ACO Comparison: LEAD, ACO REACH, and Medicare Shared Savings Program

The **Long-term Enhanced Accountable Care Organization (ACO) Design (LEAD) Model** is a 10-year voluntary ACO Model that builds on learnings from other CMS ACO models and programs, including ACO REACH and the Medicare Shared Savings Program. This resource serves as a comparison tool to help ACOs understand differences between these models and programs.

Parameters	LEAD	ACO REACH	Medicare Shared Savings Program[1]
Model and Program Overview			
Program Type	Time-limited CMS Innovation Center Model	Same as the LEAD Model	Permanent CMS Program
Performance Period	10 Years	6 Years	5-Year agreement periods, not time-limited
ACO Eligibility	ACOs can be formed by a broad range of Medicare-enrolled providers and suppliers, including primary care and specialty physicians, nurse practitioners, physician assistants, clinics and group practices, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).		
Provider Participant Categories	Participant TINs: Take direct accountability for cost and quality, drive beneficiary alignment. Cannot participate in more than one LEAD ACO. • Whole-Tax Identification Number (TIN) approach: All National Provider Identifiers (NPIs) billing under a Participant TIN are included as Participant Providers. NPIs that bill under an ACO Participant TIN may also bill under other TINs that do or do not participate with other ACOs. Preferred Providers: Take indirect financial accountability and do not drive beneficiary alignment or quality performance. • Not all clinicians billing under a Participant TIN must participate; LEAD ACO can choose who to include (a TIN-NPI approach).	Participant Providers: Same as the LEAD Model, except: • Not all NPIs billing under a Participant TIN must participate; the ACO can choose which clinicians to include (a TIN-NPI approach). Preferred Providers: Same as the LEAD Model.	ACO Participants and ACO Providers/Suppliers (only one participant category): • Same whole-TIN approach as the LEAD Model.
Retention Policy	CMS applies a 2% "Retention Incentive" to the ACO's Performance Year (PY) benchmark for PY1. ACOs must remain in the model for PY2 to earn back the 2% incentive in their PY1 final settlement.	Same as the LEAD Model.	N/A

[1]Shared Savings Program policies are applicable by Agreement Period. Policies as described may not apply to all ACOs, dependent upon Agreement Period start date.

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<table>
<tr><th>Parameters</th><th>LEAD</th><th>ACO REACH</th><th>Medicare Shared Savings Program</th></tr>
<tr><th colspan="4">Beneficiary Alignment</th></tr>
<tr><td>Beneficiary Alignment Minimums</td><td>Generally, 5,000 beneficiaries each performance year and 3,000 claims-aligned beneficiaries in at least one base year. ACOs with a high proportion of High Needs beneficiaries and Newly Entering ACOs have different alignment minimums:
<table><tr><th>PY</th><th>High Needs Eligible</th><th>New Entrant</th></tr><tr><td>2026</td><td>800</td><td>1,000</td></tr><tr><td>2027</td><td>1,000</td><td>2,000</td></tr><tr><td>2028</td><td>1,200</td><td>3,000</td></tr><tr><td>2029</td><td>1,400</td><td>4,000</td></tr><tr><td>2030-2036</td><td>1,600</td><td>5,000</td></tr></table>
The minimum number of claims-based aligned beneficiaries in base years (BYs) for ACOs serving a high proportion of High Needs beneficiaries will grow over the model performance period as follows: 500 (PY1), 625 (PY2), 750 (PY3), 825 (PY4), and 1,000 (PY5-10). For Newly Entering ACOs, the minimum number of claims-based aligned beneficiaries in the BYs will be: 600 (PY1), 1,200 (PY2), 1,800 (PY3), 2,400 (PY4), and 3,000 (PY5-10).</td><td>The table below shows the beneficiary alignment minimum for each performance year based on ACO type.
<table><tr><th>PY</th><th>Standard</th><th>High Needs Eligible</th><th>New Entrant</th></tr><tr><td>2021-2022</td><td>5,000</td><td>250</td><td>1,000</td></tr><tr><td>2023</td><td>5,000</td><td>500</td><td>2,000</td></tr><tr><td>2024</td><td>5,000</td><td>750</td><td>3,000</td></tr><tr><td>2025</td><td>5,000</td><td>1,200</td><td>5,000</td></tr><tr><td>2026</td><td>5,000</td><td>1,400</td><td>5,000</td></tr></table></td><td>ACOs must have at least 5,000 assigned beneficiaries. Please refer to 42 CFR 425.110 for additional information related to beneficiary assignment minimum requirements.</td></tr>
</table>

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Alignment Timing	Participants choose between: • Prospective: Claims-based and voluntary alignment must occur prior to the start of each PY based on a 12-month lookback window. No alignment updates during the PY aside from beneficiary exclusions due to loss of eligibility. • Hybrid: Beneficiary list updated monthly for voluntary alignment. Claims-based alignment is based on 12-month lookback window and updated yearly (prior to PY) and one additional time during the performance year for newly added TINs. Beneficiaries can only be added during the second alignment run, not removed.	Participants choose between: • Prospective: Same as the LEAD Model. • Prospective Plus: Beneficiary list updated quarterly for voluntary alignment and yearly (prior to PY) for claims-based alignment (i.e., no mid-year update).	Participants choose between: • Prospective assignment: Medicare fee-for-service beneficiaries that meet eligibility requirements are assigned to the ACO at the beginning of each benchmark or performance year based on the beneficiary's use of primary care services in the most recent 12 or 24 months, as applicable, in addition to eligible Medicare fee-for-service beneficiaries designating voluntary alignment to the ACO through September 30 of the preceding calendar year, and such beneficiaries remain assigned to the ACO at the end of the benchmark or performance year unless a beneficiary meets exclusion criteria. • Preliminary prospective assignment with retrospective reconciliation: Medicare fee-for-service beneficiaries that meet eligibility criteria are preliminarily assigned at the beginning of the performance year based on the most recent data available, and such assignment is updated quarterly based on the most recent 12 or 24 months of data, as applicable, in addition to eligible Medicare fee-for-service beneficiaries designating voluntary alignment to the ACO by September 30 of the preceding year. Final assignment is based on the relevant 12-month assignment window and the preceding 12 months, and also includes eligible Medicare fee-for service beneficiaries voluntary aligned to the ACO.

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<table>
<tr><th>Parameters</th><th>LEAD</th><th>ACO REACH</th><th>Medicare Shared Savings Program</th></tr>
<tr><th colspan="4">Financial Methodology</th></tr>
<tr>
<td>Risk Sharing Options</td>
<td>
• Global Risk Option: ACOs receive up to 100% of savings and are responsible for up to 100% of losses.
• Professional Risk Option: ACOs receive up to 50% of total savings and are responsible for up to 50% total losses.

Advanced Alternative Payment Models (APM) Qualifying: Both Global and Professional Risk Options.
</td>
<td>Same as the LEAD Model.</td>
<td>
ENHANCED Track: ACOs receive up to 75% of savings and are responsible for up to 75% of losses.
Advanced APM Qualifying: ENHANCED track and BASIC Track Level E.
<table>
<tr><th>Level</th><th>A & B</th><th>C</th><th>D</th><th>E</th><th>ENHANCED</th></tr>
<tr><td>Savings Share (max)</td><td>Up to 40%</td><td>Up to 50%</td><td>Up to 50%</td><td>Up to 50%</td><td>Up to 75%</td></tr>
<tr><td>Loss share (max)</td><td>-</td><td>30%</td><td>30%</td><td>30%</td><td>Up to 75%</td></tr>
<tr><td>Savings cap</td><td>10% of benchmark</td><td>10% of benchmark</td><td>10% of benchmark</td><td>10% of benchmark</td><td>20% of benchmark</td></tr>
<tr><td>Loss cap</td><td>-</td><td>2% of revenue /1% of benchmark</td><td>4% of revenue /2% of benchmark</td><td>8% of revenue / 4% of benchmark</td><td>15% of benchmark</td></tr>
<tr><td>Notes</td><td>One-sided (no losses)</td><td>Two-sided risk</td><td>Two-sided risk</td><td>Advanced APM-qualifying</td><td>Advanced APM-qualifying</td></tr>
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Capitation Approach	ACOs must select either: • Primary Care Capitation (PCC): Predictable, upfront monthly payments for primary care services delivered by eligible primary care specialist Participant Providers, as well as eligible Preferred Providers who elect to participate. ACOs that select PCC can also select the Advanced Payment Option and Non-Primary Care Capitation for non-primary care services. • Total Care Capitation (TCC): Capitated payments for all Medicare Parts A and B services delivered by Participant Providers, as well as Preferred Providers that elect to participate, including both primary and specialty care (only available to ACOs in Global). Administrative Add-On Payment: LEAD automatically provides eligible ACOs, with higher-than-average regional spending, with additional upfront capitation payments equal to 1.5% of the benchmark; ACOs are not required to re-pay this add-on payment, and it is not counted in total cost of care reconciliation.	Same as the LEAD model, except does not have a Non-Primary Care Capitation or Administrative Add-On Payment.	A subset of Shared Savings Program ACOs participate in the ACO Primary Care (PC) Flex Model. The ACO PC Flex Model's Prospective Primary Care Payment (PPCP) is a prospective, capitated payment for primary care services with rates based on average county spending and downside risk, plus. A portion of the payment (~25%) has no downside risk and is intended to support enhanced care management and other primary care services which overlap with covered services under the Physician Fee Schedule. Some Shared Savings Program ACOs receive advanced payments, but these payments are not considered capitated payments. Prepaid Shared Savings (PSS) option, which is an option for eligible ACOs to receive advance payments of earned shared savings that the ACO is expected to generate during a performance year and is paid in quarterly installments. Advance Investment Payments (AIP) option, which is an option for eligible ACOs to receive a one-time payment at the beginning quarter of an ACO's first performance year of the agreement period, and quarterly payments, based on risk factors-based scoring of the ACO's assigned beneficiary population, for each quarter for the first two performance years of the agreement period.

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Base Benchmark Calculation	Based on an ACO's historical expenditures in the three years immediately before the start of its LEAD performance period (the "base years"). Newly Entering ACOs: The three base years are weighted 10%, 30%, and 60%, with the greatest weight on the most recent year. Renewing ACOs: The three base years are each weighted 33%.	Standard ACOs: Based on an ACO's historical expenditures in a fixed 3-year period (2017, 2018, and 2019), weighted 10%, 30%, 60%. High Need ACOs: For PY 2021-2024, based on average regional expenditures in the ACO's service area. For 2025-2026, based on a blend of average regional expenditures and the ACO's historical expenditures in base years 2021, 2022, and 2023. New Entrant ACOs: For 2021-2024, based on average regional expenditures in the ACO's service area. For 2025-2026, based on a blend of average regional expenditures and the ACO's historical expenditures in base years 2021, 2022, and 2023.	For an ACO's first agreement period, each year of the benchmark is weighted according to the following percentage (BY1: 10%, BY2: 30%, BY3: 60%). For an ACO's second and subsequent agreement periods, each year of the benchmark is equally weighted (33% per year). The benchmark calculation in the Medicare Shared Savings Program is similar to the benchmark calculation for LEAD.
Regional Benchmark Adjustment	Positive adjustment to the benchmarks for ACOs with baseline spending lower than the regional average. No negative adjustment for ACOs with baseline spending higher than the regional average.	Regional adjustment can be positive if ACO's baseline spending is lower than the regional average or negative if ACO's baseline spending is higher than the regional average.	Positive adjustment to the benchmarks for ACOs with baseline spending lower than the regional average (unless the ACO is eligible for either a prior savings adjustment or a population adjustment and either the prior savings adjustment or the population adjustment is higher than the regional adjustment amount). No negative adjustment for ACOs with baseline spending higher than the regional average.

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Other Benchmark Adjustments	Prior Savings Adjustment: Positive adjustment to benchmarks for ACOs that have successfully achieved savings in ACO REACH or the Medicare Shared Savings Program. Calculated as 50% of average savings in the three years immediately preceding the start of the ACO's LEAD model performance period.	Population Adjustment: An adjustment to the historical benchmark to account for ACOs serving higher proportions of beneficiaries enrolled in the Medicare Part D low-income subsidy or dually eligible for Medicare and Medicaid.	Prior Savings Adjustment: Positive adjustment to an ACO's benchmark based on savings generated during Shared Savings Program participation in the 3 years prior to the ACO's current agreement period. The adjustment is calculated as the lesser of 50% of pro-rated average per capita savings or 5% of national per capita expenditures for Parts A and B services under the Original Medicare Fee-for-Service (FFS) program in BY3 for assignable beneficiaries. Population Adjustment: An adjustment to the historical benchmark to account for ACOs serving higher proportions of beneficiaries enrolled in the Medicare Part D low-income subsidy or dually eligible for Medicare and Medicaid.
Discount	For Renewing ACOs (ACO REACH or the Medicare Shared Savings Program): Fixed at 3% from the start of the model. For Newly Entering ACOs: Starts at 1.75% and grows 0.25% for 5 years, until it equals 3% in 2031. Remains at 3% thereafter. The discount is only applied to ACOs in the Global Risk Option.	3.5% discount rates for PY2025–PY2026. The discount is only applied to ACOs in the Global Risk Option.	The Shared Savings Program does not apply a "discount" to the benchmark.
Trend Factor	Uses a three-way blend of national/regional growth rates and an Accountable Care Prospective Trend (ACPT) with guardrails, calculated separately by enrollment type (e.g., aged and disabled, End-Stage Renal Disease (ESRD), High Needs).	Based on prospective US Per Capita Cost (USPCC) trend established before the start of the performance year, with Retrospective Trend Adjustment to constrain how much USPCC can diverge from actual observed national trend during the performance year.	Uses a three-way blend of national/regional growth rates and an Accountable Care Prospective Trend, calculated separately by enrollment type (e.g., ESRD, disabled, aged/dual eligible, aged/non-dual eligible) to update the benchmark.

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<tr><th>Parameters</th><th>LEAD</th><th>ACO REACH</th><th>Medicare Shared Savings Program</th></tr>
<tr><td>Risk Adjustment</td><td>Uses two risk adjustment approaches:
For beneficiaries who do not meet High Needs criteria: Prospective CMS-Hierarchical Conditions Categories (HCC) model, which uses prior year diagnoses to predict costs in the current PY.
For High Needs beneficiaries: Concurrent CMMI HCC model, which uses diagnoses from the current PY to predict costs.
Both models will be modified for use in LEAD – the prospective CMS-HCC model will be re-calibrated based solely on non-High Needs beneficiaries, and the concurrent CMMI HCC model will be re-calibrated based solely on High Needs beneficiaries.</td><td>Uses two risk adjustment approaches:
For Standard and New Entrant ACOs: Prospective CMS HCC model.
For High Needs Eligible ACOs: Concurrent CMMI HCC model.</td><td>Uses prospective CMS-HCC risk scores and (as applicable) demographic risk scores to perform risk adjustment.</td></tr>
<tr><td>Risk Mitigation
Risk corridors are risk mitigation mechanisms. The aggregate amount of savings or losses that ACOs are eligible to receive as Shared Savings are constrained corridors.</td><td>LEAD includes risk corridors that constrain the amount of savings/losses that ACOs share in beyond certain percent-of-benchmark thresholds:
Global Risk Option Corridors:<table><tr><th>Corridor</th><th>1</th><th>2</th><th>3</th><th>4</th></tr><tr><td>Benchmark</td><td>≤15%</td><td>15-35%</td><td>35-50%</td><td>>50%</td></tr><tr><td>ACO savings</td><td>100%</td><td>50%</td><td>25%</td><td>10%</td></tr></table>Professional Option Corridors:<table><tr><th>Corridor</th><th>1</th><th>2</th><th>3</th><th>4</th></tr><tr><td>Benchmark</td><td>≤10%</td><td>10-15%</td><td>15-20%</td><td>>20%</td></tr><tr><td>ACO savings</td><td>50%</td><td>35%</td><td>15%</td><td>5%</td></tr></table>LEAD also includes optional stop-loss insurance that caps ACO’s liability for high-cost outlier beneficiaries. ACOs that elect stop-loss insurance will have a per-beneficiary-per-month (PBPM) stop-loss charge deducted from their benchmark.</td><td>Risk corridors in both the Global and Professional Risk Options are tighter than those in LEAD (i.e. CMS's share of risk increases at a lower percent of benchmark threshold).

Stop loss insurance: Same as LEAD model.</td><td>Truncates annualized beneficiary-level expenditures at a threshold equal to the negative of the national unweighted 99th percentile of annualized expenditures for assignable beneficiaries. The phasing in of risk, both through the glide path and caps on shared losses, described in the risk sharing options above is also a risk mitigation measure.</td></tr>
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Specialist Integration			
Specialist Integration	Under the CMS Administered Risk Arrangements (CARA) initiative, CMS removes barriers to downstream contracting between ACOs and specialists providing ACOs with data on specialist performance and the infrastructure to integrate episode-based payment models. Allows ACO arrangements with specialists. Certain specialists are included in the alignment algorithm.	Allows Preferred Provider arrangements with specialists. Includes certain specialists in the alignment algorithm.	Includes certain specialists in the assignment algorithm.
Special Populations			
High Needs Support	High Needs beneficiaries will be treated as a distinct beneficiary category across all ACOs, with separately calculated benchmarks, trend factors, and risk adjustment. The concurrent CMMI HCC risk adjustment model will be used for all High Needs beneficiaries (see *Risk Adjustment*). Allows providers serving a high share of High Needs beneficiaries to have lower beneficiary alignment minimums.	High Needs track that allows participating ACOs to maintain lower alignment minimums and provides concurrent risk adjustment for aligned beneficiaries, but limits alignment to High Needs beneficiaries only.	Does not have High-Needs-specific policies at the ACO or beneficiary level.
Quality Approach			
Performance Based Payment	ACOs can earn back a quality withhold equal to 3% of their annual benchmark, based on their performance on the LEAD quality measure set.	In 2026, ACOs can earn back a quality withhold equal to 5% of their annual benchmark, based on their performance on the ACO REACH quality measure set.	The quality performance standard is the minimum quality performance ACOs must achieve to be eligible to share in savings at the maximum rate available for the ACO's track. Meeting the quality performance standard also allows an ACO participating in the ENHANCED track to avoid maximum shared losses (if applicable). ACOs that do not meet the quality performance standard can meet the alternative quality performance standard to be eligible to share in savings at a lower rate that is scaled based on the ACO's quality performance.

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Quality Measures	Will use all five existing quality measures used in ACO REACH, and will phase in two new electronic clinical quality measures (eCQMs): • Diabetes care – Glycemic Status Assessment greater than 9% (digital measure) • Controlling High Blood pressure (digital measure) The timeline for the phasing-in of these eCQMs is detailed in the "Quality Reporting Requirements" section below.	The quality measures used are: • All-cause unplanned admissions for older adults with multiple chronic conditions (claims-based) • Risk-standardized all-condition readmission rates (claims-based) • Days at home for patients with complex, chronic conditions (claims-based) • Timely follow-up after acute events for certain chronic conditions (claims-based) • Patient experience (Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey)	The quality measures used in 2026 are: • Diabetes: Glycemic Status Assessment Greater Than 9% (eCQM/MIPS CQM/Medicare CQM) • Controlling High Blood Pressure (eCQM/MIPS CQM/Medicare CQM) • CAHPS for MIPS Survey (Patient experience) • Preventive Care and Screening: Screening for Depression and Follow-up Plan (eCQM/MIPS CQM/Medicare CQM) • Breast Cancer Screening (eCQM/MIPS CQM/Medicare CQM) • Colorectal Cancer Screening (eCQM/MIPS CQM/Medicare CQM) • Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (claims-based) • Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for Merit-based Incentive Payment System (MIPS) Eligible Clinician Groups (claims-based)

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Quality Reporting Requirements	Measures carried over from ACO REACH will be pay-for-performance from the start of the model. For new eCQM measures: optional in PY 1–2, pay-for-reporting in PY 3–4, then pay-for-performance in PY 5–10 to give ACOs time to build reporting readiness. Reporting will focus on LEAD-aligned Medicare beneficiaries. ACOs can earn 2.5 percentage points to their Initial Quality Score per measure reporting these measures in PY 1–2. They must then report them as pay-for-reporting in PY 3–4 and shift to pay-for-performance in PY 5–10.	From 2024 onward, pay-for-performance for all measures.	Report on all quality measures in the APM Performance Pathway (APP) Plus quality measure set for the applicable year, including administering the CAHPS for MIPS survey. CMS calculates the 2 claims-based measures. These measures are used to determine whether the ACO meets the quality performance standard or the alternative quality performance standard used to determine shared savings.
Continuous Improvement (CI) and Sustained Exceptional Performance (SEP)	ACOs that meet or exceed predefined Continuous Improvement/Sustained Exceptional Performance (CI/SEP) criteria could earn back all or a portion of their quality withhold based on their quality performance scores. For ACOs that do not meet the CI/SEP criteria, a graduated scoring approach will be applied, allowing them to earn back a portion of their quality withhold based on their quality performance.	From 2026 Onward, ACOs that do not meet the CI/SEP criteria will have their Initial Quality Score automatically reduced 20%.	N/A
High Performers Pool (HPP)	Top-performing ACOs that meet HPP criteria may earn an additional bonus through the HPP, allowing ACOs to exceed their 3% Performance Year Benchmark withhold. An HPP will further incentivize high performance and continuous improvement. ACOs will qualify for an HPP bonus if they: • Meet criteria to receive CI/SEP score of at least 1, or • Receive both a CI/SEP score of 0 and the full Partially Qualifying Participant (PQP) adjustment and have an average percentile rank of 70% or more across the measures.	Top-performing ACOs that meet HPP criteria may earn an additional bonus through the HPP, allowing ACOs to exceed their 5% Performance Year Benchmark withhold.	N/A

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Flexibilities for Patients			
Benefit Enhancements	Benefit Enhancements include those from ACO REACH, as well as the following: • Medical Nutrition Therapy Expansion (2027) • Part D Premium Buydown (2029)	Benefit Enhancements include those from Shared Savings Program as well as the following: • Post-Discharge Home Visits • Care Management Home Visits • Home Health Homebound Waiver • Concurrent Care for Beneficiaries that Elect the Medicare Hospice • Nurse Practitioner (NP) and Physician Assistant (PA) Services	• Telehealth Expansion (applicable only for ACOs under two-sided tracks who have elected the prospective assignment methodology). • Skilled Nursing Facility (SNF) 3-Day Rule Waiver.
Beneficiary Engagement Incentive (BEI)	• In-Kind Items and Services • Part B Cost Sharing Support BEI • Substance Access BEI • Chronic Disease Prevention BEI	• In-Kind Items and Services • Part B Cost Sharing Support BEI • Substance Access BEI • Chronic Disease Management Reward	• In-Kind Items and Services • ACOs can establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive qualifying primary care services.