



Medicare Value-Based Programs

A Strategy Guide



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Determining Your Medicare Value-Based Strategy for 2026 and Beyond

The Time to Act is Now

Healthcare leaders must prioritize value-based care transformation now – in early 2025 – to participate in Medicare value-based programs in 2026. The next few months present an opportunity to evaluate participation in two of the most significant CMS value-based programs – the Medicare Shared Savings Program (MSSP) and Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) – both of which offer strategic positioning for financial stability and community health improvement. Delaying optimization of risk-based revenue in Medicare FFS jeopardizes long-term solvency and transformational care delivery. CMS' push to have all Traditional Medicare beneficiaries in accountable care by 2030 underscores the urgency.

Why Value-Based Payment Matters

Value-based models are no longer optional – they are essential for sustainable healthcare. These models align incentives for providers, payers, and patients, driving better outcomes and cost-effectiveness. Hospitals, health systems, and independent practices face untenable financial pressures in the fee-for-service system, with warnings from ratings agencies and industry leaders highlighting the critical need for change. Programs like MSSP and ACO REACH pave the way for preventive care, chronic disease management, and overall patient wellness, mitigating financial risks in an unstable landscape.

Strategic Planning for 2026 Performance Year

Leaders and their boards of directors must start planning now to select the right Medicare value-based program for 2026. Key considerations:

- 1. Program Design:** Assess MSSP and ACO REACH attributes – upside potential, downside risk, benchmarking, and capitation methods.
- 2. Readiness Assessment:** Evaluate network risk-adjusted performance at the NPI level to determine capability for downside risk.

Selecting a program that is too risky could lead to CMS repayment; over-cautious choices may limit savings and erode provider and patient alignment. Leaders must balance risk and reward to prevent losing providers to networks with superior population health capabilities.

Tailored Strategies for Success

Avoid one-size-fits-all contracting. NPI-level analysis and Lumeris' detailed Readiness Assessment enables customized approaches based on organizational priorities and network composition. Whether testing value-based competencies or capitalizing on population health investments, aligning the right model with your goals is essential.

Lumeris offers insights on MSSP vs. ACO REACH program dynamics, participation timelines, and strategic implications. Begin planning today to ensure your network thrives in the 2026 healthcare landscape.

Figure 1: Program Comparison and Key Considerations

Figure 1 provides a comparison between the MSSP and ACO REACH programs in alignment with key program dynamics to consider for your organization.

Program Comparison and Key Considerations

KEY: **M:** MSSP | **R:** REACH (Global Track) | ● Yes | ◐ Maybe / Sometimes True | ○ No

	MSSP	ACO REACH	KEY CONSIDERATIONS
First Dollar Earning Opportunity	◐	●	M 40-75% of first dollar shared savings once minimum shared savings rate (MSR) and quality performance threshold is met or exceeded. MSR varies depending on MSSP track selected.
			R 100% of first dollar savings following a CMS discount of 4% in 2026 No MSR
No Cap on Earnings / Losses	○	◐	M Shared savings cap (Basic Tracks: 10% of benchmark; Enhanced Track: 20% of benchmark). Shared losses cap (Basic Tracks: 0% - 4% of benchmark; Enhanced Track: 15% of benchmark).
			R Losses subject to risk corridors (CMS assumes a greater share of losses at greater amounts) with no specific cap. Additional option to purchase stop-loss from CMS.
Advanced Alternative Payment Model Eligible	◐	●	M Qualifies as an Advanced Alternative Payment Model (AAPM) in Track E or Enhanced Track only
			R Qualifies as AAPM
MA-like Benefit Enhancements and Engagement Incentives	◐	●	M SNF, Telehealth, Beneficiary Incentive Program
			R NP, SNF, Home Health, Telehealth, Hospice, Post-Discharge, Cost-Sharing Support, CDM Reward Program
Downstream Payment Flexibility	◐	●	M New and renewing ACOs may be eligible to receive advanced shared savings.
			R Primary Care Capitation with option to elect Total Care Capitation.
TIN / NPI-Level Segmentation	○	●	M Participation is at the TIN level and does not allow NPI segmentation
			R Providers contracted at TIN / NPI level and can be added or removed annually
Program Continuity	◐	●	M Statutory program with no defined end date
			R Innovation center model through 2026 (may be extended)

Program Updates to Consider in Payment Model Selection for PY 2026

The Medicare Shared Savings Program (MSSP)

What's New: CMS released the final Medicare Physician Fee Schedule (MPFS) for Calendar Year 2025 on November 1, 2024 which includes updated guidance for MSSP.

Over the past few years, CMS has adjusted MSSP rules to encourage the retention and expansion of ACOs and providers in the program. For example, CMS has implemented flexibility for ACOs to remain in upside-only tracks longer, made benchmarking methodology updates, improved financial incentives for new and existing ACOs and tweaked quality reporting requirements to give ACOs more time to prepare for all patient, all payor reporting.

Under the most recent MPFS for 2025, ACOs will continue to see new additions and incremental changes to existing program requirements (see below). Some requirements around Certified Electronic Health Record (CEHRT) usage and Promoting Interoperability reporting as an example, still need to be addressed to support continued growth and interest in the MSSP program.

Notable Changes to MSSP in 2025 and Subsequent Years:

- **Prepaid Shared Savings:** Beginning in 2026, renewing ACOs with a history of shared savings may elect to receive advanced payment (quarterly) of shared savings to accelerate adoption of value-based care practices and staffing.
- **Benchmark Methodology:** A positive health equity benchmark adjustment has been added to provide greater financial incentives for ACOs to serve a greater proportions of underserved beneficiaries.
- **Significant, Anomalous, and Highly Suspect (SAHS) Billing Activity:** Certain codes exhibiting significant, anomalous, and highly suspect billing activity found in ACO expenditures will be excluded from impacting shared savings.
- **Quality Reporting:**
 - ACOs must report the new APM Performance Pathway Plus (APP Plus Pathway) measure set for 2025 and new additional quality metrics in subsequent years.
 - CMS officially sunset the popular Web Interface quality reporting option starting in 2025.
 - Going forward, ACOs and their providers must collect and submit data for measures under the APP Plus Pathway via all-payor Electronic clinical quality measures (eCQMs)/MIPS CQMs or CQMs for Medicare FFS patients across all ACO practices.
- **Other:**
 - Modifies required beneficiary notification requirements to clarify the timing and population.
 - Creates new billable codes for Advanced Primary Care Management (APCM) services.
 - Adds new codes to the definition of primary care services used in ACO beneficiary assignment.
 - The fee-for-service payment for physicians was reduced in the Final 2025 MPFS Rule, with a conversion factor decrease of 2.83%, further jeopardizing the financial sustainability for healthcare organizations not diversifying their Medicare revenue stream with Shared Savings from ACO participation.

KEY INSIGHT

For organizations newer to value-based care that are getting their feet wet in managing total cost, MSSP remains a strong option as it has guardrails and policies in place to protect participating organizations and provides ample opportunity to achieve shared savings. However, organizations should regularly evaluate the performance of their network at the TIN and NPI level to determine whether providers are demonstrating the readiness to graduate to higher levels of risk with greater incentives. It is noteworthy that ACOs in two-sided risk models are more likely to achieve savings and have a higher average savings rate than their peers in upside only.²

ACO Realizing Equity, Access, and Community Health (ACO REACH)

The ACO REACH model incentivizes community-based physicians and health systems to provide comprehensive care coordination, accountable primary care and health and wellness services to Medicare beneficiaries with additional focus on improving health equity by bringing the benefits of accountable care to Medicare beneficiaries in underserved communities. It uses many of the same operating levers as Medicare Advantage such as beneficiary engagement incentives, benefit enhancements, and pass through of benefits to preferred providers. With full primary care capitation, claims payment on primary care claims is reduced by CMS and replaced with capitation payment from the ACO.

Participants in the ACO REACH Model receive 100% of shared savings and assume 100% financial risk for the population under management .

What's New: ACO REACH is Medicare's fastest growing program with a 24% increase in participating ACOs from 2022 to 2024. The model is currently scheduled to continue through calendar year 2026 and CMS is exploring extension of the program along with a full risk track in MSSP.

In 2024, there were 122 participating ACOs, providing care to ~2.6 million aligned beneficiaries (as compared to 53 participating ACOs providing care to ~350k aligned beneficiaries in the first year of the program (2021)). This increase in aligned beneficiaries represents a 7X growth from 2021-2024.³

Participating ACOs in the REACH program generated \$1.6 billion in savings for the Medicare program in 2023.⁴

² <https://www.lumeris.com/risk-for-reward-two-sided-risk-is-crucial-to-win-in-value/>

³ <https://www.cms.gov/files/document/aco-reach-py2024-participants.pdf>

⁴ <https://www.cms.gov/priorities/innovation/aco-reach-py2023-financial-and-quality-performance-results-fact-sheet#:~:text=In%20PY%202023%2C%20REACH%20ACOs%20generated%20approximate%20%241.643%20billion%20in,%25%20compared%20to%20model%20benchmarks>

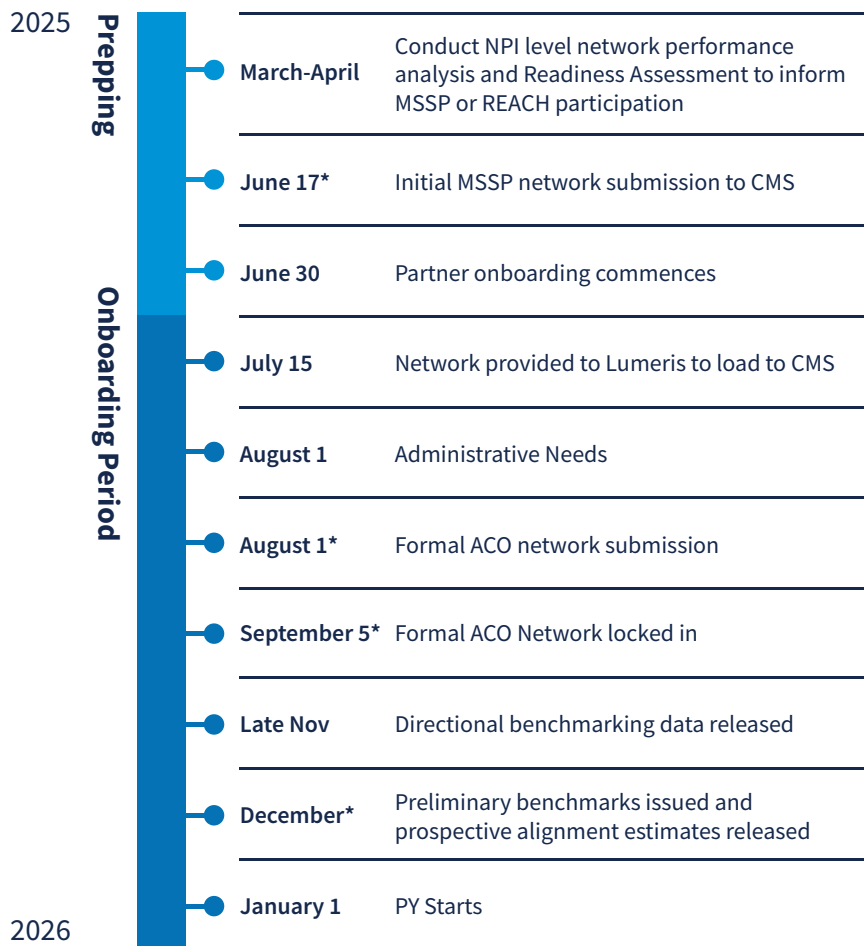
KEY INSIGHT

ACO REACH is a strong option for provider organizations that have experience in value-based care and have the capabilities to meet the advanced requirements of the ACO REACH model. With the ability to include providers at the NPI level, ACO REACH can expose high performing providers within networks to the highest level of savings while mitigating downside exposure. Of the available Medicare Programs, ACO REACH is most similar to Medicare Advantage in its ability to generate improved outcomes, significant savings and meaningful incentives for providers while incorporating options for benefit enhancements typically only found in MA that more closely align consumers to providers organizations.

Projected Medicare Program Timeline for 2026

Participation *Awaiting the release of official dates for PY26 at the time of publishing*

Medicare ACOs (REACH and MSSP)



PROGRAMMATIC NEEDS

March - April

- NPI Market Analysis
- Readiness Assessment

August 1

- Provider Participation Agreements in place and executed
- Providers confirm withdrawal from competing programs

August 1*

- The final provider list - no adds after this date

September 5*

- Last chance to drop providers from network

**CMS identified that date windows are subject to change.*

THE KEY TAKEAWAY

The time to take action in formulating your value-based care strategy for 2026 and beyond is now.

Healthcare leaders must carefully evaluate the respective benefits and risks associated with participating or not-participating in MSSP or ACO REACH as the industry continues to evolve towards more mature levels of delegated risk sharing. Within large networks of providers, it is equally important to tailor participation as it is unlikely that a one-size-fits-all approach to these value-based programs will be successful in maximizing revenue opportunity and premium capture while minimizing downside exposure.

What's next for your network in 2026?

To discuss how these programs will impact your network and discover Lumeris' approach to managing risk, contact: info@lumeris.com

ABOUT THE AUTHORS



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Joe Satorius serves as Senior Vice President, ACO Programs and Value-Based Offerings. In this capacity, he oversees comprehensive performance and operational functions related to population health initiatives, provider partnerships, and CMS value-based programs (ACO REACH and MSSP). Mr. Satorius brings deep expertise in alternative payment models which reward health care providers for delivering high-quality and cost-efficient care and is a sought after speaker and authority on CMMI programs.

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ABOUT LUMERIS

Lumeris has pioneered value-based care transformation, bringing technology driven capabilities to deliver a system of care every doctor wants for their family. As a trusted partner, Lumeris collaborates with top-tier health systems and physician practices nationwide, sharing risk and operational responsibilities to implement the most effective value-based models tailored to each population. Empowering physicians with innovative solutions infused with its AI-powered technology stack, its provider partners achieve superior quality metrics, an enhanced patient experience and much greater physician satisfaction, while significantly reducing total cost of care across Medicare Advantage, Traditional Medicare, Medicaid, and Commercial populations.

Managing over \$13 billion in medical spend across 12 markets, Lumeris maintains the industry's highest quality standards. Lumeris' owned and operated Medicare Advantage plan, Essence Healthcare, has maintained a 4.5-star or better rating from CMS for more than ten years and 5-star rating for the last three years, ranking it in the top 1-2 percent of all MAPD plans. To learn more about Lumeris and its technology and value-based care enablement solutions, please visit [Lumeris.com](https://lumeris.com).