DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

ACO REACH Model

PY 2026 Model Changes Frequently Asked Questions

July 24, 2025

Version: 1.0

Prepared by:
Centers for Medicare & Medicaid Services (CMS)
Center for Medicare & Medicaid Innovation
Seamless Care Models Group
7500 Security Boulevard, N2-13-16
Baltimore, MD 21244-1850

Dear Accountable Care Organizations (ACOs),

The purpose of this guidance document is to clarify questions pertaining to the PY 2026 model changes for the ACO REACH Model. Slides from the webinar hosted on May 29, 2025, may be accessed via the link below.

Link: ACO REACH PY 2026 Model Changes Webinar

Please submit any additional questions regarding the content in this communication to the ACO REACH Model Help Desk at ACOREACH@cms.hhs.gov.

Thank you,

The ACO REACH Model Team

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

Table of Contents

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

Preliminary PY 2023 Preview Evaluation Report

Q1: What is the future of this model, given significant increases in net spending?

A1: After reviewing the preview of PY 2023 evaluation results, CMS made changes to the financial methodology design of the model to ensure savings to the Medicare Trust Fund in the last performance year (PY 2026). These changes aim to balance CMS' statutory obligations while maintaining beneficiary and provider access to the increased flexibilities and incentives under the model that promote preventive care, chronic condition management, and high-quality person-centered care.

Q2: Why is CMS continuing the model if it is not showing savings to Medicare?

A2: CMS decided not to terminate the model and instead to make changes for several reasons. Although PY 2023 evaluation findings continue to show net losses to the Medicare program, there have been statistically significant improvements in quality and an improvement in gross savings, but not enough to offset payments.

Q3: Why are results different for the ACO REACH Model relative to prior results in the GPDC Model?

A3: The PY 2023 Evaluation Report for ACO REACH now includes the new cohort of participants who entered the model in PY 2023 when the model transitioned to ACO REACH. ACO REACH had 48 new ACOs join the model in PY 2023, effectively doubling the model's size. See the ACO REACH Performance Year 2023 Preview Evaluation Report.

Q4: What is the difference between evaluation spending results and model participant financial results, i.e., why do financial gross shared savings amounts not match the evaluation results?

A4: Evaluation spending results and model participant financial results serve distinct purposes and are calculated at different times using different methods. Financial results reflect comparison of expenditures to benchmarks established according to the model methodology. The evaluation results are based on analysis that looks at model participant performance against a counterfactual comparison group. For more details, please refer to this key concept overview.

Q5: Was spending associated with significant, anomalous, and highly suspect billing factored into the evaluation methodology for PY 2023?

A5: Yes, spending-associated HCPCS codes (A4352 and A4353) for intermittent urinary catheter supplies was excluded from PY 2023 expenditures in the PY 2023 evaluation and in calculating shared savings and losses. However, these codes contributed to the calculation of Historical Base Year Expenditures used to construct the financial benchmark for PY 2023 (claims incurred during 2017–2019). For PY 2024–PY 2026, CMS will exclude these codes from contributing to the calculation of the financial benchmark when 2023 is used as a reference year.

Q6: When will the final PY 2023 Annual Evaluation Report become available?

A6: The full PY 2023 Evaluation Report, which will include results from interviews with ACO leaders and providers, survey responses from ACOs, and additional findings related to the model, is expected to be publicly released later in 2025.

Changes to Risk Adjustment Methodology

Q7: What are the risk score constraints used by ACO REACH?

A7: CMS uses risk score constraint mechanisms to control for increases in coding intensity and risk score growth. There are three constraints applied to an ACO's normalized risk score. Specific details of each constraint vary depending on ACO type:

1. An ACO-specific 2022–2026 symmetric risk score growth cap. An ACO's normalized PY risk score is constrained to be no more than a given percent different (in the positive or negative direction) from the ACO's 2022 risk score. The magnitude of the cap varies depending on ACO type.
2. A model-wide Coding Intensity Factor (CIF). The CIF calculates the model-wide risk score growth from 2019 to 2026, after application of the 2022–2026 symmetric cap. Then, a uniform adjustment is applied to all ACOs to set the model-wide 2026 risk score equal to the model-wide 2019 risk score. CMS also includes a ceiling on the application of the CIF to provide benchmark certainty to ACOs. Separate CIFs are calculated for the Standard and New Entrant Aged and Disabled (A&D) population, High Needs AD population, and End-stage Renal Disease (ESRD) population.
3. **New for PY 2026:** An ACO-specific 2019–2026 3% asymmetric cap. After the 2022–2026 Symmetric Cap and CIF are applied, an ACO's PY risk score is constrained to be no more than 3% greater than the ACO's 2019 risk score. The 2019–2026 asymmetric cap does not apply to the High Needs AD population.

Q8: How does the PY 2026 change to the model's risk score growth constraints intersect with the existing risk score growth cap and the Coding Intensity Factor (CIF)? For example, is the additional 3% cap from 2019 additive to the first cap, or is there effectively a hard 3% cap on risk score growth from 2019? If the growth from 2022 to 2026 is lower than the growth from 2019 to 2026, would the constraint still be based on 2019 as a fixed baseline?

A8: For Standard and New Entrant ACO types only, the additional asymmetric 3% ACO-specific cap only occurs if there is excess risk score growth from 2019–2026 after applying both the 2022–2026 symmetric cap and the CIF.

Calendar year	2019 (A)	2022 (B)	Uncapped 2026 Risk Score (C)	Capped Risk Score After 3% 2022-2026 Cap (B to C)	Risk Score After 3% Cap and 1.01 CIF (E)	Percent change from 2019 (A to E)	Maximum allowed growth (G)	Final Risk Score (H)
Example 1	1.00	1.05	1.10	1.0815	1.0708	7.08%	3%	**1.03**
Example 2	1.00	0.95	1.10	0.9785	0.9688	-3.12%	3%	0.9688
Example 3	1.00	1.10	1.05	1.0670	1.0564	5.64%	3%	**1.03**

- **Step 1:** Application of symmetric risk score cap from 2022–2026 (B to C).
- **Step 2**: Application of the CIF from 2019 (capped at 1.01 for Standard and New Entrant ACOs) (E).

- **Step 3**: If ACO risk score growth from 2019–2026 still exceeds 3% after the application of the cap and CIF policy (Step 1 and 2), then risk score growth from 2019 would be capped at 3% (H).

In Example 1 above, the ACO's average risk scores steadily grows between 2019 to 2022 and continues to grow through 2026. In this scenario, after Step 1 and Step 2 (E), the ACO still has an excess of 7.08% (A to E) risk score growth from 2019–2026, so Step 3 will trigger and constrain the risk score to 3% overall growth in the final risk score (H).

In Example 2 above, the ACO's average risk score initially falls from 2019 to 2022 (B to C) and then grows from 2022 to 2026. This ACO's risk score will be constrained to 0.985 (3% growth from 2022) in Step 1 with the application of the 2022–2026 3% symmetric cap. After applying the 2022–2026 3% symmetric cap and CIF, the ACO's new risk score is lower than its risk score in 2019 so Step 3, the second 2019–2016 3% asymmetric cap, will not trigger for this ACO.

In Example 3 above, the ACO observes risk growth from 2019 to 2022 but then observes negative growth from 2022 to 2026. In this scenario, Step 1 will constrain the ACO's negative risk score growth between 2022 to 2026. After Step 1 and Step 2 are applied, the ACO still observes 5.64% risk score growth from 2019 to 2026 so Step 3 will trigger and constrain the overall risk score growth to 3% in the final score (H).

Q9: Are there differences in risk score growth constraints for PY 2026 by organizational type, i.e., for Standard, New Entrant, and High Needs Population ACOs?

A9: Yes, the table below summarizes the risk score adjustment steps that will be applied to each ACO type, and the order in which those steps will be applied. Final guidance regarding the additional 2019–2026 risk score growth cap will be provided in the forthcoming PY 2026 Risk Adjustment specification paper.

Adjustment Steps	Standard/New Entrant ACOs	High Needs Population ACOs	All ACOs
Risk score cap	Symmetric 2022–2026 3% cap applied to claims-aligned and continuously voluntarily aligned population	Symmetric 2022–2026 10% cap applied to claims-aligned and continuously voluntarily aligned population Asymmetric 8% cap for newly voluntarily aligned beneficiaries only, with no minimum beneficiary threshold	ACOs with PY beneficiary population 3x as large as their Reference Year population are no longer exempt from risk score caps
Retrospective CIF	CIF ceiling of 1.01	CIF ceiling of 1.02	Calculated as the model-wide mean of PY 2026 capped risk scores divided by the model-wide mean BY 2019 normalized risk score
Application of additional risk score cap	Asymmetric 2019–2026 +3% cap applied to claims-aligned and continuously voluntarily aligned population	No additional 2019–2026 cap	-

Q10: Is the additional 2019–2026 cap symmetric (has both ceiling and floor) or just a ceiling?

A10: The additional cap is not symmetric; risk score growth exceeding +3% from 2019 to 2026 is capped at 3%. Please see A9 for additional details.

Changes to Benchmarking Methodology

Q11: Why is CMS decreasing the regional component of the benchmark?

A11: In PY 2025, the benchmark blend for Standard ACOs was 55% historical baseline expenditures and 45% regional expenditures. New Entrant and High Needs ACOs currently use a benchmark methodology composed of a 50% Historical and 50% Regional expenditure blend.

Most ACOs have historical expenditures below their regional average. Shifting the blend to reduce the regional component will mitigate model losses. The benchmark blend for all ACOs will be reduced with the following percentage blends:

Historical/Regional Historical Expenditure Blend:

ACO Type	PY 2024	PY 2025	PY 2026
Standard ACOs	55%/45%	55%/45%	**60%/40%**
New Entrant and High Needs ACOs	-	50%/50%	**55%/45%**

Changes to Risk Corridor Methodology

Q12: What is the purpose of risk corridors in the ACO REACH model?

A12: Risk corridors are a risk mitigation measure used by CMS to constrain the aggregate amount of savings earned by REACH ACOs or losses shared by REACH ACOs prior to CMS sharing in savings or losses.

Q13: What change is CMS making to the risk corridors for Global Option ACOs and why?

A13: CMS is narrowing the first risk corridor to be up to 10% (instead of 25%) for ACOs in the Global Risk option (100% risk), so that ACO savings above 10% are shared with CMS. This will create additional savings for the Medicare Trust Fund and mitigate the effect of benchmark inaccuracy. Please refer to the table below, which indicates these changes. The risk corridors applied to an ACO that has selected the Professional Option will remain unchanged for PY 2026; for more information, please refer to the PY 2025 Financial Settlement Guide.

Component	Corridor 1	Corridor 2	Corridor 3	Corridor 4
Percent of Benchmark*	PY 2025: < 25% **PY 2026: < 10%**	PY 2025: 25%–35 **PY 2026: 10%–35%**	35%–50%	More than 50%
Savings/Losses Rate	100%	50%	25%	10%

* For all aligned beneficiaries after the application of the Discount, Quality Withhold and Quality Withhold earn back, and Population Adjustment.

Changes to Quality Methodology

Q14: What is the purpose of the quality withhold, and how does the High Performers Pool bonus work? Why is CMS changing the quality withhold and High Performers Pool bonus?

A14: The quality withhold is a portion of the Performance Year Benchmark that is held at risk and potentially earned back based on an ACO's quality performance. ACOs qualify for a bonus from the High Performers Pool (HPP) if they meet the continuous improvement/sustained exceptional performance (CI/SEP) criteria and demonstrate a high level of performance on preset criteria. The HPP is funded through quality withholds. CMS is changing the quality withhold from 2% to 5% to further incentivize ACOs to engage in improving chronic disease management and reducing unnecessary hospitalizations. The increased withhold will increase the High Performers Pool bonus.

Q15: Is CMS changing the existing Quality Measures that applied to PY 2025 for PY 2026?

A15: No, CMS does not plan to change the claims-based measures that exist in the ACO REACH model for PY 2026. Additional guidance that will be published in the forthcoming PY 2026 Quality Measurement Methodology guidance.