ACO Realizing Equity, Access, and Community Health (REACH) Model
Summary of Quality Performance, Financial Performance, and Model Payments
Updated 09/29/2023

The Centers for Medicare and Medicaid Services (CMS) conducts routine and ongoing monitoring of the quality and financial performance of innovative payment and care delivery reform models. This document will be updated regularly to provide information on the quality and financial performance of the Accountable Care Organizations (ACOs) participating in the ACO REACH Model.

Although the GPDC Model was redesigned and renamed the ACO REACH Model in PY2023, we reference some PY2022 data from the GPDC Model in this report. Participating organizations in PY2022 were referred to as Direct Contracting Entities (DCEs), whereas PY2023 participants are referred to as REACH ACOs. However, for simplicity, to avoid confusion, and because many of these organizations participated in both periods, we will not distinguish between DCEs and ACOs and will instead refer to all participating organizations as REACH ACOs in this document.

Note that the data in this document are for model monitoring purposes and are not evaluation results.

1. Quality Performance

Summary: CMS is sharing performance data on the All-Condition Readmission (ACR), Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC), and Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU) measures for all four quarters of the second Performance Year (PY) of the ACO REACH Model (January through December 2022) and the first quarter of the third PY (January through March 2023). The ACO REACH Model focuses quality measurement on a small set of critically important quality measures, including CAHPS® (beneficiary experience of care surveys)[1], ACR, UAMCC, TFU (Standard and New Entrant REACH ACOs only), and Days at Home (High Needs Population REACH ACOs only)[2]. However, in PY2021 and PY2022, only the ACR and UAMCC measures were treated as pay-for-performance measures. The remaining measures were pay-for-reporting. In PY2023, all the claims-based quality measures are pay-for-performance. Because all claims-based measures have a 12-month performance period, CMS shares performance measure data based on 12-month rolling periods for quarterly reports.

- ACR data should be read as the "percent of initial hospital admissions that resulted in an unplanned readmission." Lower values for unplanned hospital readmissions indicate higher quality. For the PY2023 Q1 reporting period, ending in March of 2023**, the average ACR score across all Standard and New Entrant ACO REACH Model participants (known as REACH ACOs) was 15.24% (i.e., 15.24% of hospital admissions resulted in an unplanned readmission for beneficiaries aligned to a REACH ACO).** For reference, the average ACR score across all non-ACO REACH TINs (including, but not limited to, TINs participating in traditional Medicare, the Medicare Shared Savings Program, and Other Alternative Payment Models) was 15.18%. This difference is not statistically significant **(i.e., ACO REACH Model participants did not score statistically better or worse on the ACR measure)**.

- UAMCC data should be read as the "number of unplanned hospital admissions per 100 person-years among beneficiaries with multiple chronic conditions." Lower values for unplanned hospital admissions indicate higher quality. For the PY2023 Q1 reporting period, ending in March of 2023, **the average UAMCC score across all Standard and New Entrant REACH ACOs was 32.53 (i.e., there were, on average, 32.53 unplanned hospital admissions for every 100 person-years among beneficiaries with multiple chronic conditions aligned to a participant in the ACO REACH Model).** For reference, the average UAMCC score across all non-ACO REACH TINs (including, but not limited to, TINs participating in traditional Medicare, the Medicare Shared Savings Program, and Other Alternative Payment Models) was 34.20. This difference is statistically significant **(i.e., ACO REACH Model participants scored statistically better on the UAMCC measure).**

[1] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] For more information on the ACO REACH Model quality policy, see PY2024 Quality Measurement Methodology paper available on our website

- TFU data should be read as the "percent of acute events related to one of six chronic conditions where follow-up care was received in a non-emergency outpatient setting within the time frame recommended by clinical practice guidelines." Higher follow-up rates indicate higher quality. For the PY2023 Q1 reporting period, ending in March of 2023, **the average TFU score across all Standard and New Entrant REACH ACOs was 68.95% (i.e., the average rate of timely follow-up after an acute exacerbation was 68.95%).** For reference, the average TFU score across all non-REACH ACO TINs (including, but not limited to, TINs participating in traditional Medicare, the Medicare Shared Savings Program, and Other Alternative Payment Models) was 67.72%. This difference is not statistically significant **(i.e., ACO REACH Model participants did not score statistically better or worse on the TFU measure).**

Table 1. ACO REACH Quality Data - June 2022 through March 2023

12-Month Period Ending:	REACH ACO[1] count	ACR[2]		UAMCC[3]		TFU[4]	
		All REACH ACO TINs[5]	All Non-REACH ACO TINs[6]	All REACH ACO TINs[5]	All Non-REACH ACO TINs[6]	All REACH ACO TINs[5]	All Non-REACH ACO TINs[6]
June 2022	91[7]	15.17%	15.13%	**31.32**	32.81	67.34%	67.44%
September 2022	91	15.21%	15.18%	**30.65**	32.54	67.58%	67.58%
December 2022	91	15.28%	15.27%	**31.63**	33.73	68.31%	68.11%
March 2023	118[8]	15.24%	15.18%	**32.53**	34.20	68.95%	67.72%

(1) REACH ACO = Participants in ACO REACH Model, referred to as Realizing Equity, Access, and Community Health Accountable Care Organizations (REACH ACOs)
(2) ACR = All-Condition Readmission; this data should be interpreted as "percent of initial hospital admissions that resulted in an unplanned readmission." Lower values are more favorable.
(3) UAMCC = Unplanned Admissions for Patients with Multiple Chronic Conditions; this data should be interpreted as "number of unplanned hospital admissions per 100 beneficiaries with multiple chronic conditions per year." Lower values are more favorable.
(4) Timely Follow-Up After Acute Exacerbations of Chronic Conditions; this data should be interpreted as "percent of acute events related to one of six chronic conditions where follow-up care was received in a non-emergency outpatient setting within the time frame recommended by clinical practice guidelines." Higher values are more favorable.
(5) Bolded data represents differences that are statistically significant between REACH ACO TINs and non-REACH ACO TINs.
(6) All Non-REACH ACO TINs = All non-REACH ACO TINs participating in traditional Medicare and the Medicare Shared Savings Program with at least 1,000 eligible beneficiaries.
(7) Data excludes 8 High Needs Population REACH ACOs given small sample size and lack of comparability to a general reference population (like all non-REACH ACO TINs).
(8) Data excludes 14 High Needs Population ACOs given small sample size and lack of comparability to a general reference population (like all non-REACH ACO TINs).

This data is based on performance data collected for purpose of quality measurement in the model and does not represent formal evaluation data.

2. Financial Performance

Summary: CMS is releasing summary statistics of ACOs' financial performance. Across the 132 ACOs participating in the ACO REACH Model in PY2023, the total number of aligned beneficiaries through the second quarter of PY2023 is approximately 1,962,000 beneficiaries. The total dollars under risk (i.e., the sum of the Performance Year Benchmark across all 132 PY2023 ACOs), which is a cumulative year-to-date (YTD) figure from January 2023 through June 2023, is consistent with an average per-beneficiary-per-month (PBPM) benchmark of approximately $1,244. Based on the first two quarters of 2023, all 132 ACOs combined for a roughly 7.7% reduction in Medicare spending compared to their combined PY benchmarks in PY2023. Combined with the capitation data (see below), this is analogous to a Medical Loss Ratio (MLR) of 92.1%[3].

[3] MLR generally refers to the percent of health care premiums spent on medical claims. Because the ACO REACH Model exists within traditional Medicare and model participants are not functioning as payers, this terminology is generally not used in the context of ACO-based models like the ACO REACH Model. However, for comparison purposes, MLR may be considered analogous to the reduction in spending compared to the benchmark (7.7% - see Table 2, most recent data for PY2023) combined with the percent of the benchmark comprised of capitation payments (3.2% - see Table 3, most recent data for PY2023) and the percentage of those payments that is not spent on Medicare Covered Services (1 – 92.9% = 7.1% - see Table 3, most recent data for PY2023). For PY2023, MLR could be estimated to be 100% - 7.7% - (3.2% * 7.1%) = 92.1%.

Average reduction in Medicare spending with just two quarters of experience in PY2023 is likely unreliable in predicting final performance for the year. For example, spending is often lower in the first quarter than for the whole performance year due to the Part B deductible, which appears to be the case in the higher-than-ordinary 7.7% reduction in spending observed as of Q2 2023. Additionally, the Retrospective Trend Adjustment has historically been applied beginning in Q1, but a policy choice was made for PY2023 to defer application until Q3; consequently, with the most recent estimate of -2.7% on the Aged & Disabled benchmark not applied, benchmarks and savings will be inflated as reflected in the Q2 2023 snapshot.

It is important to caveat that this data is not final and is subject to change. For the 108 ACOs that elected 100% risk (the 'Global' option) in PY2023, a discount of 3% is applied to PY benchmarks to ensure savings for CMS (discount has been applied in this data); **because of this, the reported reductions in expenditures are in addition to the savings for CMS.**[4]

This data does not represent formal model evaluation data but is collected for purposes of monitoring the Model's financial methodology and performance.

Table 2. ACO REACH Financial Performance Data

Period covered	Data as of	ACO Count	Avg. aligned beneficiaries across all ACOs	Total dollars under risk across all ACOs (cumulative YTD)	Aggregate reduction (increase) in spending compared to benchmark[1]	Standard Deviation[1]
PY2021						
Apr-Dec 2021	May, 2022	53	338,938	$3,514,813,246	1.7%	10.1%
PY2022						
Jan-Dec 2022	March, 2023	99	1,728,087	$23,307,949,564	2.3%	7.2%
PY2023[2]						
Jan-Mar 2023, YTD	April, 2023	132	1,976,339	$7,357,427,432	8.2%[3]	7.2%
Jan-Jun 2023, YTD	July, 2023	132	1,962,438	$14,647,053,523	7.7%[3]	7.6%

(1) Compared to benchmark across all 132 ACOs participating in PY2023
(2) In prior years, the Retrospective Trend Adjustment (RTA) was applied beginning in Q1, whereas for PY2023, application will be deferred until Q3. Through July 2023, the RTA is estimated at -2.7%, implying that benchmarks are slightly inflated relative to observed year-to-date utilization, causing an inflation in the aggregate savings rate until the RTA is applied as compared to previous years.
(3) Q1 and Q2 savings estimates tend to be overstated due to seasonality (e.g. Part B deductible effect), and lack of claims run-out (which has more pronounced effect earlier in the year) may skew results in either direction; for PY2023, deferred application of the Retrospective Trend Adjustment to Q3 also inflates benchmarks (and thus savings).

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

3. Capitation

CMS is publishing available data on capitation in the ACO REACH Model. From January to June of PY2023, 3.2% of total services provided to aligned beneficiaries were impacted by capitation (i.e., 96.8% of all Medicare payments for services to aligned beneficiaries were not impacted by capitation). Capitation in the ACO REACH Model functions differently than capitation in other health care contexts, such as Medicare Advantage (MA). In Medicare Advantage, CMS pays MA plans capitation payments covering the total cost of care, and MA plans assume responsibility for contracting a provider network and adjudicating and paying all claims that those providers bill to the plan. In the ACO REACH Model, capitation payments cover only a portion of total cost of care: Medicare Part A and Part B services rendered by health care providers participating in the Model who agree to participate in capitation. CMS retains responsibility for adjudicating all claims, including those covered by capitation, and for paying approved claims, as appropriate and in accordance with accompanying claims reduction arrangements. Beneficiaries maintain the freedom of choice to see any Medicare-enrolled provider or supplier. Capitation in the ACO REACH Model enables participating health care providers to forgo a portion of their fee-for-service (FFS) claim payments in exchange for receiving compensation from the ACO (e.g., share of savings) with the goal of better aligning financial incentives at the point of care.

There are two capitation options (called 'capitation payment mechanisms') in the ACO REACH Model. Primary Care Capitation (PCC) is a payment mechanism in which participating primary care providers in the ACO REACH Model agree to forgo between 1-100% of FFS claims payments for a specific set of services rendered to aligned beneficiaries by participating health care providers (see Table B.6.3 in the Financial Operating Guide: Overview paper for a list of these services). Total Care Capitation (TCC) is a payment mechanism in which participating health care providers in an ACO agree to forgo 100% of FFS claims payments for services rendered to aligned beneficiaries.

Health care providers who are not participating in the ACO REACH Model do not have their claims payments adjusted in any way under the model, even when providing services to aligned beneficiaries. Further, health care providers who are participating in TCC or PCC do not have their claims payments adjusted in any way under the model when providing services to beneficiaries who are not aligned to their ACO.

Because capitation only affects participating health care providers, it generally impacts a small percentage of Medicare Covered Services provided to aligned beneficiaries. During PY2023, all Participant Providers were required to have some portion of their eligible claims reduced via capitation, while Preferred Providers could choose whether to participate in capitation. Of the 132 ACOs in the model for PY2023, 102 opted for PCC and 30 for TCC. Through the first two quarters of PY2023, capitation impacted, on average, 3.2% of total cost of care (i.e., 96.8% of all Medicare payments for services furnished to aligned beneficiaries were not impacted by capitation). Two policy changes from PY2021 that may change the proportion of payments impacted by capitation are (1) all Participant Providers participating in an ACO were required to participate in capitation in PY2022 and PY2023; and (2) a higher minimum claims reduction amount for PCC was required in PY2022 and PY2023 (1-100% permitted in PY2021 vs. 5-100% in PY2022 and 10-100% in PY2023).

The total amount of these claim reduction amounts due to TCC and PCC has historically hovered near 90% of total payments levels made to ACOs. In other words, the amount of fee-for-service payments withheld has historically been approximately 90% of the capitation dollars paid to ACOs, implying that approximately 90% of capitation dollars paid are spent on Medicare Covered Services while the remaining 10% may be spent on practice infrastructure and care innovation.

This figure – percent of capitation spent on Medicare Covered Services - tends to fluctuate during the Performance Year for a variety of reasons – i.e., change in capitation payment levels (due to alignment attrition, updated Withhold Percentage, and updated PBPM benchmark); seasonality-related considerations (e.g., services at beginning of PY contribute less to benchmark expenditures due to beneficiaries' Part B deductible); and updated incurred and paid expenditure totals with varying levels of claims run-out.

This data is not final and is subject to change. Further, this data is not formal model evaluation data, but data collected for the purposes of monitoring the Model's financial methodology and performance.

Table 3. ACO REACH Capitation Data (PCC and TCC combined)

Period covered	ACO Count	Claims Runout Through Date	Aggregate % of Performance Year Benchmark paid via capitation	Preliminary % of capitation payments spent on Medicare Covered Services[1]
PY2021				
Apr-Dec 2021	36	May, 2022	2.5%	90.8%
PY2022				
Jan-Dec 2022	99	March 31, 2023	2.9%	95.5%
PY2023				
Jan-Mar 2023, YTD	132	August 31, 2023[2]	3.2%[3]	85.9%
Jan-Jun 2023, YTD	132	August 31, 2023[2]	3.2%[3]	92.9%

(1) Reflects the total amount of forgone FFS claim payment due to TCC and PCC as a proportion of total TCC and PCC payments made to ACOs; driven by many factors, such as level of capitation payment, level of claims run-out, and incidence of healthcare services furnished outside construct of Medicare fee schedule; prior quarters' data is updated to incorporate most recent estimates of accurate capitation levels.

(2) Note that an additional two months of run-out (August 31st vs. July 1st) was incorporated in calculation of capitation figures compared to the benchmark savings results calculated in Table 2 above. The inclusion of additional months reduces the forecasting error of capitation payments relative to benchmark savings results.

(3) Q1 and Q2 capitation payments are based on the preliminary benchmark, while Q3 and Q4 capitation payments were based on the Q1 and Q2 benchmark, respectively. It is expected to see a change in the % of performance year benchmark paid via capitation from Q1 and Q2 to Q3 and Q4.