly increased, but the effect size was relatively small (0.4%).

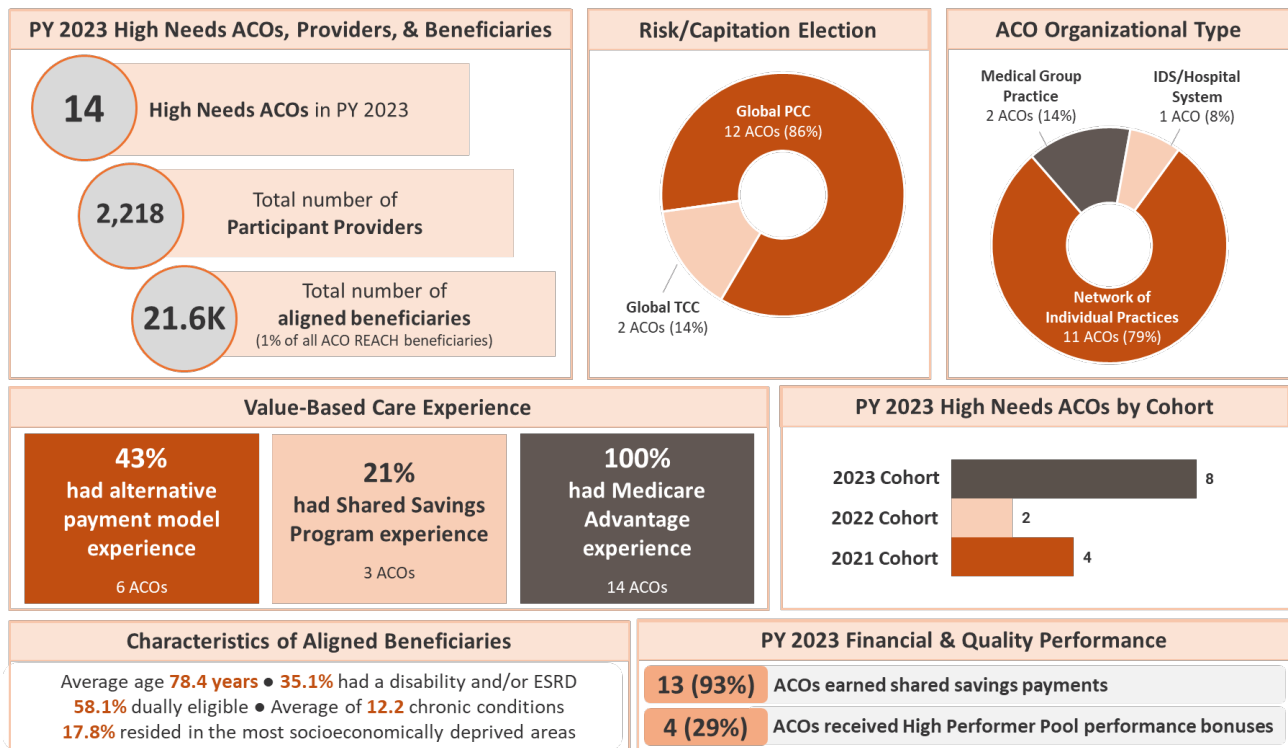
In this chapter, we provide an overview of the High Needs participants and present high-level findings on how these ACOs fared in terms of Medicare spending, service use, and quality of care. Complete results can be found in **Appendix L**.

## 8.1 Snapshot of High Needs ACOs

High Needs ACOs focus exclusively on beneficiaries with significant medical and functional complexity, who often require intensive, coordinated care across multiple settings. This contrasts with Standard and New Entrant ACOs who serve beneficiaries that more closely mirror the general Medicare population. To be eligible for alignment with a High Needs ACO in PY 2023, beneficiaries had to meet at least one of four criteria: having a serious chronic condition with a high risk score, having a moderate risk score combined with multiple unplanned hospitalizations in the past year, exhibiting signs of frailty, or having a neurological condition that limits mobility.

**Exhibit 8.1** provides a high-level overview of High Needs ACOs participating in the model. The number of High Needs ACOs more than doubled in PY 2023, increasing from six ACOs continuing from PY 2022 to 14 in PY 2023, with eight new High Needs ACOs joining the model in that year. Of the eight High Needs ACOs that started in PY 2022, one exited the model and another transitioned to a Standard ACO in PY 2023. These changes significantly altered the composition of participating organizations and their aligned beneficiary populations, which in turn influenced the outcomes observed for High Needs ACOs in PY 2023. This section examines the distinct characteristics of High Needs ACOs, focusing on differences in patient populations and care delivery approaches relative to Standard and New Entrant ACOs, along with the evolution of the cohort.

**Exhibit 8.1. High Needs ACOs Snapshot—Model Elections, Performance, and Organizational and Beneficiary Characteristics**



**SOURCE:** PY 2023 financial results; model applications and additional documentation; 2023 ACO REACH Pulse Check Survey; NORC analysis of PY 2023 Alignment Data (received from model’s implementation and monitoring contractor); and NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** ACO=Accountable Care Organization; IDS=integrated delivery system; PY=performance year; TCC=total care capitation.

## Beneficiaries in High Needs ACOs

By design, High Needs ACOs serve fewer Medicare beneficiaries than the other two ACO types in model.<sup>74</sup> In PY 2023, the 14 High Needs ACOs served 21,606 beneficiaries, representing 1% of all beneficiaries aligned to ACO REACH. On average, each High Needs ACO had 1,543 aligned beneficiaries, with the largest having 4,179 aligned beneficiaries and the smallest having 619. Because of their small size, the evaluation assessed impacts of High Needs ACOs at the cohort level, unlike Standard and New Entrant ACOs, for which the evaluation assessed impacts at the individual ACO level.

**Population Complexity.** High Needs ACOs also serve only beneficiaries with complex needs, whereas those enrolled in Standard and New Entrant ACOs more closely resemble the traditional Medicare population. All High Needs ACO beneficiaries met at least one of four eligibility criteria in PY 2023<sup>75</sup>:

- 79% of our analytic sample in PY 2023 had a serious chronic condition with a high risk score.
- 4% had a moderate risk score and two or more unplanned hospitalizations in the past year.
- 29% showed signs of frailty.
- 52% had a neurological condition that limits mobility.<sup>76</sup>

By contrast, 18% of Standard (N=335,088) and 21% of New Entrant ACO beneficiaries (N=8,615) in the evaluation's analytic sample met any of these criteria in PY 2023.

High Needs ACO beneficiaries averaged 12.2 **chronic conditions**, compared with 6.2 for Standard ACOs and 6.5 for New Entrant ACOs. They also had higher rates of:

- **Dual eligibility:** 57% (versus 15% in Standard ACOs and 16% in New Entrant ACOs)
- **Disabilities and/or ESRD:** 35% (versus 15% in Standard ACOs and 16% in New Entrant ACOs)
- **Long-term care stays in the past year:** 43% (versus 2% in Standard ACOs and 2% in New Entrant ACOs)
- **Mortality:** 20% (versus 3% in Standard ACOs and 4% in New Entrant ACOs)

In interviews, one High Needs ACO leader noted experiencing 30-35% turnover each year due to mortality alone. Another pointed out that many of their patients are in "*the last two or three years of life*" and estimated that 80% would likely require hospice services.

While High Needs ACOs serve populations with a higher average disease burden than do the other ACO types, beneficiaries enrolled in the 14 High Needs ACOs in PY 2023 varied in terms of characteristics such as:

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<sup>74</sup> REACH ACOs are required to have a minimum number of aligned beneficiaries prior to the start of each PY. For PY 2023, these minimums were 5,000 aligned beneficiaries for Standard ACOs; 2,000 for New Entrant ACOs; and 500 for High Needs ACOs.

<sup>75</sup> Two additional eligibility criteria were added to the model for determining high needs eligibility from PY 2024 onwards (to include beneficiaries that have at least 90 Medicare-covered days of Home Health services utilization or at least 45 Medicare-covered days in a Skilled Nursing Facility within the previous 12 months). Even though these criteria were not used to determine high needs eligibility in PY 2023, they were used in comparison group sampling to improve the comparability between High Needs ACO beneficiaries and their comparison groups.

<sup>76</sup> As described in [Chapter 2](#), our evaluation's analytic sample (N=16,110) excludes Prospective Plus beneficiaries (N=3,522), as well as one High Needs ACO, due to non-convergence of entropy balancing weights (N=350). The percentages in this section reflect the evaluation's analytic sample rather than the total aligned beneficiary population. The list of exclusions made along with number of excluded beneficiaries can be found in [Appendix Exhibit I.7](#).

- **Dual eligibility:** ranging from 22% to 92%
- **Disabilities and/or ESRD:** ranging from 19% to 63%
- **Long-term care stays in the past year:** ranging from 13% to 92%

The heterogeneity in their patient populations influenced both how each of the High Needs ACOs delivered care and their ability to improve outcomes.

**Differences by Cohort.** The 2023 cohort accounted for 54% of all beneficiaries in the High Needs ACO intervention group in PY 2023 and was less medically complex than earlier cohorts on many measures (for example, see rates of chronic kidney disease in **Exhibit 8.2**). Compared with beneficiaries in the 2021 and 2022 cohorts, those in the 2023 cohort also had similar or lower rates of dual eligibility, Part D low-income drug subsidies, long-term care stays, and behavioral health conditions. However, the 2023 cohort had more beneficiaries that met the frailty criterion for high needs eligibility.

**Exhibit 8.2. The 2023 Cohort Included the Largest Number of Beneficiaries, Characterized by Greater Frailty and Lower Medical Complexity**

Metric	PY 2023		
	2021 cohort	2022 cohort	2023 cohort
Number of beneficiaries	5,550	2,000	8,560
<b>Demographics</b>			
Age (mean)	78.3	80.3	78.3
Female (%)	63.1	67.2	62.8
<b>Health care coverage</b>			
Had a disability and/or ESRD (%)	36.1	26.6	35.7
Dual eligibility (%)	67.3	55.8	51.4
Received Part D Low-Income Drug Subsidy during the year (%)	66.9	55.4	52.3
<b>Complex clinical characteristics</b>			
Had long-term care stay in prior year (%)	64.6	14.6	35.1
Behavioral health conditions (%)	80.1	64.1	70.4
Chronic kidney disease (%)	42.5	65.5	41.2
Number of chronic conditions (mean)	12.4	12.2	12.0
<b>ACO REACH high needs eligibility criteria (%)</b>			
Frailty	19.4	28.8	35.2
Mobility	54.5	42.3	51.8
Chronic or serious illness	80.8	84.8	76.5
Moderate CMS-HCC risk score and 2+ admissions	3.9	2.8	4.3
HHA use	16.3	21.3	28.5
SNF use	19.4	9.9	11.5

**SOURCE:** NORC analysis of Medicare enrollment, demographic, clinical, and market data.

**NOTE:** Prospective Plus voluntary aligned beneficiaries were excluded from the evaluation’s analytic sample and are not reflected in the exhibit. ESRD=end-stage renal disease; HCC=Hierarchical Condition Category; HHA=Home Health Agency; SNF=Skilled Nursing Facility; PY=performance year.

**Beneficiary Alignment.** In PY 2023, most High Needs ACO beneficiaries (90%) were aligned via claims (similar to Standard ACOs [92%] but higher than in New Entrant ACOs [42%]). The remaining beneficiaries were aligned voluntarily. Some High Needs ACOs used prospective plus voluntary alignment, which allows ACOs to align beneficiaries throughout the performance year.<sup>77</sup> This may be particularly useful for High Needs ACOs because beneficiaries' health status changes, and they become eligible for the model once they meet the High Needs eligibility criteria. One home-care-focused ACO aligned about three-quarters of its beneficiaries via Prospective Plus. Two ACOs focused on long-term care (a high-cost area requiring robust care coordination) aligned approximately one-third of their beneficiaries this way (33% and 37%, respectively). All other High Needs ACOs aligned fewer than 20% of their beneficiaries via Prospective Plus.

### ***Structure of High Needs ACOs***

Most High Needs ACOs operated as networks of individual practices, but their lead organizations varied. Some were led by provider organizations, while many were managed by MSOs.

- **Provider Organizations.** Five High Needs ACOs were led by provider organizations. Four were physician practices operating as either networks of home-based care and palliative care providers or as medical group practices focusing on home-based care. One ACO was led by a health system.
- **MSOs.** Seven High Needs ACOs were led by MSOs that provided administrative and technical services and infrastructure to support their care models. These services included provider education, embedded care management, data reporting, and connections to health IT and quality improvement vendors, among others. Notably, four ACOs that entered the model in PY 2023 were managed by the same MSO specializing in serious illness care. This MSO implemented an identical care model and portfolio of services across its four ACOs, which together represented a large share of the High Needs ACO beneficiary intervention group—75% of the 2023 cohort and 41% of all High Needs ACO beneficiaries in PY 2023. As a result, these ACOs likely had a large influence on PY 2023 results for High Needs ACOs.
- **Other Lead Organizations.** The remaining two High Needs ACOs were led by an insurer and a primary care company, each with its own integrated care management model.

**Provider Networks.** High Needs ACOs built provider relationships tailored to both their beneficiaries' needs and their organizational structure. As with those in other ACO types (Standard and New Entrant), High Needs ACO Participant Providers were mainly primary care clinicians. However, unlike other ACOs, three-quarters were advanced practice providers, such as nurse practitioners and physician assistants, rather than primary care physicians. Few High Needs ACOs had facilities as Participant Providers, but some established Preferred Provider networks of facilities that included home health agencies, hospices, and SNFs to support care delivery.

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<sup>77</sup> Due to the complexity of creating a comparison group for beneficiaries that are aligned throughout the PY, Prospective Plus beneficiaries are excluded from evaluation analyses on cost, utilization, and quality outcomes. Therefore, the care experiences of the Prospective Plus beneficiaries are not captured in impact estimates presented in this chapter.

## Care Models

High Needs ACOs delivered care across a range of settings, with most emphasizing home-based primary care and a smaller subset operating primarily in nursing facilities. According to Medicare claims data, 76% of High Needs ACO beneficiaries received Qualified Evaluation and Management (QEM) visits in residential and long-term care settings (homes, assisted living facilities, nursing facilities). Standard and New Entrant ACOs, by contrast, primarily delivered care in office settings.

**Given their beneficiaries' complex and specific needs, High Needs ACOs deliver high-touch, interdisciplinary care wherever their patients reside.**

**Service Scope and Intensity.** High Needs ACOs varied in the scope and intensity of services offered. Some provided comprehensive home-based primary care with mobile clinical teams capable of performing labs, imaging, and medication reconciliation in the home. These ACOs typically used multidisciplinary care teams—including physicians, nurse practitioners, social workers, pharmacists, and behavioral health specialists—and offered high-frequency visits (12–18 visits annually), 24/7 hotlines, remote monitoring, and integrated behavioral health and pharmacy services. These care models aim to reduce avoidable hospitalizations through proactive, relationship-based care.

Other ACOs operated with more limited infrastructure or delegated care delivery to independent practices. As a result, care delivery models may have varied across providers within the same ACO. One ACO leader noted that, while some practices have structured interdisciplinary teams, others require additional support to meet quality benchmarks. Among ACOs serving beneficiaries in SNFs, while some used a care model premised on routine in-person visits by facility-based providers, others were still building connections and workflows for care management and coordination, including discharge planning and end-of-life care.

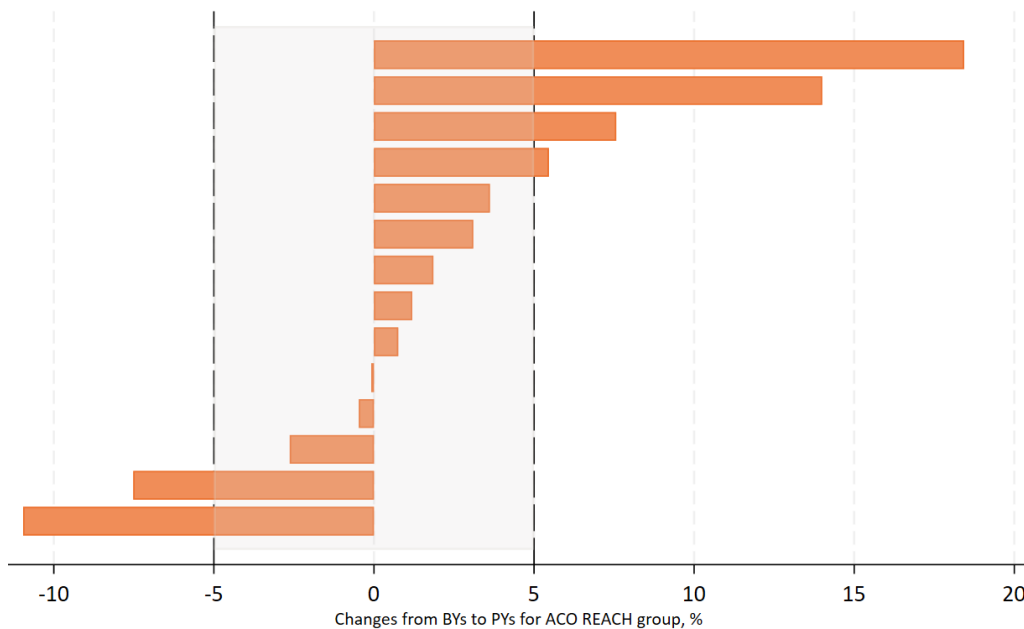
Due to the high burden of advanced illness among aligned beneficiaries, many High Needs ACOs either provided hospice care directly or partnered with hospices. In the Pulse Check Survey, all but one High Needs ACO reported offering care management programs for advanced illnesses requiring palliative, hospice, or end-of-life care.

**Use of Benefit Enhancements.** In PY 2023, High Needs ACOs submitted more claims per 1,000 aligned beneficiaries for PAC (SNF 3-day rule and home health), telehealth, concurrent care for hospice, and nurse practitioner services benefit enhancements than did Standard or New Entrant ACOs, as expected. The highest claim submission rates were for the SNF 3-day rule and home health benefit enhancements, likely related to High Needs ACOs tending to serve beneficiaries in institutional and home health settings and suggesting that these benefit enhancements were particularly valuable for managing complex needs. See **Appendix E.2** for detailed utilization of benefit enhancements by ACO type and organizational structure.

## 8.2 Impacts on Spending, Utilization, and Quality of Care

Given the heterogeneity across High Needs ACOs in their structures, beneficiary populations, and care delivery focus, we first examined changes in unadjusted PBPY gross spending between the baseline period (average spending across each cohort's three baseline years) and the PY 2023 performance period for beneficiaries aligned to High Needs ACOs. We considered a change of 5% or greater between the two periods to be meaningful (regardless of statistical significance). Among the 14 High Needs ACOs, PBPY spending increased meaningfully for four ACOs and decreased for two ACOs.

**Exhibit 8.3. Between the Baseline and Performance Periods, Unadjusted Gross Spending Increased in Four High Needs ACOs, Decreased in Two High Needs ACOs, and Did Not Change Meaningfully in Eight High Needs ACOs**



**SOURCE:** NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** Unadjusted spending changes were calculated as spending in PY 2023 minus the average annual baseline spending. The percentage change was relative to the average baseline year spending. The dashed lines in the figure indicate a 5% increase (right) and a 5% decrease (left). Changes within  $\pm 5\%$  were considered not meaningful.

### ***Impacts on Gross Medicare Spending***

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. We note that these refinements to the comparison group led to updated impact estimates for PY 2022 and PY 2023 relative to what has been previously publicly released.<sup>78</sup>

High Needs ACOs saw gross spending reductions cumulatively through PY 2023, driven by a significant 7.3% decline in PY 2022 (**Exhibit 8.4; Appendix Exhibit L.2**).<sup>79</sup> The observed reduction in gross spending in PY 2023 was not statistically significant. In some versions of regression models that were tested to improve the

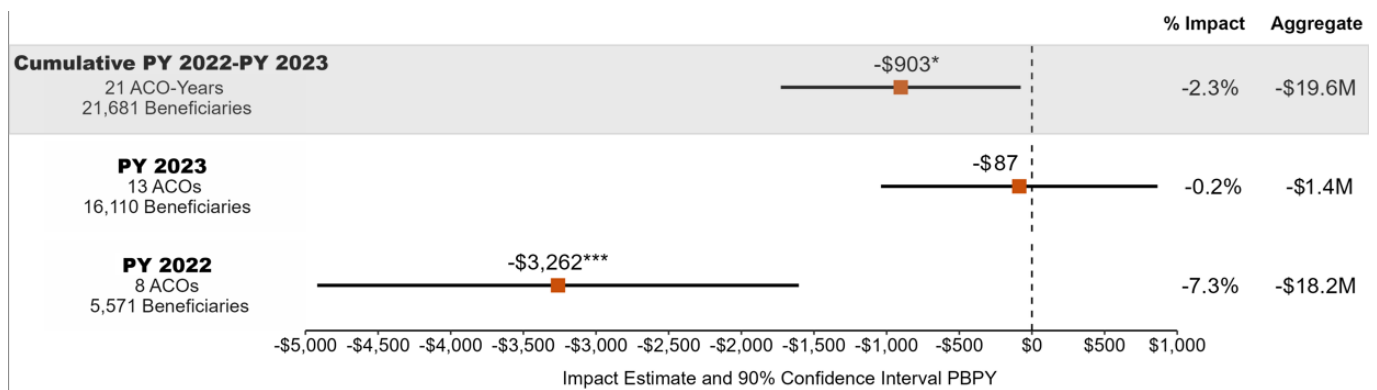
<sup>78</sup> [Evaluation Report 2: Evaluation of the GPDC Model](#) reported a statistically significant gross spending reduction in PY 2022 for High Needs ACOs of \$1,397.76 PBPY (-3.5% or \$8.1 million in aggregate). The [Preview of Findings from the Evaluation of ACO REACH Model for Performance Year 2023](#) refined the comparison group used for assessing PY 2022 and PY 2023 impact estimates relative to methods used in Evaluation Report 2. The Preview 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%) for PY 2023. Cumulatively across PY 2022 and PY 2023, there was a non-significant reduction in total spending by \$103 PBPY (0.3%). Following the publication of the Preview, additional refinements were made to the comparison groups to further improve their comparability to the treatment group. Findings in this report reflect updated impact estimates after incorporating all refinements to the comparison groups.

<sup>79</sup> These results were sensitive to model specifications such as the inclusion of specific baseline variables used to construct the comparison group and control for covariates in regression models (e.g., whether a beneficiary resided in a long-term care facility in the prior 12 months). Additionally, we found parallel trend violations for the PY 2022 cohort in PY 2021 and PY 2022, suggesting that caution should be used in interpreting the cumulative results.

comparison groups, cumulative gross spending estimates were statistically significant with similar effect sizes as are reported later in the text.<sup>80</sup>

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, particularly related to smaller sample sizes, the wide variation in types of beneficiaries with complex medical needs, and the high mortality rate within the aligned population. The refinements to the current comparison groups focused on matching beneficiaries on the 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 groups relative to 11% of those served by model participants in the baseline period).

**Exhibit 8.4. Cumulatively as of PY 2023, High Needs ACOs Significantly Decreased Gross Medicare Spending Relative to the Comparison Groups**



**SOURCE:** NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** Model impact was estimated relative to the comparison groups and baseline years using a difference-in-differences (DID) model. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in PY(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). “Aggregate” was the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year by the evaluation.

\*\*\*p<0.01.

**Impacts on Net Medicare Spending**

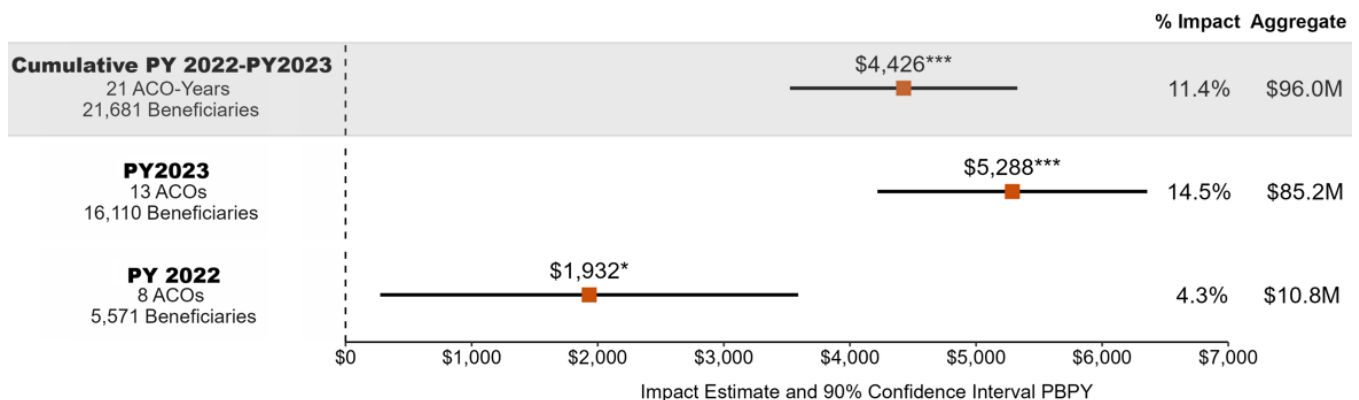
High Needs ACOs received \$89 million in CMS payments in PY 2023, with 88.4 million (99.4%) paid out via shared savings payments and the remaining \$0.5 million (0.6%) paid out as performance bonuses to 4 High Needs ACOs that met the HPP. Because a large proportion of ACO REACH providers (27%) participated in another ACO model before ACO REACH began (the baseline period), it is assumed that these providers would have continued to do

<sup>80</sup> As spending on skin substitutes has increased in recent years, particularly for the High Needs ACOs, we conducted a sensitivity analysis excluding these expenditures from gross Medicare spending. Results were directionally consistent; excluding skin substitute spending resulted in modestly larger estimated spending reductions in PY 2023, with the model-wide estimate changing from -\$87 PBPY to -\$146 PBPY, without altering statistical significance or overall conclusions.

so if the ACO REACH did not exist. Therefore, the comparison groups include a similar proportion of beneficiaries in other ACO models (in both the baseline and performance periods) to approximate what would have happened had the model not occurred. Given that providers in other ACO initiatives, such as the Medicare Shared Savings Program, receive financial incentive payments similar to providers in the ACO REACH Model, we updated evaluation methods for net spending calculations in PY 2023 to account for these payouts by incorporating estimates of the share of those payouts attributable to beneficiaries in the analysis. This allows for an equivalent adjustment of CMS incentive payments across both the intervention and comparison groups in the net spending calculations, which is in line with methods used in the difference-in-difference analyses. These updated methods improve upon prior calculations used to evaluate the GPDC model, which only accounted for financial incentives related to the model. Results for PY 2023 using this prior method are available in the technical appendix to enable comparisons with the methodology used in prior evaluation reports (Appendix L.3).

Impact estimates for net spending after factoring in CMS’ shared savings payouts for ACO REACH and other CMS ACO initiatives are shown in **Exhibit 8.5**. Overall, the High Needs REACH ACOs increased net spending by 11.4% (\$96.0 million or \$4,426 PBPY) cumulatively as of PY 2023. This increase reflects significant net spending increases across all cohorts in PY 2023, with substantially larger model-wide impacts in PY 2023 (14.5% or \$5,288 PBPY) compared to PY 2022 (4.3% or \$1,932 PBPY; **Appendix Exhibit L.5**).

**Exhibit 8.5. After Factoring in Payouts to REACH ACOs and the Comparison Groups, Cumulatively as of PY 2023, Net Medicare Spending Increased for High Needs ACOs, Reflecting Significant Increases in Net Spending in Both PY 2022 and PY 2023**



**SOURCE:** NORC analysis of Medicare claims, enrollment, and ACO REACH Model data.

**NOTE:** Model impact was estimated relative to the comparison groups and baseline years using a DID model. Both payouts to REACH ACOs and to the comparison groups were included. “Impact (%)” was relative to the expected outcome for ACO REACH beneficiaries in PY(s) had the model not existed and had the beneficiaries’ outcomes continued along the same trajectory as that of the comparison group beneficiaries. Impact estimate and 90% confidence interval are shown per beneficiary per year (PBPY). “Aggregate” was the total impact for all aligned beneficiaries. The number of beneficiaries represents the number aligned to the ACO REACH group in the performance year by the evaluation.

\*\*\*p<0.01.

### Impacts on Utilization and Quality of Care

In this section, we present the impacts of High Needs ACOs on utilization and quality of care, focusing on outcomes that showed statistically significant differences relative to the comparison groups. Detailed impact

estimates for utilization measures are provided in **Appendix Exhibits L.6 and L.7** and, for quality measures, in **Appendix Exhibit L.8**.

### Utilization

ED visits and observation stays declined by 5.1% in PY 2023 and by 5.7% cumulatively over PY 2022 and PY 2023 (**Appendix Exhibit L.6**). While IRF and LTCH days declined by 13.4% in PY 2023, there was no significant cumulative impact as of PY 2023. High Needs ACOs did not have an impact on SNF days in PY 2023, but a 13.7% decline in PY 2022 drove a significant cumulative decrease of 6.5% as of PY 2023. Finally, the number of home health episodes declined significantly in PY 2023 by 7.2% and cumulatively by 6.3% (**Appendix Exhibit L.7**).

### Quality

Similar to PY 2022, most quality of care measures for High Needs ACOs showed expected directional improvements, including those tied to financial incentives, but lacked statistical significance in PY 2023 (**Appendix Exhibit L.8**). Two exceptions were:

- A significant increase in timely follow-up after acute chronic condition exacerbation, both in PY 2023 (by 2.6%) and cumulatively (by 3.5%)
- A significant decrease in ACSC hospitalizations in PY 2023 (by 7.1%)

Days at home did not change significantly in PY 2023 but showed a marginal cumulative increase of 0.4% across PY 2022–PY 2023, driven by a larger 1.2% increase in PY 2022. The limited, statistically significant improvement in quality seen for High Needs ACOs may reflect the substantial health needs of their aligned beneficiaries, which would require a longer period of time to achieve meaningful gains, or the small sample sizes that are more sensitive to wider variation in the patient population. Because this measure is tied to financial incentives for High Needs ACOs, we may see stronger effects in future performance years.

## 8.3 Conclusion

Although all High Needs ACOs served complex, high-cost beneficiary populations using intensive wraparound care models focused on proactive care management, each ACO's makeup was unique in terms of its leadership, beneficiaries, and choices concerning provider relationships and implementation. Over the first three years of the model, High Needs ACOs' overall composition and approaches to care delivery evolved, driven by ACOs' entry and exit as well as beneficiary and provider churn within the ACOs.

In PY 2023, beneficiaries from the 2023 cohort comprised 54% of the entire High Needs ACO evaluation analytic sample (compared to 34% and 12% from the 2021 and 2022 cohorts, respectively), making the composition of High Needs ACOs markedly different from PY 2022 and PY 2021. These shifts in ACO composition and model implementation provide important context for interpreting impacts on spending and other measures observed thus far in the evaluation of High Needs ACOs.

Although High Needs ACOs reduced total spending in PY 2023, the comparison groups also reduced spending, resulting in a non-statistically significant reduction in total gross Medicare spending. Cumulatively, High Needs ACOs reduced gross spending relative to comparison groups. High Needs ACOs increased net spending through

PY 2023, prior to model design changes that could reflect smaller incentive payments to participants in future performance years.

High Needs ACOs significantly reduced ED visits and observational stays, as well as the number of home health episodes in PY 2023 and cumulatively. As expected, IRF and LTCH days declined in PY 2023, and SNF days declined cumulatively.

Timely follow-up after exacerbations of chronic conditions increased in PY 2023 and cumulatively, while ACSC hospitalizations decreased in PY 2023, as expected. Although the impact was relatively small, days at home increased cumulatively. Although the estimates did not reach statistical significance, many of the other quality of care measures for High Needs ACOs improved in PY 2023. The modest improvements in quality may reflect the severity of illness among many beneficiaries aligned to High Needs ACOs, as the beneficiaries' substantial health needs could make quality improvements more difficult to achieve or necessitate more time to achieve. Given that these measures are tied to financial incentives, stronger effects may be observed in future performance years.

## Chapter 9: Discussion

Over the course of the ACO REACH Model's implementation (beginning with GPDC in PY 2021), the model has demonstrated both promising advancements and persistent challenges in transforming care delivery and payment structures within Medicare. Across Standard, New Entrant, and High Needs ACOs, the model has tested capitation and risk-sharing for primary care and total cost of care, supported investments in population health management, and expanded care coordination efforts, while also revealing areas requiring further refinement and support. The model's evaluation also highlights the complexities of aligning financial incentives with programmatic goals in an environment characterized by diverse provider capabilities, heterogeneous patient needs, and evolving market dynamics. Insights gained from this evaluation will be valuable in shaping future models of care.

### 9.1 Successes

**Nationwide Expansion and Growing Participation.** By 2023, ACO REACH-aligned beneficiaries were present in every U.S. state, and the model saw a steady transition of New Entrant ACOs to Standard ACOs, reflecting maturation and sustained engagement. The growing participation of safety net facilities, particularly FQHCs, underscored the model's expanding footprint and inclusivity.

**Embrace of Financial Risk and Payment Innovation.** A majority of ACOs opted for the Global (full-risk) option, leveraging their prior experience with risk-based contracts to maximize shared savings. Capitated payments, particularly PCC, became the predominant financial arrangement, aligning with the model's emphasis on primary care. These arrangements allowed for flexibility and customization based on provider experience and preferences and were generally well-received by both ACO leaders and providers.

**Investment in Data Infrastructure and Population Health Capabilities.** ACOs made significant strides in their capacity to stratify risk, manage population health, and share timely data with providers. These capabilities enabled more targeted care management, especially for high-risk patients, and supported efforts to reduce unnecessary utilization. Many ACOs expanded multidisciplinary care teams, improved care transitions, and increased primary care touchpoints—strategies that collectively contributed to improved quality of care.

**Measurable Reductions in Gross Medicare Spending.** In PY 2023, both Standard and New Entrant ACOs achieved statistically significant reductions in gross Medicare spending. Standard ACOs reduced spending by 0.9%, while New Entrant ACOs achieved a more substantial reduction of 6.2%. These reductions were particularly notable among ACOs that elected higher levels of financial risk and capitation, as well as those organized as networks of individual practices. These findings suggest that the model's financial incentives and flexibility in payment mechanisms—particularly the Global risk option and PCC—enabled ACOs to invest in infrastructure and care strategies that yielded lower spending.

**Strategic Shift Toward Coordinated Care Services.** Spending on professional services and specialty care showed patterns across ACO types that were likely beneficial for beneficiaries and Medicare alike. While ACOs decreased utilization and spending across institutional settings including acute and post-acute care, they increased spending on professional services and specialty care. Standard ACOs showed a continued increase in spending on professional services and specialty visits, and New Entrant ACOs achieved reductions in ED visits, while

increasing specialty care. These spending patterns reflect ACOs' focus on complex care coordination and management, including increasing primary care touchpoints for higher risk beneficiaries. High Needs ACOs similarly employed high-touch, wraparound care models focused on proactive care management. Importantly, ACOs maintained or improved quality of care across multiple measures while successfully redirecting resources away from more expensive institutional settings, demonstrating how ACOs are effectively deploying coordinated, preventive care models that benefit both patient outcomes and system efficiency.

**Quality of Care Improvements across All ACO Types.** Standard ACOs saw significant reductions in ACSC hospitalizations and unplanned admissions for patients with MCC, alongside increases in recommended diabetes care, timely follow-up after exacerbations, and days at home. New Entrant ACOs similarly improved on these metrics, with particularly strong gains in reducing ACSC hospitalizations (11.7% in PY 2023). Even though quality improvements may be harder to achieve for High Needs ACOs given the substantial health needs of their beneficiary populations, they still achieved statistically significant gains in an important quality measure—timely follow-up after acute chronic condition exacerbation—which increased by 3.4% in PY 2023. Moreover, most quality measure impacts for High Needs ACOs moved in the expected direction in PY 2023, even though they failed to reach statistical significance.

These improvements reflect ACOs' strategic focus on care coordination, chronic disease management, and primary care engagement in the ACO REACH Model.

## 9.2 Challenges

Coupled with successes, the ACO REACH Model faced several persistent and emerging challenges.

**Operational Challenges with Model Features.** While voluntary alignment was intended to empower beneficiaries and strengthen patient-provider relationships, ACO leaders cited eligibility criteria, attribution delays, and administrative complexity as barriers to its effectiveness. Similarly, benefit enhancements, though potentially valuable, were underutilized from the operational demands they imposed.

**Provider Engagement and Risk-Taking Hesitancy.** While many ACO leaders discussed successes in engaging primary care providers, others encountered challenges, particularly from specialists and providers with limited exposure to value-based care. Some providers were hesitant to assume financial risk or had limited capacity to participate in training and transformation activities. ACOs with small numbers of aligned beneficiaries in provider panels also struggled to gain provider buy-in to accountable care.

**Questions about Long-term Financial Balance.** While ACOs received substantial shared savings and performance bonuses, these payments often exceeded the gross spending reductions achieved. As a result, net Medicare spending increased cumulatively for all ACO types, and in PY 2023, overall net Medicare spending increased by 0.8% across ACO types. For Standard ACOs, financial gains from shared savings had not yet translated into net savings for the Medicare program. With ACOs that incur shared losses expected to exit the model, it remains to be seen whether those that continue will generate net savings to Medicare in the coming years.

**High Needs ACOs' Unique Challenges.** High Needs ACOs face distinct operational challenges in realizing spending reductions due to the acuity and complexity of their patients. Many High Needs ACOs focus primarily on managing symptoms, supporting end-of-life care, and reducing avoidable hospitalizations rather than making longer-term investments in preventive care or population health management. For example, while some

hospitalizations may be preventable, shifting beneficiaries out of SNFs or LTCHs into home-based care is often constrained by the need for advanced clinical support and assistance with activities of daily living.

## 9.3 Lessons Learned

**Flexibility in Payment Models and Care Delivery.** The ACO REACH Model’s design has allowed ACOs to tailor financial arrangements and care strategies to their unique organizational structures, provider networks, and patient populations. This flexibility has been especially important for accommodating ACOs’ and providers’ varying levels of experience with risk-sharing and value-based care. For example, ACOs can choose between Global and Professional risk options, and many have adapted capitation models to suit provider preferences and capabilities. This adaptability has encouraged broader participation, including from safety net providers and smaller practices, and enabled ACOs to innovate in how they structured incentives and care delivery.

**Critical Role of Data Infrastructure and Analytics.** ACOs invested in the data infrastructure and analytic capabilities necessary for population health management. These capabilities enabled ACOs to stratify risk, identify high-need patients, and share timely, actionable data with providers. This, in turn, supported more proactive and coordinated care, especially for patients with complex needs. ACOs used these tools to reduce unnecessary utilization, improve care transitions, and expand care management programs. These experiences suggest that reliable data systems play an important role in enabling effective care delivery.

**Organizational Readiness and Risk Management Capacity.** While many ACOs embraced full-risk arrangements, others faced resistance from providers on assuming financial risk. Our findings suggest that appetite for financial risk depends heavily on organizational readiness and support. ACOs with prior experience in MA or other value-based models were better positioned to manage risk and achieve savings. However, newer or smaller ACOs—especially those entering the model for the first time—faced steeper learning curves. The model also showed that downside risk was rarely passed on to providers, suggesting a cautious approach to internal risk-sharing.

## 9.4 Next Steps for the Evaluation

Looking ahead, our evaluation will continue to examine how the model’s features impact ACOs’ implementation strategies and ultimately the cost and quality of care for ACO-aligned beneficiaries. An important step forward will be to conduct comparative case analyses to further examine how ACOs’ organizational characteristics (for example, structure, lead organization, value-based care experience) may influence quality and utilization outcomes. With about half of the New Entrant ACOs becoming Standard ACOs in PY 2024 (leaving only four New Entrant ACOs to analyze as a group), future evaluation reports will combine results for the New Entrant and Standard ACOs, particularly as alignment thresholds and benchmark factors between these two ACO types begin to converge in the later years of the model. Additionally, as the ACO REACH Model matured, it became clear that results for High Needs ACOs were influenced by cohort composition, small sample sizes, and differences with the comparison groups. These factors underscore the need for alternative methodologies to better account for the distinct beneficiary populations and operating models of High Needs ACOs.