

Long-Term Enhanced ACO Design (LEAD) Model Payment Factsheet



LEAD Model Overview

The LEAD Model is a **10-year voluntary accountable care organization (ACO) model**, beginning January 1, 2027. With **improved benchmarking** and **additional flexible payment options**, LEAD helps participants, including **providers serving specialized populations** and **those new to ACOs**, participate and succeed in **accountable care**.

Participation Options and Risk Adjustment

Risk Options

LEAD allows ACOs to choose a **level of financial risk** that fits their experience.

Global Risk Option

- ACOs can earn up to **100% of savings** but are **responsible for up to 100% of losses**.
- Accountability comes with flexibility, as this option provides the opportunity to access **total care capitation** and additional **beneficiary engagement tools**.
- ACOs are subject to a **1.75-3% “explicit discount,”** a discount rate that is directly applied against an ACO’s benchmark as a first step in shared savings calculations and represents CMS’s portion of savings.

Professional Risk Option

- ACOs can earn up to **50% of savings while capping potential losses at 50%**.
- There is **no discount** in the Professional Risk Option.

Risk Adjustment

Risk adjustment is used to adjust an ACO's benchmark based on whether its patient population is more or less sick. Risk adjustment will increase benchmarks for more sick populations and decrease benchmarks for less sick populations. LEAD uses **two risk adjustment** approaches:


The **prospective CMS-Hierarchical Conditions Categories (HCC) model**, used for non-High Needs beneficiaries, relies on beneficiaries’ prior year diagnoses to predict expected costs in the current year.

The **concurrent HCC model** uses diagnoses from the same performance year to estimate current-year expected costs and is used to risk-adjust benchmarks for the High Needs population. Ultimately, this model helps CMS more accurately **predict the risk of High Needs beneficiaries**.

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Benchmark Methodology

LEAD's benchmarking methodology is designed to work for both ACOs that are new to accountable care and experienced ACOs that have succeeded under previous ACO models. To accomplish this goal, the benchmarking methodology has the **following components**:

 **Baseline Benchmarking:** Three-year weighted average of historical claims, from the three years prior to the start of the model performance period, i.e. base years (BYs).



For **ACOs with prior experience in ACO REACH or the Shared Savings Program**, the three-year weighted average will place equal weight on each of the three base years, which helps to mitigate the impact of rebasing.

 **Annual Trend Update:** Baseline historical expenditures are then trended forward to account for annual cost increases. The trend factor is a blend of the following factors:


2/3 weighted national/regional blend:


A blend of actual observed national and regional spending trends during the performance year. The precise blend of national and regional growth rates depends on the ACO's market share; ACOs with a higher regional market share will have more weight on the national trend.


1/3 weighted Accountable Care

Prospective Trend (ACPT):


A fixed, administratively set Medicare spending growth rate determined prospectively at the start of the PY. The ACPT has a **guardrail policy** to prevent benchmarks from diverging too far from the actual observed spending trend.

 **1.5% Administrative Add-On:** High cost ACOs, defined as ACOs whose aligned Medicare beneficiaries have higher total Medicare costs than their regional average, will be eligible for a 1.5% add-on, paid as an upfront capitated payment. (see *Key Payment Components*)

 **Regional Efficiency Adjustment:** ACOs in the Global Risk Option will be eligible for a positive savings adjustment if their baseline spending is lower than average spending in their region, equal to 50% of the difference between historical and regional spending.

 **Prior Savings Adjustment:** Former Shared Savings Program and ACO REACH participants in both the Professional and Global Risk Options will be eligible for a prior savings adjustment based on savings generated in the three base years.

ACOs that are eligible for both the regional efficiency adjustment and the prior savings adjustment will receive the **higher of the two**. Both adjustments will be subject to a cap equal to 5% of US per capita cost (or 3% for ACOs transitioning from the Shared Savings Program), adjusted for each ACO's unique patient risk profile.

 **Quality Withhold and Discount:** LEAD will apply a 3% quality withhold to all ACOs' benchmark and give ACOs the opportunity to "earn back" some or all the withhold. ACOs in the Global Risk Option will also have a 1.75-3% benchmark discount.


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Key Payment Components

LEAD offers several options for **upfront or capitated monthly payments**. These payments address a key participation barrier for ACOs by enabling them to immediately invest in primary care and other enhanced services that lead to reduced Medicare expenditures over time.

All **ACOs must choose** between either **Primary Care Capitation (PCC)** or **Total Care Capitation (TCC)**, though TCC is only available to ACOs in the Global Risk Option. There are also several additional optional payment mechanisms beyond PCC and TCC.


Primary Care Capitation (PCC) Payment

 All LEAD ACOs may elect this payment mechanism, which enables them to receive **predictable monthly payments for primary care services**.


 The PCC includes a **Base PCC Amount**, which is based on the ACO's historical primary care spending, and an **optional Enhanced PCC (EPCC) Amount** that provides additional upfront resources for participating ACOs. The EPCC is calculated as the higher of:


1. The difference between 7% of the Performance Year Benchmark and the estimated Base Primary Care Capitation Amount, or
2. 2% of the Performance Year Benchmark.

Total Care Capitation (TCC) Payment


 For ACOs in the **Global Risk Option**, LEAD also offers the option of capitated payments for **all Medicare Parts A and B services** delivered by ACO Participant and Preferred Providers, including both primary and specialty care, based on providers' historical spending.

Advanced Payment Option (APO) and Non-Primary Care Capitation (NPCC)

 For ACOs that **select PCC**, the APO and NPCC are options to enter **downstream payment arrangements with non-primary care providers** (e.g., specialists and post-acute care facilities).

 **APO** is an **upfront monthly payment** that will be reconciled against actual fee-for-service (FFS) billing, while **NPCC** is a new mechanism that acts as a **true capitated payment**.

1.5% Administrative Add-On Payment

 The Administrative Add-On provides an additional source of **upfront cash flow** for high-cost ACOs, and is intended as a tailored participation incentive that can be **invested in accountable care infrastructure**. Unlike the other capitated payment options, it is not included in total cost of care reconciliation and does not need to be re-paid.

Claims Fee Reduction and Payment Operations

Under PCC, TCC, APO, and NPCC, ACOs will receive capitated payments for certain services in lieu of traditional fee for service (FFS payments). 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. Some level of claims fee reduction is mandatory for Participant Providers; the specific level depends on whether the ACO is in PCC or TCC. Claims fee reductions are optional for Preferred Providers.

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Payment Example #1

ACO Characteristics

- **1 Medical Practice**
- **12 Primary Care Providers**
- **6,000 Original Medicare Beneficiaries**
Slightly sicker than average Medicare population (1.1 CMS-HCC risk score)
- **\$3 million annual FFS revenue**
(Higher spending per capita than regional peers)
- **No experience in ACO REACH or the Shared Savings Program**

LEAD Options Selected

The practice is interested in taking accountability for patient costs and quality but does **not yet feel equipped to take on 100% risk**. It would like to implement a new nurse care navigator program and contract with a service to provide a 24/7 call line staffed by a triage nurse, but FFS revenue **has not been sufficient to support these investments**.

Selections:

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

Benchmark Calculations

\$1,250

ACO's historical risk-standardized PBPM¹ spending in base years



3%

Three-way blend update trend



1.1

ACO's average beneficiary risk score



72,000

Beneficiary Months (aligned beneficiaries x 12)

= \$102 Million Annual Benchmark

Monthly Capitated Payments

\$127K
/month

Base Primary Care Capitation (\$3 million historical primary care revenue = 3% of benchmark, adjusted for 50% fee reduction)

$$\$101,970,000 \times 0.03 \times 0.5 = \$1,529,550/12 = \mathbf{\$127,463}$$

+ \$339K
/month

Enhanced Primary Care Capitation (7% maximum PCC – 3% base PCC = 4% of benchmark)

$$\$101,970,000 \times 0.04 = \$4,078,800/12 = \mathbf{\$339,900}$$

+ \$127K
/month

1.5% Administrative Add-On (for high spending ACOs)

$$\$101,970,000 \times 0.015 = \$1,529,550/12 = \mathbf{\$127,463}$$

= \$595K

Total Monthly Upfront Payments (\$100 PBPM)

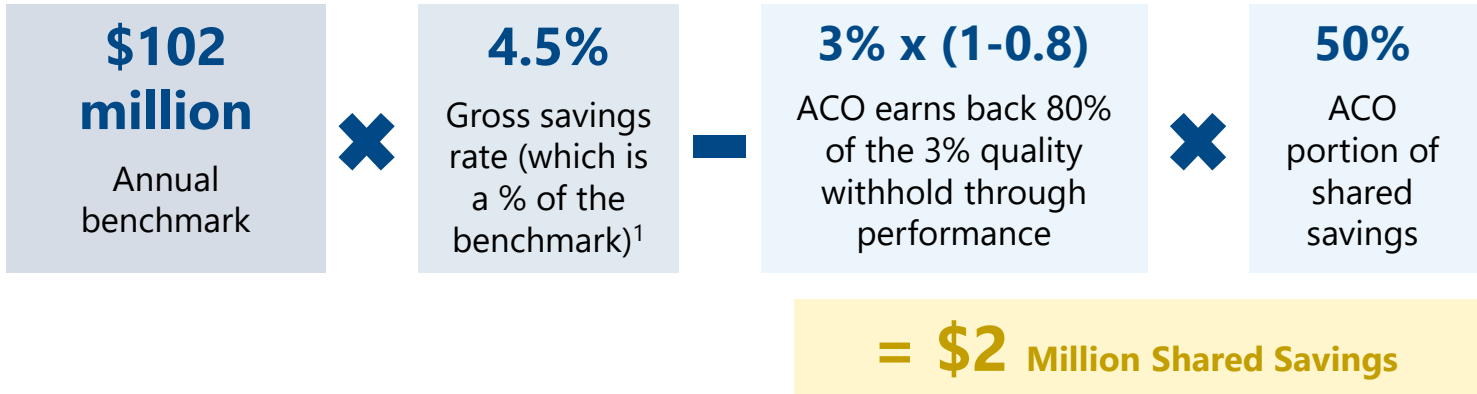
¹Per-beneficiary per-month

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Payment Example #1

Shared Savings Calculation



If the ACO had chosen the *Global Risk Option*, shared savings would have been \$2.2 million
(100% of savings, minus a 1.75% discount).

Total Revenue Impact

	\$1.5 million	Fee-for-service (FFS) revenue
+	\$1.5 million	Base PCC Capitation
+	\$0	Enhanced PCC Capitation ²
+	\$1.5 million	1.5% Administrative Add-On
+	\$2 million	Shared Savings
=	\$6.5 million (\$1,080 per beneficiary)	

...compared to annual practice revenue under FFS

\$3 million FFS revenue (\$500 per beneficiary)

¹This is a factor of actual spend by the organization and is thus not derived elsewhere.

²Represented as \$0 net new revenue because it is paid monthly but must be re-paid at the end of the year.

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Payment Example #2

ACO Characteristics

- **Health system** that owns **5 primary care practices, 10 multi-specialty practice sites**, and partners with preferred home health, skilled nursing facility, and hospice providers
- **30,000 Original Medicare** beneficiaries with average disease burden (1.0 average risk score)
- **Previous participation in ACO REACH** with 3% lower spending per capita than regional peers

LEAD Options Selected

The health system has been successful in ACO REACH and **wants to take on 100% risk**, to potentially keep more of the savings it generates. It prefers to receive a **higher share of its Medicare revenue through predictable monthly payments**, to create innovative payment and quality incentive structures. It hopes to establish **downstream value-based arrangements** with post-acute providers, with a focus on preventing readmissions.

Selections:

- Global Risk Option
- Total Care Capitation
- 100% fee reduction for primary care and specialist providers
- 60% fee reduction for post-acute providers

Benchmark Calculations

\$1,050

ACO's historical per beneficiary per month spending in the base years, with 1.0 risk score



\$16

PBPM Regional Efficiency Adjustment



3.3%

Three-way blend update trend



360,000

Beneficiary Months (aligned beneficiaries x 12)

= \$397 Million Annual Benchmark

Monthly Capitated Payments

\$10.9 million
/month
(\$360 PBPM)

Total Care Capitation (Benchmark minus historical spending for services provided by non-ACO providers, adjusted for fee reductions)¹

$$\$397,191,600 \times 0.15 \times 100\% + \$397,191,600 \times 0.30 \times 0.6 = \$131,073,228 / 12 = \mathbf{\$10,922,769}$$

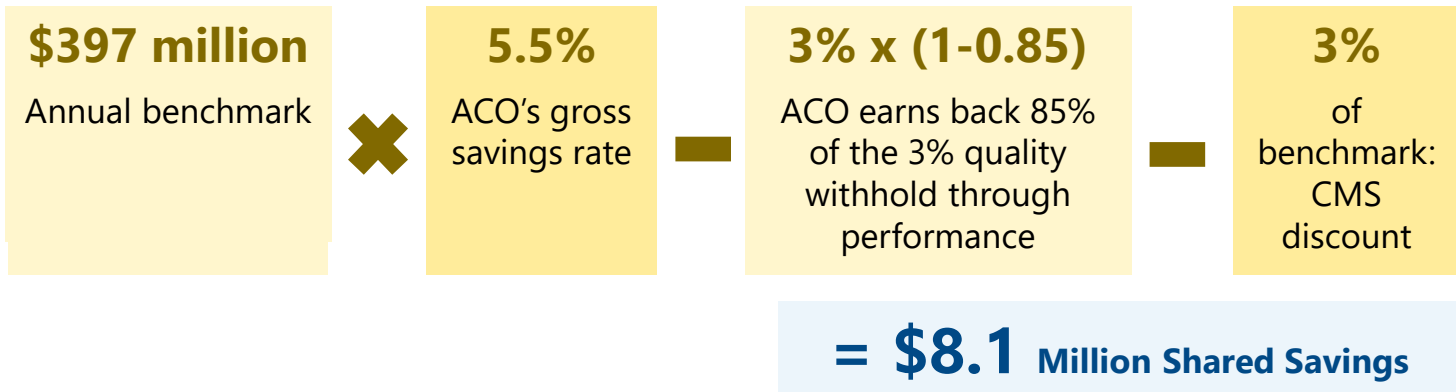
¹This example assumes that spending by the ACO's primary care providers is 3% of the benchmark (with 100% fee reduction), spending by the ACO's specialty providers is 12% of benchmark (with 100% fee reduction), and spending by the ACO's preferred post-acute providers is 30% of benchmark (with 50% fee reduction), for total participant and preferred provider spending of 30% of benchmark.

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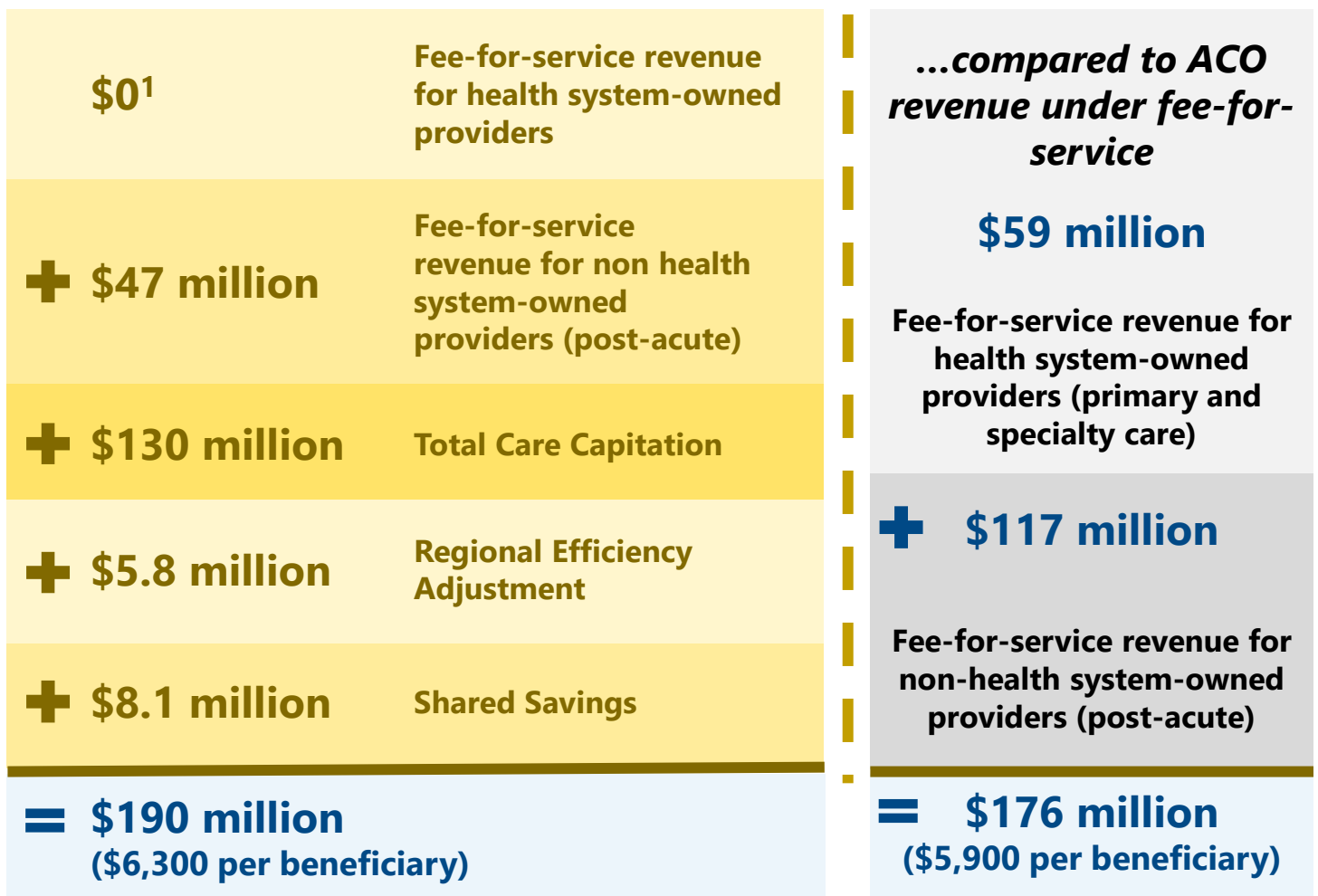


Payment Example #2

Shared Savings Calculation



Total Revenue Impact



¹Fee-for-service revenue is \$0 because primary care providers and specialists are receiving a 100% fee reduction.

Additional Resources