Long-term Enhanced ACO Design (LEAD) Model Details

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Contact us with your questions!

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Agenda

- Overview
  - Application Process
  - Eligibility
  - Participation Requirements
- Financial Methodology
  - Benchmarks
  - Risk Sharing Options and Financial Settlement
  - Payment Mechanisms
- Model Design Elements
  - Beneficiary Alignment
  - Beneficiary Engagement and Marketing
  - Medicare-Medicaid Integration
  - Healthy Living Strategy
- Quality and Performance
- Monitoring, Data Sharing, and CMS Supports

Key Links for Applicants

- Request for Applications (RFA) released March 31, includes key details for applicants
  - Application portal open through May 17, 2026 at 11:59pm ET
  - A letter of interest (LOI) is available for those interested in applying to future application cohorts
  - Current REACH ACOs may submit an abbreviated application through the portal
- LEAD Model listserv, model team contact: LEAD@cms.hhs.gov
- Additional information: Application Checklist, Model Overview Factsheet, Payment Factsheet

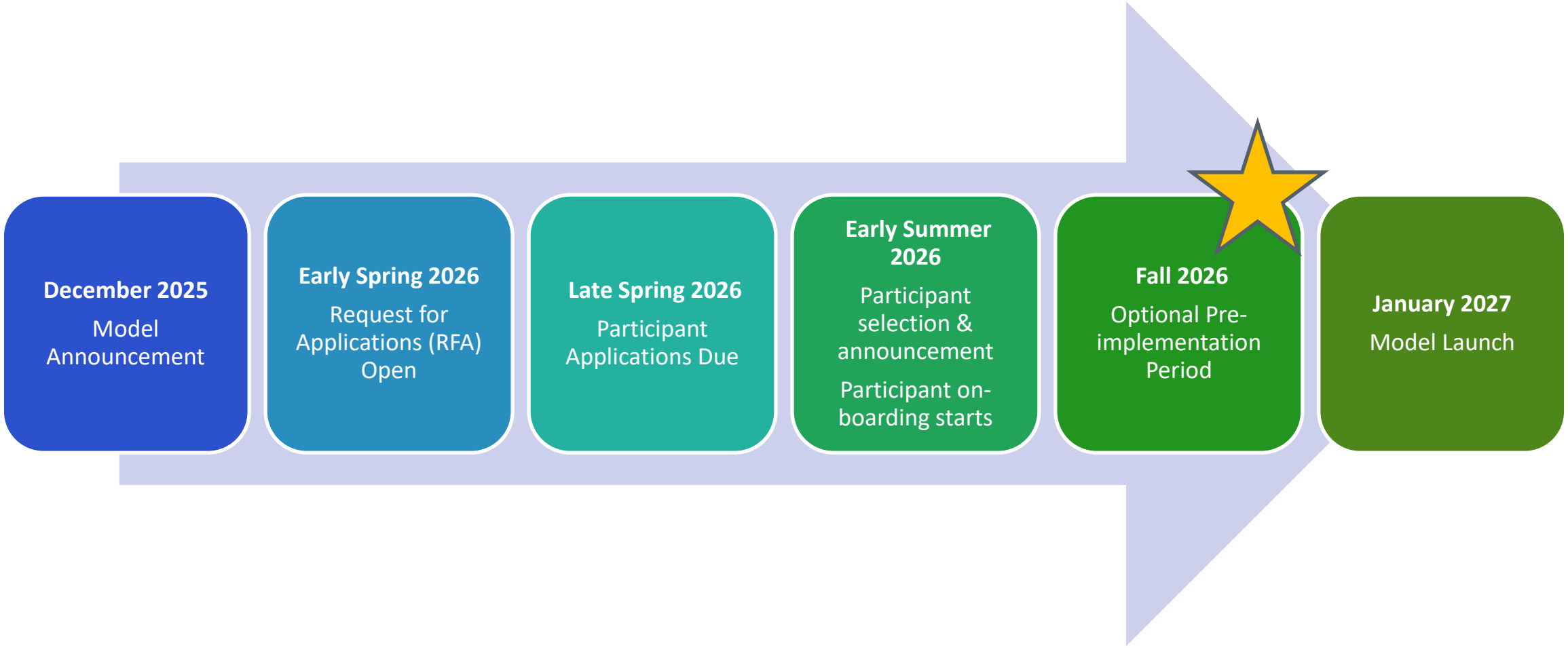
Overview, Eligibility, and Participants

A. Model Overview
B. Application Process
C. Applicant Eligibility
D. Participation Requirements

Overview

- **10-year voluntary ACO model** (Jan. 1, 2027 – Dec. 31, 2036)
  - Optional implementation period: Sept. 15 – Dec. 31, 2026
- **Builds on prior ACO initiatives with focus on long-term, sustainable benchmarks:**
  - Benchmark methodology designed to attract broad mix of ACOs and providers/suppliers
  - Additional financial support for ACOs with high-cost, complex patients
  - Options for capitation, including Primary Care Capitation and Total Care Capitation
  - New design options to facilitate downstream episode-based risk arrangements between ACOs and specialty care providers
- **Two Risk Sharing Options:**
  - *Global Risk Option* – Up to 100% of savings/losses
  - *Professional Risk Option* – Up to 50% savings/losses
- Expected to meet criteria to be an **Advanced Alternative Payment Model (Advanced APM)**

LEAD Model Timeline



Application

- Applications are due by May 17, 2026 at 11:59 PM (ET)
- CMS will assess applications based on the following domains:
  1. Organizational readiness
  2. Revenue sources and payment arrangements
  3. Beneficiary and caregiver experience
  4. Data and health information
  5. Preventive care
- ACOs participating in ACO REACH are eligible to submit an abbreviated application
- CMS anticipates offering additional application windows for subsequent Performance Years
  - Organizations that are interested in future cohorts but are not ready to apply for PY 2027 can submit a Letter of Interest (LOI) by May 17
  - CMS plans to release standardized LOI form no later than April 20, 2026

ACO Eligibility

- **Legal Entity:** Must be a recognized legal entity (Tax Identification Number, or TIN) and authorized in all states it operates
  - If the ACO includes Medicare-enrolled providers/suppliers billing under more than one TIN, the ACO must be a distinct legal entity identified by its own TIN
- **Beneficiary Minimums:**
  - At least 5,000 aligned Medicare beneficiaries per Performance Year
  - At least 3,000 claims-based aligned beneficiaries in at least one Base Year
  - Lower minimums allowed for ACOs serving high proportion of High Needs beneficiaries and for Newly Entering ACOs
- **Program Integrity:** Must pass CMS program integrity review with no disqualifying findings
- **Participation in Other Shared Savings Initiatives:** Cannot participate in overlapping Medicare shared savings initiatives or other CMS Innovation Center models where overlap is prohibited
- **Ability to Repay:** Must demonstrate ability to repay Shared Losses or Other Monies Owed (e.g., financial guarantee required)

Eligible Providers and Suppliers

- Medicare-enrolled providers/suppliers[1] can participate as part of a **Participant TIN** or as **Preferred Providers**
- LEAD ACOs must submit Participant TIN and Preferred Providers lists before each Performance Year (PY) and have written agreements in place with each entity

Participant TIN

- **Whole TIN Approach** – all providers/suppliers billing under a Participant TIN must agree to participate in LEAD
- Usually (but not required to be) primary care providers

Preferred Providers

- **Participation at TIN-NPI Level**
- Usually (but not required to be) specialists or post-acute care providers
- Identified on the ACO's Preferred Provider List

(1) The following types of providers are prohibited from participating: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier; (2) an ambulance supplier; (3) a drug or device manufacturer; and/or (4) excluded or otherwise prohibited from participation in Medicare or Medicaid

Participant and Preferred Providers

- **Participant TINs and Providers.** ACO's Participant TIN List will identify all Participant TINs that comprise ACO
  - Participant Providers billing under Participant TIN will contribute to claims-based alignment
- **Preferred Providers.** ACO's Preferred Provider List will identify Preferred Providers that have written agreement with ACO to provide services to aligned beneficiaries

Differences Between LEAD Participant TINs and Preferred Providers

Relationship to ACO	Participant TIN	Preferred Provider
Used for Alignment	Yes	No
Capitation	Mandatory	Optional
Quality Reporting	Yes	No
Access to Benefit Enhancements and Beneficiary Engagement Incentives	Optional	Optional
Eligible for Shared Savings	Yes	Yes
Whole TIN Participation	Yes	No
CARA Eligible	No	Yes

ACO Structure and Governance

- Must have **identifiable governing body** with authority to execute functions and make final decisions on behalf of ACO
  - Separate and unique from the ACO and cannot be the same as the governing body of an entity participating in the ACO[1]
- **Responsibilities:** Oversight and strategic direction of the ACO; hold ACO management accountable
- **Composition:** At least 75% control (as apportioned through voting power) held by Participant Providers, Preferred Providers, or designated representatives[2]
- **Beneficiary Representation:** Must engage beneficiaries through one of the following:
  - Beneficiary representation on governing body
  - Beneficiary and Consumer Advisory Committee

Additional information on the governing body and ACO leadership and management requirements included in the RFA

(1) Exception is if the providers/suppliers that comprise the ACO bill under a single TIN
(2) ACO can seek exception from CMS for this requirement

High Needs ACO Eligibility

- **High Needs ACOs** will be eligible for lower alignment minimums
- ACOs will be designated as High Needs if:
  - At least 40% of total aligned beneficiary population meets High Needs eligibility criteria
  - Have certain care delivery capabilities, such as 24/7 access to health care provider with access to patient's electronic record; providers with training in advanced care planning conversations; and the ability to deliver care in patients' homes
- CMS will assess if an ACO meets the eligibility threshold prior to the start of each PY

Newly Entering ACO Eligibility

- **Newly Entering ACOs** are eligible for lower alignment minimums
- ACOs are defined as "Newly Entering" if:
  - ACO entity has not participated in MSSP or ACO REACH;
  - Less than 40% of the ACO's Participant TINs participated in MSSP or ACO REACH in past 5 years; and
  - Less than 50% of the ACO's Participant Providers have participated in Medicare ACO initiatives in the past 5 years

Use of Certified EHR Technology (CEHRT)

- If an arrangement between an ACO and a Participant TIN and/or Preferred Provider involves EHR software, the software must be "interoperable" at the time of provision (i.e., meets ONC certification)
- **Transitional CEHRT Pathway.** Model includes a one-year on-ramp for ACOs and clinicians for whom 100% CEHRT compliance is operationally complex
  - During transitional period, ACOs can identify clinicians that require a temporary and targeted exception for CEHRT compliance
  - Clinicians must attest to having a plan to achieve future CEHRT compliance
  - Targeted exceptions may continue beyond first PY, subject to CMS discretion
- **CEHRT Exception for Advanced Custom Health IT Implementation.** Model includes three-year CEHRT deferral pathway for providers utilizing "advanced, custom, or homegrown Health IT systems"
  - Must attest to meeting several technical capabilities in the first year of participation that will be specified in the participant agreement
  - Additional standards and implementation specifications apply (*see RFA for additional details)*

Program Overlaps

- LEAD ACOs may not simultaneously participate in more than one LEAD risk sharing option (e.g., Professional Risk and Global Risk)
- LEAD ACOs and Participant TINs can generally not participate in other shared savings initiatives
- Some overlap allowed with other CMS Innovation Center models
  - CMS plans to issue overlap policies with its annual LEAD methodology paper
  - CMS will also issue additional guidance to assist ACOs and Participant TINs in determining which models can be combined with LEAD and whether beneficiaries may align with more than one initiative
- Providers may participate in another model under a different TIN that is not under ACO LEAD
- Overlap requirements generally do not apply for Preferred Providers
  - E.g., can be a be preferred provider for more than one LEAD ACO, a Participant TIN in another LEAD ACO, or a MSSP Participant

Other Models and Programs	Can LEAD Participant TINs participate?
MSSP	*Participation prohibited*
Other CMS Innovation Center models or initiatives involving shared savings (e.g., Kidney Care Choices)	*Participation prohibited*
AHEAD Hospital Global Budget and Geo AHEAD	*CMS anticipates that participation will be prohibited*
Primary Care AHEAD	*CMS anticipates participation will be allowed in certain circumstances*
GUIDE, TEAM, ACCESS, ASM, and EOM Model	*CMS anticipates that participation will be allowed*

Financial Methodology

Benchmarking

A. Overview
B. Calculating Historical Baseline Expenditures
C. ACO-Specific Benchmark Adjustments
D. Trending Benchmarks to the PY
E. Risk Adjustment
F. Discount and Quality Withhold
G. Retention Incentive
H. Regional Rate Book Transition

Benchmarking Methodology: Overview

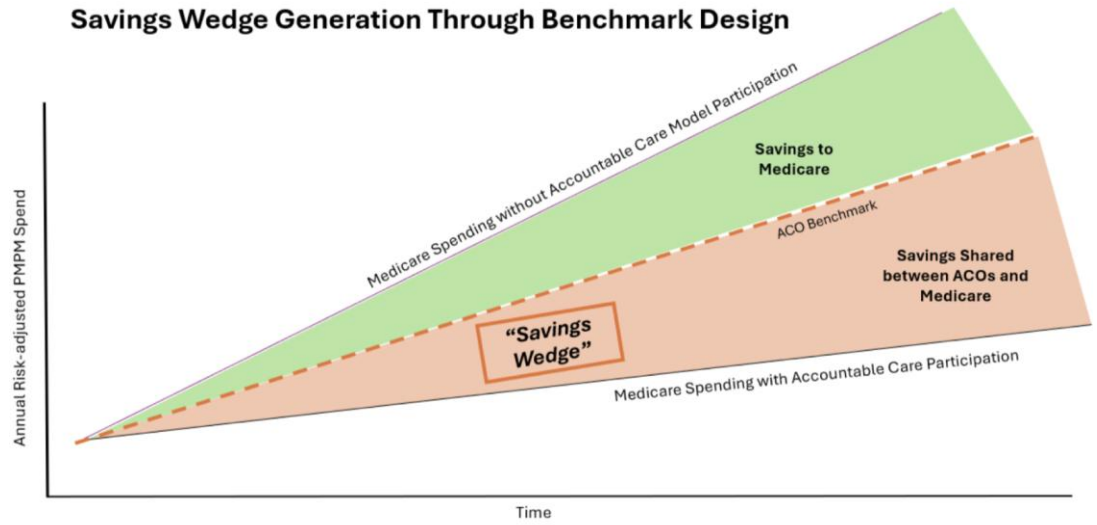
- **"Performance Year Benchmark"** – ACO's expected Medicare Parts A and B expenditures for aligned beneficiaries in a given PY
- Builds on MSSP and ACO REACH methodologies with enhancements, including addressing the "ratchet" effect
- Three separate per-beneficiary per-month (PBPM) benchmarks:
  1. Aged & Disabled (A&D)
  2. End-Stage Renal Disease (ESRD)
  3. High Needs
- Benchmarks also separately calculated for beneficiaries who are voluntary aligned versus claims-based aligned

Benchmarking: Addressing Ratchet Effect

- **Issue:** As ACOs become more efficient it lowers national and regional spending growth, causing benchmarks to ”ratchet” downward and making long-term ACO participation unsustainable
- **LEAD Solution:** Two approaches to allow total payments to rise above realized spending as ACOs collectively lower spending:
  - ***Positive regional efficient adjustment*** available to lower-spending ACOs and ***1.5% administrative add-on capitation payment*** available to higher-spending ACOs
  - ***Accountable Care Prospective Trend (ACPT)***

Allows up to 3% difference (or “wedge”) between average benchmarks (inclusive of the add-on capitation) and average expenditures by year 5.

Figure 1. New Benchmarking Approach under LEAD and Generation of a Savings Wedge



Source: CMS Innovation Center, Long-term Enhanced ACO Design (LEAD) Model Request for Applications, https://www.cms.gov/priorities/innovation/files/lead-rfa.pdf

Performance Year Benchmark Methodology

- Five steps for setting **historical expenditure-based benchmarks**:
  1. Calculation of the ACO's historical baseline expenditures
  2. ACO-specific benchmark adjustments
  3. Trending the ACO's historical baseline expenditures forward
  4. Risk adjustment
  5. Withholds for quality performance and the discount (*Global Risk Option only*)
- CMS intends to phase in a regional rate book-based benchmark that will ultimately replace historical expenditure-based benchmarks

Step 1: Historical Baseline Expenditures

- Baseline set using fixed 3-year period of most recent calendar years before ACO's first performance year ("base years")
  - E.g., for ACOs starting in PY 2027, base years are CYs 2024-2026
- *Baseline period* remains static for duration of model
- *Baseline expenditures* recalculated each PY based on Participant TIN list

- Base years vary based on ACO experience
  - Newly Entering ACO base years weighted toward more recent years
  - Renewing ACO base years equally weighted
  - CMS may modify the weight of base years if it determines an ACO does not have sufficient claims history to construct baseline expenditures for any of the base years

Base Year	Base Year Weight	
	Newly Entering ACO	*Renewing ACO*
Year 1	10%	33.3%
Year 2	30%	33.3%
Year 3	60%	33.3%

Historical Baseline Expenditures by Alignment

- Different methodologies to calculate historical baseline expenditures based on beneficiary alignment

Claims-Aligned Beneficiaries

- Constructed using ACO's Participant TIN List for current PY
- Expenditures based on historical spending for beneficiaries who *would have been aligned* to ACO in each base year had current-year Participant TINs been participating in those years

Voluntarily Aligned Beneficiaries

- Constructed using beneficiaries aligned in current PY
- Expenditures based on historical spending for beneficiaries that are voluntarily aligned in current PY

NOTE: If voluntarily aligned population's historical expenditures differ by > 10% from claims-aligned benchmark, then the voluntarily aligned benchmark will be set so difference is no more than 10% from claims-aligned benchmark

Differs from ACO REACH (which sets benchmarks using regional rate)

CMS believes the LEAD approach removes incentive for ACOs to voluntarily align beneficiaries expected to have spending below regional average

Step 2: ACO-Specific Benchmark Adjustments

- **ACO-specific benchmark adjustments** applied to historical baseline expenditures:
  1. ***Regional Efficiency Adjustment***
  2. ***Prior Savings Adjustment***
  3. ***1.5% Administrative Add-on Capitation***
- Combined adjustments **capped at either 3%** (*for ACOs previously in MSSP*) **or 5%** (*all other ACOs*) of risk-standardized national average per capita spending (i.e., United States Per Capita Costs, USPCC)
  - Renewing ACOs that have more than 40% of Participant TINs that participated in a MSSP ACO within the previous two years will have benchmark adjustment capped at 3% of USPCC
  - Cap will be adjusted for each ACO's specific population risk
- If ACO is eligible to receive both regional efficiency and prior savings adjustments, will receive higher of the adjustment amounts (subject to the cap)

Regional Efficiency Adjustment

☑ Global Risk Track

☑ **Lower-Spending ACOs:** Baseline spending lower than average Medicare FFS spending in region

✕ *No negative adjustment for higher-spending ACOs*

To calculate regional efficiency adjustment:

1. Determine the ACO's historical base year expenditures
2. Determine average Medicare FFS spending in the ACO's region during the historical base years
3. Adjust for the proportions of beneficiaries that are A&D, High Needs and ESRD between the ACO's aligned population and the ACO's regional align-able population
4. Determine the risk-adjusted difference between an ACO's historical base year expenditures and its regional base year expenditures

$$\text{Regional Adjustment*} = 50\% \times \left(\begin{array}{c} \textit{Regional base year expenditures} - \\ \textit{ACO's historical base year expenditures} \end{array} \right)$$

** Subject to cap on benchmark adjustments; CMS applies the higher of the regional adjustment or prior savings adjustment if ACO is eligible for both*

Prior Savings Adjustment

☑ Global Risk Track ☑ Professional Risk Track

☑ Renewing ACOs

Adjustment based on savings generated in the three calendar years immediately preceding start of LEAD performance period (*similar to MSSP methodology*):

1. **Calculate total per-capita savings** (or losses) for each of the three prior performance years:
   - Reflects gross Medicare savings (not just savings retained by ACO)
2. **Determine eligibility for adjustment**
   - If average savings across three years is positive, eligible for adjustment
3. **Apply proration factor** to account for changes in size of ACO's beneficiary population:

$$\frac{Beneficiary\ years\ in\ current\ PY}{Average\ beneficiary\ years\ across\ three\ historical\ base\ years}$$

4. **Calculate Final Adjustment:**

$$\text{Prior Savings Adjustment*} = 50\% \times (\boldsymbol{prorated\ average\ savings\ rate})$$

** Subject to cap on benchmark adjustments; CMS applies the higher of the regional adjustment or prior savings adjustment if ACO is eligible for both*

Step 3: Trending Benchmarks

To account for annual Medicare cost growth, historical baseline expenditures trended forward to current PY using **three-way blended update factor***:

- ***Two-Way Blend of National and Regional Growth*** (2/3)
- ***Accountable Care Prospective Trend (ACPT)*** (1/3)

ACPT Guardrail Policy:

- For PY 2027 (PY1), guardrail caps three-way blend update factor to within +0.3/-0.2 percentage point of Two-Way National and Regional Blended Updated Factor
- For subsequent PYs, upper and lower bounds of guardrails may be widened by +0.3 or -0.2 percentage points, respectively, each year
  - E.g., PY2 +0.6/-0.4 percentage points; PY3 +0.9/-0.6 percentage points; etc.
- Policy could be revised in future to align with MSSP

*CMS will calculate separate trend for each LEAD beneficiary category

Two-Way Blend of National and Regional Growth

- **Weighted average of national and regional FFS growth rates**
  - *National growth rates* based on CMS OACT national Medicare expenditure data
  - *Regional growth rates* based on expenditures for the ACO's regional service area
- Weights based on share of alignment-eligible beneficiaries in region aligned to ACO – inversely proportional
  - ACOs with lower share of aligned beneficiaries in region → more weight on regional growth trend
  - ACOs with higher share → more weight on national growth trend

Accountable Care Prospective Trend (ACPT)

- Prospectively set growth rate established at start of ACO's Agreement Period
- Calculated using one or more annual growth rates based on national FFS Medicare expenditures projected by CMS OACT
- Methodology aligns with MSSP ACPT

Step 4: Risk Adjustment

Risk adjustment varies based on beneficiary category:

A&D Beneficiary Category

- Benchmarks risk adjusted using modified version of the prospective CMS-Hierarchical Condition Categories (HCC) Risk Adjustment Model (Version 28) – "***CMMI HCC Prospective Risk Adjustment Model V1***"
- Recalibrated to remove the High Needs population

ESRD Beneficiary Category

- Benchmarks risk adjusted using ***2023 ESRD CMS-HCC Risk Adjustment Model***

High Needs Beneficiary Category

- Benchmarks risk adjusted using ***CMMI HCC Concurrent Risk Adjustment Model V2***
- Applies to all High Needs beneficiaries, regardless of whether aligned to a High Needs ACO
- Modified version of the concurrent risk adjustment model used in ACO REACH

Coding Intensity Mitigation Strategy: CMS plans to apply a risk score growth cap (using Base Year 3 as the reference)

- *A&D and ESRD Populations:* 3% cap
- *High Needs:* TBD (expected to be 3-8%)

AI-Inferred Risk Adjustment: CMS plans to roll-out an AI-inferred risk adjustment model for A&D population:

- *2028* → shadow test use of risk scores generated from an AI-inferred model
- *2029* → Blended risk score (1/3 AI and 2/3 CMMI HCC Prospective Risk Adjustment Model V1)
- *2030* → Blended risk score (2/3 AI and 1/3 CMMI HCC Prospective Risk Adjustment Model V1)
- *2031* and subsequent years → 100% AI inferred risk scores

CMS may consider AI-inferred risk model for High Needs beneficiaries in the future

Step 5: Discount and Quality Withhold

- **Discount applied to benchmark for ACOs in Global Risk Option**
  - Similar to ACO REACH
  - Represents savings retained by CMS when ACO generates shared savings
- PY benchmark reduced by discount during financial settlement – varies by ACOs:

Low-Spending ACOs	Higher-Spending ACOs
3% (*static)*	2027: 1.75% 2028: 2.0% 2029: 2.25% 2030: 2.5% 2031: 2.75% 2032-2036: 3.0%

- **Quality withhold of 3% applied to all ACOs' PY financial benchmark calculations** – opportunity to "earn back" based on quality performance

Additional Benchmarking Policies

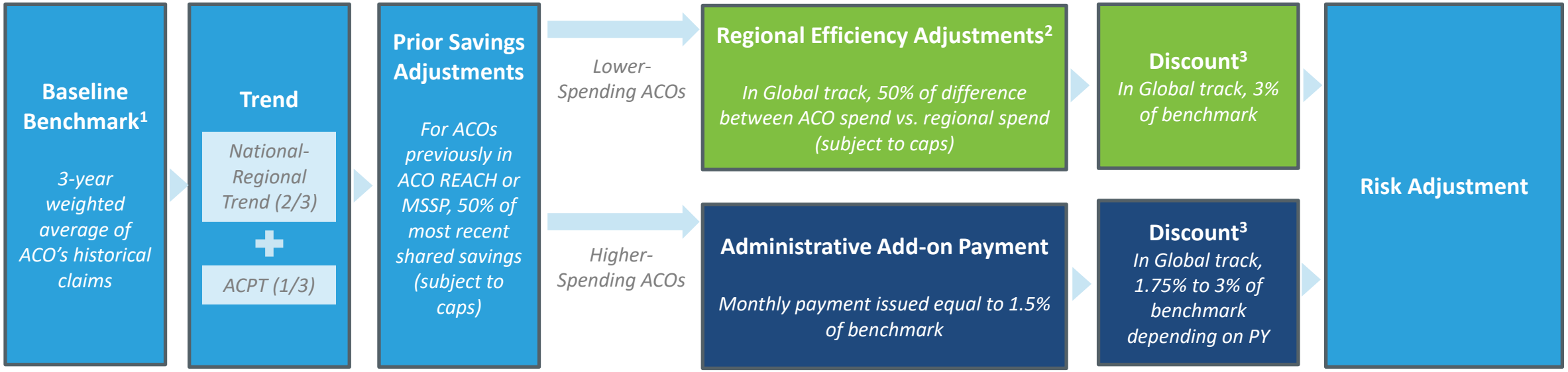
Retention Incentive:

- Intended to incentivize participation for a minimum of two PYs
- ACOs that terminate participation after one PY will have their PY benchmark reduced by 2% at Final Settlement
- ACOs that do not terminate their participation on or before the Termination Without Liability Date of the ACO's second PY will "earn back" the incentive during Final Settlement for their first PY

Regional Rate Book Transition

- No sooner than 2031, CMS will phase in benchmarks based on region-wide "rate book"
- Timeline will be based on regions meeting certain region-level criteria:
  1. Proportion of beneficiaries by region aligned to LEAD, MSSP, or other accountable care models
  2. Amount of savings that ACOs have already generated
  3. Proportion of higher-spending ACOs

LEAD Benchmarking Approach Overview



(1) Benchmarks calculated separately for each beneficiary category and for voluntary and claims-based alignment.
(2) CMS will apply the higher of the prior savings or regional efficiency adjustments, subject to caps.
(3) 2% of benchmarks will be withheld for the first year of participation and earned back by ACOs upon completion of two full performance years.

Financial Methodology

Risk Sharing Options, Risk Mitigation, Financial Settlement

A. Risk Sharing Options
B. Risk Corridors
C. Stop Loss
D. Financial Settlement
E. Significant, Anomalous, and Highly Suspect (SAHS) Billing Policies

Risk Sharing Options

Professional Risk

- Eligible for up to 50% shared savings/losses
- Required to stay in option for minimum of 4 performance years -> option to transition to Global Risk

Global Risk

- Eligible for up to 100% shared savings/losses
- Eligible to receive positive regional efficiency adjustment
- Newly Entering ACOs can switch to Professional Risk after completing PY if determine not ready for Global Risk
- Subject to discount applied to benchmark

Applicant ACOs must submit their risk sharing option at time of application

- Before signing PY Participant Agreement, ACO may switch from Global to Professional
- After signing PY Participant Agreement, Renewing ACOs are prohibited from switching from Global to Professional

Under both Professional and Global Risk Options:

- **No minimum savings rate or minimum loss rate**
  - ACOs retain "first dollar" savings or losses
- **Restricted from holding 100% of total downside risk**
  - ACOs must allocate at least 1% of total downside risk on average across Participant providers
  - Benchmark base used to determine 1% can be adjusted to account for documented regulatory restrictions that limit Participant's ability to accept downside risk

Risk Corridors

- Aggregate amount of savings/losses constrained by risk corridors.
- ACOs eligible to receive portion of shared savings (or liable for portion of shared losses) above each risk band

Corridor	Corridor 1	Corridor 2	Corridor 3	Corridor 4
Professional Risk Option				
Percent of Benchmark	Up to 10%	10-15%	15-20%	>20%
Savings/Losses Rate	50%	35%	15%	5%
Global Risk Option				
Percent of Benchmark	Up to 15%	15-25%	35-50%	>50%
Savings/Losses Rate	100%	50%	25%	10%

Stop Loss

- **Optional stop-loss arrangement** to reduce financial uncertainty
  - ACOs must make selection (and can change preference) prior to start of each PY
- **"Residual Based Reinsurance" approach** designed to protect against outlier deviations that exceed predicted spending ("attachment point")
- **PBPM stop-loss "charge" applied to ACO's PY benchmark** – based on percentage of expenditures above each of the ACO's attachment points in baseline period
  - Predicted spending determined by ACO's benchmark and beneficiary's risk score
  - CMS to calculate model-wide stop-loss attachment points prospectively prior to start of each PY based on expenditure data derived from national reference population
  - Model-wide attachment points adjusted to beneficiary level using beneficiary risk scores and ACO's benchmark
  - Stop-loss payouts cover share of expenditures once attachment point is surpassed
  - Uniform multiplier budget neutrality adjustment may be applied at financial settlement to ensure that model-wide payouts equal model-wide charges

Financial Settlement

- **Final Financial Settlement process** to be conducted in Q3 of the CY following close of PY
- **Optional Provisional Financial Settlement** intended to provide timelier disbursement of provisional shared savings
  - CMS may use default quality score and preliminary risk score
  - CMS may make adjustments to account for differences between provisional and final financial settlement (e.g., Incurred But Not Reported expenditures; seasonal adjustments)

Comparison of Provisional and Final Financial Settlement

	Provisional Financial Settlement	Final Financial Settlement
Target Date for Financial Settlement	Q1 of CY following PY	Q3 of CY following PY
Claims Included in Financial Settlement	PY expenditures incurred through June 30 of PY	PY expenditures incurred through Dec. 31 of PY
Claims Run-Out	Through Dec. 31 of PY	Through March 31 of the CY following PY
Risk Scores	Preliminary	Final

Financial Guarantee & Extended Repayment Option

Financial Guarantee: ACOs must secure a financial guarantee to ensure CMS is able to recoup Shared Losses and/or Other Monies Owed (e.g., capitated payments)

- ACOs who elect Global Risk Option and/or Enhanced Primary Care Capitation will be required to maintain larger financial guarantees
- Financial guarantee must be one of the following:
  1. Funds placed in escrow
  2. Line of credit
  3. Surety bond

See Appendix for more details on financial guarantee requirements by Risk Sharing Option and Capitation Payment Mechanism

Extended Repayment Option (ERO): Option for ACOs continuing in model to request CMS repayment of Shared Losses or Monies Owed to CMS over time

- Similar to the Extended Repayment Schedule available to Medicare enrolled providers
- Subject to CMS approval and satisfaction of ERO eligibility requirements

Financial Guarantee Requirements

- ACOs electing to receive Enhanced Primary Care Capitation have option of securing two separate financial guarantees or one combined financial guarantee.
- ACOs that elect Total Care Capitation must only secure one financial guarantee
- CMS will notify ACOs annually on the amount that must be funded by financial guarantee
- ACOs will be required to submit draft financial guarantees to CMS for review
- ACOs must submit documentation of its compliance with the financial guarantee by December 31st prior to start of PY
  - If ACO fails to submit documentation, CMS will withhold monthly payments to ACO under selected capitation payment mechanism until documentation is submitted

Financial Guarantee Requirement by Risk Sharing Option and Capitation Payment Mechanism Election

Track	Shared Losses and Base Primary Care Capitation Payment Only	Enhanced Primary Care Capitation Only (optional)	Combined Shared Losses, Base Primary Care Capitation, and Enhanced Primary Care Capitation Payment (optional)	Shared Losses and Total Care Capitation Payment
Professional	2% of Previous Year's Part A & B Expenditures[1]	1.5% of Previous Year's Part A & B Expenditures[1]	3.5% of Previous Year's Part A & B Expenditures[1]	N/A
Global	2.5% of Previous Year's Part A & B Expenditures[1]	1.5% of Previous Year's Part A & B Expenditures[1]	4% of Previous Year's Part A & B Expenditures[1]	4% of Previous Year's Part A & B Expenditures[1]

(1) Refers to ACO's total Medicare Part A and B expenditures from the previous calendar year for the expected aligned population for upcoming performance year based on the providers on the Participant TIN list

Significant Anomalous, and Highly Suspect Billing Activity

- CMS plans to implement similar reopening policies for significant, anomalous, and highly suspect (SAHS) billing activity as in ACO REACH and MSSP
- Billings identified as SAHS will be removed from financial calculations, including shared savings/losses, historic benchmarks, trend rates, repayment mechanisms, high-low revenue status
  - CMS intends to use this authority in "rare and extreme cases"
- CMS gives itself sole discretion to identify SAHS billings that warrant adjustments using the following criteria:
  - The billings have national or regional impact or significance in either volume or dollars;
  - Inaction would create an imbalance between ACO performance and historic benchmark expenditures;
  - Anomalous billings could result in significantly inaccurate and inequitable determinations that are outside of an ACOs' control; or
  - The claims may disproportionately represent Medicare providers or suppliers whose Medicare enrollment status has been revoked

Financial Methodology

LEAD Payment Mechanisms

A. Prospective Payments

B. CMS Administered Risk Arrangements (CARA) Initiative

Prospective Payments

- Prospective payments enable more flexible care delivery and predictable cash flow
- ACOs must select one of two capitation options:
  - **Primary Care Capitation (PCC),** required for Professional Risk ACOs, available to Global Risk ACOs
  - **Total Care Capitation (TCC),** available to Global Risk ACOs
- Additional payment options available:
  - **Non-Primary Care Capitation (NPCC)**
  - **Advanced Payment Option (APO)**
  - **Administrative add-on** for higher spending ACOs

Capitation Options

Primary Care Capitation

- PBPM, paid monthly, derived from PY benchmarks
  - Base PCC calculated using historical claims
  - FQHC/RHC "true-up" ensures PCC payments are not lower than fee reductions
  - Enhanced PCC is greater of 7% of TCOC – Base PCC or 2% of TCOC; counts towards PY expenditures
- Covers Medicare primary care services delivered by primary care specialists
  - 100% fee reduction required for PCP Participant Providers who participated in REACH
  - For new and previous MSSP participants, required fee reduction: PY27= 1-100%, PY28=5-100%, PY29=10-100%, PY30=20-100%, PY31=100%
  - 1-100% fee reduction optional for Preferred Providers

Total Care Capitation

- PBPM, paid monthly, calculated based on historical spending patterns
  - Calculations updated quarterly
- Covers all Medicare services provided to aligned beneficiaries by Participant TINs and Preferred Providers who have opted in
  - 100% fee reduction required for Participant Providers
  - 1-100% fee reduction optional for Preferred Providers
- Under or over-payments reconciled in final financial settlement

Supplemental Payment Options

Non-Primary Care Capitation (NPCC)

- Extends capitation to non-primary care services
- Not reconciled against actual FFS claims
- Best suited for ACOs that are ready to shift providers away from FFS and capture savings from fixed, prospective payments

- ***Global Risk ACOs—***
  - PCP Participants may elect PCC+NPCC or just PCC
  - Non-PCP Participants may elect NPCC or APO
  - Preferred Providers may elect PCC+NPCC, only PCC, or only NPCC
- ***Professional Risk ACOs—***
  - PCP Participants may only elect PCC
  - Non-PCP Participants may elect NPCC or APO
  - Preferred Providers may elect PCC, NPCC, or APO

Advanced Payment Option (APO)

- Alternative to NPCC, but reconciled against actual FFS claims
- ACO determines fee reduction amount
- Like REACH APO, functions as a cash flow mechanism with lower financial risk

Administrative Add-on

- Upfront benchmark adjustment designed to incentivize higher-spending organizations to invest in population health
- Equal to 1.5% of benchmark, paid monthly
- Not included in PY expenditure or subject to repayment

CMS Administered Risk Arrangements (CARA)

- Only Medicare FFS beneficiaries aligned to LEAD ACO are eligible to participate
- Voluntary episode-based risk arrangements (EBRA) - allows specialists to take on financial risk for aligned beneficiaries that begin an episode of care
- Arrangements between ACOs and specialists (Preferred Providers)
- LEAD ACOs participating in CARA must select the Global Risk Option
- Builds upon existing "shadow bundles data" initiative or "nested episode bundles" to ACOs

- **CARA Timeline:**
  - Q2 2027 – CARA reports available with target prices for PY 2028
  - End 2027 – episode risk parameter submission and EBRA validation
  - Jan. 1, 2028 – first performance year; episodes begin to trigger
  - Q2 2028 – Quarterly performance reports available
  - Mid 2029 – First concurrent LEAD-CARA reconciliation

CARA Participation Overview

- Specialists still bill through Medicare FFS
- CMS will compare CARA episode payments against the risk-adjusted target price to calculate Preferred Provider performance
- Episode costs are included in ACOs final financial settlements
- CMS reconciles concurrently with LEAD settlement:
  - If FFS is less than target price, the specialist receives payment
  - If FFS is more than target price, the specialist owes repayment

Participation Options

Default Approach

- CMS constructed EBCMs are used
- ACOs cannot customize episode components such as episode triggers, length, inclusions and exclusions
- ACOs can specify discounts/premiums to target prices, select quality measures, and performance adjustment specifications (subject to CMS review)

Max Flex

- ACOs can select and customize EBCMs
- ACOs can customize episode components such as episode triggers, length, inclusions and exclusions
- ACOs may partner with external vendors for episode construction (grouper) methods
- ACOs can specify episode risk parameters, episode selection, discounts/premiums to target prices, quality measures, and performance adjustment specifications (subject to CMS review)

CARA Episode Offerings

- Established within CMS QPP as part of MIPS cost category
- CARA offers medical and procedural episode-based cost measures (EBCMs) in 2028
- Phase in chronic condition EBCMs in the future
- Performance adjustments will be based on quality measures:
  - Q484 Risk Standardized Hospital Admission Rates (used in MIPS, claims-based)
  - Other Merit-Based Incentive Payment System (MIPS)-comparable measure
- Participating ACOs may select multiple quality measures for each EBRA

IP Medical Conditions

- Sepsis, psychoses and related, intracranial hemorrhage/cerebral infarction, respiratory infection, IP COPD, IP PCI

Procedural

- Orthopedic (knees, hips, spine), cardiovascular (PCI, CABG), urologic, ophthalmologic, GI, vascular, renal
- General surgery such as melanoma resection, colorectal resection, femoral hernia repair, lumpectomy, partial or simple mastectomy

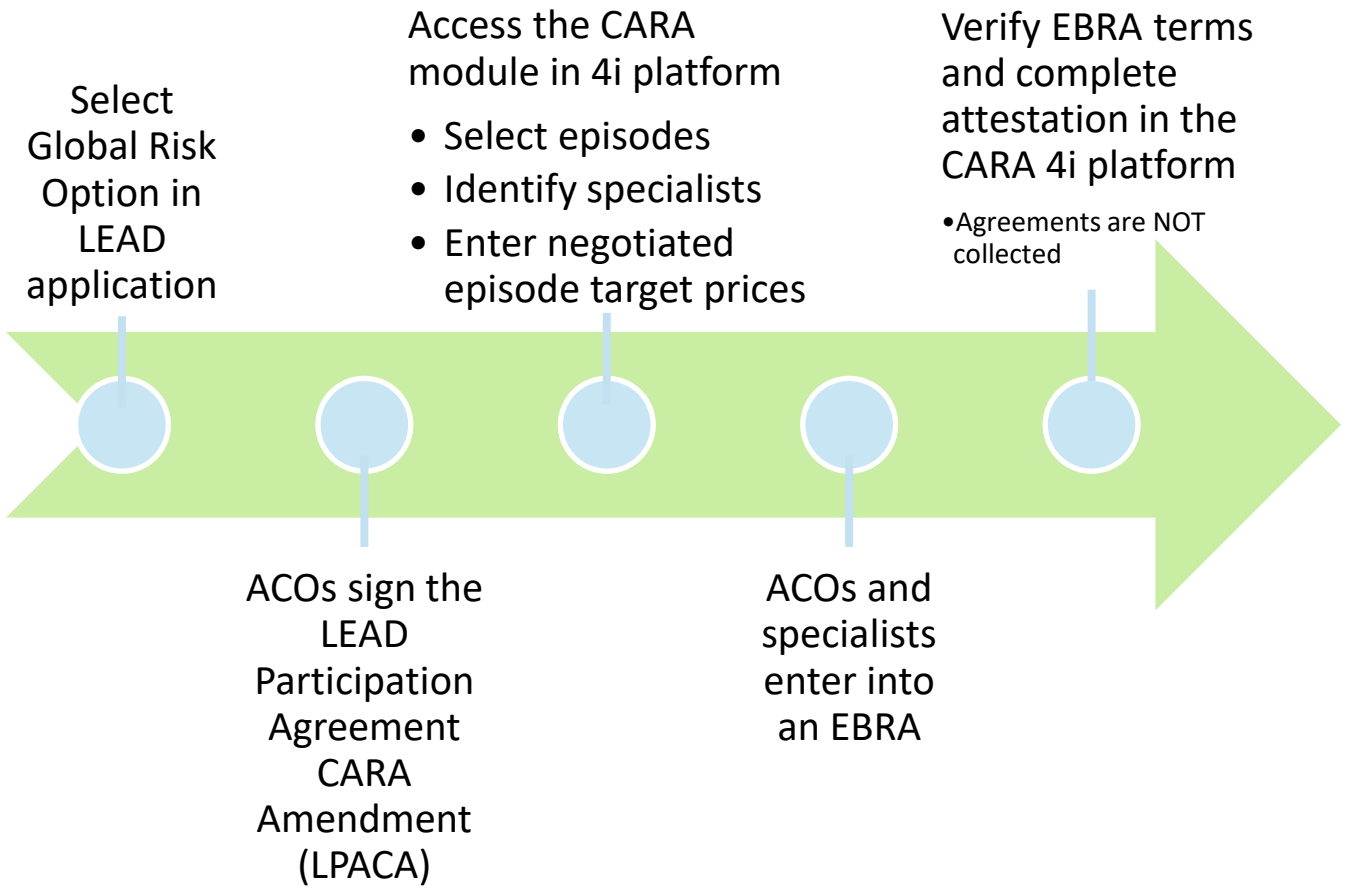
Chronic Conditions

- Diabetes, heart failure, CKD, ESRD, COPD
- Mental health (depression)

Other Conditions

- Low back pain, rheumatoid arthritis, oncology, kidney transplant

CARA Contracting Process



CARA Participants may receive:

- Episode data and benchmarks
- EBRA standard provisions
- Access to episode selections platform
- Payment reconciliation data
- Quality performance data
- Continued support and technical assistance

Resilience and Independence in a Safe Environment (RISE) Episode

- Fall-prevention focused episode: ACOs that choose RISE as their prevention intervention would satisfy PQP requirement (meet PQP milestones and reporting requirements)
- Provides home-based interventions to identify falls risk and deliver targeted preventive services for patient safety, such as increase activities of daily living (ADLs)
- Decrease risk of falls and acute events by evidence-based, in-home falls prevention services
- Home-based support provided by falls prevention care team consisting of OTs and RNs who deliver falls risk assessments, strength training, balance exercises, and patient communications plans
- Care team may engage a licensed handyperson for conducting home safety requirements and implementing modifications

Episode Length

- 3 months: required elements (falls risk assessment, medication review, patient goal setting and communications, care plans)
- 6 months: all visits within the tier

Payment Structure

- Initial visit: OT/RN visit billed FFS (billed by RISE entity)
- Follow-Up Visits: bundled payments based on low, medium high acuity
- Handyperson: funded by ACO
- Does not have a target price

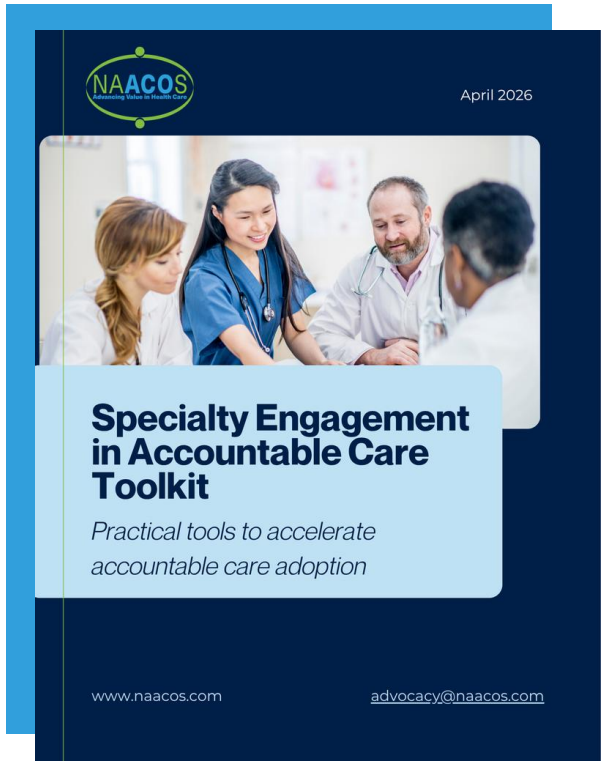
Quality Measure

- Days at Home (patients with chronic conditions)

Specialty Engagement in Accountable Care Toolkit

NAACOS released the *Specialty Engagement in Accountable Care Toolkit* to support meaningful specialty engagement across the continuum of care.

- ✓ Voluntary best practices
- ✓ Step-by-step guidance
- ✓ Practical, adaptable tools



Download your free copy of the toolkit and resources now!

Model Design Elements

A. Beneficiary Eligibility
B. Beneficiary Alignment
C. Beneficiary Engagement and Marketing
D. Medicare-Medicaid Integration
E. Healthy Living Strategy

Beneficiary Eligibility

- To be aligned to a LEAD ACO, a beneficiary must:

1. Be enrolled in Medicare Parts A & B
2. Not be enrolled in MA
3. Have Medicare as the primary payer
4. Be a resident of the U.S.
5. Be a resident of a county in the ACO's service area

Similar to eligibility criteria in ACO REACH and MSSP

High Needs Eligibility Criteria

There are additional criteria for beneficiaries to be considered "High Needs" for purposes of applying those policies. A beneficiary must:

1. Have 1+ conditions that impair mobility
2. Exhibit signs of frailty supported by claims
3. Meet frailty definition through Kim Claims-based Frailty Index (0.35+)
4. Have 1+ significant chronic condition or serious illness with risk score of 3.0+ for Aged and Disabled (A&D) beneficiaries
5. Have a risk score of 0.35 for ESRD beneficiaries
6. Have a risk score between 2.0-3.0 for A&D or 0.24-0.35 for ESRD and 2+ unplanned admissions in past 12 months
7. Have qualified and received 45+ Medicare-covered days in SNF in past 12 months

★ Once considered High Needs, a beneficiary retains that status for the duration of the model

Dually Eligible Beneficiaries

- Once Medicaid integration and partnership features begin, there will be additional eligibility criteria for dually eligible beneficiaries to be aligned under such partnerships
- To be aligned based on Medicaid affiliation, a beneficiary must:
  1. Be a full benefit dually eligible beneficiary
  2. Receive Medicaid benefits through a SMA or Medicaid MCO that has entered into a partnership agreement with the LEAD ACO

Only affects LEAD ACOs in states participating in Medicaid component

Beneficiary Alignment

- **Two purposes of alignment** in LEAD;
  1. CMS prospectively aligns beneficiaries for ACOs to assume accountability for TCOC for the PY
  2. CMS uses beneficiary alignment to determine historical baseline for calculating benchmarks

- **Types of alignment**:
  1. Claims-based alignment
  2. Voluntary alignment

- **Alignment options for ACOs** (timeliness)
  1. Prospective (no mid-year updates)
  2. Hybrid (mid-year update for claims, monthly updates for voluntary)

Claims-Based Alignment

- Based on plurality of Primary Care Qualified Evaluation and Management (PQEM) services (see Appendix C for list of codes)
- Performed prospectively based on a 1-year lookback
  - Mid-year updates use the same lookback period
- All FQHC and RHC services are considered primary care services for purposes of alignment

Similar to current REACH approach

- **Two-step alignment algorithm**
  - ***Step 1:*** Primary Care Specialist: if 10%+ of a beneficiary's PQEM allowable charges were billed by PCPs
  - ***Step 2:*** Selected Non-Primary Care Specialist: if less than 10% of a beneficiary's PQEM charges were billed by PCPs, will use certain specialists that manage chronic or complex conditions (see Appendix C for list of specialties)

Voluntary Alignment

Changes to voluntary alignment from REACH:

- Option to align to a practice at the TIN-level or an individual clinician
- Enables home-based voluntary alignment for beneficiaries served by home-based practices
- More frequent alignment updates (monthly vs. quarterly) for Hybrid Alignment option

Beneficiaries must maintain an active relationship with selected provider/practice to remain aligned

- If beneficiary has no claims with ACO participants and has a claim with a non-ACO provider, the beneficiary will be retroactively removed from the ACO's alignment

Two mechanisms for voluntary alignment:

1. Electronic Voluntary Alignment (EVA) designation using Medicare.gov
2. Signature-based Voluntary Alignment (SVA)

- Form may be signed manually or electronically (e.g., through patient portal)
- Form must indicate: (1) beneficiary's choice of Participant TIN or Participant Provider, (2) effective PY, (3) confirmation that the beneficiary understands they may still seek care from any Medicare provider

- CMS will carryover valid voluntary alignment attestations from ACO REACH when the provider participated in LEAD under the same ACO entity and beneficiary is notified of transition

Frequency of Alignment

Hybrid Alignment

- Lookback period (one year) ends the day prior to the start of the PY
- Used for:
  1. Calculating financial benchmark
  2. Determining alignment for monthly capitated payments
- Voluntarily aligned beneficiaries added monthly throughout the PY
- Additional round of claims-based alignment added mid-PY if the ACO adds new TINs

Prospective Alignment

- Conducted prior to the start of each PY
  - Applies to both claims-based and voluntary alignment
- Lookback period (one year) ends 3 months prior to the start of the PY
- May participate in optional implementation period for voluntary alignment prior to the start of 1st PY in the model

Alignment Hierarchies

Voluntary alignment takes precedence over claims-based alignment

- If multiple voluntary alignment attestations, most recent valid attestation takes precedence

CMS governance rules will determine which model a beneficiary is aligned to if they are eligible for multiple models (e.g., MSSP, KCC)

For dual-eligible beneficiaries, Medicare alignment under LEAD will govern payment and reporting requirements

- MCO enrollment-based alignment subordinate in hierarchy to claims-based and voluntary alignment

Minimum Alignment Thresholds

PY	LEAD PY min.	LEAD Claims-Based min.	PY min. for Newly Entering ACOs	Claims-Based min. for Newly Entering	PY min. for High Needs Eligible	Claims-Based min. for High Needs Eligible
1	5,000	3,000	1,000	600	800	500
2	5,000	3,000	2,000	1,200	1,000	625
3	5,000	3,000	3,000	1,800	1,200	750
4	5,000	3,000	4,000	2,400	1,400	825
5-10	5,000	3,000	5,000	3,000	1,600	1,000

- ACOs falling within 10% below min. will be allowed a two-time "alignment buffer" to continue participation
  - If they do not meet min. after utilizing buffer, they will be terminated
  - Alignment buffers may not be used in consecutive PYs
- ACOs with high proportion of High Needs eligible will be allowed a similar buffer when falling below the required proportion of High Needs beneficiaries to have lower alignment min. (40%)
  - Would allow those ACOs to keep lower alignment min. if at least 30% of beneficiaries meet criteria
  - If High Needs beneficiaries fall below 30%, the ACO would be subject to the 5,000 min.

Beneficiary Engagement & Marketing

- Must provide notices to aligned beneficiaries and display signs with notice information in all settings where beneficiaries receive primary care services *(similar to MSSP and REACH)*
- Must submit written materials regarding Benefit Enhancements and Beneficiary Engagement Incentives to CMS for review and approval
- Must submit any marketing materials and activities to CMS for review and approval
- May proactively communicate with beneficiaries about voluntary alignment
- REACH ACOs transitioning to LEAD with previously approved voluntary alignment marketing materials may update model name, PY, and ACO name (if applicable)

Medicare – Medicaid Integration

Goals:

1. Expand access to integrated care for dually-eligible beneficiaries
2. Realign financial incentives towards increased accountability for this population and mitigate existing incentives for cost shifting across the two programs

- **Planning period** (Mar 2026 – Dec 2027): CMS will identify 2 states ("DUAL states") and develop the framework for partnership agreements with SMAs and MCOs
- State selection based on:
  - Markets with large, high-cost dual populations
  - High-cost markets
  - ACO penetration
  - Disposition toward integrated care
  - Medicaid data quality

- **Partnership arrangements**: framework to be developed collaboratively between CMS and DUAL states. CMS would not be a party to the agreements; Medicaid entity (i.e., SMA or MCO) would contract with the ACO directly. Arrangements will include, at minimum:
  - Formal relationship
  - Roles and responsibilities
  - Strategies for care coordination and care improvement
  - Bilateral risk sharing arrangements
  - Data sharing
- **Alignment:** Full-benefit dually-eligible beneficiaries would be aligned to an ACO if:
  - Enrolled for Medicaid benefits in the MCO or FFS Medicaid program that serves as the ACO's partner
  - Enrolled in traditional Medicare
  - Meet requirements for alignment to LEAD
  - Reside in the ACO's service area

Health Living Strategy

Model features to promote a healthy lifestyle that ACOs can leverage and offer to their beneficiaries to facilitate beneficiaries' access to high-value, proactive, and coordinated care

1. **Prevention and Quality Plan Requirement**: must develop and implement a prevention intervention
   - May be new initiative or expansion/enhancement of current activities
   - Payment will be tied to development, implementation, and meeting established goals
2. **Tech Enabler Initiative**: CMS-led effort to facilitate ACOs' adoption of innovative tech tools to promote high-value care
   - CMMI will identify high-value tech and AI use cases and establish a channel for vendors to provide info to ACO participants
3. **Benefit Enhancements:** new benefit enhancement for PY 2027 for Medical Nutrition Therapy (MNT), expands conditions to beneficiaries with prediabetes and hyperlipidemia; only available for Global Risk ACOs
   - All benefit enhancements previously used in ACO REACH will be available
4. **Patient Incentives:** in-kind items and services, beneficiary engagement incentives

Benefit Enhancements from REACH

Benefit Enhancement	*Description*
3-Day SNF rule waiver	Flexibility from the three-day inpatient stay rule, similar to MSSP
Telehealth	Waives geographic and originating site restrictions, allows asynchronous telehealth for dermatology and ophthalmology services
Post-Discharge Home Visits	Allows home visits following discharge from inpatient /LTC/SNF stay to prevent readmissions
Care Management Home Visits	Allows home visits for beneficiaries determined to be at risk of hospitalization
Home Health Homebound waiver	Waives requirement to have homebound status to access home health services
Concurrent care for Hospice	Allows for smoother transition into hospice
NP and PA services	NPs/PAs may certify hospice, need for diabetic shoes, cardiac rehab plan, home infusion therapy plan, pulmonary rehab plan, and refer for MNT

Patient Incentives

In-Kind Items and Services:

- Must be a direct connection between items/services and beneficiary's medical care
- Must support prevention, chronic disease management, or one of LEAD's goals
- Cannot be a Medicare-covered item/service
- Cannot use to induce beneficiary to voluntarily align to ACO provider
- Cannot include cash/cash equivalents
- Must be furnished directly by the ACO, participant TIN, or participant/preferred provider

Beneficiary Engagement Incentives:

- ***Chronic Disease Prevention***
  - Incentive in form of healthy food products no more than $150 value
  - Designed to incentivize participation in evidence-based programs and healthy living activities to prevent or manage chronic conditions
  - Examples: chronic disease self-management, tobacco cessation, consistent exercise, etc.)
- ***Part B Cost Sharing Support***
  - ACO may enter cost sharing agreement with participants to not collect cost sharing amounts (whole or partial) from categories of aligned beneficiaries or categories of Part B services
  - Beneficiaries with supplemental insurance not eligible
- ***Substance Access***
  - Facilitate access to eligible hemp products, subject to state and local laws
  - Specific beneficiary eligibility based on medical conditions and status

BEs & BEIs Under Consideration

Part D Premium Buydown	Could be available in 2029 for higher spending ACOs and top 30% of earned savings
DMEPOS Flexibility	Exploring options to support improved access to DMEPOS in the model
AWV Flexibility	Allow beneficiaries to access their AWV in a calendar year instead of every 12 months
Other Substance Access Beneficiary Engagement Incentives	Facilitate access to other medically approved and beneficial substances that can improve health outcomes
Beneficiary Savings Program	Could offer beneficiaries direct or indirect financial incentives to improve health

Quality and Performance

A. Quality Measure Selection and Additional Reporting Requirements

B. Quality Performance and Impact on PY Financial Benchmarks

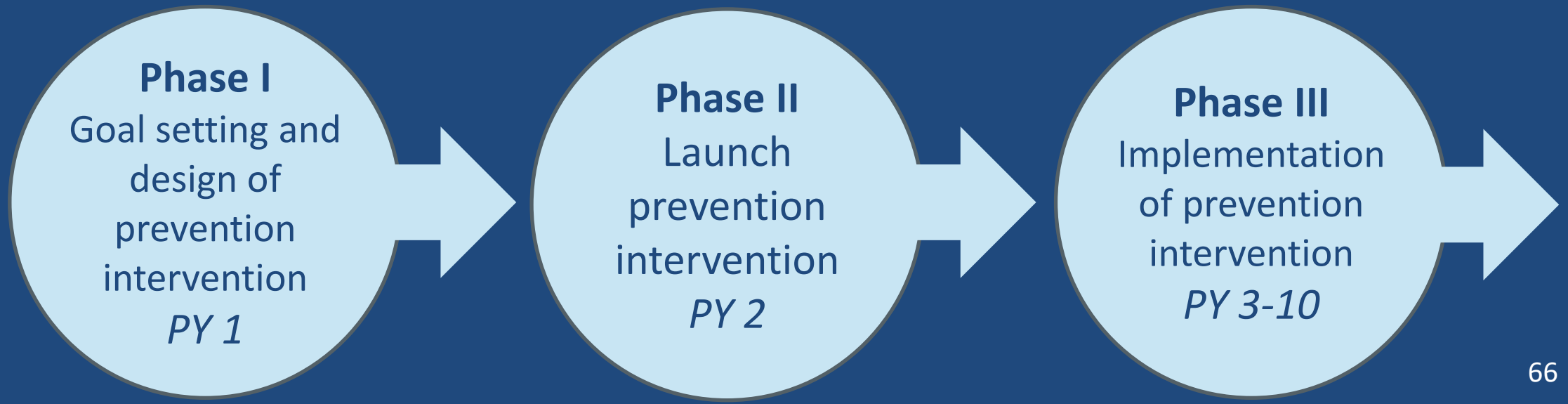
C. Quality Score Calculations and Quality Withhold Earn Back

Quality Measures and Reporting Requirements

- Retains 5 quality measures from REACH (4 claims-based and CAHPS), scored by performance from the model start
  - Risk-standardized all-condition readmission 30-day
  - All-cause unplanned admissions for patients with multiple chronic conditions
  - Days at home for patients with complex, chronic conditions
  - Timely follow-up after acute exacerbations of chronic conditions
- Adds 2 eCQMs from MSSP, phased in over time: optional PYs 1 and 2, pay-for-reporting PYs 3 and 4, pay-for-performance PYs 5-10
  - Controlling high blood pressure
  - Diabetes: Glycemic status assessment greater than 9% (inverse measure)
- Phased approach in recognition of the additional complexities for ACOs to report quality measures as eCQMs
  - NAACOS continues to work with CMS to address quality reporting challenges for ACOs

Prevention and Quality Plan Requirement

- All LEAD ACOs will be required to develop and implement a prevention intervention, with payment tied to established goals
- Must conduct a needs assessment prior to design to identify core needs of beneficiary population
- Must identify specific measures to track impact of intervention
- ACOs encouraged to identify and partner with local community organizations to inform development and support implementation



Prevention and Quality Plan

Three optional, but recommended tracks for prevention interventions:

Cardiovascular morbidity and mortality, including cardiovascular disease, hypertension, cardiometabolic-kidney disease, and tobacco cessation

Falls prevention/ Prevention out of home placement

Nutrition services to mitigate chronic disease and frailty

- ***PQP Reporting Adjustment***—additional quality points tied to PQP progress and submitting participant-level data on intervention
  - PYs 1-2, up to 5 percentage points
  - PYs 3-10, up to 10 percentage points for meeting PQP goals
  - Total quality score may not exceed 100%

Quality Performance Financial Implications

- All LEAD ACOs will be subject to a quality withhold equal to three percent of the PY benchmark
  - Quality performance affects how much of the quality withhold can be earned back by the ACO
- **Continuous improvement/sustained exceptional performance** (CI/SEP) policies designed to incentivize quality improvement and maintenance
  - Performance on each measure assessed; ACOs that meet/exceed CI/SEP criteria could earn back all or a portion of the quality withhold, ACOs that no not meet CI/SEP criteria could earn back a portion of the withhold
- **High Performers Pool (HPP) bonus** funds distributed proportionately based on aligned beneficiaries
  - Funded by quality withholds not earned back by ACOs

Similar to current quality approach in REACH

Quality Score Calculations and Earn Back

1. Earn up to 10 Quality Measure Points for each required measure, sum and divide by total possible points for initial quality score
2. Calculate CI/SEP multiplier and apply to initial quality score
3. Add eCQM reporting adjustment (up to 2.5 percentage points, PY 1-2 only)
4. Add PQP reporting adjustment (up to 5 percentage points for PY 1-2, up to 10 percentage points for PY 3-10)
5. Multiply total quality score (cannot exceed 100%) by the quality withhold (3%) to calculate the quality withhold earn back (0-3%)
6. Add HPP bonus, if applicable
   - If ACO meets CI/SEP criteria and average measure performance ≥ 70th percentile, then ACO earned HPP $ per aligned beneficiary

Additional Policies

A. Monitoring, Auditing, and Terminations
B. Data Sharing and Reports
C. Additional CMS Supports

Participant Monitoring, Auditing and Terminations

- Model Participants required to comply with certain safeguards that will be specified in the participant agreements for the implementation period and performance years, including having a compliance plan in place
- Noncompliance with terms of provider agreement will trigger remedial actions which vary based on the nature of the noncompliance, degree of severity, and the ACO's compliance record
- CMS may immediately or with advance notice terminate an ACOs participant agreement at any time for noncompliance with the terms and conditions of the agreement
- ACOs can notify CMS of termination at any time
  - Effective date of termination at least 30 days after notice is given
  - ACOs that terminate participation on or before the Termination Without Liability deadline in their second PY will be subject to the Retention Incentive policy

Additional details on monitoring, auditing, and termination is available in the RFA

Data Sharing and Reports

- **Opportunity to request several types of Medicare data** for aligned beneficiaries to support care coordination and quality improvement activities
  - Data may only be used consistent with terms of applicable CMS agreements and forms
  - All data requests are subject to CMS' sole discretion based on available resources and technological capabilities and limitations in applicable CMS agreements and applicable law
- **Beneficiary-identifiable data and reports:** During PY, CMS will offer ACOs opportunity to request certain beneficiary-identifiable data and reports, including (but not limited to):
  - Alignment reports on aligned beneficiaries
  - Risk score reports that provide individual risk scores for aligned beneficiaries
  - Claim and Claim Line Feed (CCLF) file for services furnished to aligned beneficiaries during PY. (ACOs can also request historical CCLF files with 26-month historical lookback for newly aligned beneficiaries)
  - Fee Reduction Files to assist in implementing Capitation Payment Mechanism and Advanced Payment Option
- **Aggregate reports:** CMS will also periodically provide aggregate reports, which may include utilization and expenditure data, benchmark and other financial reports, and other quality reports
- **Beneficiary Opt Out:** ACOs must provide beneficiaries with information on how to change data-sharing preferences and opt-out of certain data sharing if they inquire
  - Beneficiaries who opt out will not have their identifiable data included in ACO reports
  - Aggregate reports will incorporate de-identified data from aligned beneficiaries who have opted out
  - Opt-out choices from prior Medicare ACO programs will continue to be honored

Additional details on data sharing and beneficiary opt out are included in the RFA

Additional CMS Supports

Tech Enabler Initiative

- Goal is to reduce administrative barriers to adopting technology that may improve outcomes and increase operational efficiency
- CMS will work with providers to identify high-value technology and AI use cases, build out tech application requirements, and establish a channel for vendors to share information on their technology
- Potential use cases could include (but are not limited to): (1) care navigation, (2) condition management, and (3) community providers

Rapid Cycle Innovation Program

- ACOs will have optional opportunities to conduct time-limited quality improvement tests ("rapid randomized controlled trials," or rapid RCTs) as part of learning and diffusion efforts
- Participants would use Rapid RCTs to quickly assess the impact of specific prevention and care delivery strategies that align with their goals
- Effective strategies would be rapidly shared with all eligible participants

Learning System

- ACOs will have opportunity to participate in various group-learning forums for peer-to-peer collaboration, networking, and real-time problem solving with LEAD and other CMS Innovation Center model participants

Upcoming Events

Title	Date(s) and Times	Location	More information
NAACOS ACO REACH/LEAD Roundtable Meeting **With CMMI LEAD Team**	April 30: noon ET	Virtual	Register
Monthly ACO REACH/LEAD Roundtable Meeting **Series**	4th Thursday each month: noon ET	Virtual	Register
Specialty Care Deep Dive Roundtable	4th Wednesday each month: noon ET	Virtual	Register
Other Deep Dive Roundtable Series	Schedules Vary	Virtual	Register
NAACOS CY27 **Medicare Advantage** Final Rule and Rate Announcement	May 5: noon ET	Virtual	Registration coming soon
NAACOS **CJR-X Model** Overview and Discussion	May 6: noon ET	Virtual	Registration coming soon
Boot Camp 101: Data and Analytics	June 2-4: 1-5pm ET each day	Virtual	Register

Become a NAACOS member to participate in these and other events!

NAACOS Regional Map

Northwest

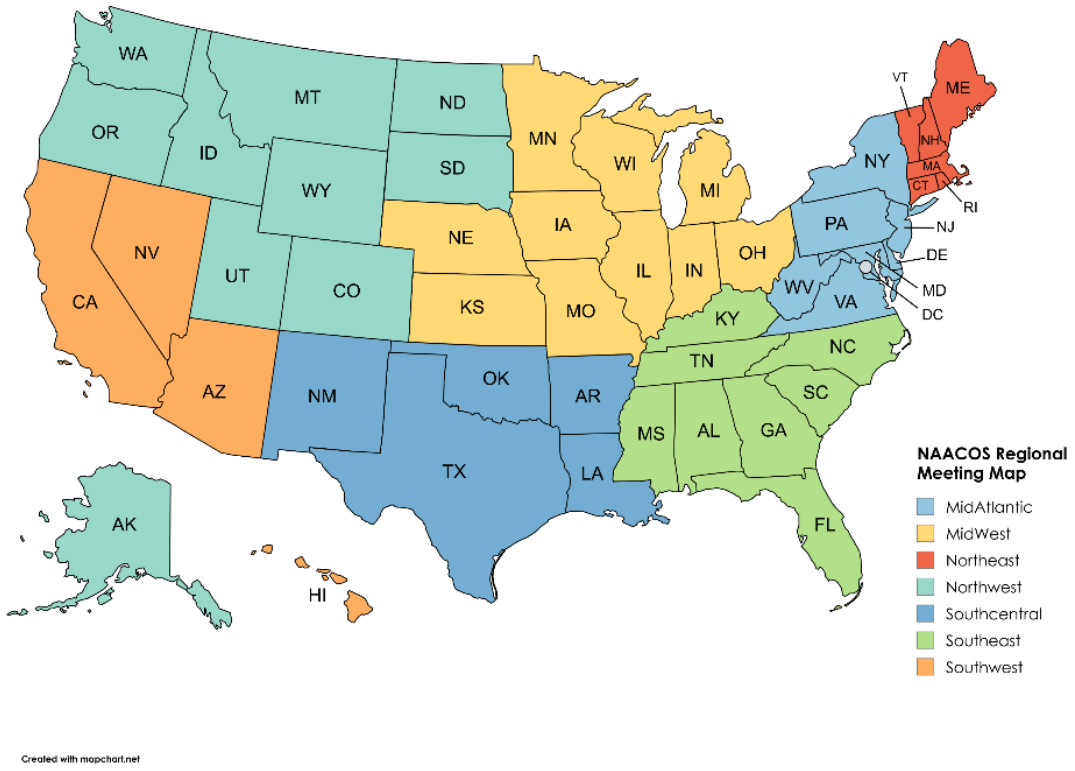
- August 13, 2026 - Boise Idaho
- March 2027 - TBA

Southwest

- November 2026 - TBA
- May 19, 2026 - Virtual

South Central

- January 2027 - TBA
- August 25, 2026 - Virtual



Northeast

- July 28, 2026 - Providence, RI
- March 2027 - Virtual

Mid-Atlantic

- June - TBA
- December 2, 2026 - Virtual

Midwest

- July 16, 2026 - Milwaukee, WI
- February 2027 - TBA

Southeast

- February 2027 - TBA
- September 14, 2026 - Virtual