Long-term Enhanced Accountable Care Organization (ACO) Design (LEAD)

Alignment and Financial Methodology Office Hour

May 5, 2026

Housekeeping and Logistics

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Welcome and Introductions

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Alignment Methodology

Beneficiary Alignment

LEAD introduces a new option for faster beneficiary alignment and gives participating ACOs greater transparency. LEAD ACOs can choose one of two alignment approaches (prospective or hybrid) and will receive beneficiary alignment in two ways:

Methods for Beneficiary Alignment

- **Claims-Based Alignment:** Beneficiaries align to ACOs based on their claims history and utilization patterns.
- **Voluntary Alignment:** Beneficiaries voluntarily align to an ACO by choosing a provider affiliated with that ACO as their primary provider, practice, or other source of care.

Alignment Frequency and Update Approach

Prior to the Start of the PY

- **Prospective (Claims-Based and Voluntary)**: Alignment occurs once a year, prior to the start of the PY.
  - No updates allowed during the PY, drops may occur due to beneficiary loss of eligibility.
  - Lookback period is from October 1-September 30 prior to the PY.
- **Hybrid (Claims-Based)**: First of two alignment runs occurs prior to the PY.
  - Lookback period is from October 1 – September 30 prior to the PY.

Start of the PY

During the PY

- **Hybrid Claims-Based**: Second of two alignment runs occurs mid-PY to align beneficiaries ***effective April 1***.
  - Lookback period is from January 1 – December 31 prior to the PY.
  - Second alignment run will include beneficiary additions from newly added TINs only. Drops will only occur due to loss of eligibility.
- **Hybrid Voluntary**: Alignment occurs monthly.
  - Updates may include additions throughout the PY.

Claims-Based Alignment

Claims-based alignment is one of two ways that ACOs will receive beneficiary alignment. It is performed prospectively based on a one-year look-back period of qualifying claims.

Claims-Based Alignment Details

PQEM Services: Beneficiaries are assigned to an ACO when their Participant TIN delivered the plurality[1] of Primary Care Qualified Evaluation and Management (PQEM) services.[2] PQEM services include (but are not limited to):

- Evaluation and Management visits
- Chronic Care Management codes
- Annual Wellness Visits

Full list of PQEM services is available in Appendix C of the LEAD RFA.

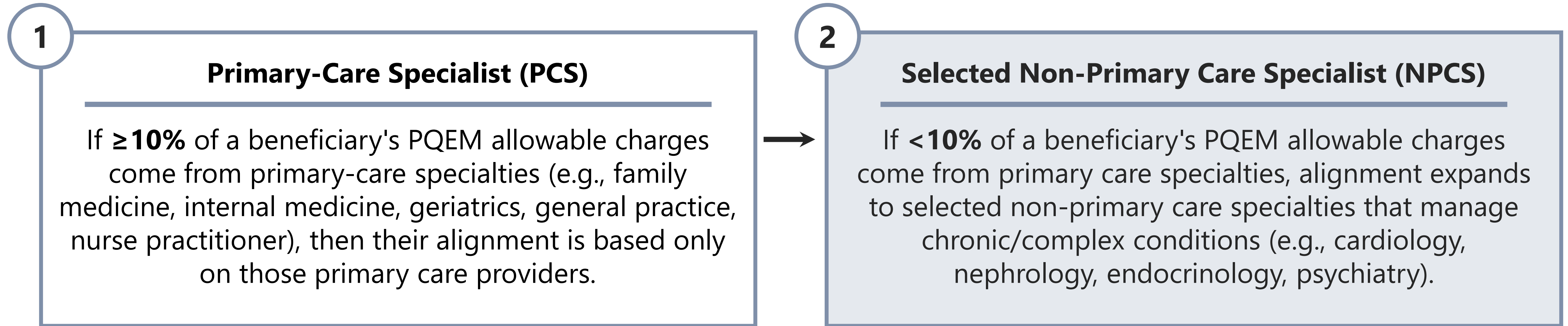
Look-Back Period: To identify PQEM services for alignment, CMS reviews one year of Medicare Fee-For-Service (FFS) Part A and B claims.

PQEM Updates: PQEM code list is updated annually (as needed based on changes in the Physician Fee Schedule).

[1]Plurality refers to the greatest share of PQEM services provided by one Participant TIN, not necessarily the majority.
[2]PQEM Services means a claim for a primary care service provided by a primary care specialist or one of the selected non-primary care specialists and identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in Appendix C of the RFA.

Claims-Based Alignment Algorithm

The Claims-Based Alignment Algorithm assigns each beneficiary to the eligible Participant TIN who provided the most PQEM services during the look-back period. It does this using a two-step process described below.



Specialist Treatment for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs):
All services are treated as primary care services for alignment purposes to account for the comprehensive nature of care delivered in those settings.

Voluntary Alignment

Voluntary alignment is one of two ways that ACOs will receive beneficiary alignment. Beneficiaries can designate their main source of care, thereby maintaining patient choice and continuity of care.

Voluntary alignment allows beneficiaries to **their main source of care,** thereby making that LEAD ACO accountable for their cost and quality of care. CMS will **prospectively align the beneficiary** based on the most recent valid attestation.

Mechanisms for Voluntary Alignment

Beneficiaries can elect Voluntary Alignment through two attestation mechanisms:

- **Electronic Voluntary Alignment (EVA)**: Beneficiaries can select a "primary clinician" on Medicare.gov, and that EVA choice is sent directly to CMS.
- **Signature-Based Voluntary Alignment**: Beneficiaries can submit a form via participating ACOs that names the Participant TIN/provider that the beneficiary chooses as their main source of care. The form will confirm that Medicare beneficiaries can see any Medicare-enrolled provider regardless of signing the voluntary alignment form.

Risk Sharing Options

Risk Sharing Options

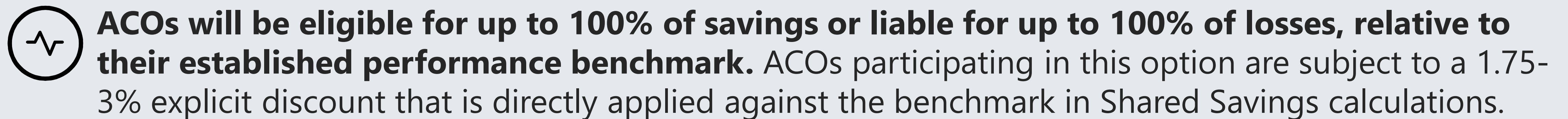
The risk sharing option that a participating ACO selects will determine the portion of savings or losses that will accrue to the ACO. LEAD offers two risk sharing options. Applicants will indicate their risk sharing option when applying to LEAD.

Professional Risk Option

ACOs will be eligible to receive up to 50% of total savings or be liable for up to 50% of total losses relative to their performance year benchmark. There is no discount and ACOs are required to stay in this option for at least four performance years, after which they can switch to the Global Risk Option.

Before signing the Participation Agreement (PA), an ACO may switch from the Global Risk Option to the Professional Risk Option.

Global Risk Option



ACOs will be eligible for up to 100% of savings or liable for up to 100% of losses, relative to their established performance benchmark. ACOs participating in this option are subject to a 1.75-3% explicit discount that is directly applied against the benchmark in Shared Savings calculations.

After signing the PA, renewing ACOs may not switch back to the Professional Risk Option for the remainder of the model. Newly entering ACOs may switch only after completing the Performance Year covered by their Global Agreement.

Benchmarking Methodology

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Benchmarking Structure

One of LEAD's core goals is to attract both higher- and lower-spending ACOs while creating a path to more stable and predictable benchmarks over time.

Higher- and Lower-Spending ACO Designation

- **Designation is based on a comparison of ACO spending to regional spending.** CMS compares the ACO's historical base benchmark (weighted blend of the three base years) to average spending for the rest of the eligible Medicare population in the ACO's region in Base Year 3, adjusted for differences in case mix (beneficiary categories) and severity (risk scores).
- **CMS determines each ACO's designation before the start of each Performance Year.** The designation is fixed for the full PY and will not change mid-year, including for mid-year Participant TIN additions.
- **Annual updates are limited**. Changes to the designation from year to year reflect changes to the ACO's Participant TIN list, not changes in spending during the model performance period. ACOs' designation will always be based on historical base-year spending so that ACOs that start higher-spending but reduce expenditures during the model are not reclassified based on their improvement during the model.
- **Region is defined using the ACO's county-based service area.** Regional expenditures are calculated using a population-weighted county average. County weights reflect the share of the ACO's aligned beneficiaries in each county.

Base Benchmark

CMS calculates base benchmarks using an ACO's historical expenditures, with benchmark weighting varying for new and renewing ACOs based on prior program experience.

Calculate Base Benchmark Using Historical Expenditures

- Base benchmarks are calculated using a **three-year weighted average of historical claims** from the three base years (BYs) prior to ACO's first performance year (PY).
- Base benchmarks are **calculated separately** for voluntarily-aligned and claims-aligned beneficiaries within each beneficiary category:
  - Aged and Disabled
  - End-Stage Renal Disease
  - High Needs

BY Weighting for New and Renewing ACOs:

Base Year	New ACOs	Renewing ACOs
BY 1 (Oldest)	10%	33%
BY 2	30%	33%
BY 3 (Most Recent)	60%	33%

ACO-Specific Adjustments

After calculating an ACO's historical baseline expenditures, CMS will apply additional ACO-specific benchmark adjustments.

Apply ACO-Specific Adjustments

Prior Savings Adjustment

- **Eligibility:** Renewing ACOs.
- **Calculation:** 50% of average annual savings in three BYs. Years without savings set to $0.

Positive Regional Efficiency Adjustment

- **Eligibility:** Lower-Spending ACOs in Global Risk Option.
- **Calculation**: 50% of difference between ACO's historical base benchmark and average regional spending in BY3.

Administrative Add-On (Capitated Payment)

- **Eligibility**: Higher-Spending ACOs.
- **Calculation**: 1.5% of ACO's total benchmark (before discount).

- Lower-spending ACOs eligible for both the Prior Savings Adjustment and Positive Regional Efficiency Adjustment will receive the higher adjustment.
- Higher-spending ACOs eligible for both the Prior Savings Adjustment and the Administrative Add-on can receive both
- The Prior Savings Adjustment and the Positive Regional Efficiency Adjustment are subject to a risk-adjusted cap of 5% of U.S. per capita cost for most ACOs. The Administrative-Add on is not subject to the cap.
- Lower-spending ACOs with 40% of more TINs that participated in the Shared Savings Program in the prior two years have a lower cap of 3%.

Update Factor

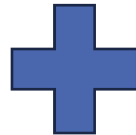
To ensure that benchmark amounts remain current, CMS applies an annual update that accounts for changes in Medicare spending over time.

Trend Benchmarks Forward to the Performance Year

- CMS will trend an ACO's benchmark forward to the current Performance Year.
- The trend will be calculated separately for each beneficiary category (Aged and Disabled, ESRD, and High Needs)
- This trend is based on a **three-way blended update factor**:

2/3 National/Regional Blend

- A blend of actual national and regional spending trends during PY.
- Weighting is adjusted by an **ACO's regional market share,** so ACOs with a higher market share have more weight on the national trend, and vice versa.
- "Region" is defined as ACO's **county-based service area**, with county weights based on share of the ACO's aligned beneficiaries in each county



1/3 Accountable Care Prospective Trend (ACPT)

- A **projected growth rate** set prospectively before start of the PY.
- This trend is **subject to guardrails** that limit how much trend including ACPT can differ from national/regional blend.
- Guardrails are **asymmetric**, providing more protection when ACPT is below trend, and widen over time to allow ACO **savings to grow.**

ACPT Guardrails

Amount that 3-Way Trend Can Diverge from 2-Way Trend

	Upper	Lower
PY 1	+0.3%	-0.2%
PY 2	+0.6%	-0.4%
PY 3	+0.9%	-0.6%
PY 4	+1.2%	-0.8%
PY 5	+1.5%	1.0%

Risk Adjustment

LEAD will apply a risk adjustment model to benchmarks specific to Aged & Disabled, End-Stage Renal Disease, and High Needs Beneficiary populations.

Aged & Disabled (A&D) Beneficiary Population

- **Risk Adjustment Model:** CMMI-Hierarchical Condition Categories (HCC) Prospective Risk Adjustment Model V1.
- The model will be recalibrated to remove High Needs beneficiaries to avoid overpredicting risk.

End-Stage Renal Disease (ESRD) Beneficiary Population

- **Risk Adjustment Model:** 2023 ESRD CMS-HCC Risk Adjustment Model.

High Needs Beneficiary Population

- **Risk Adjustment Model:** CMMI HCC Concurrent Risk Adjustment Model V2.
- The model will be recalibrated to include only the High Needs population.
- The model will be applied to all High Needs beneficiaries aligned to a LEAD ACO, regardless of whether the ACO they are aligned to has a high proportion of High Needs beneficiaries.

Risk Score Growth Cap: CMS will apply a 3% risk score growth cap for A&D and ESRD populations using BY 3 as the static reference year. The HN population will be subject to a risk score growth cap between 3-8%; the final HN cap amount will be released prior to the start of PY2027. CMS will re-visit whether the caps are still needed once the AI-inferred risk adjustment model is fully phased in.

Risk Adjustment – AI-Inferred Risk Adjustment Model

CMS is currently developing a new AI-inferred risk adjustment model with the goal of improving the accuracy of risk adjustment and reducing reliance on diagnosis coding.

2028: Phase 1 – Shadow Testing

- CMS will conduct significant testing and validation of the model before moving forward with implementation.
- Testing and validation will focus on overall predictive accuracy, as well as impact across beneficiary subgroups, provider types, and participant characteristics to avoid systematic over- or under-prediction for key populations
- In 2028, CMS will share AI-inferred risk scores with ACOs so they can understand how the new model impacts scores at the beneficiary level.

2029-2031: Phase 2 – Payment Phase-In

- Assuming successful testing and validation, in PY 2029, CMS will begin phasing in the use of AI-inferred risk scores for payment according to the following schedule:
  - **PY 2029**: **1/3** AI-Inferred model, **2/3** CMMI HCC Prospective Risk Adjustment Model V1.
  - **PY 2030**: **2/3** AI-Inferred model, **1/3** CMMI HCC Prospective Risk Adjustment Model V1.
  - **PY 2031**: **Full** phase-in of AI-Inferred model.
- Phase-in will apply to calculations for both performance year and base years

Quality Withhold and Discount

The benchmark is further adjusted through a quality withhold and, for Global Risk ACOs, a discount that varies by spending profile and year of participation.

Apply Quality Withhold and Discount

- **Quality Withhold**: 3% of the benchmark is at risk based on quality performance. The quality withhold will be applied directly during financial settlement, and will not be withheld from payments during the year.
- **Discount**: A 1.75-3% discount is applied to the benchmark for ACOs in the Global Risk Option.

Discount Rate Schedule for Lower and Higher-spending ACOs in the Global Risk Option:

Type of ACO	Discount Rate Schedule
Lower-Spending ACOs	• 3% static discount rate
Higher-Spending ACOs	• 2027: 1.75% • 2028: 2% • 2029: 2.25% • 2030: 2.5% • 2031: 2.75% • 2032-2036: 3%

Risk Mitigation and Financial Settlement

Risk Corridors

The aggregate amount of savings or losses that ACOs in the Global or Professional Risk Options will be eligible to receive as Shared Savings or be required to repay as Shared Losses will be constrained by a series of risk corridors.

Professional Risk

- For all savings and losses up to and including **10%** of the Performance Year Benchmark, the ACO is responsible for 50% of the savings or losses and CMS is responsible for the remaining 50%.
- ACOs retain a smaller share of additional savings and bear a smaller share of additional losses as performance moves into risk corridors (2-4).

Global Risk

- For all savings and losses up to and including **15%** of the Performance Year Benchmark, the ACO is responsible for 100% of the savings or losses and CMS is responsible for the remaining 100%.
- Global risk option generally has wider risk corridors that allow participants to retain a higher share of savings while being at risk for a higher share of losses.

Risk Corridors for Professional Risk Option

Corridor	1	2	3	4
Percent of Benchmark	Up to 10%	10-15%	15-20%	More than 20%
Savings/ Losses Rate	50%	35%	15%	5%

Risk Corridors for Global Risk Option

Corridor	1	2	3	4
Percent of Benchmark	Up to 15%	15-35%	35-50%	More than 50%
Savings/ Losses Rate	100%	50%	25%	10%

Stop-Loss Arrangements

Optional stop-loss is available to help reduce financial uncertainty associated with infrequent but high-cost expenditures for aligned beneficiaries. ACOs in both the Global and Professional Risk Options will be able to elect stop-loss.

Arrangement Selection

- ACOs who elect stop-loss must make their selection **prior to the start of each Performance Year**.
- The arrangement is designed to **protect ACOs against exposure to high-cost beneficiaries** whose health care spending exceeds their predicted spending by a certain amount.
- A per-beneficiary per-month “stop-loss charge” will be applied to each ACO’s Performance Year Benchmark.

Calculation Specifications

- The LEAD stop-loss is "residual" stop loss, meaning that it protects against the "residual" portion of costs that are higher than a beneficiary's "expected" costs, based on their individual risk score
- Once the amount of residual costs exceeds a certain threshold ("attachment point"), stop loss insurance will apply, and the ACO will not be liable for the majority of costs above the attachment point.
- Stop-loss payouts are budget neutral, meaning CMS will only pay out as much in stop loss as we have collected in stop-loss charges.

Calculation Example

1. Beneficiary has a risk score of 1.5, and their expected costs are $15,000 per year. Their actual cost is $200,000 per year.
2. Residual costs are $185,000 ($200,000-$15,000).
3. Attachment point[1] is $100,000
4. Residual costs that exceed the attachment point ($185,000-$100,00=$85,000) are subject to stop loss protections

[1]Attachment point is illustrative; actual attachment points will be calculated with the intent that the top 2% of expenditures are covered by stop loss

Optional Provisional and Final Financial Settlements

Financial Settlements determine whether an ACO earns Shared Savings or owes Shared Losses for a Performance Year by comparing the Performance Year Benchmark to actual Medicare Part A and B spending for aligned beneficiaries.

LEAD ACOs will have the option to **select Provisional Financial Settlement**, which will include ACO expenditures for the full Performance Year with no claims run-out. This will be calculated in Q1 of the following Performance Year.

Final Financial Settlement will be conducted for all LEAD ACOs after the end of the Performance Year to allow sufficient time for claims processing.

Financial Settlement Specification	Provisional Financial Settlement	Final Financial Settlement
Target Date for Financial Settlement	Quarter 1 of calendar year following the Performance Year	Quarter 3 of calendar year following Performance Year
Claims Included in Financial Settlement	Performance Year expenditures incurred through December 31st of the Performance Year	Performance Year expenditures incurred through December 31st of the Performance Year
Claims Run-Out	Through December 31st of the Performance Year, with a claims completion factor	Through March 31st of the calendar year following Performance Year
Risk Scores	Preliminary Risk Scores	Final Risk Scores
EPCC and Stop Loss included?	Yes	Yes

Financial Guarantees

ACOs must be able to repay all Shared Losses and Other Monies Owed for which it may be liable. Therefore, they must secure a financial guarantee to ensure that CMS can recoup accordingly.

	Primary Care Capitation (PCC) Payment			Total Care Capitation Payment
	Shared Losses and Base PCC	Enhanced Primary Care Capitation Payment (Optional)	Combined Shared Losses, Base PCC, and Enhanced PCC	
Professional Risk Option	2.0% of Previous Year's Part A & B Expenditures	1.5% of Previous Year's Part A & B Expenditures	3.5% of Previous Year's Part A & B Expenditures	N/A
Global Risk Option	2.5% of Previous Year's Part A & B Expenditures*	1.5% of Previous Year's Part A & B Expenditures	4.0% of Previous Year's Part A & B Expenditures	4.0% of Previous Year's Part A & B Expenditures

Retention Incentive

CMS will also apply a 2% "Retention Incentive" to the ACO's Performance Year benchmark for PY 1.
ACOs must remain in the model for PY2 (i.e., do not drop out before the PY2 termination without liability deadline) to earn back the withhold in their PY1 final settlement.

*Previous year's Part A & B Expenditures in the table above refers to the ACO's total Medicare Part A and B expenditures from a prior 12-month period for the expected aligned population for the upcoming Performance Year.

Prospective Payments

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Primary Care Capitation (PCC)

PCC is a capitation option than applies only to primary care services delivered by primary care specialists to aligned beneficiaries.

PCC Payment Breakdown

The PCC Payment consists of two components: A **Base Primary Care Capitation** amount and an **Enhanced Primary Care Capitation (EPCC)** amount. The Base PCC is intended to approximate the expected cost of primary care services; the Enhanced PCC provides additional upfront funding to support investments in primary care infrastructure.

Base PCC Amount

Base PCC payments are derived from the **ACO's Performance Year benchmark**. CMS uses **historical claims data** to identify the portion of total spending that is: 1) attributable to primary care services 2) furnished by **primary care specialists in Participant TINs** and eligible **Preferred Providers** that elect to participate in PCC 3) to aligned beneficiaries.

FQHCs and RHCs

The Base PCC includes a **Federally Qualified Health Center (FQHC)** or **Rural Health Center (RHC) True-up** to ensure an ACO is adequately funded for beneficiaries aligned through FQHCs and RHCs. All services provided by FQHCs and RHCs are considered primary care services.

Enhanced Primary Care Capitation

The EPCC amount equals the greater of (1) the difference between 7% of the ACO's Performance Year benchmark and the Base PCC amount, or (2) 2% of the Performance Year benchmark. The EPCC must be repaid during financial settlement.

Primary Care Capitation (PCC) Requirements

ACO Participant and Preferred Providers will continue to bill Medicare claims as usual and CMS will partially or fully reduce FFS claims payments, depending on the claims fee reduction amount (1-100%) the ACO has selected.

Provider Type	PCC Participation Requirement	Claims Reductions Requirements
Primary Care Specialist Participant Providers (Previous ACO REACH Participants*)	Mandatory participation	100%
Primary Care Specialist Participant Providers (New ACOs and Previous Shared Savings Program Participants)	Mandatory participation	• PY2027: 1-100% • PY2028: 5-100% • PY2029: 10-100% • PY2030: 20-100% • PY2031-2035: 100%
Preferred Providers	Optional participation	1-100%

CMS will recalculate capitation payments quarterly to reflect alignment, benchmark/risk score updates, and (if relevant) provider spending share changes, with any residual over/under-payments trued up in a final financial settlement.

*All Primary Care Specialists in a Participant TIN that participated in ACO REACH in 2026 will be required to select 100% PCC claims reduction.

Total Care Capitation (TCC)

TCC is a per-beneficiary, per-month (PBPM) capitated payment for all services provided to aligned beneficiaries by all Participant TINs and those Preferred Providers who have opted to participate in TCC Payment.

TCC Payment Coverage

For ACOs that elect TCC, the TCC payment covers Medicare services for aligned beneficiaries delivered by **all Participant TINs and by any Preferred Providers who opt into TCC.**

TCC Fee Reduction for Aligned Beneficiary Services

Participant TINs must fully participate with a **100% fee reduction**, meaning all Medicare payment for their aligned beneficiary services flows through the ACOs via TCC and they receive no claims-based payment. Preferred Providers may opt in or out, and the ACO sets their fee reduction, so they may receive some, all, or none of their payment through TCC.

Provider Type	TCC Participation Requirement	Fee Reductions
Participant TINs	Mandatory participation	100%
Preferred Providers	Optional participation	1-100%; selected by ACO

Additional Payment Components

Non-Primary Care Capitation (NPCC)

The NPCC lets ACOs that choose PCC also capitate non-primary care services: CMS turns the relevant share of the ACO benchmark (based on historical claims) into a prospective monthly payment to support downstream sub-capitation (e.g., with cardiology groups), shifting accountability for cost and quality from fee-for-service towards value-based care in Original Medicare.

Advanced Payment Option (APO)

APO is an alternative to NPCC for ACOs electing PCC: CMS prepays an amount for participating non-primary care services based on historical spend but reconciles it to actual fee-for-service claims.

If claims are higher, the difference is added to the ACO's total cost of care at reconciliation. **If lower**, the ACO does not keep the savings. ACOs set the claims-reduction percentage (1-100%) for participating providers, and CMS continues paying the non-reduced portion of FFS claims.

Administrative Add-On

LEAD offers higher-spending ACOs an upfront benchmark adjustment to enable them to immediately invest in care transformation and quality improvement.

Eligible ACOs receive an extra monthly capitated "Administrative Add-On" equal to 1.5% of their benchmark, which is excluded from shared savings/loss calculation.

Participation Rules by Risk Track and Provider Type

Participation rules differ by risk track and provider type. The chart below describes the rules for participating ACOs, based on whether they are participating in the Global Risk or Professional Risk Option .

Payment Component	Global Risk Option			Professional Risk Option		
	Primary Care Specialist Participant Providers	Non-PC Specialist Participant Providers	Preferred Providers	Primary Care Specialist Participant Providers	Non-PC Specialist Participant Providers	Preferred Providers
PCC	Required	Non-eligible	Eligible	Required	Non-eligible	Eligible
NPCC	Eligible	Eligible	Eligible	Non-eligible	Eligible	Eligible
APO	Eligible	Eligible	Eligible	Non-eligible	Eligible	Eligible
PCC+NPCC	Eligible	Non-eligible	Eligible	Non-eligible	Non-eligible	Non-eligible
PCC+APO	Eligible	Non-eligible	Eligible	Eligible	Non-eligible	Eligible
TCC	Required if selected	Required if selected	Eligible	Non-eligible	Non-eligible	Non-eligible

Model Payment Example

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Financial Example (1/4)

Below, and on the slides that follow, is an example of model payment under LEAD for a small, independent practice.

ACO Characteristics

1 practice with 12 primary care providers

6,000 Original Medicare beneficiaries, slightly sicker than the average Medicare population (**1.1 average risk score**)

$3 million annual fee-for-service Medicare revenue (higher spending per capita than regional peers)

Has not previously participated in the Shared Savings Program or ACO REACH

LEAD Options Selected

- Professional Risk Option
- Primary Care Capitation + Enhanced
- 50% fee reduction on primary care claims

Benchmark Calculation

(**$1,250** ACO's risk-standardized historical per beneficiary per month spending in the base years + **3%** Three-way blend update trend) X **1.1** ACO's average beneficiary risk score X **72,000** Beneficiary Months (aligned beneficiaries x 12)

= $101.97 Million Annual Benchmark[1]

[1]Illustrative example; not guaranteed payments.

Financial Example (2/4)

Below, and on the slides that follow, is an example of model payment under LEAD for a small, independent practice.

Monthly Capitated Payments

$127K /month

Base Primary Care Capitation

(Historical primary care revenue = 3% of benchmark, adjusted for 50% fee reduction)

$101,970,000 x 0.03 x 0.5 = $1,529,550/12 = $127,463

+

$334K /month

Enhanced Primary Care Capitation

(7% maximum PCC - 3% base PCC = 4% of benchmark)

$101,970,000 x 0.04 = $4,078,800/12 = $339,900

+

$127K /month

1.5% Administrative Add-On

(for high spending ACOs)

$101,970,000 x 0.015 = $1,529,550/12 = $127,463

= **$595K** **Total Monthly Upfront Payments**[1]

[1]Illustrative example; not guaranteed payments.

Financial Example (3/4)

Below, and on the slides that follow, is an example of model payment under LEAD for a small, independent practice.

Shared Savings Calculation

$102 million
Annual Benchmark

X (

4.5%
ACO's gross savings rate

–

3% x (1-0.8)
ACO earns back 80% of the 3% quality withhold through performance

) **X**

50%
ACO portion of Shared Savings

= $2 Million **Annual Shared Savings**[1]

If the ACO had selected the Global Risk Option, its Shared Savings would have been $2.2 million.

[1]Illustrative example; not guaranteed payments.

Financial Example (4/4)

Below is the rest of the example of model payment under LEAD for a small, independent practice.

Total Revenue Impact

Total Annual Practice Revenue under LEAD	Type of Revenue
$1.5 million	Fee-for service revenue
+$1.5 million	Base PCC Capitation
+$0	Enhanced PCC Capitation[1]
+$1.5 million	Administrative Add-On
+$2.0 million	Shared Savings
=$6.5 million	**Total Revenue[2]**

In comparison, this ACO would have made $3 million in revenue through fee-for-service.

[1]Represented as $0 net new revenue because it is paid monthly but must be re-paid at the end of the year.
[2]Illustrative example; not guaranteed payments.

Q&A

Live Q&A

Please type your question in the **Q&A box.**

If we do not get to your question, we welcome you to email the LEAD Team at LEAD@cms.hhs.gov. We will aim to answer unaddressed questions via emails and upcoming FAQs.

Closing and Resources

Resources

Email: LEAD@cms.hhs.gov

Visit: LEAD Model Webpage, where you can view the:

- LEAD Model RFA Webinar Slides and Recording
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Thank You

We appreciate your time and interest!

Please share your feedback via the survey following this event.

Questions? Email LEAD@cms.hhs.gov