Long-term Enhanced Accountable Care Organization (ACO) Design (LEAD)
Alignment and Financial Methodology Office Hour
May 5, 2026

>>Aditi Desai, Deloitte: Hello, and welcome to the Long-Term Enhanced Accountable Care Organization Design, or LEAD, Alignment and Financial Methodology Office Hour. Thank you for joining us today. Next slide, please.

Before we get started, we will share some brief housekeeping remarks. During today's presentation, all participants will be in listen-only mode. We recommend that you listen via your computer speakers. There is also the option to dial-in from your phone. The dial-in information is available on the screen. Today's presentation is being recorded. If you have any objections, please disconnect from the call at this time. Closed captioning is also available at the bottom of your screen. Additionally, at the end of the webinar, you will be directed to a brief survey to collect your feedback on the event. Next slide, please.

Now we will review our agenda for today. First, we will begin with welcome and introductions. We will use most of our time to discuss LEAD's alignment and benchmarking methodologies, risk sharing options, and risk mitigation. This will then be followed by an overview of the payment mechanism used in the LEAD Model, along with a payment example. Afterwards, we will spend the rest of the session answering common questions you submitted in your registration forms. With any remaining time, we will take questions live from the audience. Please feel free to submit any questions you have in the Q&A box. If we do not get to your questions, we welcome you to email the LEAD team at LEAD@cms.hhs.gov. We will share this email address in the chat, and we aim to answer any unaddressed questions via email or upcoming frequently asked questions (FAQs). This slide deck, along with a recording and a transcript of today's event, will be available on the LEAD Model webpage in the coming weeks. I will now pass it over to Lucy Sola for a welcome and introduction. Next slide, please.

>>Lucy Sola, CMS: Hello, everyone! My name is Lucy Sola, and I am a co-lead of the LEAD Model here at the Centers for Medicare & Medicaid Services (CMS) Innovation Center. We are so excited to have you all here with us today to learn more about the alignment and financial methodology of the LEAD Model. Our goal is to be able to provide a little bit more detail around that methodology, so that way you all can make decisions around whether you are going to submit an application to the LEAD Model by the May 17th deadline. We can go ahead and jump to the next slide.

I will introduce the rest of today's speakers now. We are joined by Meredith Yinger, the other co-lead for the LEAD Model, and Emily Bezold, a technical advisor on the accountable care organization (ACO) portfolio here at the CMS Innovation Center. We can jump to the next slide.

Now we will jump right into the alignment methodology in the LEAD Model. We can go to the next slide, please.

So, LEAD ACOs can choose multiple mechanisms for beneficiary alignment in LEAD. The two approaches are prospective, which is set at the start of the performance year, and then no updates are made to alignment, or hybrid, where mid-year updates are made to alignment for the ACO. There are two methods for beneficiary alignment. The first is claims-based alignment, which is when we are looking at claims history for ACOs. To see who the beneficiary has received a majority of their care from in the look-back period. And then voluntary alignment is when a beneficiary is voluntarily aligning to an ACO by choosing that provider that they identify as their main source of care.

At the bottom of this slide, we have a timeline showing how this will all work during the performance year, leading up to the performance year, and then during the performance year. So, prior to the start of the performance year, we are going to do a prospective, run of alignment, and that would be claims-based and voluntary alignment, and then there would be no updates allowed during the performance year (PY), and drops may occur due to beneficiary loss of eligibility only. And then, for that prospective alignment run, the look-back period that we are using to look at the claims history is going to be October 1st from September 30th prior to the performance year. And then for hybrid alignment, the first claims-based alignment run will occur prior to the start of the performance year with that same look-back period that the prospective run is using. So, still using that October 1st to September 30th prior to the performance year.

And then, as you move over to the bottom right corner, you will see that there is then a mid-year update that occurs for the hybrid alignment on claims-based alignment and that will be used to align beneficiaries effective April 1. The look-back period is from January 1st to December 31st prior to the performance year, so that look-back period is rolling forward a quarter compared to the prospective alignment run. And this second alignment run on claims-based alignment will be used to include beneficiary additions for newly added TINs only. Drops will only occur due to loss of eligibility. We would not be dropping beneficiaries from other models to then become part of LEAD or anything like that. And then in hybrid, we will be updating voluntary alignment on a monthly basis, and that can occur throughout the entire performance year. We can go ahead and go to the next slide.

As discussed on the prior slide, one of the methods that we will use to align beneficiaries to LEAD is claims-based alignment. So, that is done prospectively based on a one-year look-back period of qualifying claims. And we will basically be looking for Primary Care Qualified Evaluation and Management, or PQEM services, and we'll be looking to see who the beneficiary has received the plurality of those PQEM services, and they are including services like

evaluation and management visits, chronic care management services, annual wellness visits, and a full list of those services is available in Appendix C of the LEAD Request for Applications (RFA).

And then we have the two look-back periods that I talked about on the prior slide. So that is when we are going and looking for PQEM services for alignment, and we will be reviewing one year of Medicare fee-for-service, Part A and Part B claims to identify which provider has provided, the majority of that care to the beneficiary. And we will update that PQEM list on an annual basis as needed, based on changes to the physician fee schedule. And then we can go ahead and go to the next slide.

This slide provides a little bit more detail on how we take into account specialists in the alignment algorithm. So, there is a two-step process that we use when looking at the claims-based alignment algorithm. So, the first step is looking for allowable charges coming from primary care specialists like family medicine providers, internal medicine, geriatric providers, general practice, nurse practitioners, physician assistants, and a few more. And then, if we are seeing 10% or more of a beneficiary's PQEM allowable charges coming from those primary care specialties, then their alignment is based only on those primary care providers. If we were seeing fewer than 10% of a beneficiary's PQEM allowable charges coming from the primary care specialists, then we would expand and look for non-primary care specialties that often manage chronic and complex conditions for beneficiaries. So, that would include specialists like cardiologists, nephrologists, endocrinologists, psychiatrists, and there are multiple others that are all included in the RFA.

All services that are provided at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) are considered primary care for alignment purposes, and that is to really make sure that we are accounting for the comprehensive nature of the care delivered in those settings. We can go to the next slide.

This slide goes over the second way that we will align beneficiaries to ACOs which is voluntary alignment. So, beneficiaries can designate their main source of care, and this is really meant to empower beneficiaries and provide that continuity of care.

So, beneficiaries will either select their main source of care through electronic voluntary alignment, which is when a beneficiary is selecting their primary clinician on Medicare.gov, and then that choice is shared directly with CMS.

Or, signature-based voluntary alignment, which is when beneficiaries are signing a form via the ACO that names the participant in or participant provider that the beneficiary chooses as their main source of care. The form will also confirm that Medicare beneficiaries can see any

Medicare-enrolled provider, regardless of signing the voluntary alignment form, and that is in order to be responsive to some of the questions that we have received from beneficiaries. And we can hop to the next slide.

Next, we will go over the risk sharing options, in the LEAD Model, and we can go to the next slide.

So, LEAD will have two risk sharing options. The first is the Professional Risk Option, which is where ACOs are eligible to receive up to 50% of total savings and also be held liable for up to 50% of total losses relative to their performance year benchmark. In the Professional Risk Option, there is not a discount, but ACOs are required to stay in this option for at least 4 performance years, after which they can switch to the Global Risk Option.

And a question we have been receiving is whether ACOs are able to switch from the Global Risk Option to the Professional Risk Option, and they are able to before signing the Participation Agreement (PA), but once that Participation Agreement is signed, then we will not permit those switches.

And then the Global Risk Option is when ACOs are eligible for up to 100% of savings or liable for up to 100% of losses compared to their performance year benchmark. ACOs participating in this option are subject to a discount that is directly applied to their benchmark in the shared savings calculations.

It is important to note that after signing the Participation Agreement, that renewing ACOs may not switch back to the Professional Risk Option for the remainder of the model, but there is a policy in place where newly entering ACOs may switch only after completing the performance year covered by their global Participation Agreement, and that's intended to really help those who maybe haven't participated in ACOs previously or in recent years to move back into professional, if that ends up being a better option for their ACO after they've dipped their toes in for that first year. And we can go ahead and go to the next slide, and I will go ahead and pass it over to Emily.

>>Emily Bezold, CMS: Thank you, Lucy. And we can go to the next slide.

So, I think everyone has recognized at this point, based on the questions that we get, the importance of the higher and lower spending ACO designation in LEAD, which dictates some of the key benchmark adjustments that ACOs will be eligible for. So, we just want to spend a little bit of time going over how we will be making that higher and lower spending designation, and some of the key elements of that determination.

So first, the designation is based on comparing ACO spending to regional spending. And what we will be doing specifically is taking the ACO's historical base benchmark, which is the weighted blend of the three base years. And then we will be comparing that to average spending for eligible Medicare beneficiaries, and that's beneficiaries who are eligible to be aligned to an ACO but are not aligned.

Comparing average, Medicare spending for that population in the ACO's region in base year 3. And we will be adjusting for differences in case mix, so your mix of, aged and disabled (A&D), End-Stage Renal Disease (ESRD), and High Needs beneficiaries, as well as your severity as measured by risk scores.

We will be determining each ACO's designation before the start of each performance year, and then it will be fixed for the full performance year. So, it will not change during the year based on additional claims run out, or, due to mid-year participant Tax Identification Number (TIN) additions. It will be set for that full performance year.

We will be checking the designation annually, and what we will be doing is calculating based on the ACO's current performance year participant list. So, we will be looking at the TINs on the current list, looking at their spending in the historical base years.

The base years themselves will not be changing, so we will always be looking at base year 1 through 3, which is the 3 years before the start of the model. So, any changes would just be driven by changes in your participant TIN list and their underlying, base year spending.

The region that we will be using is defined by the ACO's county-based service area. So, we will be doing a population-weighted county average, and that population weighting will be based on where the ACO's aligned beneficiaries are. So, more weight on counties where you have more beneficiaries, and vice versa. Next slide, please.

From here, we are going to get into the steps that we use to build up the benchmark. So, we start by looking at the ACO's historical expenditures and as I mentioned, we will be doing a 3-year weighted average of historical claims, for the 3 years prior to the start of the ACO's first performance year. So, for an ACO starting in 2027, this would be 2024, 2025, and 2026.

We'll be calculating these separately, both for voluntarily aligned and claims-aligned beneficiaries, and then for each of the beneficiary categories, aged and disabled, end-stage renal disease, and High Needs.

We'll be doing a different weighting of the base years depending on whether an ACO is classified as new or renewing. For those new ACOs, we'll be putting more weight on the most

recent base year, which is base year 3, with a 60% weight, and less weight on the oldest base year, base year 1, which has a 10% weight.

For renewing ACOs, we'll put an equal one-third, one-third, one-third weight on each of those base years. Next slide, please.

Then we'll take that historical base that we've just calculated, and we'll apply some ACO-specific adjustments and this is where high spending and low spending designation becomes important. So, for those ACOs, who are lower spending, they'll likely be eligible for a positive regional efficiency adjustment. This is lower spending ACOs, specifically in the Global Risk Option who are eligible for this adjustment.

The way the regional efficiency adjustment is calculated, it's 50% of the difference between the ACO's historical base benchmark and average regional spending in base year 3. The methodology there is the same as what I just went through for the higher spending and lower spending designation. So, same approach, to which expenditures we're looking at, which base years, and how we're defining a region.

We also have the prior savings adjustment which is specific to renewing ACOs. This can apply to ACOs in either the professional or the Global Risk Option. And it also applies to ACOs who are coming from both the Shared Savings Program and ACO REACH. The calculation here will be 50% of average annual savings in the three base years. If there are years without savings, those will be set to $0 in the averaging calculation. An ACO that's eligible for both the prior savings adjustment and the positive regional efficiency adjustment will receive the higher of those two adjustments.

We also have an adjustment that is the administrative add-on, and actually, this is not administered as a benchmark adjustment, it's administered as a capitated payment, and so we'll talk about it further when we get into the capitated payment mechanism section. But this is specifically for higher spending ACOs whose historical spending is above their region, and they'll be able to receive a capitated payment equivalent to 1.5% of their total benchmark before the discount is applied.

Now, an ACO could be eligible for both a prior savings adjustment and the administrative add-on and in that case, we would allow them to receive both of those. The administrative add-on in that case would not be subject to the cap that we apply to benchmark adjustments. So that benchmark adjustment cap is just for the prior savings adjustment and the regional efficiency adjustment. That benchmark cap is 5% for all ACOs except for lower-spending ACOs who have more than 40% of their TINs that participated in the Shared Savings Program in the last 2 years. ACOs that meet those criteria will have a benchmark adjustment cap of 3%. Next slide, please.

The next step, then, is to trend our benchmarks forward to the performance year. And so, we'll be trending an ACO's, base benchmark, to the performance year, separately for each of those three beneficiary categories. So, for aged and disabled, ESRD, and High Needs, we'll be doing a different trend for each category and the trend will be a 3-way blended update factor.

Two-thirds of the trend will be a national and regional blend that looks at actual national and regional spending trends during the performance year. The specific weight of national and regional will depend on the ACO's market share. So, ACOs that have a higher regional market share will put more weight on their national trend. And vice versa, ACOs that have a lower regional market share, will have more weight on their regional trend.

The idea is that if an ACO has a high market share, and therefore has a significant influence on the regional trend, we don't want to penalize them by applying a trend that they're directly contributing to so that's the thinking behind that weighting.

And again, here, when we say region, we're talking about the ACO's county-based service area weighted for where the ACO has its significant proportion of beneficiaries.

The remaining one-third of the trend will be based on the Accountable Care Perspective Trend, or ACPT. This is a projected growth rate that is set prospectively before the start of the year. Now, because this is prospective, it can be subject to forecasting errors so we will be applying guardrails that limit how much the trend can differ, when we blend in ACPT, how much that can move the trend away from just the national and regional blend.

These guardrails are asymmetric, and that means that they provide more protection when the ACPT is below the actual trend, so they prevent the ACPT from dragging the trend down too much. They have greater upsides, so if the ACPT is greater than national trend, they allow the overall trend factor to be higher. And the guardrails widen over time, so that ACOs are able to benefit more from that ACPT as their savings grow over time.

The box on the right of the slide shows specifically the approach for those… for how the guardrails widen. They start at 0.3% on the upside, and grow 0.3% each year. On the downside, they start at negative 0.2% and grow by 2.2% each year. Next slide, please.

So next, we risk adjust our benchmarks. We'll be using a different risk adjustment methodology for each of the three beneficiary categories. For the aged and disabled population, we'll be using, the Prospective Risk Adjustment Model. It's the Center for Medicare and Medicaid Innovation (CMMI) Hierarchical Condition Categories (HCC) Prospective Risk Adjustment Model which is a recalibrated version of the general CMS Prospective Model that's been recalibrated to remove

High Needs beneficiaries in order to more accurately predict risk, for the non-High Needs population.

For the ESRD population, we'll be using the 2023 ESRD CMS HCC Risk Adjustment Model.

And for the High Needs population, we'll be using the CMMI HCC Concurrent Risk Adjustment Model, but an updated version that's recalibrated to include only the High Needs population, which, again, is intended to improve the accuracy of the model.

We will be applying a risk score growth cap, to each of these three beneficiary segments. For the A&D and ESRD populations, we'll be using base year 3, so the year exactly before the start of the performance period as the static reference year.

For the High Needs population, we're still working on model calibration, and so have not set the risk score growth cap for that population yet, but expect it to fall between 3% and 8%. And we'll be releasing that final cap before the start of 2027.

We've gotten some questions about whether this cap will apply for the entire 10-year performance period of the model, and we note that the model intends to phase in a new AI-inferred risk adjustment model beginning in 2029. We'll talk about that on the next slide, and expect that once we move to that new model, we'll be revisiting whether caps are still needed. So, it is not necessarily a given that these caps will apply for the full 10-year performance period, and in fact, our hope is that the improved AI-inferred risk adjustment model may eliminate the need for these caps. Next slide, please.

So, to talk a little bit more about that AI-inferred risk adjustment model. This is a new model that CMS is developing with the goal, first, of improving the accuracy of risk adjustment, and second, reducing the reliance on diagnosis coding, and also, frankly, reducing the potential gaming related with, overcoding and intensive coding.

So, this model will be rolled out in two phases. Starting in 2028, we'll be shadow testing the model. What that means is, first that we'll be doing significant testing and validation, focused both on the model's overall predictive accuracy, but then also the impact of the model on specific beneficiary subgroups, different types of providers, and different participant characteristic groups. So, looking to make sure that we are not introducing any sort of systematic over- or under prediction for our key populations and key participant types.

Then in 2028, we'll be sharing AI-inferred risk scores with ACOs. So, you'll receive in your risk score reports at the beneficiary level, both the risk score under the old HCC model side-by-side with the risk score under the new AI-inferred model. And so, you'll be able to compare and see

the impact of the model side-by-side down to the beneficiary level as well as guidance and methodology on some of those results of testing and validation that we're doing. So, some context around what we're seeing as far as the impact of the model at the larger level.

Then, in Phase 2 of the model, we'll start, phasing it in for payment. So, beginning in 2029 and running through 2031 will be our payment phase-in. Of course, this is assuming successful testing and validation. If there were to be major issues, or we didn't feel that the model was improving predictive accuracy, I think it's fair to say we wouldn't be phasing in for payment. We'd be needing to address those issues first. So that's what we'd be surfacing in 2028. But assuming successful testing and validation, we would start in 2029 to phase in the use of risk scores, with a blend with one-third weight on the AI-inferred model, two-thirds weight on the CMMI HCC Prospective Model.

In 2030, the second year, we'd put two-thirds… There's one-third weight on the HCC Prospective Model and then by 2031, we'd have the full phase-in of the AI-inferred model.

And just to note, the phase-in will apply to calculations both for the performance year and for the base year. So, when we're looking at base year spending and standardizing base year spending for risk, we'll be using the AI-inferred model for that base year period as well. Next slide, please.

Alright, so the final step, with the benchmarks then, is to apply the quality withhold, and then for ACOs that have selected the Global Risk Option, we'll be applying a discount.

So, to start with the quality withhold, this is 3% of the benchmark that is at risk based on quality performance, and that means that ACOs can earn back some, all, or none of the 3% based on their performance on the measures, the model's quality measures. The quality withhold will be applied directly during financial settlement. So, it's called a withhold, but we won't actually be withholding payments during the performance year. That withhold will only come into play when we're calculating your final reconciliation at the end of the year.

Then the discount is an amount that is applied, again, just for ACOs in the Global Risk Option. This represents the portion of savings that CMS is able to share in. And the discount can range from 1.75 to 3%, depending on whether an ACO is lower or higher spending.

Lower spending ACOs will have a 3% static discount rate starting in year one of the model, and continuing throughout the life of the model. Higher spending ACOs will have a phase-in of the discount rate, so they'll start with a lower discount of 1.75% in 2027, and then that discount amount will go up by 0.25% every year until, 2032, where it's fully phased in at the 3% rate. Next slide, please.

Alright, so that's the benchmark, and that then takes us to risk mitigation and financial settlement and we'll start by talking about risk corridors. So, we've talked about the global and Professional Risk Option, and the fact that under Professional Risk, ACOs share in savings and losses 50/50 with CMS, and in Global Risk, ACOs are responsible for 100% of savings and losses. Now that is true-up to a certain percent of benchmark and then after a certain percent of benchmark, these risk corridors start to phase in. And what that means is ACOs are sharing in a lower percent of savings and losses, as those savings and losses increase. The idea here is that this is a risk mitigation approach, so that the sort of downside here is capped for participants.

So just to be specific about what that looks like, the bottom half of the slide shows the specific risk corridor tables. They differ for Professional Risk versus Global Risk. They are narrower for Professional Risk. And so, what that means is up to 10% of benchmark, so savings or losses that are equivalent to 10% of benchmark. And ACO is sharing in 50/50 of those savings or losses.

Above 10%, that moves into the second risk corridor, and so savings and losses between 10% and 15% then have applied a savings and loss rate of 35%. So the ACO is only responsible for 35% of savings or losses in the second corridor.

The third corridor is 15-20% and the ACO portion moves to 15%, and above 20%, it moves to 5% that the ACO is accountable for.

Global risk has significantly wider risk corridors. So, the first risk corridor in global is up to 15%, where that 100% savings loss rate applies. Then from 15% to 35% of the benchmark, the ACO is sharing with CMS 50/50. From 35% to 50% of the benchmark, they're sharing at a 25% rate, and above 50%, they're sharing at a 10% rate. Next slide, please.

Stop Loss is another risk mitigation method that will be available, in LEAD that was also available in REACH. So, for those of you who are familiar with the REACH approach, the LEAD approach to stop loss will be very similar.

It's an optional stop-loss program, so ACOs have the ability to elect it before the start of each performance year. It's designed to help cap ACO's exposure to rare but very high-cost expenditure beneficiaries. ACOs in both global and Professional Risk will be able to elect it.

And those that do elect it will be charged a per-beneficiary per month stop-loss charge that is applied to your benchmark, so this isn't something you have to pay up front or during the year. Again, it'll be just included as part of your final settlement report but it'll be that per beneficiary per month charge that you're then paying for the stop loss protection.

The way that protection works is that it is residual stop loss. So that means it protects against the residual portion of costs that are above what a beneficiary's expected costs were based on their risk score.

So, the sort of point where the stop loss kicks in will vary beneficiary by beneficiary. It's not a flat dollar amount. It depends on the beneficiary and their risk score, and how much their costs are above what we would have predicted them to be based on their risk score. And so, once those residual costs, the amounts that are above what we would have predicted, exceed a certain threshold, which we call the attachment point. That's where the stop loss insurance would apply, and the ACO would not be liable for a majority of costs above the attachment point.

Stop-loss payouts are designed to be budget neutral, which means that we'll only pay out as much in stop loss as we've collected in stop-loss charges. And so, if we were to collect less in stop-loss charges than we had in payouts, we would apply a scaling factor to scale back payouts so that the approach was budget neutral.

The dual concept can be a little bit tricky, so we have an example here to help walk through it, just at the beneficiary level. So, in this example, we have a beneficiary who has a risk score of 1.5, and their expected costs are $15,000 per year. In practice, their actual cost was $200,000 per year. So, their residual costs are $185,000, that's $200,000, their actual, minus $15,000 their expected, and that remaining portion is residual. The attachment point in this example is $100,000. That's just illustrative. We have not announced attachment points yet. Those will be announced each year before the start of the year. But just for this example, we'll call it $100,000. So, residual costs that exceed the attachment point are subject to stop-loss protections. So here, it's $185,000 that were residual, minus the $100,000, attachment point is $85,000 that will be subject to stop-loss protection. Next slide, please.

All right, so here we're moving into talking about provisional and final financial settlement. So, financial settlement is where we determine whether an ACO earns shared savings or losses for the year by comparing their benchmark to their actual Medicare spending for aligned beneficiaries.

In LEAD, like in REACH, will be offering both a provisional and a final financial settlement option. The provisional option is optional for ACOs that would most likely to be able to see their shared savings sooner in the year and not have to wait significantly beyond the end of the year to see those shared savings.

So that's the intent behind the provisional settlement option.

So for ACOs that select provisional settlement, this will be calculated in quarter one of the following performance year. So if the performance year is January through December, then it's Q1 of the next year where we're doing provisional settlement and it'll be based on claims from the full performance year, but with no claims run out. So we'll be applying a completion factor, because we don't have any claims run out at that time. So it'll be an estimate of what your financial settlement is projected to look like. It'll be based on preliminary risk scores and it will have EPCC, the Enhanced Primary Care Capitation and stop loss, included in that calculation.

So for ACOs that elect provisional financial settlement, they'll be able to either receive a payment from CMS or make a payment if they had losses in Q1 of the calendar year. Final financial settlement will apply to everybody. It will occur in Q3 of the calendar year after the performance year. It will be based on full performance year expenditures with 3 months of runout and it'll have final risk scores.

So for ACOs that did not elect provisional settlement, this will be the primary settlement process. For those who did elect provisional settlement, we'll be doing the final calculation and true-up. If with additional claims run out and final risk scores there were slight changes to your financial performance, we would conduct final settlement to reflect those changes. Next slide, please.

Finally, we have a financial guarantee requirement in LEAD as we did in REACH. And what this means is that ACOs need to obtain a financial guarantee that basically says they'll be able to repay the shared losses and other monies owed that they are liable for. And so, the financial guarantee is something that CMS would be able to call upon to recoup if an ACO had shared losses.

The calculation for the amount of the financial guarantee will be based on a few things. First, whether the ACO is in Professional Risk or Global Risk, whether they are doing just a basic Primary Care Capitation (PCC) or an enhanced Primary Care Capitation and whether they are doing Total Care Capitation as opposed to Primary Care Capitation.

The slide has different cells for each of those different combination of options. I won't march through all of them, but roughly the guarantee will be a percent of the ACO's prior year Part A and B expenditures adjusted for their alignment in the performance year. So we'll look at what were your per beneficiary per month costs in the prior year, and then we'll multiply that by your projected aligned, beneficiaries for the current year to come up with that amount.

We will also have a retention incentive, which is a 2% applied to the benchmark for performance year one. The incentive is just to remain in the model through the second performance year- so to not drop out before performance year two termination without liability deadline.

So ACOs that stay in through that second year deadline will be able to fully earn back the 2%, in their first year final settlement. ACOs that drop out of year one will have this 2% deducted from their year one final settlement. Next slide, please.

Alright, with that, I'm going to hand it to my colleague Meredith to talk about prospective payments.

>>Meredith Yinger, CMS: Thanks so much, Emily. Hi everyone, I'm Meredith Yinger, I'm the other co-model lead for the LEAD Model. We're going to talk about LEAD's prospective payments, and then walk through a payment example, and then we're gonna move into answering some of your questions. Lots of great questions in the Q&A. So let's go ahead and go to the next slide, please.

Okay, so we're going to dive right in talking about Primary Care Capitation. As a reminder, all ACOs participating in the LEAD Model are required to participate in either Primary Care Capitation or Total Care Capitation, which we'll talk about next.

Let's start with PCC. So, Primary Care Capitation, or PCC, is a prospective payment option. It's a true capitated payment for primary care services delivered by primary care specialists and any other enrolled providers in the PCC payment mechanism to aligned LEAD beneficiaries.

PCC consists of two separate payment components. The first one is the base Primary Care Capitation, or the base PCC, and the second is enhanced Primary Care Capitation, or EPCC. The base PCC is meant to approximate the cost of primary care services delivered to aligned beneficiaries, and the enhanced PCC is meant to provide additional upfront funding to support investments in infrastructure and care transformation. We calculate the base PCC as a percentage of the ACO's performance year benchmark. In order to do that, we look back at historical claims data to identify the portion of total spending on aligned beneficiaries.

For primary care services furnished by primary care specialists in participant TINs, and any other enrolled preferred providers. We then apply that historic utilization as a percent of the benchmark. That's how we determine the base PCC amount. The base PCC in LEAD includes a true-up policy for FQHCs and RHCs to ensure that these types of providers are being adequately funded for their beneficiaries. The true-up allows us to essentially look back at how actual fee-for-service spending on PCC services for aligned beneficiaries compares to the amount provided in capitation. If the actual fee-for-service spending in a quarter during the performance year is higher than what we provided in PCC, we will provide a true-up to the ACO in the following quarter. And so this is really meant to provide some security for those FQHCs and RHCs.

The EPCC is calculated also as a percentage of benchmark. You'll see here that it equals the greater of either the difference between 7% of the benchmark and the base PCC amount, or 2% of the performance year benchmark. It's important to remember that the EPCC has to be repaid during financial settlement. Let's go to the next slide, please.

Alright, so all ACOs are required to elect a claims reduction percentage for PCC. This, essentially, is the percent of the fee-for-service payments that we are reducing in order to reflect the fact that we are paying for these services through capitated payments. There are differing requirements on which types of participants can choose their fee reduction amount- primary care specialists, participant providers that previously participated in ACO REACH, are required to have their PCC fee-for-service payments reduced at 100%. All other providers that enroll in PCC have the option in PY2027 of electing a claims reduction percentage between 1 and 100%.

The reasoning for that is that our ACOs, and participant providers who've been in the ACO REACH Model gained really valuable experience ramping up to that 100%, fee reduction, and we want to maintain that experience. Let's go ahead and go to the next slide, please.

Next, we're going to talk about Total Care Capitation. So Total Care Capitation (TCC) is only available to those LEAD ACOs that are participating in the Global Risk Option. TCC is a per beneficiary, per month capitated payment for all services provided to aligned beneficiaries by participant TINs and enrolled preferred providers. So that includes both primary care services as well as non-primary care services.

Those ACOs who participate in TCC are required to elect 100% fee reduction, so all Medicare payments for aligned beneficiaries for participant providers and preferred providers who enroll in TCC will be reduced at 100%. For all of the payment mechanisms, preferred provider enrollment is optional, but in TCC, all participant providers are required to enroll in TCC. Let's go to the next slide, please.

LEAD also has a couple of other payment components, so let's go through these one by one.

ACOs that elect to participate in Primary Care Capitation have the option of also participating in non-Primary Care Capitation or the advanced payment option. These are both prospective payment opportunities for non-primary care services delivered to aligned beneficiaries but there are some important differences.

NPCC is a true capitated payment, so we calculate that based on historical claims as similar to how we discussed for PCC. For APO, we do a similar calculation, but we ultimately reconcile APO with actual fee-for-service spending at the end of the performance year as part of final settlement. So that's one key difference between these two, but the goal is really to provide

ACOs with options for how they can receive prospective payments for non-primary care services.

Finally, Emily mentioned the administrative add-on when she was talking about LEAD's benchmarking methodology. The administrative add-on is available only to higher spending ACOs in LEAD. Higher spending ACOs receive an additional capitated payment equal to 1.5% of their benchmark. It's also a monthly payment, but it's very important to note that the administrative add-on does not have to be repaid at the end of the performance year. It's excluded from shared savings calculations, and it's not associated with any claims reductions. Let's go to the next slide, please.

Alright, so this is an overwhelming table, I will recognize that, but the goal of providing this table in the RFA and in this slide deck was to help answer questions about ACO's eligibility for different payment mechanisms and how they can be combined. So you'll note here that ACOs in both the Global Risk Option and Professional Risk Option who elect PCC will be required to enroll all of their primary care specialist participant providers in PCC.

You'll also note that there are differences in eligibility when it comes to combining payment mechanisms. So, ACOs that are in the Professional Risk Option are not eligible to have the same participating provider, so National Provider Identifier (NPI) or CMS Certification Number (CCN), enrolled in both PCC and NPCC, or PCC and APO. Only ACOs that are enrolled in the Global Risk Option are eligible to do that. And you'll note that ACOs in the Global Risk Option are eligible for TCC, and those who are in the Professional Risk Option are not. Okay, let's go ahead and go to the next slide.

We are going to walk through a brief LEAD payment example. Next slide, please.

Okay, so in this example, we are looking at an ACO that's made up of 1 practice with 12 primary care providers. They have 6,000 Original Medicare beneficiaries that are slightly sicker than the average Medicare population, so they have a risk score of 1.1. They have $3 million annual fee-for-service Medicare revenue and overall higher spending than their regional peers, so this is going to be a higher spending LEAD ACO. They've not previously participated in the Shared Savings Program or in ACO REACH, so this is going to be a newly entering ACO. They've elected the Professional Risk Option, PCC, including the enhanced PCC, and a 50% fee reduction on primary care claims.

You can see here at the bottom of the slide how the annual benchmark is calculated. So, first, we start with risk standardized historical per beneficiary per month spending in the base years. That's equal to $1,250 per beneficiary and then we add the trend to trend forward, the historical spending to the current performance year. We apply the risk score, and then multiply all of that

by the eligible beneficiary months to get an annual benchmark of around $102 million. Next slide, please.

In terms of the capitated payments, there's an example here of how we would calculate the base PCC and the enhanced PCC for this ACO. The base PCCs has been adjusted to account for the fee reduction. Note that there is no fee reduction associated with the EPCC. And then because this is a higher spending ACO, this ACO will receive the 1.5% administrative add-on payment, so they're receiving $595,000 upfront monthly payments due to participation in LEAD. Let's go to the next slide, please.

Okay, and then here you can see how we calculate shared savings, and this is sort of an abbreviated version of how financial settlement works at the end of a performance period. So, we take the $102 million annual benchmark that we discussed on a previous slide, we look at the ACO's gross savings rate, and also how much of that 3% quality withhold that the ACO has earned back. And so those are used to adjust the performance year benchmark. And then we multiply the eventual shared savings by 50%, because this ACO is in the Professional Risk Option, so the ACO keeps 50% of their shared savings, and CMS keeps the other 50%, to get 2 million annual shared savings. Let's go to the next slide, please.

So here you'll see a breakdown of all of the revenue that's provided in LEAD for this ACO. It equals $6.5 million total per year, whereas this ACO would have made $3 million in revenue if they stayed in fee-for-service and weren't participating in LEAD or another accountable care model. Hopefully that's helpful for folks to see it laid out that way. Let's go to the next slide, please.

We are going to transition to Q&A and try and answer some of the great questions that you have put, in the Q&A box, so thank you. Keep those coming, and I will transition it back to Lucy.

>>Lucy Sola, CMS: Thanks, Meredith. I think the first question that I was going to go over is, I saw a couple questions around the effective date of alignment for the hybrid alignment refresh. So, we have not shared the date that beneficiaries would become claims-based aligned under the hybrid alignment refresh, and today we did share the date, and it's April 1st. So, we do not have the date yet for when TINs will need to be added to the roster, but this is intended to give a couple month gap between when ACOs are doing the participant management cycle for the summer and then when you would need to do that participant management process for the April 1st effective date, and be able to contract with providers in that time. So, this is not a change. We had just not previously reflected the effective date, and what that means is that beneficiaries would become claims-based aligned as of April 1st to the ACO, and then benchmarks and payment mechanisms and all those things would be updated accordingly.

Emily, do you want to go next?

>>Emily Bezold, CMS: Yeah, I can do a question I've seen a couple times about trending benchmarks forward. So I focused in the benchmark section on trending from the base year to the performance year, but there's also a need to trend base year one and base year 2 up to base year 3, to sort of standardize the amounts. And the approach for doing that will be, just the two-way blend of national and regional. Again, calculated the same way, based on market share, but without the ACPT. So that it will just be the two-way national-regional blend used to trend Base Year 1 and Base Year 2 forward to base year three. I will pass it to Meredith for the next question.

>>Meredith Yinger, CMS: Thanks so much, Emily. So we've received a couple questions about whether participant providers would still need to submit claims to CMS during participation in LEAD, and whether the selected, fee reduction amount matters there. So, just to be very clear, all participant providers are required to continue submitting claims for Medicare services as they normally would during LEAD participation. This is really important, as you probably gathered from Lucy's presentation at the beginning here, for the alignment methodology.

We use historical claims for alignment and for capitated payment calculations so continuing to submit those claims is really important. The same is true for folks who are enrolled in 100% fee reduction for any of the capitated payments, so please plan to continue submitting claims.

>>Lucy Sola, CMS: I can go next. I saw a couple questions on if nurse practitioners will be part of the look-back for attribution for PQEM services- so whether we're including nurse practitioners in our alignment. And we are including them in addition to physician assistants. So yeah, we hope that answers that question.

And then, Emily, want to go next?

>>Emily Bezold, CMS: Yeah, I saw a request to explain the enhanced PCC one more time, so I just want to go over that again. This is specifically for ACOs that choose the Primary Care Capitation. So then within that, there's the base Primary Care Capitation, which reflects the ACO's own historical spending on primary care services. And then there's the enhanced Primary Care Capitation which is optional, so ACOs get to elect whether they want to receive the EPCC and how much they want to receive. The maximum amount that they can receive under the EPCC is equivalent to 7% of the benchmark minus the base PCC, so we look at what percent of benchmark your base PCC is. For most ACOs, we see this ranges from roughly 2% to 4% of benchmark and then we subtract that out from 7%.

So just to give an example, let's say your base PCC, your historical primary care spending, was equal to 3% of your benchmark. We'd subtract 3% from 7%, and your enhanced PCC could be up to 4%. But you can choose anywhere from 0 to 4. There's also an additional twist to that. Most ACOs won't apply for this, but if for some reason your base PCC, is as significant as 6% or higher, your EPCC can cap out at 2%, even if subtracting your base PCC from 7% would be less than 2%, we will level you up to a 2% EPCC. But again, most ACOs won't be in that position.

Meredith, maybe I'll pass it to you for one last live question?

>>Meredith Yinger, CMS: Sure, I think before I go into a question, I'll just note for folks there are a lot of really good questions in the Q&A, that are very detailed and, that we aren't quite ready to answer yet, and so I just want folks to know, it's not that we aren't thinking about those policies or actively working on them- we are, but we're just not ready to share the full information yet that you really need for planning purposes.

The vast majority of that information will be available in the financial methodology paper that will be published over the summer. So thank you for your patience. I'll also put in a plug for folks to please keep an eye on the LEAD Model webpage, including the FAQs, because that's where we also are able to post updates as they become available. There's a link to the technical FAQ document in the chat as we speak.

There were a couple questions in the chat about the FQHC and RHC true-up. So, to be clear, the PCC, or Primary Care Capitation payment, includes an FQHC or RHC true-up. That allows CMS to compare the amount provided through capitated payments to actual fee-for-service spending, such that if the actual fee-for-service spending during a quarter is higher than is reflected in the capitated payments we're providing to, that ACO with participating FQHCs and RHCs, we can provide a true-up in a subsequent quarter. This is partially important because all services provided by FQHCs and RHCs are considered primary care services. And so the true-up allows us to, take care of some of those edge cases that might, might occur.

I think we are just about out of time, so let's go ahead and go to the next slide, please.

Thank you very much, everyone, for joining us today. Really important to note that the LEAD Model application deadline is May 17th at 11:59 PM Eastern Time.

Folks who are interested in applying, or are interested in the model at all are encouraged to apply by the deadline. The application is non-binding, so if you are selected to participate in 2027, you are not required to. So if you're not sure and you want to keep your options open, we would encourage you to go ahead and submit an application. The link to the application is available on

the LEAD Model webpage. There's a link to the webpage in the chat. Usually it also comes up if you google LEAD CMMI so please be sure to submit applications.

Also, note that you can always reach out to us with any questions, at LEAD@cms.hhs.gov. Those questions come right to us at CMS, and we're able to help answer them, so please continue using that resource.

I think we had one more slide, I can't remember. But thank you, everybody, for joining us today. We really appreciate your time, all of your great questions. Keep sharing your feedback and your questions. There will be a event survey at the end of this webinar. Please go ahead and fill it out, your feedback is really helpful to us as we plan future webinars. Thanks again.