

# ACO Realizing Equity, Access, and Community Health (REACH) Model Summary of Quality Performance, Financial Performance, and Model Payments Updated 06/25/2024

The Centers for Medicare & 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 updated and renamed the ACO REACH Model in performance year (PY) 2023, we reference PY2022 data from the GPDC Model. Participating organizations in PY2022 were referred to as Direct Contracting Entities (DCEs), whereas PY2023 participants are referred to as REACH ACOs. However, 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 six quarters – the last two quarters of PY2022 as well as all four quarters of PY2023. The ACO REACH Model focuses quality measurement on a small set of critically important quality measures, including CAHPS® (beneficiary experience of care surveys),<sup>1</sup> ACR, UAMCC, TFU (Standard and New Entrant REACH ACOs only), and Days at Home (High Needs Population REACH ACOs only).<sup>2</sup> 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 in any quarterly reporting.

- 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 Quarter 4 (Q4) reporting period, ending in December of 2023, the average ACR score across all Standard and New Entrant ACO REACH Model participants (known as REACH ACOs) was 14.97% (i.e., 14.97% 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 14.99%. 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 Q4 reporting period, ending in December of 2023, the average UAMCC score across all Standard and New Entrant REACH ACOs was 31.69 (i.e., there were, on average, 31.69 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

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<sup>1</sup> Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

<sup>2</sup> For more information on the ACO REACH Model quality policy, please see the Quality Measurement Methodology paper available on our website (for PY2024): <https://www.cms.gov/files/document/aco-reach-quality-msr-meth-py24.pdf>.

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).

- 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 Q4 reporting period, ending in December of 2023, the average TFU score across all Standard and New Entrant REACH ACOs was 70.65% (i.e., the average rate of timely follow-up after an acute exacerbation was 70.65%). 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 69.10%. This difference is not statistically significant (i.e., ACO REACH Model participants did not score statistically better on the TFU measure).

**Table 1. ACO REACH Quality Data September 2022 through December 2023**

12-Month Period Ending:	REACH ACO <sup>1</sup> count	ACR <sup>2</sup>		UAMCC <sup>3</sup>		TFU <sup>4</sup>	
		All REACH ACO TINs <sup>5</sup>	All Non-REACH ACO TINs <sup>6</sup>	All REACH ACO TINs <sup>5</sup>	All Non-REACH ACO TINs <sup>6</sup>	All REACH ACO TINs <sup>5</sup>	All Non-REACH ACO TINs <sup>6</sup>
September 2022	917	15.21%	15.18%	<b>30.65</b>	32.54	67.58%	67.58%
December 2022	91	15.28%	15.27%	<b>31.63</b>	33.73	68.31%	68.11%
March 2023	118 <sup>8</sup>	15.24%	15.18%	<b>32.53</b>	34.20	68.95%	67.72%
June 2023	118	15.30%	15.25%	<b>31.77</b>	33.79	69.37%	68.15%
September 2023 <sup>9</sup>	118	15.06%	15.04%	<b>31.03</b>	33.24	69.53%	68.29%
December 2023 <sup>10</sup>	118	14.97%	14.99%	<b>31.69</b>	34.20	70.65%	69.10%

- REACH ACO = Participants in ACO REACH Model, referred to as Realizing Equity, Access, and Community Health Accountable Care Organizations (REACH ACOs)
- 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.
- 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.
- 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.
- Bolded data represents differences that are statistically significant between REACH ACO TINs and non-REACH ACO TINs.
- 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.
- 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).
- 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).
- Starting with the Q3 PY 2023 reporting period, the ACO REACH Model transitioned to a one-month claims runout to improve the timeliness of quarterly quality reporting for participants. The reduced runout has a limited impact on average performance scores across the quality measures for both non-REACH and REACH ACOs.
- Note that the Q4 PY 2023 data is based on a one-month claims runout as well. The final quality measure performance that will be used for PY 2023 final financial settlement will be based on a 3-month run-out.

*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 115 ACOs<sup>3</sup> participating in the ACO REACH Model in PY2024, the total number of aligned beneficiaries through the first quarter of PY2024 is approximately 2,430,000 beneficiaries. The total dollars under risk (i.e., the sum of the Performance Year Benchmark across all 115 PY2024 ACOs), which is a cumulative year-to-date (YTD) figure from January 2024 through March 2024, is consistent with an average per-beneficiary-per-month (PBPM) benchmark of approximately \$1,278. **Based on the first quarter of 2024, all 115 ACOs combined for a roughly 14.8% reduction in Medicare spending compared to their combined PY benchmarks in PY2024.** Combined with the capitation data (see below), this is analogous to a Medical Loss Ratio (MLR) of 84.3%<sup>4</sup>.

Average reduction in Medicare spending with just one quarter of experience in PY2024 is likely unreliable in predicting final performance for the year for several reasons. First, spending is often lower in the first quarter than for the whole performance year due to the Part B deductible. Second, a policy choice was made for PY2024 Q1 to defer application of the Retrospective Trend Adjustment to later in the PY; consequently, with the most recent estimate of -3.7% on the Aged & Disabled benchmark not applied, benchmarks (and more prominently, savings) will be inflated as reflected in the Q1 2024 snapshot. Third, because no claims run-out is included in this report, it is highly likely that expenditures in the quarter are understated, causing an inflation in the snapshot savings estimate. While an estimated incurred-but-not-reported (IBNR) adjustment is applied to claims to account for the lack of claims runout, it is often unreliable early in the performance year. Finally, external events may have slowed claims processing during PY2024 Q1, which temporarily deflates claims-based expenditures.

It is important to caveat that this data is not final and is subject to change. For the 98 ACOs that elected 100% risk (the 'Global' option) in PY2024, 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 against benchmark for CMS.**<sup>5</sup>

*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 <sup>1</sup>	Standard Deviation <sup>1</sup>
<b>PY2021</b>						
Apr-Dec 2021	May, 2022	53	338,938	\$3,514,813,246	1.7%	10.1%
<b>PY2022</b>						
Jan-Dec 2022	March, 2023	99	1,728,087	\$23,307,949,564	2.3%	7.2%
<b>PY2023</b>						
Jan-Mar 2023, YTD	April, 2023	132	1,976,339	\$7,357,427,432	8.2%	7.2%
Jan-Jun 2023 YTD	July, 2023	132	1,962,438	\$14,647,053,523	7.7%	7.6%
Jan-Sep 2023, YTD	October, 2023	132	1,953,942	\$21,152,520,497	5.1%	7.7%

<sup>3</sup> Seven ACOs have terminated from the model since the [ACO REACH PY 2024 Participant List](#) was published in late January

<sup>4</sup> 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 (14.8% - see Table 2, most recent data for PY2024) combined with the percent of the benchmark comprised of capitation payments (3.1% - see Table 3, most recent data for PY2024) and the percentage of those payments that is not spent on Medicare Covered Services (1 - 72.2% = 27.8% - see Table 3, most recent data for PY2024). For PY2024, MLR could be estimated to be 100% - 14.8% - (3.1% \* 27.8%) = 84.3%.

<sup>5</sup> For a full explanation of the benchmark methodology, please see the [Financial Operating Guide: Overview](#) paper available on our website

Jan-Dec 2023, YTD	December, 2023	132	1,947,932	\$28,395,758,492	4.2%	8.0%
Jan-Dec 2023, YTD	March, 2024	132	1,924,155	\$27,896,450,925	4.0%	7.7%
<b>PY2024<sup>2</sup></b>						
Jan-Mar 2024, YTD	March, 2024	115	2,429,577	\$9,316,107,099	14.8% <sup>3</sup>	9.3%

1. Compared to benchmark across all ACOs participating in the performance year.
2. A policy choice was made for PY2023 and onward to defer application of the Retrospective Trend Adjustment to later in the PY; consequently, with the most recent estimate of -3.7% on the Aged & Disabled benchmark not applied, benchmarks (and more prominently, savings) will be inflated as reflected in the Q1 2024 snapshot. In prior years, the Retrospective Trend Adjustment (RTA) was applied beginning in Q1, whereas for PY2023 and PY2024, application has been deferred until Q3
3. Q1 savings estimates tend to be overstated due to seasonality (e.g. Part B deductible effect), lack of claims run-out (which has more pronounced effect earlier in the year), and deferred application of the Retrospective Trend Adjustment; for PY2024, exogenous events impacting claims processing may also have thus far deflated expenditures (and thus inflated savings).

### 3. Capitation

CMS is publishing available data on capitation in the ACO REACH Model. **From January to March of PY2024, 3.1% of total services provided to aligned beneficiaries were impacted by capitation (i.e., 96.9% 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 PY2024, 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 115 ACOs in the model for PY2024, 96 opted for PCC and 19 for TCC. Through the first quarter of PY2024, capitation impacted, on average, 3.1% of total cost of care (i.e., 96.9% 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, PY2023, and PY2024; and (2) a higher minimum claims reduction amount for PCC was required in PY2022, PY2023, and PY2024 (1-100% permitted in PY2021 vs. 5-100% in PY2022, 10-100% in PY2023, and 20-100% in PY2024).

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. We would expect the early PY 2024 estimate below to increase as greater performance year experience is accumulated.

*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 <sup>1</sup>
<b><i>PY2021</i></b>				
Apr-Dec 2021	36	May 31, 2022	2.5%	90.8%
<b><i>PY2022</i></b>				
Jan-Dec 2022	99	March 31, 2023	2.9%	95.5%
<b><i>PY2023</i></b>				
Jan-Mar 2023, YTD	132	March 31, 2024	3.3% <sup>2</sup>	87.5%
Jan-Jun 2023, YTD	132	March 31, 2024	3.3% <sup>2</sup>	92.9%
Jan-Sep 2023, YTD	132	March 31, 2024	3.4% <sup>2</sup>	94.0%
Jan-Dec 2023, YTD	132	March 31, 2024	3.5% <sup>2</sup>	95.0%
<b><i>PY2024</i></b>				
Jan-Mar 2024, YTD	115	April 30, 2024 <sup>3</sup>	3.1% <sup>2</sup>	TBD <sup>4</sup>

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. To include the most up-to-date figures, the PY2023 Capitation Data included in Table 3 includes S1 capitation payments calculated during PY3 Preliminary Settlement which incorporates S1 benchmarks. PY2024 Capitation Data uses the most up-to-date retrospectively updated capitation payments calculated in the PY4Q2 APA reports.
3. Note that an additional month of run-out (April 30 vs March 31) 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.
4. Not included in this report due to 1) system-wide claims processing disruptions in Q1 that understate volume of claims reductions and 2) limited run-out in Q1 that understates incurred claims-based expenditures.