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CMMI's Evolving Strategy: Initial Indications from Recent Actions

On May 13, 2025, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI) introduced a new strategic plan for its models going forward. After ending four payment models early and canceling two not-yet-implemented models in March 2025, the agency had promised to release a new strategy.[1] Nearly two weeks later, CMMI released that strategy, as well as a preliminary evaluation of, and changes to, one of its core payment models. This Health Capital Topics article will review CMMI's recent actions and what initial indications these actions provide.

CMMI was created by the Patient Protection & Affordable Care Act (ACA) to "test new payment and delivery models to lower costs and improve quality in government healthcare programs."[2] CMMI models "are time-limited experiments that provide a controlled environment to determine, through rigorous evaluation, what approaches should be expanded nationwide, what specific components of an approach need further testing in successor models and what approaches are not viable for expansion."[3] CMMI currently operates 23 payment models.[4]

One of these models, the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model, is an "advanced" ACO initiative that "provides novel tools and resources for health care providers [both primary and specialty care] to work together in an ACO to improve the quality of care for people with Traditional Medicare."[5] The model is a revision and replacement of the Global and Professional Direct Contracting (GPDC) model and its subset, Geographic Direct Contracting (Geo Model) model, which launched in 2021.[6] The ACO REACH model advances health equity, increases access, and drives affordable accountable care more comprehensively than the GPDC model,[7] specifically by promoting:

(1) A greater focus on health equity and closing disparities in care;
(2) An emphasis on provider-led organizations and strengthening beneficiary voices to guide the work of model participants;
(3) Stronger beneficiary protections through ensuring robust compliance with model requirements;
(4) Increased screening of model applicants and increased monitoring of model participants;
(5) Greater transparency and data sharing on care quality and financial performance of model participants; and
(6) Stronger protections against inappropriate coding and risk score growth.[8]

The GPDC Model converted to ACO REACH in 2023, and currently has 103 participants across three types:

(1) **Standard ACOs**: Providers that have experience in a Medicare alternative payment model and are already aligned to an ACO voluntarily or though claims-based alignment;

(2) **New Entrant ACOs**: Providers that do not have previous experience in a Medicare alternative payment model or ACO, which typically achieve members through voluntary alignment; and

(3) **High Needs Population ACOs:** Providers that serve Medicare beneficiaries with complex needs and utilize a care model designed for patients with complex needs to coordinate care.[9]

ACO REACH participants may select between two voluntary risk-sharing options:

(1) **Professional**: A 50% risk sharing arrangement and a risk-adjusted monthly capitation payment for primary care services; or

(2) **Global**: A 100% risk- sharing arrangement and either a risk-adjusted monthly capitation payment for primary care services or a risk-adjusted monthly capitation payment for all services (including specialty care).[10]

On May 21, 2025, CMMI released a preliminary evaluation of the ACO REACH model through Performance Year (PY) 2023 (Evaluation Report) and its "impact on Medicare [fee-for-service (FFS)] spending, health services utilization, and quality of care for beneficiaries."[11] In PY 2023, the 132 ACO REACH participants served over 2 million beneficiaries, mostly through Standard ACOs.[12] Earlier reports found that REACH participants generated over $1.64 billion in gross savings; after accounting for shared savings and losses, CMS realized $694.6 million in net savings (a substantial increase from the $371.5 million in net savings achieved in PY 2022), while ACOs retained $948.4 million.[13] Notably, 73% of participating ACOs achieved net savings, with High Needs Population ACOs demonstrating particularly strong performance.[14] The

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evaluation also highlighted improvements in quality measures. The average total quality score across all ACOs was 79.4%, with High Needs Population ACOs achieving an even higher average of 86.73%.[15] These results suggest that the ACO REACH model is effectively promoting patient-centered care, reducing costs, and improving quality within the Medicare FFS population, which is important given that the model is set to expire at the end of 2026 unless CMMI extends the program.

For PY 2026, the last year of ACO REACH, CMS announced six changes "that are expected to improve the model test by adjusting the financial methodology to improve model sustainability based on" the Evaluation Report's findings that although gross savings are increasing, the model is still operating at a "net cost to the government."[16] For example, financial benchmarks and risk-adjustment formulas will be updated. Perhaps most notably, the threshold at which ACOs must share savings/losses with CMS will be reduced from 25% to 10%. This means if an ACO saves (or loses) 10% more than the benchmark, anything above that must be shared with the government.[17] ACOs will also have to achieve higher quality thresholds to receive additional savings (as CMS holds back a portion of savings that can be clawed back by achieving certain quality scores).[18]

These changes are in line with CMMI's recently-released strategic plan to prioritize "shared risk and prospective payments, streamlined quality measurement, artificial intelligence and other technologies…"[19] CMMI "will be guided by three interrelated strategic pillars": "prevention, individual empowerment, and choice and competition."[20] Notably, CMS is abandoning its goal set four years prior to enroll all FFS Medicare beneficiaries in an accountable care arrangement by 2030.[21] Nevertheless, CMMI commits to "mov[ing] forward with value-based payment and care delivery models that show the greatest promise for expansion."[22]

Although CMS has not yet commented on ACO REACH's future, participants are hopeful that the priorities highlighted in CMMI's strategic plan, the savings being generated by the model to date, and the tweaks made to the model for PY 2026 indicate CMS's interest in extending the ACO REACH model beyond its 2026 expiration.[23]

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6 "CMS Redesigns Accountable Care Organization Model to Provide Better Care for People with Traditional Medicare" Centers for Medicare and Medicaid Services, February 24, 2022, https://www.cms.gov/newsroom/press-releases/cms-redesigns-accountable-care-organization-model-provide-better-care-people-traditional-medicare (Accessed 3/4/22).

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8 Centers for Medicare and Medicaid Services, February 24, 2022.

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10 *Ibid.*

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13 Centers for Medicare & Medicaid Services, https://www.cms.gov/priorities/innovation/aco-reach-py2023-financial-and-quality-performance-results-fact-sheet (Accessed 5/27/25).

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