

119TH CONGRESS
2^D SESSION

H. R. 8129

To amend title XVIII of the Social Security Act to establish a full risk
ACO program.

IN THE HOUSE OF REPRESENTATIVES

MARCH 26, 2026

Ms. TENNEY (for herself and Mr. SCHNEIDER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to establish
a full risk ACO program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. FULL RISK ACO PROGRAM.**

4 Title XVIII of the Social Security Act (42 U.S.C.
5 1395 et seq.) is amended by adding at the end the fol-
6 lowing new section:

7 “FULL RISK ACCOUNTABLE CARE ORGANIZATION

8 PROGRAM

9 “SEC. 1899B.

1 “(a) FINDINGS.—Congress finds as follows:

2 “(1) Successful pilots over the last decade have
3 demonstrated that full risk accountable care organi-
4 zations (ACOs), including full risk ACOs that focus
5 on a complex care population are successful at im-
6 proving health outcomes while lowering costs in tra-
7 ditional Medicare.

8 “(2) Traditional Medicare lacks a permanent
9 program that allows providers flexibility to engage in
10 full risk models outside of time-limited pilot projects.

11 “(3) A wide range of organizations serving a
12 range of traditional Medicare beneficiaries, including
13 rural and underserved areas, would benefit from per-
14 manent options for full risk accountable care.

15 “(4) Full risk models can transform care by al-
16 lowing more flexible and diverse payment options be-
17 yond fee-for-service reimbursement, impact cash
18 flow, and tailor experiences for clinicians and bene-
19 ficiaries.

20 “(5) ACO options must encourage better care
21 coordination for complex care beneficiaries, those
22 with six or more chronic conditions.

23 “(b) ESTABLISHMENT.—By June 30, 2026, the Sec-
24 retary shall establish a full risk ACO program (in this sec-
25 tion referred to as the ‘program’) that adopts proven pro-

1 vider incentives to deliver high-quality care to better meet
2 the needs of Traditional Medicare beneficiaries (as defined
3 in subsection (1)). Under such program—

4 “(1) groups of health care professionals shall
5 work together to manage and coordinate care for
6 Medicare fee-for-service beneficiaries through a
7 ‘standard’ or ‘complex care’ full risk ACO.

8 “(2) providers and suppliers participating in
9 this program shall be paid in a manner that
10 incentivizes furnishing items and services in such
11 practice to provide high-quality care tailored to meet
12 the needs of Medicare fee-for-service beneficiaries
13 while reducing the cost of care.

14 “(c) FULL RISK ACO PROGRAM WITH STANDARD
15 AND COMPLEX CARE TRACK OPTIONS.—

16 “(1) IN GENERAL.—An ACO participating in
17 this program is a group of providers and suppliers
18 focused on individualizing care to meet the specific
19 needs of Traditional Medicare beneficiaries by em-
20 phasizing advanced primary care, care coordination,
21 and the delivery of care in alternate settings for
22 beneficiaries needing medical and nonmedical assist-
23 ance in managing their health.

24 “(2) REQUIREMENTS.—In order to participate
25 in the program under this program, an ACO:

1 “(A) Must be formed by the following ACO
2 participants or combinations of ACO partici-
3 pants, consistent with the Medicare Shared
4 Savings Program:

5 “(i) ACO professionals in group prac-
6 tice arrangements.

7 “(ii) Networks of individual practices
8 of ACO professionals.

9 “(iii) Partnerships or joint venture ar-
10 rangements between hospitals and ACO
11 professionals.

12 “(iv) Hospitals employing ACO pro-
13 fessionals.

14 “(v) CAHs that bill under Method II
15 (as described in section 413.70(b)(3) of
16 this chapter).

17 “(vi) RHCs.

18 “(vii) FQHCs.

19 “(viii) Teaching hospitals that have
20 elected under section 415.160 of this sub-
21 chapter to receive payment on a reasonable
22 cost basis for the direct medical and sur-
23 gical services of their physicians.

24 “(B) Shall be structured to allow the orga-
25 nization to receive and distribute payments for

1 services and performance incentives to partici-
2 pant and preferred providers and suppliers.

3 “(C) Shall include a sufficient number and
4 type of providers for the Medicare fee-for-serv-
5 ice beneficiaries aligned or assigned to the
6 ACO, as determined by the Secretary.

7 “(D) Shall serve a required minimum
8 number of aligned and/or attributed bene-
9 ficiaries.

10 “(i) A Standard Full Risk ACO shall
11 have at least 2,500 aligned and/or assigned
12 beneficiaries.

13 “(ii) A complex care full risk ACO
14 shall have at least 250 aligned and/or as-
15 signed beneficiaries in the first year; at
16 least 500 aligned or assigned beneficiaries
17 in the second year; and at least 1,000
18 aligned and/or assigned beneficiaries in the
19 third year and in every participation year
20 after that.

21 “(E) May establish ‘preferred provider’ re-
22 lationships, and may pay such providers a por-
23 tion or all of the provider’s fee-for-service
24 claims in lieu of fee-for-service reimbursement
25 from CMS.

1 “(F) Shall have a financial guarantee
2 mechanism in place commensurate with the fi-
3 nancial arrangement selected in this program.

4 “(G) Shall enter into an agreement with
5 the Secretary to participate in the program for
6 a five-year period. The agreement may be re-
7 newed for additional performance periods.

8 “(H) Shall permit participation in the pro-
9 gram at the TIN-NPI level.

10 “(3) CLINICAL SERVICES.—An ACO partici-
11 pating in this program shall provide individualized
12 care to meet the specific needs of Medicare fee-for-
13 service beneficiaries attributed or aligned to the
14 ACO. This may include the following:

15 “(A) Coordinated care across the care con-
16 tinuum, including transitions.

17 “(B) Social support services.

18 “(C) Behavioral health services.

19 “(D) Nonvisit-based care (including email,
20 text, phone, video, or other technology).

21 “(E) Extended care access options and
22 technology platforms enabling patient stratifica-
23 tion, outcomes tracking, and practice-based
24 population management.

25 “(F) In-home care.

1 “(G) Palliative care.

2 “(H) Other items and services as deter-
3 mined appropriate by the Secretary.

4 “(4) QUALITY AND REPORTING REQUIRE-
5 MENTS.—The Secretary shall develop quality per-
6 formance standards for full risk ACOs.

7 “(A) STANDARD FULL RISK ACOS.—The
8 Secretary shall deploy a limited set of quality
9 measures that prioritize patient experience and
10 health outcomes while reducing clinician bur-
11 den.

12 “(B) ADDITIONAL REQUIREMENT FOR
13 QUALITY PERFORMANCE FOR COMPLEX CARE
14 FULL RISK ACOS.—The Secretary shall deploy
15 the quality measures in (c)(4)(A) and include a
16 Days at Home measure.

17 “(C) OVERLAP WITH MEDICARE ACCESS
18 AND CHIP REAUTHORIZATION ACT.—All full
19 risk ACO program participants shall be exempt
20 from the Merit-Based Incentive Payment Sys-
21 tem (MIPS).

22 “(5) BENEFICIARY COMMUNICATIONS.—The
23 Secretary shall promulgate requirements for ACO
24 marketing to Medicare fee-for-service beneficiaries

1 that educates and informs beneficiaries about their
2 care options.

3 “(d) PAYMENT ARRANGEMENTS FOR ACOs, PARTIC-
4 IPANT AND PREFERRED PROVIDERS.—

5 “(1) IN GENERAL.—A full risk ACO is eligible
6 to receive the following payments under the program
7 under this section:

8 “(A) PRIMARY CARE CAPITATION.—A per-
9 beneficiary, per-month capitated payment for
10 primary care services provided by Participant
11 Providers and preferred providers who have
12 opted into the capitated arrangement with the
13 full risk ACO reflective of the predicted Medi-
14 care Part B costs representing professional
15 services for which the ACO is directly respon-
16 sible. In a given year, such payment may be up
17 to 7 percent of the total health care spending
18 for the beneficiary under this title for the year.
19 The program shall include a repayment mecha-
20 nism for the primary care capitation to ensure
21 that this does not result in additional Medicare
22 spending.

23 “(B) TOTAL CARE CAPITATION.—A per-
24 beneficiary, per-month capitated payment for
25 all Medicare Part A and Part B services pro-

1 vided to aligned beneficiaries by all Participant
2 Providers and by preferred providers who have
3 opted into the capitated arrangement. The TCC
4 payment amount will reflect the estimated total
5 cost of care for the full risk ACO’s aligned pop-
6 ulation for services provided by the providers
7 participating in the capitation mechanism. Pro-
8 viders that elect to participate in Total Care
9 Capitation will agree to a 100 percent reduction
10 of their fee-for-service claims.

11 “(C) OPTION FOR CLAIMS REDUCTION AND
12 POPULATION-BASED PAYMENT.—Full Risk
13 ACOs can enter into arrangements whereby
14 CMS would reduce claims payments for aligned
15 beneficiaries for Participant and Preferred Pro-
16 viders and CMS would make a monthly pay-
17 ment to the ACO equivalent to the estimated
18 value of the FFS claims reductions for those
19 services.

20 “(2) FINANCIAL ARRANGEMENTS.—

21 “(A) IN GENERAL.—This program shall
22 offer full financial risk for participant ACOs.

23 “(B) FINANCIAL ARRANGEMENTS.—The
24 Secretary shall make multiple financial arrange-
25 ments available to ACOs, reflecting varying ex-

1 perience with and ability to assume risk for
2 Medicare fee-for-service beneficiaries. The Sec-
3 retary shall make one or more financial ar-
4 rangements available to ACOs under both of
5 the following solutions:

6 “(i) FULL RISK ARRANGEMENT.—
7 ACOs participating in full risk arrange-
8 ments shall share in 100 percent of savings
9 and losses, subject to a discount and risk
10 corridors.

11 “(ii) DISCOUNT.—The Secretary shall
12 determine and apply a discount to the full
13 risk ACO’s benchmark.

14 “(C) BENCHMARK FOR STANDARD FULL
15 RISK ACOS.—The benchmark for Standard Full
16 Risk ACOs shall be developed by—

17 “(i) calculating the ACOs historical
18 baseline spending for its aligned bene-
19 ficiary population;

20 “(ii) trending the historical baseline
21 expenditures forward based on an adjusted
22 version of the U.S. Per Capita Cost growth
23 trend;

24 “(iii) blending the historical baseline
25 expenditures with regional expenditures

1 using an adjusted Medicare Advantage
2 rate book;

3 “(iv) risk adjust the blended expendi-
4 tures; and

5 “(v) apply the discount.

6 “(D) BENCHMARK FOR COMPLEX CARE
7 FULL RISK ACOS.—The benchmarking method-
8 ology for Complex Care Full Risk ACOs shall
9 be developed separately, taking into account the
10 appropriate weighting of the regional compo-
11 nent (at least half) and remove the ceiling on
12 the regional blend.

13 “(E) RISK CORRIDORS.—The Secretary
14 shall develop risk corridors appropriate to this
15 program.

16 “(e) RISK ADJUSTMENT.—

17 “(1) PROSPECTIVE RISK ADJUSTMENT.—Sub-
18 ject to paragraph (2), the Secretary shall use pro-
19 spective risk adjustment for a standard full risk
20 ACO. Risk adjustment methodologies should be
21 identical to Medicare Advantage to the extent prac-
22 tical.

23 “(2) CONCURRENT RISK ADJUSTMENT FOR
24 COMPLEX CARE FULL RISK ACO.—The Secretary

1 shall use concurrent risk adjustment to adjust the
2 benchmark for a complex care full risk ACO.

3 “(f) BENEFICIARY ASSIGNMENT.—

4 “(1) IN GENERAL.—Full Risk ACO program
5 participants shall use the Medicare Shared Savings
6 Program alignment and assignment methodologies,
7 including a choice of prospective assignment or pro-
8 spective assignment with retrospective reconciliation.

9 “(2) SIGNED VOLUNTARY ALIGNMENT.—In ad-
10 dition to the methodology in subsection (f)(1),
11 Standard and Complex Care Full Risk ACOs shall
12 be permitted to use signed voluntary alignment.
13 Such alignment shall take effect on a monthly basis.

14 “(3) OPT-OUT.—Medicare beneficiaries shall
15 have the ability to opt out of participating in the full
16 risk ACO program.

17 “(g) WAIVERS.—The Secretary may waive such pro-
18 visions of this title and title XI as the Secretary deter-
19 mines necessary in order to implement the demonstration
20 program.

21 “(h) DATA.—The Secretary shall provide to program
22 participants under this section regular reports with up-
23 to-date provider claims data and payment information
24 with respect to Medicare fee-for-service beneficiaries at-

1 tributed or aligned in the ACO and shall provide other
2 data to ACOs as necessary.

3 “(i) TREATMENT UNDER THE MEDICARE ACCESS
4 AND CHIP REAUTHORIZATION ACT.—An ACO partici-
5 pating in this program shall be considered an ‘advanced
6 alternative payment model’.

7 “(j) DEFINITIONS.—In this section:

8 “(1) CONCURRENT RISK ADJUSTMENT.—The
9 term ‘concurrent risk adjustment’ means a risk ad-
10 justment model that uses current year diagnoses, de-
11 mographics, and other factors to predict cost in that
12 same year.

13 “(2) MEDICARE FEE-FOR-SERVICE BENE-
14 FICIARY.—The term ‘Medicare fee-for-service bene-
15 ficiary’ means an individual who is enrolled in the
16 original Medicare fee-for-service program under
17 parts A and B and is not enrolled in a Medicare Ad-
18 vantage plan under part C, an eligible organization
19 under section 1876, or a PACE program under sec-
20 tion 1894.

21 “(3) PHYSICIAN.—The term ‘physician’ means
22 a physician as defined in section 1861(r)(1).

23 “(4) STANDARD FULL RISK ACO.—The term
24 ‘standard full risk ACO’ means an ACO composed
25 of Medicare fee-for-service beneficiaries, less than

1 two-thirds of which have six or more chronic co-
2 morbidities.

3 “(5) COMPLEX CARE FULL RISK ACO.—The
4 term ‘complex care full risk ACO’ means an ACO
5 composed of Medicare fee-for-services beneficiaries,
6 at least two-thirds of which have six or more chronic
7 co-morbidities.”.

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