Long-term Enhanced ACO Design (LEAD) Model

Performance Year 2027 Alignment and Financial Methodology Paper

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Version History

Version Number	Update	Date	Updates
1.0	First release	July 15, 2026	N/A
1.1	Update 1	August 5, 2026	Update to the PY 2027 Alignment and Financial Methodology Paper includes corrected errors in Table 2.3.3 of the PY 2027 Alignment and Financial Methodology Paper, including the omission of Sports Medicine and incorrect specialty code mappings.
1.2	Update 2	August 27, 2026	Updates to Financial Guarantee section 5.9.
1.3	Update 3	November 9, 2026	Updates to the following sections: • Key Policy Updates and New Methodology Information • Section 1.1: Renewing vs. Newly Entering ACOs • Section 1.3: ACO Risk Sharing Options • Section 1.3.1: Provider-Level Downside Risk Requirement • Table 2.5.2: Clinical Measurement Periods to Determine High Needs Eligibility • Section 2.6: Minimum Beneficiary Alignment Threshold • Section 2.7: Model Overlaps and Alignment Precedence Rules • Section 3.2.2: Historical Baseline Expenditures by Beneficiary Category • Section 3.2.3: Approach for Finalizing BY 3 Historical Benchmark Expenditures • Section 3.2.5: Voluntarily Aligned Beneficiaries • Section 3.3.2: Trend Base Year 1 and Base Year 2 Expenditures to Base Year 3 • Section 3.4: Apply ACO-Specific Benchmark Adjustments • Section 3.4.2: Higher-/Lower-Spending Designation and Hybrid Alignment • Section 3.4.3: Regional Efficiency Adjustment • Section 3.4.4: Prior Savings Adjustment • Section 3.5.1: Three-Way Blended Trend Factor • Section 3.5.2: Risk Adjustment • Section 3.5.3: Hybrid Alignment Benchmark Adjustment • Table 3.5.4: Combined Benchmark Calculation • Section 4: Capitation • Table 4.1.1: Payment Mechanism Participation Rules by Provider Type • Section 4.6: Insufficient Claims History • Section 5.3.3: Stop-Loss Reinsurance • Section 5.9: Financial Guarantee • Appendix B: Codes Related to High Needs Eligibility Criteria • Appendix D: PCC HCPCS Codes

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Key Policy Updates and New Methodology Information as of November 9, 2026

This methodology paper includes several important policy updates, clarifications, and additional methodological detail on the policies described in prior versions of the LEAD Alignment and Financial Methodology Paper. Key updates include:

- **Renewing and Newly Entering ACO Determinations** – The methodology provides additional detail on how CMS will determine whether an ACO qualifies as Newly Entering or Renewing. For PY 2027, CMS will assess participation during the five-calendar-year period from January 1, 2022, through December 31, 2026. Medicare ACO initiative participation for this determination is limited to the ACO REACH Model and Medicare Shared Savings Program. Participant Provider history is assessed at the individual NPI level rather than the TIN-NPI combination. Participation solely as an ACO REACH Preferred Provider is not considered prior participation for this purpose. The methodology also clarifies that Newly Entering or Renewing status is determined separately for each Performance Year based on the applicable Participant TIN List and Participant Provider information. (see **Pages 5–6**).

- **Risk Option Changes for Newly Entering ACOs** – Additional detail clarifies that an ACO that qualified as Newly Entering for its first Performance Year and initially elected the Global Risk Option may move to the Professional Risk Option for its second Performance Year even if changes in participant composition result in the ACO being reclassified as Renewing for the second Performance Year (see **Pages 6-7**).

- **Provider-Level Downside Risk Requirement** – A new section provides an updated methodology for the requirement that ACOs allocate, in aggregate, at least 1% of the ACO's total downside risk across Participant TINs. The required amount is calculated annually based on the ACO's elected Risk Option and Performance Year Benchmark. The paper also provides additional detail on permissible approaches for allocating this risk among Participant TINs, while clarifying that the ACO remains responsible to CMS for repayment of Shared Losses and maintenance of the required financial guarantee (see **Pages 7-8**).

- **Benchmark for Voluntarily Aligned Beneficiaries –** This version announces a new policy for calculating benchmarks for voluntarily aligned beneficiaries in PY 2027. In PY 2027, CMS will apply the claims-based Historical Benchmark to voluntarily aligned beneficiaries. In other words, CMS will not calculate a separate Historical Benchmark for voluntarily aligned beneficiaries. Voluntarily aligned beneficiaries will contribute to the Performance Year average risk score (See **Pages 32 and 53-56**).

- **Prior Savings Adjustment** – Additional methodology clarifies the treatment of active Participant TINs and Legacy TINs when determining continuity with predecessor ACOs. The paper also provides additional detail on the calculation of the proration factor (see **Pages 45-51**).

- **Accountable Care Prospective Trend (ACPT)** – The ACPT for 2027 will be released in December with the preliminary benchmark report (See **Pages 51-53**).

- **Normalization –** CMS will use normalized risk scores for all benchmark calculations (See **Pages 54-55**).

- **Prospective Payment Mechanism Elections and Claims History** – The methodology clarifies that ACOs elect their applicable capitation payment mechanisms for each Performance Year and that these elections may change between Performance Years, subject to the ACO's Risk Option and other participation requirements. (see **Page 60-61**).

- **High Needs Eligibility Codes** – Appendix B includes a corrected description of the methodology for identifying which beneficiaries meet certain High Needs eligibility criteria. Previous versions inaccurately state that beneficiaries must have one inpatient claim with a diagnosis from Table B.1 or two claims with a HCPCS code from Table B.2. This version clarifies that beneficiaries must have one inpatient claim or two outpatient claims with a diagnosis from Table B.1, or one claim with a HCPCS code from Table B.2. (see **Page 103-107**).

Key Policy Updates and New Methodology Information as of July 14, 2026

This methodology paper update included several important policy updates and additional methodological detail on the policies described in the LEAD Request for Applications. This section is included for historical reference. Key updates included:

- **Higher Shared Savings Rate for the Professional Risk Option** – The methodology reflected an increase in the Professional Risk Option Shared Savings rate from 50% to 60%, strengthening incentives for participation while maintaining accountability for performance (see **Page 6**).
- **Exception to Whole TIN Alignment** – The paper provided additional methodological detail on the Whole Taxpayer Identification Number (TIN) alignment process, including exclusion of certain primary care services delivered during a short skilled nursing facility (SNF) stay (see **Page 16**) and exclusion of Non-Physician Practitioners (NPPs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) that are specialty care providers (see **Pages 14-15**).
- **Treatment of SAHS and Skin Substitute Expenditures** – The paper provided additional information on the treatment of SAHS and skin substitute expenditures within benchmark and financial calculations (see **Pages 28-29** and **91-92**).
- **Treatment of the 2026 Base Year** – The paper described how financial calculations will account for 2026 as a key benchmark base year, despite complete data not being available at the time initial financial calculations are performed, including how and when CMS will determine whether an ACO is higher- or lower-spending (see **Pages 30-32**).
- **Voluntary Alignment Benchmarks** – The methodology included additional detail on the approach for establishing voluntary alignment (VA) benchmarks for High Needs beneficiaries, as well as a minimum alignment threshold for determining whether VA-based or claims-based benchmarks are applied to an ACO's voluntarily aligned beneficiaries (see **Page 32-33**).
- **Regional Efficiency Adjustment for Lower-Spending ACOs** – The paper described a policy for excluding expenditures associated with higher-spending TINs that are new to ACO models from the calculation of the Regional Efficiency Adjustment for lower-spending ACOs (see **Pages 41-45**).
- **High Needs Risk Score Growth Cap** – The paper announced that the risk score growth cap for the High Needs beneficiary category will be 4% for at least PY 2027 and PY 2028 (See **Pages 55-56**).
- **Mid-Year Alignment and High-Needs Status Changes** – Additional methodology was provided describing how benchmarks will be adjusted for beneficiaries who align to an ACO during the Performance Year or who meet the High Needs eligibility criteria mid-year (see **Pages 56-58**).

Introduction

The Long-Term Enhanced Accountable Care Organization Design (LEAD) Model is a voluntary Accountable Care Organization (ACO) model offered by the Centers for Medicare and Medicaid Services (CMS) that will begin on January 1, 2027, and run through December 31, 2036. The model is designed to improve care quality and reduce expenditures for Medicare beneficiaries while encouraging participation in ACOs by a wider array of organization types, including those that have been historically underrepresented in other ACO models and programs. LEAD offers participating ACOs a choice of risk sharing options and prospective payment mechanisms to provide greater flexibility, reduce barriers to participation, and enable a broader range of organizations with different levels of accountable care experience to participate successfully.

This document provides information about the alignment and financial methodologies used in the LEAD Model. It describes the methodologies used to determine beneficiary alignment, develop Performance Year Benchmarks, calculate capitated payments, and conduct financial settlement.

Section 1 describes key LEAD participant categories, including Renewing and Newly Entering ACOs, ACOs serving a high proportion of High Needs and ESRD beneficiaries, and the available risk sharing options.

Section 2 describes the beneficiary alignment methodology, including claims-based alignment, voluntary alignment, alignment frequency, alignment precedence rules, and High Needs eligibility criteria.

Section 3 describes the methodology used to develop the Performance Year Benchmark, including the calculation of Historical Baseline Expenditures to develop a Historical Benchmark, applying ACO-specific benchmark adjustments including the Regional Efficiency Adjustment and the Prior Savings Adjustment, and risk adjusting and trending the Historical Benchmark to the Performance Year.

Section 4 describes the available prospective payment mechanisms, including Total Care Capitation (TCC), Primary Care Capitation (PCC), Non-Primary Care Capitation (NPCC), the Advanced Payment Option (APO), and the 1.5% Administrative Add-On payment. This section also describes claims fee reduction and claims processing policies.

Section 5 describes the financial settlement methodology, including the calculation of Performance Year expenditures, Shared Savings and Shared Losses, Total Monies Owed, financial guarantees, and Stop-Loss reinsurance.

The methodologies described in this document apply beginning with Performance Year (PY) 2027, unless otherwise noted. Certain operational details may be refined through future financial methodology papers, operational guidance, or other communications issued by CMS. In addition,

CMS may periodically update methodologies as necessary to ensure sound implementation of the model and to reflect policy changes announced through future guidance.

1. ACO Participant Categories

Several aspects of the LEAD methodology vary based on an ACO's prior experience in accountable care models, aligned beneficiary population, and selected risk sharing option. This section defines the ACO participation categories that are used throughout this methodology paper and describes how these categories affect key model policies.

1.1 Renewing vs. Newly Entering ACOs

For purposes of LEAD, ACOs will be categorized as either Newly Entering ACOs or Renewing ACOs based on the prior participation history of the ACO legal entity, its Participant TINs, and its Participant Providers.

A Newly Entering ACO is an ACO that meets all three of the following criteria:

1. The ACO legal entity has not previously participated, and is not currently participating, in a Medicare ACO initiative;
2. Less than 40% of the ACO's Participant TINs have participated in a Medicare ACO initiative in the past five years; and
3. Less than 50% of the ACO's Participant Providers have participated in a Medicare ACO initiative in the past five years.

For purposes of determining whether a Participant TIN or Participant Provider has participated in a Medicare ACO initiative in the past five years, CMS will use the five-calendar year period ending immediately before the start of the applicable Performance Year. For PY 2027, this period is January 1, 2022, through December 31, 2026. Any participation during this five-year period, including participation during only a portion of a calendar year, will be considered participation for purposes of determining Renewing versus Newly Entering ACO status. A Medicare ACO initiative will be limited to participation in the ACO REACH Model or the Medicare Shared Savings Program. Participation in other CMS Innovation Center models or initiatives will not be considered participation in a Medicare ACO initiative for purposes of determining Renewing versus Newly Entering ACO status. Participant Provider participation history will be assessed at the individual National Provider Identifier (NPI) level and not at the TIN-NPI combination level.

Participation as a Preferred Provider in the ACO REACH Model will not be considered participation in a Medicare ACO initiative for the purposes of determining Renewing versus Newly Entering ACO status. Only participation as an ACO REACH Participant Provider, Participant TIN, or ACO legal entity will be considered. A Renewing ACO is an ACO that does not meet all three of the Newly Entering ACO criteria. ACOs will be informed in December 2026 whether they qualify as a Renewing or Newly Entering ACO for PY 2027.

CMS will determine an ACO's status as Newly Entering or Renewing separately for each Performance Year using the Participant TIN List and Participant Provider information applicable to that Performance Year. Accordingly, an ACO's classification may change between

Performance Years if its participant composition changes. An ACO's status as Newly Entering or Renewing is determined before the start of the Performance Year for assigning applicable alignment minimums. TINs added in the Hybrid TIN addition window will not be used to change the Newly Entering or Renewing status that was determined before the start of the Performance Year.

1.2 ACOs with a High Proportion of High Needs and ESRD Beneficiaries

ACOs that serve a high proportion of seriously ill beneficiaries will be eligible for lower beneficiary alignment minimums if at least 40% of their total aligned beneficiary population is in the High Needs and/or ESRD beneficiary categories and the ACO demonstrates the following care delivery capabilities that are important for caring for seriously ill beneficiaries:

1. 24 hours a day/7 days a week access to a healthcare provider with access to the patient's electronic medical record;
2. Providers with training in advance care planning conversations; and
3. The ability to deliver care in patients' homes.

ACOs were required to demonstrate these care delivery capabilities in the LEAD application if they were interested in qualifying for this designation. In addition, CMS will require LEAD ACOs that meet the care delivery requirements to submit an attestation prior to the PY in order to qualify for the lower beneficiary alignment minimums. ACOs will be informed in December 2026 if they qualify for lower beneficiary alignment minimums for PY 2027.

1.3 ACO Risk Sharing Options

LEAD allows ACOs to choose from two options for sharing financial risk between participating ACOs and CMS: the Professional Risk Option and the Global Risk Option. An ACO's selected risk sharing option determines the percentage of savings the ACO may receive, or losses for which the ACO may be liable, depending on how its Performance Year expenditures compare to its Performance Year Benchmark. It also determines an ACO's eligibility for a number of other LEAD model features, including capitated payment options, benchmark adjustments, and benefit enhancements and beneficiary engagement incentives.

- Under the **Professional Risk Option**, ACOs are eligible to receive up to 60% of total savings and are liable for up to 50% of total losses. ACOs that elect the Professional Risk Option must remain in that option for at least four Performance Years, after which they may elect to transition to the Global Risk Option.
- Under the **Global Risk Option**, ACOs are eligible to receive up to 100% of total savings and are liable for up to 100% of total losses. ACOs may either enter LEAD in the Global Risk Option or transition into the Global Risk Option after at least four Performance Years in the Professional Risk Option. Only ACOs participating in the Global Risk Option are eligible to receive a positive Regional Efficiency Adjustment and elect Total Care Capitation (TCC).

Newly Entering ACOs that elect the Global Risk Option for their first Performance Year may switch to the Professional Risk Option if the ACO determines that it is not ready to participate under Global Risk. Renewing ACOs may not move from the Global Risk Option to the Professional Risk Option.

An ACO that qualified as Newly Entering in its first Performance Year and elected the Global Risk option retains the ability to move to the Professional Risk Option for its second Performance Year, even if the ACO is subsequently reclassified as a Renewing ACO for the second Performance Year based on changes to its participant composition.

1.3.1 Provider Level Downside Risk Requirement

LEAD requires ACOs to allocate, in aggregate, at least 1% of the ACO's total downside risk across all of its Participant TINs. Each Participant TIN is not required to take on 1% of the ACO's total downside risk. Rather, the aggregate potential liability held by the Participant TINs in an ACO should add up to at least 1% of downside risk. The required Participant TIN potential liability amount is calculated annually based on the ACO's elected Risk Option and applicable Performance Year benchmark.

The goal of this policy is to ensure that Participant TINs share in financial accountability under the LEAD Model while providing ACOs flexibility in how risk is allocated among Participant TINs. The ACO remains solely responsible to CMS for repayment of any shared losses and for maintaining the required financial guarantee. CMS does not require Participant TINs to establish separate financial guarantees or repayment mechanisms.

For ACOs participating under the Professional Risk Option, total potential liability equals 50% of 1% of the total Performance Year benchmark, or 0.5 x (.01 x PY Benchmark). For ACOs participating under the Global Risk Option, total downside risk equals 100% of 1% of the Performance Year benchmark, or .01 x PY Benchmark. The Participant TIN potential liability requirement therefore must equal at least 1% of the ACO's total downside risk exposure for the applicable Performance Year. As the Performance Year benchmark is updated annually, the Participant TIN potential liability calculation is also performed annually.

The provider-level downside risk requirement does not mean that Participant TINs must be responsible for the entire first dollar of an ACO's losses. ACOs may spread Participant TIN downside risk such as through a percentage-based risk share arrangement that extends to 5% of the Performance Year benchmark. From a flexibility standpoint, the percentage of each dollar of loss borne by Participant TINs may vary, as long as the arrangement provides Participant TINs with potential downside exposure equal to at least the required amount (0.5% of the Performance Year benchmark for ACOs participating under the Professional Risk Option, or 1% of the Performance Year benchmark for ACOs participating under the Global Risk Option).

For example, in the Global Risk Option, where the required Participant TIN potential liability is 1% of the Performance Year benchmark, an ACO could require Participant TINs to be responsible for 20% of each dollar of ACO losses, up to ACO losses equaling 5% of the benchmark. If the ACO incurs losses equal to 5% or more of the benchmark, the Participant

TINs' total liability would equal 1% of the benchmark. If the ACO incurs losses equal to only 2% of the benchmark, for example, the Participant TINs would be responsible for 0.4% of the benchmark. ACOs have broad flexibility to establish arrangements within these limits. For instance, an ACO could require Participant TINs to bear 25% of losses within the first 4% of benchmark losses, 50% of losses within the first 2%, or another combination of loss-sharing percentages and loss ranges. The arrangement can also vary by Participant TIN within the same ACO.

If entity types such as FQHCs, RHCs, etc. are not legally permitted to accept downside risk, then this requirement would not apply to them and they would take on 0% of downside risk. The PY benchmark used in the calculation of the 1% of downside risk can be reduced by the amount applicable to FQHCs, RHCs, and any providers that are not legally permitted to accept downside risk.

Additionally, ACOs have significant flexibility to determine how to distribute risk appropriately among its Participant TINs. All of the following examples are acceptable:

1. For an ACO's first year in LEAD only, the ACO may purchase reinsurance or offer reinsurance directly to its Participant TINs to cover the 1% provider-level risk. The cost of reinsurance, as applicable, would be allocated to Participant TINs, and reinsurance proceeds would be used to satisfy Participant TIN downside exposure in loss years.

2. Establishing a pooled reserve (e.g., escrow or withhold) equivalent to 1% of risk, funded through incentive or shared savings-related dollars, which would be used to cover Participant TIN downside exposure when the ACO is in a loss position (or otherwise be distributed back to providers when in a savings position).

3. Withholding a percentage of capitated payments to Participant TINs to cover their share of losses when the ACO is in a loss position (or otherwise distributed back to Participant TINs when in a savings position).

2. Beneficiary Alignment

A beneficiary is aligned to an ACO through claims-based alignment and/or voluntary alignment. CMS performs claims-based alignment for every ACO based on the Participant TIN list submitted for that Performance Year. Beneficiaries may voluntarily align through Medicare.gov, known as Medicare.gov Voluntary Alignment (MVA), or through Signature-based Voluntary Alignment (SVA). CMS incorporates MVA submissions automatically for all ACOs. However, SVA is optional, and ACOs must choose to participate in the SVA process.

2.1 Beneficiary Eligibility

Beneficiary eligibility for alignment to a LEAD ACO is verified on a monthly basis throughout the Performance Year. For both base years and Performance Years, the population of alignment-eligible beneficiaries, also known as the LEAD National Reference Population, includes any beneficiary who meets all of the following criteria:[1]

- Is alive;
- Is enrolled in Medicare Parts A and B;
- Is not enrolled in Medicare Advantage or other Medicare-managed care plan; and
- Does not have Medicare as a secondary payer.

Additionally, to be eligible for alignment to a specific ACO, the beneficiary must reside in a county that is included in the ACO's service area.

A beneficiary is considered alignment-eligible for a given month only if the beneficiary meets all alignment eligibility criteria as of the first day of that month. Beneficiaries who lose eligibility during a month remain alignment-eligible through the end of that month. Once a beneficiary loses eligibility during the Performance Year, they are not eligible for alignment for the remainder of the year, even if they meet the eligibility criteria again in a subsequent month (though they may still be aligned in a future year).

For purposes of benchmark construction, expenditure calculations, risk adjustment, regional expenditure calculations, capitation payments, and financial settlement, CMS includes only those months in which a beneficiary is alignment-eligible. Expenditures incurred during months in which a beneficiary is not alignment-eligible are excluded from LEAD financial calculations.

As a result, LEAD financial calculations are based on eligible beneficiary months rather than simple beneficiary counts. Beneficiaries who are eligible and aligned for more months contribute proportionally more experience to expenditure, benchmark, and risk-score calculations than beneficiaries who are eligible and aligned for fewer months.

[1] Criteria for Medicare Parts A and B, Medicare Advantage and managed care enrollment, and service area residence are verified on the first day of the month (e.g., January eligibility is determined as of January 1). Medicare as a secondary payer is determined using a 3-month lag (e.g., January eligibility is checked on April 1).

For example, if a beneficiary is aligned and eligible for all twelve months of a Performance Year, the beneficiary contributes twelve eligible beneficiary months to LEAD expenditure and risk score calculations. If another beneficiary is aligned and eligible for only six months of the same year, only expenditures and risk-score experience associated with those six eligible months are included. This monthly eligibility framework applies consistently throughout the LEAD financial methodology unless otherwise specified.

2.2 Alignment Frequency

ACOs will have two choices for the frequency of alignment of beneficiaries through voluntary and claims-based alignment: (1) Prospective Alignment or (2) Hybrid Alignment. The alignment frequencies are compared in **Table 2.2.1**.

Prospective Alignment

Prospective alignment will be conducted prior to the start of each Performance Year. ACOs that elect prospective alignment will not be able to align new beneficiaries during the Performance Year.

Hybrid Alignment

ACOs that elect hybrid alignment will have initial prospective alignment conducted prior to the start of each Performance Year. They will also have additional opportunities to align beneficiaries during the Performance Year. ACOs that elect hybrid alignment will have one additional opportunity to add new Participant TINs during the Performance Year, and CMS will run claims-based alignment for these TINs. For PY 2027, the mid-year Participant TIN Add Window will be December 14, 2026, through January 14, 2027. The effective alignment date for beneficiaries aligned through new Participant TINs will be April 1 during the Performance Year.

Hybrid alignment will also allow ACO to add voluntarily aligned beneficiaries on a rolling monthly basis throughout the Performance Year, including beneficiaries aligned through both MVA and SVA. For SVA to become effective on the first day of a given month, the ACO must submit the applicable SVA information to CMS at least 45 days before the start of that month.

Only those beneficiaries who are not already (1) aligned to another LEAD ACO via claims or voluntary alignment, (2) aligned to a participant in another Shared Savings initiative, or (3) aligned to another model for which beneficiary overlap with LEAD is prohibited for the Performance Year can be aligned to the ACO mid-year under Hybrid Alignment.

Table 2.2.1: Alignment Frequency Differences

Method	Claims-Based Alignment Frequency	Voluntary Alignment Frequency
Prospective	Once a year, prior to the PY, effective January 1 of the PY. Drops due to loss of eligibility only.	Once a year, prior to the PY, effective January 1 of the PY.
Hybrid	Twice a year, once prior to PY and once mid-PY. Additions only for newly added TINs. Drops due to loss of eligibility only. Alignment is effective on January 1 and April 1 of PY, respectively. Mid-year Participant TIN add window for PY 2027 is December 14, 2026—January 14, 2027.	Monthly, to be effective by the first of each month. For each month, the deadline for submitting SVA forms will be 45 calendar days prior to the start of the month.

Pre-Implementation Period

All ACOs, regardless of whether they elect Prospective or Hybrid Alignment, may participate in a pre-implementation period to begin SVA activities before PY 2027. The pre-implementation period will run from September 15, 2026, through December 31, 2026. However, for a beneficiary's SVA to be effective January 1, 2027, the ACO must submit the applicable SVA information to CMS by October 23, 2026.

For ACOs that elect Hybrid Alignment, SVA information submitted after the deadline for a January 1, 2027, effective date may be used for alignment in a subsequent month of PY 2027, consistent with the monthly SVA submission and effective-date requirements described above. For ACOs that elect Prospective Alignment, SVA information submitted after the deadline will not be used for PY 2027 alignment but may be used for prospective alignment for PY 2028.

2.3 Claims-Based Alignment

2.3.1 Definitions

1. Alignment Period

Each Performance Year and base year is associated with a 12-month alignment claims lookback period that ends three months before the start of the relevant Performance Year or base year, as applicable. **Table 2.3.1** specifies the alignment claims lookback period for each Performance Year and the relevant base years, as well by the alignment frequency (Prospective or Hybrid).

Table 2.3.1: Alignment Claims Lookback Periods for Each Performance Year and Base Year

Calendar Year	Prior to PY Alignment Period (Prospective & Hybrid)	Mid-PY Alignment Period (Hybrid Only)
BY 1 (CY 2024)	10/1/2022–9/30/2023	N/A
BY 2 (CY 2025)	10/1/2023–9/30/2024	N/A
BY 3 (CY 2026)	10/1/2024–9/30/2025	N/A
PY 2027	10/1/2025–9/30/2026	1/1/2026–12/31/2026
PY 2028	10/1/2026–9/30/2027	1/1/2027–12/31/2027
PY 2029	10/1/2027–9/30/2028	1/1/2028–12/31/2028

Calendar Year	Prior to PY Alignment Period (Prospective & Hybrid)	Mid-PY Alignment Period (Hybrid Only)
PY 2030	10/1/2028–9/30/2029	1/1/2029–12/31/2029
PY 2031	10/1/2029–9/30/2030	1/1/2030–12/31/2030
PY 2032	10/1/2030–9/30/2031	1/1/2031–12/31/2031
PY 2033	10/1/2031–9/30/2032	1/1/2032–12/31/2032
PY 2034	10/1/2032–9/30/2033	1/1/2033–12/31/2033
PY 2035	10/1/2033–9/30/2034	1/1/2034–12/31/2034
PY 2036	10/1/2034–9/30/2035	1/1/2035–12/31/2035

BY = Base Year; CY = Calendar Year; PY = Performance Year

2. Claims-Alignable Beneficiary

The population of "claims-alignable beneficiaries" includes all alignment-eligible beneficiaries (as defined in **Section 2.1**) who had at least one Primary Care Qualified Evaluation and Management (PQEM) service that was paid by Medicare Fee-for-Service (FFS) during the alignment period.

3. Primary Care Services

In the case of claims submitted by physicians and non-physician practitioners (NPPs), a Primary Care Service is identified by the Healthcare Common Procedure Coding System (HCPCS) code appearing on the claim line and identified by one of the HCPCS codes listed in **Appendix A**.

In the case of claims submitted by a Federally Qualified Health Center (type of bill = 77x) or Rural Health Clinic (type of bill = 71x), all services are considered primary care services.

In the case of claims submitted by a Critical Access Hospital Method 2 (CAH2) (type of bill = 85x), a Primary Care Service is identified by the HCPCS code appearing on the line-item claim (for revenue centers 096x, 097x, or 098x) for the service.

4. Primary Care Qualified Evaluation and Management (PQEM) Service for Claims-Based Alignment

PQEM Service means a Primary Care Service (furnished by a Primary Care Specialist or a Selected Non- Primary Care Specialist).

5. Primary Care Specialist

A Primary Care Specialist is a physician or NPP whose principal specialty is included in **Table 2.3.2**.

Table 2.3.2: Specialty Codes Used to Identify Primary Care Specialists[2]

Code	Specialty
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

A physician or NPP's specialty is determined based on the CMS Specialty Code recorded on the claim. Except as provided in **Definition 7 – ACO Review of Specialty Identification for Certain Providers**, in the case of claims submitted by an FQHC or RHC, all services are considered to be provided by primary care specialists. In the case of a claim submitted by a CAH2, the specialty code is determined based on the physician's or NPP's primary specialty as recorded in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

6. Selected Non-Primary Care Specialists

A Selected Non-Primary Care Specialist is a physician whose principal specialty is included in **Table 2.3.3**.

A physician specialty is determined based on the CMS Specialty Code recorded on the claim. Except as provided in **Definition 7 – ACO Review of Specialty Identification for Certain Providers**, in the case of claims submitted by a FQHC or RHC, all services are considered to be provided by primary care specialists. In the case of a claim submitted by a CAH Method 2, the specialty code is determined based on the physician's primary specialty as recorded in PECOS.

Table 2.3.3: Specialty Codes Used to Identify Selected Non-Primary Care Specialists[3]

Code	Specialty
6	Cardiology
10	Gastroenterology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology

[2] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the **Taxonomy Crosswalk** page of the CMS website.

[3] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the **Taxonomy Crosswalk** page of the CMS website. The table published in the July 14, 2026 version of the paper has been updated for the August 5, 2026 paper due to an error in the version.

Code	Specialty
17	Hospice and palliative medicine
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
29	Pulmonology
39	Nephrology
44	Infectious disease
46	Endocrinology
66	Rheumatology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology
84	Preventive medicine
86	Neuropsychiatry
90	Medical oncology
98	Gynecological/oncology

7. ACO Review of Specialty Identification for Certain Providers

CMS recognizes that certain NPPs and safety net providers identified by CMS Certification Numbers (CCNs), e.g. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), primarily furnish specialty care services and, therefore, it may not be appropriate to include these providers or suppliers for the purposes of claims-based beneficiary alignment or Primary Care Capitation (PCC).

For physicians, CMS determines specialty based on the CMS Specialty Code reported on the claim when running LEAD alignment or, for CAH2 claims, the specialty recorded in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). However, CMS available data do not consistently identify the specialties in which NPPs practice or the types of services furnished by FQHCs and RHCs.

Accordingly, CMS will provide each ACO with a list of NPP National Provider Identifiers (NPIs) and safety net provider CCNs billing under the ACO's Participant TINs. For alignment, the TIN is determined by the TIN on the claim for professional claims. However, for outpatient claims where a CCN is used, the TIN is determined by the TIN associated with the CCN listed on the provider's PECOS enrollment. The ACO will have an opportunity to identify NPPs, FQHCs, and RHCs that

primarily furnish specialty care services and request that they be excluded from use in claims-based beneficiary alignment and Primary Care Capitation.

CMS will review these submissions and apply approved exclusions prospectively for the applicable Performance Year. CMS will provide additional operational guidance regarding the timing of the review process, submission requirements, and effective dates in a separate methodology document.

2.3.2 Claims-Based Alignment Process

1. General

Claims-based alignment of a beneficiary compares the following:

a. The allowable charges for all PQEM Services that the beneficiary received from Participant TINs in each ACO participating in LEAD, and

b. The allowable charges for all PQEM Services that the beneficiary received from each provider or supplier that is not a Participant Provider and identified by a Medicare-enrolled billing TIN.

For purposes of this comparison, CMS will exclude allowable charges for PQEM Services billed under a TIN that is not on the ACO's Participant TIN List when the clinician who furnished the service is an ACO Participant Provider. CMS will identify the furnishing clinician based on the NPI reported on the claim. Accordingly, PQEM Services furnished by an ACO Participant Provider but billed through a non-Participant TIN will not be counted towards the non-Participant TIN's PQEM charges for purposes of determining the plurality of PQEM Services. This policy prevents services furnished by an ACO Participant Provider outside of an ACO Participant TIN from counting against alignment to the ACO.

To match PQEM claims to Participant TINs, CMS will review the following CCN and TIN according to the Medicare claims:

a. **Institutional (Part A) Claims:** To determine if the provider furnishing PQEM Services from a Part A claim is a Participant TIN within the ACO, CMS will check:

   - For FQHC, CAH Method 2, and RHC claims, the TIN that the CCN from the claim is enrolled under, as recorded in PECOS, must match a TIN on the ACO's Participant TIN list.

b. **Professional (Part B) Claims:** To determine if the provider furnishing PQEM Services from a Part B claim is a Participant TIN within the ACO:

   - CMS will check that the Rendering TIN on the claim matches a TIN on the ACO's
   - Participant TIN List.

- Primary care services in Skilled Nursing Facilities (SNFs) are excluded as qualifying PQEM claims for beneficiary alignment determination if both of the following criteria are met:
    1. The professional service is billed under CPT codes 99304–99318, **or** an FQHC or RHC submits a claim containing a qualifying CPT code within that range; **and**
    2. A SNF facility claim present in CMS's claims files reflects dates of service that overlap with the date of service for the professional, FQHC, or RHC service in question.

2. Allowable Charges

The allowable charge on paid claims for services received during the alignment period associated with a Performance Year or base year will be used to determine the Participant TINs in each ACO or other provider or supplier TIN from which the beneficiary received the plurality of PQEM Services. The allowable charges that are used in alignment will be obtained from claims for PQEM Services that are:

a. Incurred in the alignment period as determined by the date-of-service on the claim line; and

b. Paid within three months following the end of the alignment period as determined by the effective date of the claim.

3. The Two-Track Algorithm

Alignment for a Performance Year or base year uses a two-track alignment algorithm.

a. **Alignment based on PQEM Services provided by Primary Care Specialists:** If 10% or more of the allowable charges incurred on all PQEM Services received by a beneficiary during the alignment period are furnished by Primary Care Specialists (as defined in **Section 2.3.1**), then beneficiary alignment is based on the allowable charges incurred on PQEM Services furnished by Primary Care Specialists.

b. Alignment based on Primary Care Services provided by Selected Non-Primary Care Specialists: If less than 10% of all PQEM Services received by a beneficiary during the alignment period are furnished by Primary Care Specialists, then beneficiary alignment is based on the PQEM Services furnished by Selected Non-Primary Care Specialists (as defined in **Section 2.3.1).**

4. Tie-Breaker Rules

In the case of a tie in the dollar amount of the allowed charges for PQEM Services, the beneficiary is aligned to the ACO if a Participant TIN has billed the most recent PQEM Service for the beneficiary in the alignment period.

5. Alignment to the ACO

CMS aligns a beneficiary to the ACO based on claims alignment if CMS determines that (1) the beneficiary is a claims-alignable beneficiary, (2) the beneficiary is an alignment-eligible beneficiary as of January 1 of the PY, (3) the beneficiary received the plurality of their PQEM Services (as measured by allowed charges) during the alignment period from the collection of Participant TINs on the ACO's Participant TIN List, and (4) the beneficiary is not already aligned to a participant in the Medicare Shared Savings Program or other Medicare value-based initiatives that take precedence over the LEAD Model for purposes of beneficiary alignment (see **Section 2.7**).

2.4 Voluntary Alignment

2.4.1 Signature-Based Voluntary Alignment (SVA) Definition

If the ACO elects to participate in SVA, CMS aligns a beneficiary to the ACO based on SVA if the beneficiary:

1. Is alignment-eligible as of the effective date of the beneficiary's alignment (e.g., January 1, or the first day of the month for Hybrid Alignment); and
2. Has completed an SVA form designating a Participant TIN as their main doctor, main provider, or the main place they receive care, provided that the designation is valid and more recent than any other designation made by the beneficiary. Note: although this alignment mechanism is referred to as SVA, electronic forms and signatures are also acceptable.

A voluntary alignment attestation whether through MVA or SVA, is considered "valid" for a given

Performance Year if either:

1. The designation was made no earlier than two years before the start of that Performance Year; or
2. The provider on the ACO'S Participant TIN List designated by the beneficiary has submitted a claim for a PQEM Service furnished to the beneficiary in the 24-month period ending one month before the start of that Performance Year.

During prospective alignment conducted before the start of the Performance Year, a valid voluntary alignment election generally takes precedence over claims-based alignment, and CMS will align the beneficiary to the ACO identified through voluntary alignment regardless of whether the beneficiary would otherwise be aligned based on claims. The most recent valid voluntary alignment election, whether through MVA or SVA, supersedes any prior or invalid voluntary alignment election. Please note that these rules only apply to prospective alignment performed prior to the Performance Year. Under hybrid alignment, with one additional claims-based alignment window and monthly voluntary alignment during the Performance Year, if the beneficiary is already aligned to a LEAD ACO via claims-based or voluntary alignment, they will not be removed from alignment or switched to a different ACO if they attest to a provider who is not a Participant Provider or to a Participant Provider in a different ACO.

A beneficiary who is claims-based aligned to an ACO may also voluntarily align to the same ACO through SVA or MVA. In such cases, the beneficiary will continue to be treated as claims-based aligned for purposes of benchmark construction and other financial calculations that distinguish between claims-based and voluntarily aligned beneficiaries.

2.4.2 Medicare.gov Voluntary Alignment (MVA) Definition

CMS will align a beneficiary to an ACO based on MVA if the beneficiary:

1. Is alignment-eligible as of the effective date of the beneficiary's alignment (e.g., January 1, or the first day of the month for Hybrid Alignment); and
2. Has designated a Participant Provider on the ACO Participant Provider List as their primary clinician through Medicare.gov (or any successor site), provided that the designation is valid and more recent than any other designation made by the beneficiary.

CMS will align the beneficiary to the ACO through MVA regardless of whether the beneficiary would be aligned to the ACO based on claims alignment.

2.4.3 Removal of Voluntarily Aligned Beneficiaries

A beneficiary aligned to an ACO for a Performance Year via voluntary alignment only (i.e., not also claims aligned) will be removed from alignment to that ACO for purposes of financial settlement for that Performance Year if both of the following are true:

1. The beneficiary has not received any covered service from a Participant TIN or Preferred Provider (excluding labs or imaging services) in the ACO where the beneficiary is aligned via voluntary alignment during the Performance Year; and
2. The beneficiary did receive a PQEM Service from a provider outside their ACO but within the ACO's Service Area during the Performance Year.

Time Period: CMS will perform both parts of this check (for covered services and PQEM Services) using the entire 12-month period of the Performance Year (e.g., January 1, 2027, through December 31, 2027, for PY 2027), with three months of run-out applied.

1. The check will not be limited to the months during the Performance Year that a beneficiary was actively aligned (due to either Hybrid Alignment or due to loss of eligibility).
2. The check will disregard the start and end dates for those Participant TINs and Preferred Providers on the final PY 2027 Provider List. Therefore, covered services provided during a month that the Participant TINs or Preferred Provider was not participating in the ACO will still count for this check.

Participants and Preferred Providers: Participant TINs and Preferred Providers on the ACO's Participant TIN and Preferred Provider List will be used to identify Part A and Part B covered services. CMS will identify Part A covered service claims with CCN-Organization combinations that match the ACO's Participant TIN List. For FQHC, RHC, and CAHs, CMS will identify Part A covered service claims from CCNs whose enrollment TIN, as recorded in PECOS, matches the

ACO's Participant TIN List. CMS will also identify Part B covered service claims from Participant TINs that match the ACO's Participant TIN List.

Covered Services: All Part A and Part B services (excluding durable medical equipment [DME] claims and lab claims as outlined below) are considered covered services. CMS will retain final action claims that were approved for payment when identifying covered services. To exclude DME claims, CMS will exclude claim type codes 81, 82, and 72. Part B claims for lab and diagnostic services from TINs on the ACO's Preferred Provider list, as described above, will not be considered covered services.

Service Area: CMS will determine whether a PQEM Service was provided within the ACO's Service Area by identifying the zip code of the provider on the claim for professional claims and the facility location for FQHC, RHC, and CAH claims.

2.4.4 Carryover of Signed Voluntary Alignment

CMS intends to incorporate valid voluntary alignment attestations established under the ACO REACH Model as participating REACH ACOs transition into the LEAD Model. This approach is designed to promote continuity and recognize the relationships established between ACOs and beneficiaries through voluntary alignment. Specifically, if a beneficiary previously completed a voluntary alignment form within the past 24 months under ACO REACH designating a participating provider as their primary source of care, and that provider participates in LEAD through the same ACO entity, CMS will treat that attestation as effective for purposes of alignment under LEAD. As part of this transition, ACOs will be required to provide notice to beneficiaries whose voluntary alignment will be carried forward, including clear information about the model transition and instructions for opting out if the beneficiary does not wish to maintain voluntary alignment under LEAD. CMS will issue forthcoming guidance outlining the operational parameters, beneficiary notification requirements, and any additional conditions associated with carrying voluntary alignment forward into LEAD.

For Current High Needs REACH ACOs, CMS will not carry forward any designations that did not pass eligibility vetting due to the beneficiary not meeting High Needs eligibility criteria.

2.5 High Needs Eligibility

To be considered a High Needs beneficiary, a beneficiary must meet **one of the following** additional criteria:

1. Have one or more conditions that impair a beneficiary's mobility (as identified through Mobility Impairment ICD-10 Codes; see **Appendix B** for a list of these codes);
2. Exhibit signs of frailty, as evidenced by a claim submitted by a provider or supplier for a hospital bed or transfer equipment for use in the home (see **Appendix B** for a list of qualifying DME codes);
3. Meet a comprehensive definition of frailty, as measured by the Kim claims–based frailty index;

4. Have at least one significant chronic condition or other serious illness that is defined as having a risk score of 3.0 or greater for Aged and Disabled (A&D) beneficiaries using either 1) the 2024 CMS-Hierarchical Condition Categories (HCC) Risk Adjustment Model (Version 28) (hereafter referred to as CMS HCC Prospective Risk Adjustment Model) or 2) the CMMI HCC Concurrent Risk Adjustment Model V1 (hereafter Concurrent Risk Adjustment Model V1);
5. A risk score of 0.35 or greater for ESRD beneficiaries measured using the CMS Prospective Risk Adjustment Model for the ESRD beneficiaries;
6. A risk score between 2.0 and 3.0 for A&D beneficiaries measured using the CMS HCC Prospective Risk Adjustment Model or a risk score between 0.24 and 0.35 for ESRD beneficiaries measured using the 2023 CMS-HCC ESRD Risk Adjustment Model for ESRD beneficiaries, and two or more unplanned hospital admissions in the previous 12 months;[4] or
7. Have qualified and received at least 45 Medicare-covered days in a Skilled Nursing Facility within the past twelve months.

Recognizing that the health of High Needs beneficiaries can deteriorate quickly and that eligibility determinations must be made in a timely manner to provide the necessary support to at-risk beneficiaries, CMS checks High Needs eligibility of beneficiaries on a quarterly basis. Beneficiaries who are aligned to an ACO through claims or voluntary alignment but are not in the High Needs beneficiary category have up to four chances to become High Needs each Performance Year.

CMS will reassess High Needs eligibility for all of an ACO's aligned beneficiaries (who have not already been determined to be High Needs) on a quarterly basis using an updated rolling lookback period (see **Tables 2.5.1** and **2.5.2** for the High Needs lookback periods). If CMS determines that an aligned beneficiary newly meets the High Needs eligibility criteria during a quarterly reassessment, the beneficiary will be retroactively assigned to the ACO's High Needs beneficiary category effective as of the beginning of the Performance Year.

For ACOs that have elected hybrid alignment, CMS will evaluate High Needs eligibility for newly aligned beneficiaries at the time of alignment. Beneficiaries who meet the High Needs eligibility criteria will be assigned to the High Needs beneficiary category effective as of their alignment date. Beneficiaries added through hybrid alignment who do not initially qualify as High Needs will continue to be evaluated during subsequent quarterly High Needs eligibility updates. In other words, regardless of when a beneficiary is first determined to meet the High Needs eligibility criteria during the Performance Year, the beneficiary will be treated as High Needs for the full period during which they were aligned to the ACO for purposes of benchmark development, expenditure calculations, and financial settlement.

[4] An unplanned hospital admission is defined as the claim for the inpatient stay being coded as non-elective, specifically based on the "reason for admission" code (CLM_IP_ADMSN_TYPE_CD is not 3).

For example, if a beneficiary is aligned to an ACO as of January 1 and is first determined to meet the High Needs eligibility criteria during the July quarterly High Needs eligibility check, the beneficiary will be treated as High Needs beginning January 1 for all LEAD financial calculations. Similarly, if a beneficiary first becomes aligned to the ACO on April 1 under hybrid alignment and is first determined to meet the High Needs eligibility criteria during the July quarterly High Needs eligibility check, the beneficiary will be treated as High Needs beginning April 1 for all LEAD financial calculations.

Once a beneficiary is determined to be High Needs, the beneficiary will be deemed High Needs for the duration of their alignment to a LEAD ACO, even if the beneficiary subsequently ceases to meet the High Needs eligibility criteria (unless the beneficiary no longer meets the general eligibility requirements described in **Section 2.1** or is otherwise retrospectively removed from alignment). This policy is intended to support continuity of care for High Needs beneficiaries and to avoid creating disincentives for ACOs to improve the health status of beneficiaries with complex care needs.

For each quarterly High Needs eligibility check, CMS uses the most recent period of claims history available at that time. To generate risk scores for the eligibility criteria listed above, diagnoses from the most recent 12-month period are run through both the prospective CMS-HCC risk adjustment model and the concurrent CMMI-HCC risk adjustment model, and a beneficiary will be considered eligible if they meet the requirements with either risk score. This 12-month period is also used to check for claims-based eligibility criteria like mobility and unplanned hospitalizations (see **Table 2.5.1**). The most recent 60-month period will be used for the frailty criteria that is based on hospital bed or transfer equipment for the home, in recognition that DME equipment does not need to be replaced annually (see **Table 2.5.2**).

Table 2.5.1: Clinical Measurement Periods to Determine High Needs Eligibility (all eligibility criteria except Frailty)

Effective Date	Lookback Period for Data to Determine High Needs Eligibility: January 1 of PY	Lookback Period for Data to Determine High Needs Eligibility: April 1 of PY	Lookback Period for Data to Determine High Needs Eligibility: July 1 of PY	Lookback Period for Data to Determine High Needs Eligibility: October 1 of PY
PY 2027	11/1/25–10/31/26	2/1/26–1/31/27	5/1/26–4/30/27	8/1/26–7/31/27
PY 2028	11/1/26–10/31/27	2/1/27–1/31/28	5/1/27–4/30/28	8/1/27–7/31/28
PY 2029	11/1/27–10/31/28	2/1/28–1/31/29	5/1/28–4/30/29	8/1/28–7/31/29
PY 2030	11/1/28–10/31/29	2/1/29–1/31/30	5/1/29–4/30/30	8/1/29–7/31/30
PY 2031	11/1/29–10/31/30	2/1/30–1/31/31	5/1/30–4/30/31	8/1/30–7/31/31
PY 2032	11/1/30–10/31/31	2/1/31–1/31/32	5/1/31–4/30/32	8/1/31–7/31/32
PY 2033	11/1/31–10/31/32	2/1/32–1/31/33	5/1/32–4/30/33	8/1/32–7/31/33
PY 2034	11/1/32–10/31/33	2/1/33–1/31/34	5/1/33–4/30/34	8/1/33–7/31/34
PY 2035	11/1/33–10/31/34	2/1/34–1/31/35	5/1/34–4/30/35	8/1/34–7/31/35
PY 2036	11/1/34–10/31/35	2/1/35–1/31/36	5/1/35–4/30/36	8/1/35–7/31/36

Table 2.5.2: Clinical Measurement Periods to Determine High Needs Eligibility (Frailty only)

Effective Date	Lookback Period for Data to Determine High Needs Eligibility: January 1 of PY	Lookback Period for Data to Determine High Needs Eligibility: April 1 of PY	Lookback Period for Data to Determine High Needs Eligibility: July 1 of PY	Lookback Period for Data to Determine High Needs Eligibility: October 1 of PY
PY 2027	11/1/21–10/31/26	2/1/22–1/31/27	5/1/22–4/30/27	8/1/22–7/31/27
PY 2028	11/1/22–10/31/27	2/1/23–1/31/28	5/1/23–4/30/28	8/1/23–7/31/28
PY 2029	11/1/23–10/31/28	2/1/24–1/31/29	5/1/24–4/30/29	8/1/24–7/31/29
PY 2030	11/1/24–10/31/29	2/1/25–1/31/30	5/1/25–4/30/30	8/1/25–7/31/30
PY 2031	11/1/25–10/31/30	2/1/26–1/31/31	5/1/26–4/30/31	8/1/26–7/31/31
PY 2032	11/1/26–10/31/31	2/1/27–1/31/32	5/1/27–4/30/32	8/1/27–7/31/32
PY 2033	11/1/27–10/31/32	2/1/28–1/31/33	5/1/28–4/30/33	8/1/28–7/31/33
PY 2034	11/1/28–10/31/33	2/1/29–1/31/34	5/1/29–4/30/34	8/1/29–7/31/34
PY 2035	11/1/29–10/31/34	2/1/30–1/31/35	5/1/30–4/30/35	8/1/30–7/31/35
PY 2036	11/1/30–10/31/35	2/1/31–1/31/36	5/1/31–4/30/36	8/1/31–7/31/36

2.6 Minimum Beneficiary Alignment Threshold

LEAD ACOs will maintain a minimum number of aligned beneficiaries so that CMS can reliably calculate capitation payments and financial benchmarks. Required minimums for Renewing ACOs not serving a high proportion of High Needs or ESRD beneficiaries will be set at 5,000 aligned beneficiaries during the first Performance Year, with a required minimum of 3,000 claims-based aligned beneficiaries (i.e., not inclusive of voluntarily aligned beneficiaries) in at least one of the base years (BY) to allow for accurate calculation of the benchmark. ACOs serving a high proportion of High Needs or ESRD beneficiaries (those with at least 40% of the ACO's total alignment in the High Needs or ESRD beneficiary category) have a lower alignment minimum, recognizing that organizations focused predominantly on complex and High Needs beneficiaries tend to have smaller patient panels. The alignment minimum for organizations serving a high proportion of High Needs and ESRD beneficiaries will start at 800 total beneficiaries during the Performance Year (in aggregate across all beneficiary categories, including A&D) and grow to 1,600 total beneficiaries. LEAD will allow Newly Entering ACOs to participate at lower beneficiary alignment minimums and slowly grow to 5,000 by the end of the model (as outlined in **Table 2.6.1** below).

ACOS must only meet the base year alignment minimum in one of the three historical base years to be eligible for participation in LEAD. However, as described in **Section 3.3.4**, for a base year to be included in the ACO's Historical Benchmark calculation, the ACOs must meet the applicable base year alignment minimum from **Table 2.6.1** in that base year.

CMS will offer LEAD ACOs that are falling within 10% below alignment minimums a two-time alignment buffer to allow them to continue participation in the model. If they do not meet

minimums after utilizing both of their buffers, they will be terminated from the model. For ACOs that have a high proportion of High Needs or ESRD beneficiaries, a two-time buffer would be available to such ACOs that fall below the proportion of High Needs and ESRD beneficiaries required to have a lowered alignment minimum (i.e., the buffer would permit such ACOs to have a lower alignment minimum if at least 30% of aligned beneficiaries are High Needs or ESRD). If an ACO falls below this 30% threshold, the ACO will be subject to the 5,000 claims-based aligned beneficiary minimum. ACOs would not be permitted to use both alignment buffers in consecutive Performance Years. ACOs may use one of their alignment buffers in their first Performance Year.

For 2027, the Performance Year alignment minimum buffer is increased to 25%. This increased buffer does not apply to the Base Year minimums or to the High Needs/ESRD threshold minimums. Those buffers will remain at 10% in PY 2027 and for subsequent years of the model. This increased buffer only applies to PY 2027. All buffers will revert back to 10% for PY 2028 and for the rest of the LEAD model.

For 2027, ACOs will receive a determination of their applicable alignment minimum standard (e.g., standard, Newly Entering, or serving a high proportion of High Needs and ESRD beneficiaries), as well as whether they meet the relevant alignment minimum, with or without an alignment buffer, in December 2026, before the start of PY 2027.

Table 2.6.1. Alignment Minimums

PY	LEAD PY Alignment Minimum	LEAD Claims-based Alignment Minimum in BY	PY Alignment Minimum for Newly Entering ACOs	Claims-based Alignment Minimum in BY for Newly Entering ACOs	PY High Needs/ESRD Eligible ACO Alignment Minimum	Claims-based Alignment Minimum in BY for High Needs/ESRD Eligible ACOs
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	5,000	3,000	5,000	3,000	1,600	1,000
6	5,000	3,000	5,000	3,000	1,600	1,000
7	5,000	3,000	5,000	3,000	1,600	1,000
8	5,000	3,000	5,000	3,000	1,600	1,000
9	5,000	3,000	5,000	3,000	1,600	1,000
10	5,000	3,000	5,000	3,000	1,600	1,000

2.7 Model Overlaps and Alignment Precedence Rules

CMS employs a formal, cross-agency governance structure to execute hierarchical decision making to prevent the alignment of beneficiaries to multiple models involving shared savings or other value-based initiatives and resolve conflicts when they occur. For PY 2027, the following initiatives will take precedence over LEAD for beneficiary alignment (if applicable): the Kidney

Care Choices (KCC) Model, the Medicare Shared Savings Program (MSSP) (Prospective Alignment only), and the ACO Primary Care Flex Model (PC Flex).

Initiatives for which Beneficiary Overlap with LEAD is Prohibited:

- Kidney Care Choices Model (KCC)
- Medicare Shared Savings Program (MSSP)
- ACO Primary Care Flex Model (PC Flex)
- Another LEAD ACO
- Maryland Primary Care Program (MDPCP)

Participant TINs may not simultaneously participate in LEAD and another model tested or expanded under section 1115A of the Act that involves Shared Savings, or any other Medicare initiative that involves Shared Savings unless otherwise permitted by CMS. For example, Participant TINs may not participate in the Kidney Care Choices Model. Participant TIN and beneficiary overlap is permitted with several other models that do not involve shared savings. In most circumstances, LEAD Preferred Providers are permitted to participate in other CMMI models and Medicare initiatives, including the Shared Savings Program. The Participant TIN and Preferred Provider overlap policies are detailed in **Table 2.7.1.**

CMS anticipates that LEAD-aligned beneficiaries could also be impacted by the Wasteful and Inappropriate Service Reduction (WISeR) or Increasing Organ Transplant Access (IOTA) models, but we would not anticipate provider overlap in these models.

Table 2.7.1: LEAD Participant TIN and Preferred Provider Overlap Policies

Initiative	Participant TIN Overlap*	Preferred Provider Overlap
Kidney Care Choices Model	Prohibited	Allowed
Medicare Shared Savings Program	Prohibited	Allowed
ACO Primary Care Flex Model	Prohibited	Allowed
Another LEAD ACO	Prohibited	Allowed
Primary Care and Hospital Global Budget AHEAD Model	Overlap permitted with conditions**	Overlap permitted with conditions*
MDPCP	Prohibited	Allowed
GUIDE Model	Allowed	Allowed
TEAM Model	Allowed	Allowed
ACCESS Model	Allowed***	Allowed

* Participant Providers may participate in other models if they are billing under a different TIN than their LEAD Participant TIN for the purpose of participation in another model.

** Overlaps are prohibited between Hospital Global Budget AHEAD and LEAD for Participant TINs and Preferred Providers that elect certain LEAD payment mechanisms, including TCC, APO, and NPCC. In 2027, overlap with Primary Care AHEAD is permitted. Beginning in 2028, overlaps are prohibited between Primary Care AHEAD and LEAD Participant TINs when the TIN is enrolled in PC AHEAD capitated pathways (Advanced-Hybrid and Advanced-Capitation). Further details can be found in the AHEAD Model Overlaps Policies Fact Sheet.

*** ACCESS Model participants are prohibited from billing ACCESS codes and typical Medicare fee-for-service codes for the same beneficiary during a given treatment period.

A parent organization may operate an ACO participating in the Medicare Shared Savings Program and a separate ACO participating in the LEAD Model simultaneously, provided that there is no overlap in Participant TINs between the two ACOs and all applicable overlap requirements are satisfied. Each ACO entity must be identified by a separate ACO entity TIN. CMS does not require separate legal, compliance, financial, operational, or reporting infrastructure beyond the requirements applicable to each program. Each ACO must independently satisfy all participation, governance, and program integrity requirements of the program in which it participates.

3. Performance Year Benchmark

This section describes the methodology CMS will use to establish a LEAD ACO's Performance Year Benchmark. The Performance Year Benchmark represents the expected Medicare Parts A and B expenditures for the ACO's aligned beneficiary population in a Performance Year, before applying any discount, Quality Withhold, or Quality Earn Back.

CMS will calculate each ACO's Performance Year Benchmark through four steps, described in more detail in the following sections:

Section 3.2: Calculate Historical Baseline Expenditures

CMS identifies the beneficiaries and expenditures that will be used to construct the ACO's Historical Baseline Expenditures for each beneficiary category (A&D, ESRD, and High Needs).

Section 3.3: Risk Standardize, Trend, and Weight Historical Baseline Expenditures to Create the Historical Benchmark

CMS standardizes the Historical Baseline Expenditures so that the three base years can be combined into a single Historical Benchmark. This includes risk-standardizing BY 1–BY 3 expenditures, trending BY 1 and BY 2 expenditures to BY 3 dollars, and applying Base Year weights.

Section 3.4: Apply ACO-Specific Benchmark Adjustments to Create the Adjusted Historical Benchmark

CMS determines whether the ACO is higher or lower spending relative to its regional FFS expenditures and applies any applicable ACO-specific benchmark adjustments. These adjustments include the Regional Efficiency Adjustment or the Prior Savings Adjustment. Higher-spending ACOs may also receive a separate 1.5% Administrative Add-On capitation payment, which is not included in the Performance Year Benchmark (see **Section 4.5** for more information on the 1.5% Administrative Add-on).

Section 3.5: Update the Adjusted Historical Benchmark to the Performance Year to Create the Performance Year Benchmark

CMS trends the Adjusted Historical Benchmark to the applicable Performance Year using the three-way blended trend factor, applies Performance Year risk adjustment, applies a Hybrid Alignment Benchmark Adjustment if applicable, and combines the resulting beneficiary category–level benchmarks into a single Performance Year Benchmark.

3.1 Benchmark Definitions

Historical Baseline Expenditures are the ACO's Medicare Parts A and B expenditures for aligned beneficiaries in the three base years, calculated using the ACO's current Performance Year Participant TIN List.

Historical Benchmark means the risk-standardized, trended, and weighted-average blend of the ACO's Historical Baseline Expenditures across the three base years.

Adjusted Historical Benchmark means the ACO's Historical Benchmark with applicable ACO-specific benchmark adjustments (i.e., the Regional Efficiency Adjustment or Prior Savings Adjustment).

Performance Year Benchmark means the benchmark after CMS applies the risk adjustment and trend factor for the applicable Performance Year to the Adjusted Historical Benchmark, applies the Hybrid Alignment Benchmark adjustment for beneficiaries aligned during the Performance Year, and combines the beneficiary category–specific benchmarks into a single benchmark amount. The Performance Year Benchmark is used to determine the ACO's shared savings or shared losses for the Performance Year.

3.2 Calculate Historical Baseline Expenditures

Historical Baseline Expenditures shall be based on Medicare Parts A and B expenditures from a three-year historical baseline period representing the three calendar years (CYs) immediately before the start of an ACO's first Performance Year in LEAD. For ACOs entering PY 2027, the historical BYs are as follows:

- BY 1: CY 2024,
- BY 2: CY 2025, and
- BY 3: CY 2026.

The baseline period will remain fixed for the duration of the ACO's participation in LEAD. However, CMS will recalculate Historical Baseline Expenditures for each Performance Year using the ACO's Participant TIN List for that Performance Year. For example, the Historical Baseline Expenditures used to calculate PY 2027 benchmarks will be CY 2024, CY 2025, and CY 2026 expenditures for providers on the PY 2027 Participant TIN List. The Historical Baseline Expenditures used to calculate PY 2028 benchmarks will be derived from the same time period (CY 2024–2026) but will be based on the providers on the PY 2028 Participant TIN List.

3.2.1 Costs Included in Historical Baseline Expenditures

The expenditure incurred by an alignment-eligible beneficiary for a base year is the sum of all Medicare payments on claims for services covered under Medicare Parts A and B. Historical Baseline Expenditures include only expenditures incurred during months in which a beneficiary is alignment-eligible, consistent with **Section 2.1**.

Expenditures include payments associated with all Medicare-covered Part A and Part B services, including but not limited to:

- Inpatient hospital claims,
- Skilled nursing facility claims,

- Home health agency claims,
- Hospice claims,
- Physician and supplier claims,
- Outpatient hospital claims, and
- Durable medical equipment claims.

Expenditures include all eligible claims with dates of service in the relevant base year or Performance Year, allowing for a 3-month claims run-out period. The date of service is generally the through date of the period covered by the claim. CMS excludes denied claims and denied claim lines from expenditure calculations.

CMS adjusts claim payments as necessary to ensure expenditures reflect Medicare payment amounts on a consistent basis. For example, amounts withheld due to sequestration as required by the Budget Control Act of 2011 are added back into expenditures. CMS also adds back reductions for payments associated with population-based payments or other prospective payment arrangements under Medicare models or initiatives, including but not limited to the Guiding an Improved Dementia Experience (GUIDE) Model,[5] Vermont All-Payer ACO Model, ACO REACH Model, Primary Care First, ACO Primary Care Flex (ACO PC Flex) Model, Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, and Kidney Care Choices (KCC) Model.

Certain Medicare payments are excluded from expenditure calculations, including Disproportionate Share Hospital (DSH) payments. Indirect Medical Education (IME) payments **are included** in expenditure calculations.

CMS also excludes all Medicare payment amounts on claims for specified claim types associated with a HCPCS or CPT code identified to be significant, anomalous, and highly suspect (SAHS) billing activity, as discussed in greater detail below.

Treatment of Significant, Anomalous, and Highly Suspect Billing Activity and Skin Substitute Expenditures

CMS will adjust Historical Baseline Expenditure calculations under the LEAD Model to account for certain spending that is not expected to be representative of expenditures during the model performance period.

Significant, anomalous, and highly suspect (SAHS) billing activity is addressed in 42 CFR § 425.670 for CY 2023 and 42 CFR § 425.672 for CY 2024 and subsequent calendar years. Under these regulations, CMS may determine that billing for one or more specified HCPCS or CPT codes

[5] The GUIDE model care management G-codes are included in expenditure calculations because they represent an alternative payment method for covered Medicare services. The GUIDE respite G-codes are excluded from expenditures because they provide payment for services that are not covered by Medicare outside of the context of a CMS Innovation Center model.

represents significant, anomalous, and highly suspect billing activity for a calendar year and warrants adjustment to calculations made under Medicare accountable care programs.

For CY 2024, CMS has designated HCPCS codes A4353 and A5057 as SAHS billing activity, and for CY 2025, CMS has designated HCPCS codes A4352, A4353, A6197, L0486, L1852, and L3916 as SAHS billing activity. One hundred percent of expenditures associated with designated

SAHS codes will be excluded from the calculation of Historical Baseline Expenditures and national and regional expenditure calculations for BY 1 and BY 2.

In addition, CMS observed substantial growth in Medicare spending for skin substitute products during the LEAD historical baseline period. In the CY 2026 Physician Fee Schedule final rule, CMS finalized changes to Medicare payment for skin substitute products that are expected to reduce Medicare spending for these products by approximately 90%. As a result, expenditures for skin substitute products in CY 2024 and CY 2025 are not expected to be representative of expenditures during the LEAD performance period.

Because CY 2024 and CY 2025 represent BY 1 and BY 2 for ACOs entering LEAD in PY 2027, including the full amount of skin substitute expenditures from these years could result in Historical Baseline Expenditures that reflect spending levels that are unlikely to persist during the model performance period. To address this issue, CMS will exclude 65% of skin substitute expenditures from Historical Baseline Expenditures for CY 2024 and CY 2025.

CMS recognizes the importance of avoiding unintended differences across its portfolio of models and programs. The Shared Savings Program applies truncation to historic expenditures in setting benchmarks, which in CY 2025 removed more than 65% of skin substitute billing activity from expenditures. LEAD's carveout of 65% of skin substitute expenditures in CY 2024 and CY 2025 is intended to promote consistency and minimize unintended program differences.

To operationalize this adjustment, for each ACO in each affected base year, CMS will identify expenditures associated with a specified set of skin substitute product codes (see **Appendix C** for the full list of skin substitute HCPCs codes). CMS will multiply these expenditures by 0.35 and include the resulting amount in the ACO's total Historical Baseline Expenditures for the relevant base year. The remaining 65% of identified skin substitute expenditures will be excluded from the ACO's Historical Baseline Expenditures.

The skin substitute adjustment is separate from CMS's SAHS billing policies. While CMS has designated certain HCPCS codes as SAHS billing activity and excludes those expenditures accordingly, the LEAD skin substitute adjustment is intended to account for substantial changes in Medicare payment policy that are expected to materially reduce future expenditures for skin substitute products relative to the historical baseline period.

See **Section 5.9** for more information about how CMS will handle future SAHS determinations and reopening of financial settlements.

3.2.2 Historical Baseline Expenditures by Beneficiary Category

For 2027, CMS shall calculate Historical Baseline Expenditures separately for each beneficiary category, resulting in three possible Historical Baseline Expenditure amounts: Aged and Disabled (A&D), End-Stage Renal Disease (ESRD), and High Needs. In future years, CMS will calculate historical baseline expenditures separately for claims aligned and voluntarily aligned beneficiary categories.

Aligned beneficiaries will be included in the A&D and ESRD beneficiary categories based on their reason for entitlement to Medicare. Aligned beneficiaries will be included in the High Needs beneficiary category based on the High Needs eligibility criteria (see **Section 2.5** for a complete list of the High Needs eligibility criteria). If a beneficiary meets the High Needs eligibility criteria, the High Needs beneficiary category will take precedence over A&D for the purposes of benchmark calculations, while ESRD will take precedence over High Needs.

Consistent with **Section 2.5**, High Needs status is applied retroactively to the beneficiary's effective alignment date. Therefore, beneficiaries who are newly identified as High Needs during the Performance Year will be included in the High Needs beneficiary category for benchmark and financial calculations for the full period during which they were aligned to the ACO during that Performance Year.

3.2.3 Approach for Finalizing BY 3 Historical Benchmark Expenditures

For ACOs entering LEAD in PY 2027, CY 2026 constitutes BY 3 of the three-year historical baseline period. Because complete CY 2026 experience will not be available at the time of the initial benchmark calculation and release, CMS will operationalize a phased methodology to develop BY 3 benchmark expenditures. Under this approach, preliminary benchmark amounts will be calculated using partially incurred and paid CY 2026 claims experience, subject to claim run-out completion and other adjustments. The subsequent CY 2026 benchmark releases will replace the earlier estimated amounts with more complete expenditures as the actual claims experience emerges. This approach maintains CY 2026 as the applicable benchmark year, while supporting timely and transparent benchmark development for program operations.

CMS will estimate the full year BY 3 expenditures by applying several adjustment factors.

1. **Completion factors:** CMS will apply completion factors to partially incurred and paid CY 2026 claims experience. This adjustment is needed to account for claims incurred in the most recent service months, which will not yet be fully adjudicated and paid in the available expenditure data. CMS will apply a completion factor based on the average claims completion rate in the LEAD National Reference Population in 2024 and 2025 (CMS will use a simple average of the completion rate from each year), with three months of claims run-out considered to be complete. For example, when calculating initial benchmarks for PY 2027, CMS will apply a completion factor to expenditure data from Q1–Q3 2026 to account for the fact that some claims with dates of service from this period will not be paid or reflected in the expenditure data. The completion factor will estimate spending as if three months of claims run-out was available.

2. **Q4 Seasonality adjustment:** CMS will apply a Q4 seasonality adjustment to account for systematic differences in expenditures during the fourth calendar quarter relative to the first three quarters of the year. These differences reflect both seasonal variation in healthcare utilization and annual Medicare payment updates, including changes to the Inpatient Prospective Payment System (IPPS) that take effect on October 1.

CMS will calculate the seasonality adjustment as the ratio of Q1–Q4 per beneficiary per month (PBPM) expenditures to Q1–Q3 PBPM expenditures in the LEAD National Reference Population in CY 2024 and CY 2025 (CMS will use a simple average of the ratio from each year). CMS will multiply an ACO's Q1–Q3 PBPM expenditures by this factor to estimate full-year PBPM expenditures for BY 3.

To estimate total calendar year expenditures, CMS will also apply an alignment completion factor to estimate full-year aligned beneficiary months based on Q1–Q3 alignment experience. The alignment completion factor will reflect the expected relationship between beneficiary months observed during the first three quarters of the year and total beneficiary months for the full calendar year. CMS will multiply the estimated full-year PBPM expenditures by the estimated full-year aligned beneficiary months to calculate estimated full-year expenditures.

Beginning in 2028 and for subsequent Performance Years, complete claims run-out data will be available before the start of the Performance Year, so preliminary reports will not require completion factors or seasonality adjustments. **Table 3.2.1** below summarizes the benchmark reports that ACOs will receive for PY 2027, and the relevant completion factors/seasonality adjustment that will be included in each report.

Table 3.2.1: Benchmark Release Information

Report	Report Date	CY 2026 Incurred Claims (Lookback) Period	Claims Run Out (Paid Through Month)	BY 3 Completion Factor/ Seasonality Adjustment
1) Preliminary Benchmark Report	December 2026	January–September 2026	October 2026	Q1–Q3 completion factor, Q4 seasonality adjustment
2) Preliminary Benchmark Report Update	February 2027	January– December 2026	No run out	Q1–Q4 completion factor
3) Q1 Benchmark Report	May 2027	January– December 2026	March 2027	No completion factor
4) Q2 Benchmark Report	August 2027	January– December 2026	March 2027	No completion factor
5) Q3 Benchmark Report	November 2027	January– December 2026	March 2027	No completion factor
6) Q4 Benchmark Report	February 2028	January– December 2026	March 2027	No completion factor

Impact on Higher-/Lower-Spending ACO Designation

As discussed in **Section 3.4.2**, all LEAD ACOs will be designated as higher- or lower-spending for the purpose of determining their eligibility for several benchmark adjustments and prospective payments, as well as the discount rate for ACOs in the Global Risk Option. For PY 2027 only, CMS will provide ACOs with a preliminary spending designation (higher-spending or lower-spending ACO) in conjunction with the December 2026 Preliminary Benchmark Report. The final spending designation will be provided in conjunction with the May 2027 Q1 Benchmark Report. Participant TINs added during the Hybrid Alignment window will not impact an ACO's final spending designation, as described in Section 3.4.2. If an ACO's designation changes between these two benchmark report releases, the ACO may elect to retain either designation for PY 2027. This transitional policy is intended to mitigate potential operational disruption associated with the phased incorporation of BY 3 expenditures during the first year of model implementation. In subsequent years, ACOs will receive their final spending designation before the start of the Performance Year.

3.2.4 Claims Aligned Beneficiaries

For claims-aligned beneficiaries, Historical Baseline Expenditures are constructed by taking the ACO's Participant TIN List for the current Performance Year and applying the claims-based alignment algorithm to those Participant TINs for each historical base year. This identifies the beneficiaries who *would have been aligned* to the ACO in each base year had the current-year Participant TINs been participating during those years.

For example, for PY 2027, CMS will determine which beneficiaries would have been aligned to providers on the PY 2027 Participant TIN List in CY 2024, CY 2025, and CY 2026 if the claims-based alignment algorithm were applied in those years. CMS then aggregates base year Medicare Parts A and B expenditures for beneficiaries who would have been aligned in that base year.

Beneficiaries do not have to be aligned in the current Performance Year to be included in a base year's expenditure calculation. As a result, the base year expenditure calculation may include beneficiaries who are not aligned to the ACO in the current Performance Year, but who would have been aligned to the ACO's current participants in one or more historical base year.

Beneficiaries can contribute to base year expenditures for one, two, or three base years, depending on which years they would've met the claims-based criteria to be aligned to the ACO. Within each base year, only expenditures from months that a beneficiary was alignment-eligible are included.

If a beneficiary meets requirements to be both claims-aligned and voluntary-aligned to the same ACO, they will be treated as claims-aligned for the purposes of benchmarking and receive the applicable claims-aligned benchmark based on their beneficiary category.

3.2.5 Voluntary Aligned Beneficiaries

In general, historical Baseline Expenditures for voluntarily aligned beneficiaries are also calculated using Medicare expenditures in the base years. However, as there is no way to determine which beneficiaries "would have been" voluntary aligned in the historical base years,

for PY 2027, an ACO's benchmark for its voluntarily aligned population will be set to equal the benchmark for its claims-aligned population. In other words, CMS will calculate historical baseline expenditures for claims-aligned beneficiaries only, per the methodology in Section 3.2.4, and apply these amounts to the voluntarily aligned population – voluntarily aligned beneficiaries will not be included in the historical baseline expenditure calculations for PY 2027.

In future years of the model, CMS expects to base an ACO's voluntary alignment benchmark on expenditures for beneficiaries that were voluntarily aligned to the ACO during early model PYs (i.e., based on beneficiary costs during a time period in which they were voluntarily aligned to the ACO). More information on this transition will be available in a future Alignment and Financial Methodology Paper update.

3.3 Risk Standardize, Trend, and Weight Historical Expenditures

After Historical Baseline Expenditures from the three Base Years are calculated, they are risk standardized, trended, and blended to develop a Historical Benchmark, according to the following process.

3.3.1 Risk Standardize Historical Baseline Expenditures

Risk standardization is a method for standardizing expenditures by removing variation that is due to differences in population health risks. It is necessary to risk standardize Historical Baseline Expenditures to account for any underlying differences in the ACO's population health risk across the three Base Years. To risk standardize, for each beneficiary category, CMS will divide the ACO's Historical Baseline Expenditures for each base year by the ACO's average risk score for beneficiaries who would have been claims-aligned in that beneficiary category for the respective base year. Every beneficiary has a risk score that is a measure of their total risk status based upon demographic characteristics and medical conditions (HCCs). The ACO's average risk score for a beneficiary category in a given base year is a beneficiary month–weighted average of the risk scores of aligned beneficiaries in that beneficiary category, using eligible beneficiary months. CMS will use the applicable risk adjustment models described in **Section 3.5.2** to calculate average risk scores for each beneficiary category.

3.3.2 Trend Base Year 1 and Base Year 2 Expenditures to Base Year 3

After risk standardizing historical expenditures, CMS trends BY 1 and BY 2 expenditures forward to BY 3 dollars. To trend expenditures, CMS uses a blend of national and regional Medicare FFS expenditure growth rates. This blended growth rate is referred to as the **national-regional blended trend factor** or **two-way blended trend factor**. CMS applies the following process to calculate separate expenditure trends for each beneficiary category (A&D, ESRD, and High Needs).

Box 3.3.2: Calculating the National-Regional Blended Trend Factor

Step 1: Calculate national growth rates

CMS calculates the national component of the trend using Medicare Parts A and B expenditure data for the LEAD National Reference Population. For each base year and beneficiary category, CMS calculates the national growth rate as the ratio of national FFS expenditures in BY 3 to national FFS expenditures in the relevant base year. Specifically:

BY 1 to BY 3 national growth rate = National BY 3 FFS expenditures / National BY 1 FFS expenditures

BY 2 to BY 3 national growth rate = National BY 3 FFS expenditures / National BY 2 FFS expenditures

CMS calculates these growth rates using national FFS expenditures for alignment-eligible beneficiaries in the applicable beneficiary category. Expenditures for each year include a 3-month claims run-out period, which aligns with the run-out period used to calculate Historical Baseline Expenditures.

Step 2: Calculate regional growth rates

CMS calculates the regional component of the trend using Medicare Parts A and B FFS expenditures for alignment-eligible beneficiaries in the ACO's service area. For purposes of calculating regional growth rates, the ACO's service area is defined as all counties in which one or more beneficiaries aligned to the ACO reside for the relevant historical base year.

For each base year, CMS calculates the regional growth rate as the ratio of risk-standardized regional FFS expenditures in BY 3 to regional FFS expenditures in the prior base year.

Specifically:

BY 1 to BY 3 regional growth rate = Regional BY 3 FFS expenditures / Regional BY 1 FFS expenditures

BY 2 to BY 3 regional growth rate = Regional BY 3 FFS expenditures / Regional BY 2 FFS expenditures

The regional growth rate captures both changes in Medicare FFS expenditures within the counties in the ACO's service area and changes in the geographic distribution of the ACO's aligned beneficiary population across those counties.

Step 3: Calculate the national and regional weights

CMS blends the national and regional growth rates using weights that reflect the ACO's market share in its service area in BY 3. CMS calculates these weights separately for each LEAD beneficiary category.

The weight assigned to the national component represents the share of alignment-eligible beneficiaries in the ACO's service area that would be aligned to the ACO in BY 3 (i.e., the ACO's market share). CMS calculates this share using a weighted average of county-level ACO shares, according to the following process:

Step 1: For each county in the ACO's service area, and each beneficiary category, calculate the ACO's market share in the county as:

ACO-aligned beneficiary months in the county ÷ total alignment-eligible beneficiary months in the county

This step produces the ACO's market share in each county, by beneficiary category.

Step 2: For each county in the ACO's service area, and each beneficiary category, calculate the county weight as:

ACO's aligned beneficiary months in the county ÷ the ACO's total aligned beneficiary months.

This step produces the share of the ACO's total aligned population that resides in each county.

Step 3: For each county in the ACO's service area, multiply the county-level market share from Step 1 by the county weight from step 2.

Step 4: Sum the product for each county from step 3 to produce the ACO's county-weighted average market share.

The percent value of the ACO's county-weighted average market share is the weight applied to the national trend component. For example, if the ACO's weighted average market share is 15%, the weight placed on the national component of the trend for that ACO will be 15%. The regional weight is equal to one minus the national weight.

As the ACO's penetration in its region increases, CMS places more weight on the national growth rate and less weight on the regional growth rate. This reduces the extent to which the ACO's own performance can influence the regional growth rate used to trend its benchmark.

Step 4: Calculate the national-regional blended trend factor

CMS calculates the national-regional blended trend factor by taking a weighted average of the national and regional growth rates, using the weights determined in the prior step. CMS calculates a separate blended trend factor for BY 1 to BY 3 and BY 2 to BY 3. CMS then applies the applicable blended trend factor to the ACO's risk-standardized Historical Baseline Expenditures for each beneficiary category and alignment type.

Example: Calculating the National-Regional Blended Trend Factor

Assume CMS is calculating the BY 1 to BY 3 trend factor for the A&D claims-aligned beneficiary category for an ACO with aligned beneficiaries in two counties.

National A&D FFS expenditures are:

- BY 1: $1,000 PBPM
- BY 3: $1,120 PBPM

The **national growth rate** is:

$1,120 / $1,000 = 1.120

Regional A&D FFS expenditures for the ACO's service area are:

- BY 1: $1,050 PBPM
- BY 3: $1,155 PBPM

The **regional growth rate** is:

$1,155 / $1,050 = 1.100

Next, CMS calculates the ACO's market share.

In County A, there are 100,000 alignment-eligible A&D beneficiary months, and 20,000 are aligned to the ACO. The county-level ACO market share is:

20,000 / 100,000 = 20%

In County B, there are 50,000 alignment-eligible A&D beneficiary months, and 5,000 are aligned to the ACO. The county-level ACO market share is:

5,000 / 50,000 = 10%

Then, CMS calculates the ACO's county weights (i.e., how the ACO's aligned beneficiaries are distributed across the counties in its service area)

- County A weight: 20,000 of 25,000 aligned beneficiary months = 80%
- County B weight: 5,000 of 25,000 aligned beneficiary months = 20%

The national weight is the county-weighted average of the county-level ACO shares:

(20% × 80%) + (10% × 20%) = 18%

The **regional weight** is:

1 − 18% = 82%

The **national-regional blended trend factor** is:

(1.120 × 18%) + (1.100 × 82%) = 1.104

CMS would apply a BY 1 to BY 3 trend factor of 1.104 to the ACO's BY 1 risk-standardized A&D expenditures.

3.3.3 Apply Base Year Weighting

After CMS risk-standardizes historical expenditures and trends BY 1 and BY 2 to BY 3 dollars, it will apply base year weights.

For all Newly Entering ACOs, Base Year 1 is weighted 10%, BY 2 is weighted 30%, and BY 3 is weighted 60%. The calculation is as follows:

Historical Benchmark = (BY 1 x 10%) + (BY 2 x 30%) + (BY 3 x 60%)

For Renewing ACOs, the Base Years will be weighted equally. The calculation is as follows:

Historical Benchmark = (BY 1 x (1/3)) + (BY 2 x (1/3)) + (BY 3 x (1/3)))

The resulting risk standardized, trended, and blended base year expenditures represent the ACO's Historical Benchmark. See **Table 3.3.3** for an example of the calculation of the Historical Benchmark for a Newly Entering ACO's A&D population:

Table 3.3.3: Historical Benchmark Calculation

Line	Step	Historical Baseline Experience: CY 2024	Historical Baseline Experience: CY 2025	Historical Baseline Experience: CY 2026	Historical Benchmark
1.	Total A&D Claims-Aligned Beneficiary Claim Payments	$87,856,003.26	$93,375,409.42	$106,794,359.82	-
2.	DIVIDED BY: Eligible Months	91,366	94,577	104,671	-
3.	EQUALS: Claim-Based Expenditure PBPM	$961.58	$987.30	$1,020.29	-
4.	DIVIDED BY: ACO Average Risk Score (eligible beneficiary month weighted)	1.122	1.115	1.087	-
5.	EQUALS: ACOPBPM Risk-Standardized Baseline Expenditure	$857.03	$885.47	$938.63	-

Line	Step	Historical Baseline Experience: CY 2024	Historical Baseline Experience: CY 2025	Historical Baseline Experience: CY 2026	Historical Benchmark
6.	TIMES: National-Regional Blended Trend Factor	1.104	1.076	1.000	-
7.	EQUALS: PBPM Risk-Standardized, Trended, Baseline Expenditure	$946.16	$952.76	$938.63	-
8.	TIMES: Base Year Weights	0.100	0.300	0.600	-
9.	EQUALS: PBPM Historical Benchmark	$94.62	$285.83	$563.18	**$943.62**

3.3.4 Sufficient Claims

If CMS determines that an ACO does not have sufficient claims history to construct credible Historical Baseline Expenditures for a given base year, CMS will not use that base year in the calculation. "Sufficient claims history" will be defined as meeting or exceeding the base year alignment minimum, outlined in **Table 2.6.1**, for a given base year for that ACO type (standard, Newly Entering, or caring for a high proportion of High Needs and ESRD beneficiaries).

Alignment minimums are not specific to beneficiary categories. Even if individual beneficiary categories have a small number of aligned beneficiaries in a given base year, as long as an ACO's total aligned beneficiary population exceeds the minimum alignment threshold, CMS will use that base year to construct the Historical Benchmark.

For Renewing ACOs, if two base years are determined to have sufficient claims history, CMS will average the two base years, with equal weight. For all Newly Entering ACOs, if two base years are determined to have sufficient claims history, CMS will average the two base years with the more recent base year weighted two-thirds and the less recent base year weighted one-third. For all LEAD ACOs, if only one base year is determined to have sufficient claims history, CMS will weight that year at 100% for calculating the Historical Baseline Expenditures.

CMS will also monitor whether individual Participant TINs have sufficient claims history. If CMS identifies a pattern of Participant TINs with zero claims history in the base years, it may consider additional policies to ensure that expenditures for these Participant TINs are accurately reflected in the ACO's Performance Year Benchmark.

3.4 Apply ACO-Specific Benchmark Adjustments

After calculating an ACO's Historical Benchmark, CMS will apply additional ACO-specific benchmark adjustments that the ACO is eligible for, namely the Regional Efficiency Adjustment and the Prior Savings Adjustment. If an ACO is eligible for both the Regional Efficiency Adjustment and the Prior Savings Adjustment, it will receive the higher of the two adjustments, subject to a benchmark adjustment cap. This cap limits the amount of positive benchmark adjustment CMS will apply to an ACO's Historical Benchmark. If an ACO is eligible for both the Regional Efficiency Adjustment and the Prior Savings Adjustment and the two adjustments

are equal after the application of the applicable benchmark adjustment caps, CMS will apply the Regional Efficiency Adjustment. The adjustment amount applied to the ACO's benchmark will be identified in the ACO's benchmark report.

In general, the benchmark adjustment cap is 5% of the modified U.S. Per Capita Cost (USPCC)–based national average spending amount, risk adjusted to reflect the ACO's Performance Year population risk (see **Section 3.5.1** for a definition of modified USPCC). The Performance Year risk score used for the benchmark adjustment cap will be the risk score after the application of the applicable risk score growth cap. A lower 3% benchmark adjustment cap applies only for lower-spending ACOs with more than 40% of Participant TINs that have participated in a Shared Savings Program ACO within the previous two years. Because the Regional Efficiency Adjustment and Prior Savings Adjustment are calculated differently, CMS applies the benchmark adjustment cap differently for each adjustment. The mechanics for applying the cap to each adjustment are described in the relevant sections below.

3.4.1 Calculating Regional FFS Expenditures

As a first step to determine whether an ACO is higher or lower-spending, and therefore for which benchmark adjustments it is eligible, CMS must calculate regional FFS expenditures in the ACO's service area.

For each ACO, CMS calculates regional FFS expenditures by identifying the counties in the ACO's service area, calculating risk-standardized county-level Medicare FFS expenditures for alignment-eligible beneficiaries in those counties, and weighting those county-level expenditure amounts based on the distribution of the ACO's aligned beneficiaries across counties. CMS performs this calculation separately for each beneficiary category (but does not calculate separate regional expenditures by alignment type).

CMS calculates county-level FFS expenditures using the same expenditure rules used to calculate Historical Baseline Expenditures and Performance Year expenditures. This ensures parity between the calculation of ACO expenditures and regional expenditures. See **Section 3.2** for more detail on expenditure calculations.

For purposes of calculating regional FFS expenditures, the ACO's service area is defined as all counties in which one or more beneficiaries aligned to the ACO reside. CMS determines the ACO's service area using beneficiary alignment for the relevant base year or Performance Year.

For each county in the ACO's service area and for each beneficiary category, CMS calculates average per-beneficiary-per-month (PBPM) Medicare Parts A and B FFS expenditures for alignment-eligible beneficiaries. In calculating this average, CMS includes each beneficiary's Medicare Parts A and B FFS expenditures only for the months in which the beneficiary is eligible for alignment.

County PBPM FFS expenditures =
Total eligible Medicare Parts A and B FFS expenditures ÷ total alignment-eligible beneficiary months

CMS then risk-standardizes the county-level FFS expenditure amount using the applicable HCC risk score model for the beneficiary category. To do so, CMS calculates the average county-level HCC risk score as the beneficiary month–weighted average risk score for alignment-eligible beneficiaries in the county. CMS then divides the county's average PBPM FFS expenditure amount by the county's average HCC risk score.

County average HCC risk score =
∑ (Each beneficiary's HCC risk score × their eligible months) ÷ total eligible beneficiary months

Risk-standardized county FFS expenditures =
County PBPM FFS expenditures ÷ county average HCC risk score

After calculating risk-standardized county-level FFS expenditures, CMS weights those county-level amounts based on the distribution of the ACO's aligned beneficiaries across counties. CMS assigns each county a weight equal to the share of the ACO's total aligned beneficiary months in the county. CMS then multiplies each county's risk-standardized FFS expenditure amount by the county's weight and sums the weighted amounts across all counties in the ACO's service area to determine the ACO's regional FFS expenditures.

County weight =
ACO aligned beneficiary months in the county ÷ total ACO aligned beneficiary months

Regional FFS expenditures =
∑ county weight × risk−standardized county FFS expenditures

3.4.2 Higher-/Lower-Spending Designation

The higher-/lower- spending designation is used to determine whether the ACO may be eligible for a Regional Efficiency Adjustment or the 1.5% Administrative Add-On.

CMS will determine whether an ACO is higher-spending or lower-spending by comparing the ACO's Historical Benchmark calculated under **Section 3.3** to the FFS expenditures in the ACO's service area for BY 3 as calculated under **Section 3.4.1**. If the ACO's Historical Benchmark is higher than its regional FFS expenditures for BY 3, the ACO will be considered higher spending. If the ACO's Historical Benchmark is lower than its regional FFS expenditures for BY 3, the ACO will be considered lower spending.

The base years used to calculate whether an ACO is higher or lower spending will remain fixed for the duration of the ACO's participation in LEAD. However, CMS will recalculate the ACO's spending designation for each Performance Year using the ACO's Participant TIN List for that Performance Year. For example, for PY 2027, the spending designation will be based on CY 2024, CY 2025, and CY 2026 expenditures for providers on the PY 2027 Participant TIN List. In PY 2028, the spending designation will be based on the same time period (CYs 2024–2026) but will use the providers on the PY 2028 Participant TIN List. An ACO's spending designation will not change during the Performance Year, even if the ACO elects hybrid alignment and adds new Participant TINs during the mid-year Participant TIN list update.

CMS will compare an ACO's Historical Benchmark to regional FFS expenditures separately for each beneficiary category and then combine the category-level spending differences into a single ACO-level spending difference using BY 3 beneficiary category weights.

For each beneficiary category, CMS will calculate the beneficiary-category weight as the ACO's aligned beneficiary months in the category in BY 3 over the ACO's total aligned beneficiary months in BY 3. CMS will then calculate the ACO-level spending difference as:

((A&D regional expenditures – A&D Historical Benchmark) × A&D category weight) + ((ESRD regional expenditures – ESRD Historical Benchmark) × ESRD category weight) + ((High Needs regional expenditures – High Needs Historical Benchmark) × High Needs category weight)

Table 3.4.2: Calculation of Higher- or Lower-Spending Designation

Beneficiary Category	ACO-Risk-Standardized Regional FFS Expenditure	ACO Historical Benchmark	Difference	ACO BY 3 Beneficiary-Category Weight
A&D	$1,050 PBPM	$1,000 PBPM	$50 PBPM	80%
ESRD	$8,000 PBPM	$8,500 PBPM	-$500 PBPM	5%
High Needs	$3,700 PBPM	$3,200 PBPM	$500 PBPM	15%

The **ACO's spending difference** is calculated as:

($50 × 80%) + (-$500 × 5%) + ($500 × 15%)
= $40 − $25 + $75
= $90 PBPM

Because the ACO-level spending difference is positive, the ACO's Historical Benchmark is lower than risk-adjusted regional FFS expenditures on a weighted basis. CMS would designate the ACO as lower spending for the Performance Year.

Higher-/Lower-Spending Designation for PY 2027

As described in **Section 3.2.3**, for ACOs entering LEAD in PY 2027, for PY 2027 only, ACOs will receive a preliminary higher- or lower-spending designation in December 2026 and a final designation in May 2027. If an ACO's designation changes between the preliminary and final report, it will have the option to select which designation it wants to use for PY 2027. TINs added during hybrid alignment for PY 2027 will not be included in the calculation of the final higher/lower-spending designation. However, if the ACO is eligible for a Regional Efficiency Adjustment or Prior Savings Adjustment, TINS added during hybrid alignment will be incorporated into the applicable adjustment calculation. See sections 3.4.3 and 3.4.4 for additional information on the Regional Efficiency and Prior Savings Adjustments, respectively. For PY 2028 and subsequent Performance Years, ACOs will receive their final designations in Q4 of the year prior to the Performance Year.

3.4.3 Regional Efficiency Adjustment

Lower-spending ACOs in the Global Risk track will be eligible for a positive Regional Efficiency Adjustment to their benchmark.

To calculate an ACO's Regional Efficiency Adjustment, CMS will follow the same methodology outlined in **Section 3.4.1** to determine the difference between the ACO's Historical Benchmark and its BY 3 regional FFS expenditures.

The Regional Efficiency Adjustment will be equal to 50% of the positive difference between BY 3 regional FFS expenditures and the ACO's Historical Benchmark. The Regional Efficiency Adjustment will be calculated and applied separately for each beneficiary category. The uncapped Regional Efficiency Adjustment is calculated as:

Uncapped REA =
50 percent × positive difference between BY 3 regional FFS expenditures and the ACO's Historical Benchmark

If the ACO's Historical Benchmark is lower than BY 3 regional FFS expenditures for the applicable beneficiary category, the ACO receives a positive Regional Efficiency Adjustment for that category. If the ACO's Historical Benchmark is equal to or higher than BY 3 regional FFS expenditures for the applicable beneficiary category, the ACO does not receive a Regional Efficiency Adjustment for that category.

Example: Calculating the Regional Efficiency Adjustment Before Applying the Benchmark Adjustment Cap

Using the same example from **Section 3.4.2**, the ACO is designated as lower spending because its Historical Benchmark is $90 PBPM below risk-standardized regional FFS expenditures on a weighted ACO-level basis. If the ACO participates in the Global Risk track, it would therefore be eligible for a Regional Efficiency Adjustment.

The Regional Efficiency Adjustment is calculated separately for each beneficiary category.

Table 3.4.3.1: Calculating the Regional Efficiency Adjustment Before Cap

Beneficiary Category	Risk-Standardized Regional FFS Expenditure	ACO Historical Benchmark	Difference	Regional Efficiency Adjustment, Before Cap
A&D	$1,050 PBPM	$1,000 PBPM	$50 PBPM	$25 PBPM
ESRD	$8,000 PBPM	$8,500 PBPM	-$500 PBPM	$0 PBPM
High Needs	$3,700 PBPM	$3,200 PBPM	$500 PBPM	$250 PBPM

For the A&D beneficiary category, the ACO's Historical Benchmark is $50 PBPM below risk-standardized regional FFS expenditures. The uncapped Regional Efficiency Adjustment is therefore:

$50 × 50% = $25 PBPM

For the High Needs beneficiary category, the ACO's Historical Benchmark is $500 PBPM below risk-standardized regional FFS expenditures. The uncapped Regional Efficiency Adjustment is therefore:

$500 × 50% = $250 PBPM

For the ESRD beneficiary category, the ACO's Historical Benchmark is $500 PBPM above risk-standardized regional FFS expenditures. Because the Regional Efficiency Adjustment is based only on the positive difference between regional FFS expenditures and the ACO's Historical Benchmark, the ACO does not receive a Regional Efficiency Adjustment for the ESRD beneficiary category.

Before applying to any benchmark adjustment cap, the ACO's Adjusted Historical Benchmark would be:

Table 3.4.3.2: Calculating the ACO's Adjusted Historical Benchmark Before Cap

Beneficiary Category	ACO historical Benchmark	Uncapped REA	Adjusted Historical Benchmark, Before Cap
A&D	$1,000	$25	$1,025
ESRD	$8,500	$0	$8,500
High Needs	$3,200	$250	$3,450

Applying the Benchmark Adjustment Cap to the Regional Efficiency Adjustment

As described above, the Regional Efficiency Adjustment is subject to a benchmark adjustment cap equal to 5% of modified USPCC, multiplied by the ACO's average risk score for the Performance Year. This does not include lower-spending ACOs with more than 40% of Participant TINs that have participated in a Shared Savings Program ACO within the previous two years, who have a benchmark adjustment cap of 3% of modified USPCC, risk adjusted.

Because the Regional Efficiency Adjustment is calculated separately for each beneficiary category, CMS applies the cap separately for each beneficiary category. For each beneficiary category, CMS compares the uncapped Regional Efficiency Adjustment to the applicable risk-adjusted cap amount and applies the lesser of the two amounts.

Example: Applying the Regional Efficiency Adjustment Cap

Continuing the example above, assume the ACO is subject to the 5% cap. CMS calculates a separate Regional Efficiency Adjustment cap amount for each beneficiary category.

Table 3.4.3.3: Applying the Regional Efficiency Adjustment Cap

Beneficiary Category	Uncapped REA	USPCC Base Amount	PY Average Risk Score	REA Cap Amount	Applied REA
A&D	$25	$1,000	1.02	$51	$25
ESRD	$0	$8,000	0.99	$396	$0
High Needs	$250	$3,500	1.03	$180.25	$180.25

The **Regional Efficiency Adjustment cap amounts** are calculated as:

A&D: $1,000 × 1.020 × 5% = $51 PBPM
ESRD: $8,000 × 0.990 × 5% = $396 PBPM
High Needs: $3,500 × 1.030 × 5% = $180.25 PBPM

For A&D, the uncapped Regional Efficiency Adjustment is $25 PBPM, which is below the $51 PBPM cap. CMS would therefore apply the full $25 PBPM adjustment.

For ESRD, the uncapped Regional Efficiency Adjustment is $0 PBPM because the ACO's Historical Benchmark is higher than risk-standardized regional FFS expenditures for that category. CMS would therefore apply no Regional Efficiency Adjustment for ESRD.

For High Needs, the uncapped Regional Efficiency Adjustment is $250 PBPM, which exceeds the $180.25 PBPM cap. CMS would therefore cap the High Needs Regional Efficiency Adjustment at $180.25 PBPM.

After applying the cap, the ACO's adjusted Historical Benchmark would be:

Table 3.4.3.4: Calculating the ACO's Adjusted Historical Benchmark

Beneficiary Category	ACO Historical Benchmark	Applied REA	Adjusted Historical Benchmark
A&D	$1,000 PBPM	$25	$1,025
ESRD	$8,500 PBPM	$0	$8,500
High Needs	$3,200 PBPM	$180.25	$3,380.25

Exclusion of New, Higher-Spending TINs in Lower-Spending ACOs

CMS will exclude certain higher-spending TINs that are new to Medicare ACO programs from the calculation of a lower-spending ACO's Regional Efficiency Adjustment. CMS will first determine whether an ACO is higher spending or lower spending using all Participant TINs, including any new higher-spending TINs. This exclusion policy is only available to ACOs that are lower spending overall and is intended to avoid penalizing lower-spending ACOs for recruiting higher-spending providers who have not previously participated in Medicare ACO models.

Specifically, if a lower-spending ACO includes a TIN that is both new to Medicare ACO models and higher spending, that TIN's historical experience will be excluded when calculating the ACO's Regional Efficiency Adjustment.

For purposes of this policy, a TIN would be considered new to Medicare ACO models if the TIN has not participated in a Shared Savings Program or REACH ACO in the prior two years.

A TIN's higher- or lower-spending status would be determined using the same general methodology used to determine whether an ACO is higher- or lower-spending. CMS would compare the TIN's Historical Benchmark, calculated as a three-year weighted blend of base year expenditures, to regional spending in BY 3. The relevant region would be defined using the TIN's aligned beneficiary weighted county average.

This exclusion applies only for purposes of calculating the Regional Efficiency Adjustment. Higher-spending TINs that are new to Medicare ACO models will remain included in the ACO's benchmark and aligned beneficiary population. However, these TINs will not receive the benefit of any Regional Efficiency Adjustment generated by other Participant TINs within the ACO. CMS will only apply the Regional Efficiency Adjustment to the benchmark for beneficiaries aligned through TINs that contributed to the adjustment calculation.

Additionally, the benchmark adjustment cap associated with the Regional Efficiency Adjustment will be calculated using only the beneficiaries aligned through TINs that contribute to the Regional Efficiency Adjustment calculation. Excluded TINs and their aligned beneficiaries will not be used when determining the maximum allowable benchmark adjustment.

Example: Exclusion of a New, Higher-Spending TIN from the Regional Efficiency Adjustment Calculation

Continuing the example above, assume that within the High Needs beneficiary category, the ACO includes both existing Participant TINs and a new, higher-spending TIN that is excluded from the Regional Efficiency Adjustment calculation.

Table 3.4.3.5: Example Higher-Spending TIN in ACO

Beneficiary Group	Aligned Beneficiary Months in PY	Historical FFS Expenditures
Beneficiaries aligned through Participant TINs included in the Regional Efficiency Adjustment calculation	8,000	$3,000 PBPM
Beneficiaries aligned through a new, higher-spending TIN excluded from the Regional Efficiency Adjustment calculation	2,000	$4,000 PBPM
Total High Needs population	10,000	$3,200 PBPM

CMS first determines whether the ACO is higher spending or lower spending using all Participant TINs, including the new, higher-spending TIN. The ACO's overall High Needs Historical Benchmark remains $3,200 PBPM and is therefore $500 PBPM below the $3,700 PBPM Regional Benchmark.

However, CMS calculates the Regional Efficiency Adjustment using only beneficiaries aligned through Participant TINs included in the Regional Efficiency Adjustment calculation.

Table 3.4.3.6: Regional Efficiency Adjustment Calculation Using Only Beneficiaries Aligned Through Participant TINs

Calculation Component	Amount
Risk-standardized regional FFS expenditure	$3,700 PBPM
Historical FFS Expenditures for included TINs	$3,000 PBPM
Difference	$700 PBPM
Uncapped Regional Efficiency Adjustment (50% × $700)	$350 PBPM

To develop a single Adjusted Historical Benchmark PBPM amount that applies to all aligned beneficiaries in the beneficiary category, CMS calculates a weighted average Regional Efficiency Adjustment. CMS first determines the capped Regional Efficiency Adjustment applicable to beneficiaries aligned through included Participant TINs as the lower of the uncapped Regional Efficiency Adjustment and the applicable benchmark adjustment cap.

Continuing the example, the uncapped Regional Efficiency Adjustment is $350 PBPM. The benchmark adjustment cap is $180.25 PBPM ($3,500 USPCC × 1.030 average ACO High Needs beneficiary risk score × 5 percent). Therefore, the Regional Efficiency Adjustment applicable to beneficiaries aligned through included Participant TINs is capped at $180.25 PBPM. Beneficiaries aligned through the excluded TIN receive a $0 PBPM Regional Efficiency Adjustment.

CMS then weights these amounts based on the share of aligned beneficiary months associated with included and excluded Participant TINs in the PY:

Weighted Average Regional Efficiency Adjustment

= ($180.25 PBPM × 8,000 included TIN beneficiary months ÷ 10,000 total beneficiary months) + ($0 PBPM × 2,000 excluded TIN beneficiary months ÷ 10,000 total beneficiary months)

= $144.20 PBPM

The resulting $144 PBPM Regional Efficiency Adjustment reflects the weighted average adjustment across all aligned beneficiaries in the High Needs beneficiary category in the PY. In this example, 80% of aligned beneficiary months are associated with Participant TINs that receive a $180 PBPM Regional Efficiency Adjustment, while 20% are associated with the excluded TIN and receive no Regional Efficiency Adjustment.

3.4.4 Prior Savings Adjustment

Renewing ACOs in both the Professional and Global Risk Options will be eligible for a Prior Savings Adjustment based on savings generated in the three calendar years immediately preceding the start of the LEAD performance period.

To determine whether a LEAD ACO is eligible for a Prior Savings Adjustment, CMS will first determine whether the LEAD ACO has sufficient continuity with one or more predecessor REACH or Shared Savings Program ACOs. A predecessor ACO may contribute to the LEAD

ACO's Prior Savings Adjustment if at least 40% of the LEAD ACO's Participant TINs participated in that predecessor ACO.

CMS will assess each potential predecessor ACO separately. A predecessor ACO will qualify for purposes of the Prior Savings Adjustment if at least 40% of the LEAD ACO's Participant TINs were associated with that predecessor ACO.

For each potential predecessor ACO, CMS will calculate the continuity percentage as follows:

> Continuity Percentage = (Number of LEAD ACO TINs associated with the predecessor ACO ÷ Total number of LEAD ACO TINs included in the continuity assessment)

The denominator will consist of:

- all Participant TINs on the LEAD ACO's Performance Year Participant TIN list, including Legacy TINs with active PECOS enrollment; and
- all Legacy TINs with inactive PECOS enrollment that the LEAD ACO submitted on its Legacy TIN list.

For each predecessor ACO, the numerator will consist of the TINs included in the denominator that also participated in that predecessor ACO. For a Shared Savings Program predecessor ACO, predecessor TINs will include ACO Participants. For an ACO REACH predecessor ACO, predecessor TINs will include both Participant TINs and Legacy TINs (but not Preferred Provider TINs).

If one predecessor ACO meets the 40-percent threshold, the LEAD ACO's Prior Savings Adjustment will be based on that predecessor ACO's savings history. If more than one predecessor ACO meets the 40-percent threshold, CMS will calculate a beneficiary-weighted average of the predecessor ACOs' per-beneficiary savings, weighted based on the beneficiaries associated with the LEAD Participant TINs from each qualifying predecessor ACO.

If the LEAD ACO's Participant TINs participated in different ACOs in different base years, CMS will identify the qualifying predecessor ACO or ACOs based on BY 3, the most recent base year. For BY 1 and BY 2, CMS will include savings for a qualifying BY 3 predecessor ACO only if at least 30% of the LEAD ACO's Participant TINs participated in that same predecessor ACO in the applicable year (i.e., if a LEAD ACO meets the 40-percent threshold for BY 3, it will have the lower 30 percent threshold for BY 1 and BY 2 to avoid losing eligibility based on changes to a small number of Participant TINs in earlier base years). If the 30-percent threshold is not met for BY 1 or BY 2, savings for that predecessor ACO for that year will be set to $0, and the average beneficiary month calculation for that predecessor ACO, which is used to calculate the proration factor, would be based exclusively on BY3. CMS will not substitute a different predecessor ACO for BY 1 or BY 2. CMS will calculate total per-capita savings or losses for each of the three prior Performance Years as the difference between the ACO's Performance Year Benchmark and Performance Year expenditures, divided by aligned beneficiary months. This calculation reflects

gross Medicare savings, not just the portion of savings the ACO retained (i.e., it represents total savings, before the application of the Global Risk Option discount in ACO REACH or CMS's share of savings in the ACO REACH Professional Risk Option and the Shared Savings Program Basic and Enhanced Tracks).

CMS then takes a simple average of the three annual PBPM values to determine eligibility for the Prior Savings Adjustment. ACOs with a positive average are eligible for an adjustment; ACOs with an average that is zero or negative are not eligible.

For eligible ACOs, CMS applies a proration factor to account for changes in the size of the ACO's aligned beneficiary population between the base years and the current Performance Year. This factor scales the adjustment when the benchmark population differs from the population that generated the prior savings, preventing savings earned on a smaller population from being fully applied to a substantially larger one. The proration factor is calculated at the ACO level: the average number of beneficiary months of the predecessor ACO (all aligned beneficiaries, not only those associated with the LEAD ACO's Participant TINs) during the prior savings period, divided by the total number of beneficiary months of the LEAD ACO in the current Performance Year, capped at 100%.
For example, if an ACO had an average of 100,000 beneficiary months in the base years and grew to 200,000 beneficiary months in the current Performance Year, its proration factor would be 50%.

The uncapped Prior Savings Adjustment is equal to 50% of the prorated average per-capita savings. Unlike the Regional Efficiency Adjustment, the Prior Savings Adjustment is calculated as a single ACO-level PBPM adjustment and is not differentiated by beneficiary category. Accordingly, CMS applies the benchmark adjustment cap to the ACO's overall Prior Savings Adjustment, rather than applying separate caps to the Prior Savings Adjustment by beneficiary category.

To calculate the ACO-level Prior Savings Adjustment cap, CMS first calculates a sub-population cap amount for each beneficiary category, using the applicable USPCC-based amount and the ACO's Performance Year average risk score for that beneficiary category and alignment type. CMS then combines those sub-population cap amounts into a single ACO-level cap using the beneficiary category shares of total Performance Year ACO alignment.

For each beneficiary category and alignment type, the sub-population cap amount is calculated as:

Sub-population cap amount =

applicable cap percentage (5% or 3%) × USPCC-based national average spending amount × ACO's Performance Year average risk score

CMS then calculates the ACO's Prior Savings Adjustment cap as:

ACO Prior Savings Adjustment cap =

sum across beneficiary categories of:
sub-population cap amount × sub-population share of total ACO alignment

CMS then compares the uncapped Prior Savings Adjustment to the Prior Savings Adjustment cap and applies the lesser amount.

Example 1: Prior Savings Adjustment for a Single Predecessor ACO

Assume a Renewing ACO qualifies for a Prior Savings Adjustment based on the savings history of one predecessor ACO. CMS calculates the predecessor ACO's gross savings or losses for each of the three prior base years as follows:

Table 3.4.3.7: Calculation of Predecessor ACO's Gross Savings or Losses

Base Year	PY Benchmark	Actual Expenditures	Gross Savings/ Losses	PY Aligned Beneficiary Months	PBPM Savings/ Losses
Year 1	$120,000,000	$114,250,000	$5,750,000	115,000	$50 PBPM
Year 2	$125,000,000	$126,200,000	-$1,200,000	120,000	-$10 PBPM
Year 3	$130,000,000	$121,250,000	$8,750,000	125,000	$70 PBPM

CMS then calculates the simple average of the three annual PBPM savings/loss amounts:

($50 + -$10 + $70) ÷ 3 = $36.67 PBPM

Because the average is positive, the ACO is eligible for a Prior Savings Adjustment.

CMS then applies the proration factor to account for changes in the size of the ACO's aligned beneficiary population. Assume the predecessor ACO had an average of 120,000 beneficiary months during the base years, and the LEAD ACO has 240,000 beneficiary months in the current Performance Year.

The **proration factor** would be:

120,000 ÷ 240,000 = 50%

The **prorated average savings amount** would be:

$36.67 × 50% = $18.33 PBPM

The **Prior Savings Adjustment** is equal to 50% of the prorated average savings amount:

$18.33 × 50% = $9.17 PBPM

Assuming the adjustment cap does not apply, CMS would add a $9.17 PBPM Prior Savings Adjustment to the ACO's Historical Benchmark.

Example 2: Prior Savings Adjustment with Multiple Qualifying Predecessor ACOs

Assume a LEAD ACO has sufficient continuity with two predecessor ACOs in BY 3. Predecessor ACO A is associated with 80,000 beneficiary months attributable to the LEAD ACO's Participant TINs in the PY, and Predecessor ACO B is associated with 20,000. These TIN-level months are used only to weight each predecessor's savings. Separately, across all of their aligned beneficiaries, Predecessor ACO A averaged 150,000 beneficiary months and Predecessor ACO B averaged 50,000 during the prior savings period. These ACO-level months are used for proration.

CMS calculates each predecessor ACO's average prior savings as follows:

Table 3.4.3.8: Calculating Predecessor ACO's Average Prior Savings

Predecessor ACO	Average PBPM Prior Savings	Beneficiary Months Associated with LEAD Participant TINs in the PY	Weight	Average Beneficiary Months of the Predecessor ACO,Prior Savings period (Proration)
Predecessor ACO A	$30 PBPM	80,000	80%	150,000
Predecessor ACO B	$70 PBPM	20,000	20%	50,000

CMS calculates the **beneficiary-weighted average** prior savings amount as:

($30 × 80%) + ($70 × 20%)
= $24 + $14
= $38 PBPM

The proration factor is calculated at the ACO level, using all beneficiary months of the predecessor ACOs and all beneficiary months of the LEAD ACO. The predecessor ACOs

together averaged 200,000 beneficiary months during the prior savings period (150,000 + 50,000), and the LEAD ACO has 250,000 beneficiary months in the current Performance Year.

The **proration factor** would be:

200,000 ÷ 250,000 = 80%

The **prorated average savings amount** would be:

$38 × 80% = $30.40 PBPM

The **Prior Savings Adjustment** is equal to 50% of the prorated average savings amount:

$30.40 × 50% = $15.20 PBPM

Assuming the adjustment cap does not apply, CMS would add a $15.20 PBPM Prior Savings Adjustment to the ACO's Historical Benchmark.

Example 3: Applying the Prior Savings Adjustment Cap

Assume the ACO in Example 2 has an uncapped Prior Savings Adjustment of $15.20 PBPM. Because the Prior Savings Adjustment is calculated as a single ACO-level PBPM adjustment, CMS applies the benchmark adjustment cap to the overall Prior Savings Adjustment.

Assume the ACO is subject to the 5% cap and has the following Performance Year beneficiary-month distribution and average risk scores.

Table 3.4.3.9: Applying the Prior Savings Adjustment Cap

Beneficiary Category	PY beneficiary-Category Share	USPCC-Based Amount	PY Average Risk Score	Sub-population Cap Amount
A&D	80%	$1,000	1.02	$51
ESRD	5%	$8,000	0.99	$396
High Needs	15%	$3,500	1.03	$180.25

The **beneficiary category sub-population** cap amounts are calculated as:

A&D: $1,000 × 1.020 × 5% = $51 PBPM
ESRD: $8,000 × 0.990 × 5% = $396 PBPM
High Needs: $3,500 × 1.030 × 5% = $180.25 PBPM

CMS then calculates the **Prior Savings Adjustment** cap by weighting each beneficiary category sub-population cap amount by the beneficiary category share:

($51 × 80%) + ($396 × 5%) + ($180.25 × 15%)
= $40.80 + $19.80 + $27.04
= $87.64 PBPM

Because the ACO's uncapped Prior Savings Adjustment of $15.20 PBPM is below the Prior Savings Adjustment cap of $87.64 PBPM, CMS would apply the full $15.20 PBPM Prior Savings Adjustment. As described in Section 3.4, if there is a tie between the ACO's Prior Savings Adjustment and the ACO's beneficiary-weighted Regional Efficiency Adjustment, which happens when the ACO's Prior Savings Adjustment and beneficiary category Regional Efficiency Adjustments are all equal to or greater than the cap amounts, CMS will apply the Regional Efficiency Adjustment.

3.4.5 Percent Administrative Add-On Capitation

Higher-spending ACOs, as determined per the methodology in **Section 3.4.2**, will receive an additional incentive equal to 1.5% of the ACO's total benchmark (the "1.5 percent Administrative Add-On"), provided in the form of a monthly capitated payment in lieu of a benchmark adjustment. The goal of converting this benchmark adjustment to a capitated payment is to provide higher-spending ACOs with additional upfront cash flow to invest in care transformation activities that can improve outcomes and reduce costs. This capitated payment mechanism is described in more detail in **Section 4.5**. The 1.5 percent Administrative Add-On is not included in the Performance Year Benchmark or Performance Year expenditures. A higher-spending ACO may be eligible for and receive both a Prior Savings Adjustment and a 1.5 percent Administrative Add-On. In this case, the 1.5 percent Administrative Add-On does not count towards the ACO's benchmark adjustment cap.

3.5 Update Adjusted Historical Benchmark to the Performance Year

The result of applying any ACO-specific benchmark adjustments that an ACO is eligible for, i.e. the Regional Efficiency Adjustment or Prior Savings Adjustment described in **Section 3.4**, is the Adjusted Historical Benchmark. Then, to update the Adjusted Historical Benchmark to the current Performance Year, CMS will trend and risk adjust the Adjusted Historical Benchmark and apply an adjustment for beneficiaries that are only aligned for a partial Performance Year. CMS will blend the resulting benchmarks for each beneficiary category and alignment type into a single Performance Year Benchmark.

3.5.1 Three-way Blended Trend Factor

To account for annual Medicare cost growth, CMS will trend an ACO's Adjusted Historical Benchmark forward to the current Performance Year using a three-way blended trend factor. CMS will calculate a separate trend factor for each beneficiary category.

The three-way blended trend factor is a weighted average of two components: (1) a two-way blend of observed national and regional growth rates from BY 3 through the current Performance Year, and (2) a fixed, prospectively set growth rate established at the start of each Performance Year, known as the Accountable Care Prospective Trend (ACPT). For PY 2027, CMS expects to make the ACPT available to ACOs in December 2026, in the ACOs' Preliminary Benchmark Reports.

Two-thirds of the trend factor will reflect a two-way blend of the actual national and regional growth rates observed in the LEAD National Reference Population in each Performance Year. The weights used to blend the national and regional growth rates would be calculated in the same manner as described in **Box 3.3.2**, except the weight applied to the national growth rate is calculated as the share of aligned beneficiaries in the ACO's regional service area that are aligned to the ACO for the applicable performance year (rather than for BY3). The remaining one-third will be set prospectively using the ACPT, subject to a set of guardrails that limit how much the ACPT can influence the three-way blended trend factor.

Accountable Care Prospective Trend

For each Performance Year, CMS will incorporate the Accountable Care Prospective Trend (ACPT), a prospectively determined external growth factor used in updating the benchmark. For the purposes of LEAD, the ACPT is a modified USPCC growth rate.

The ACPT is based on projected growth in national fee-for-service Medicare expenditures as estimated by the CMS Office of the Actuary (OACT). Specifically, the ACPT is derived from the fee-for-service United States Per Capita Cost (USPCC) projections used annually in the Medicare Advantage rate-setting process, modified to reflect the exclusion of payments for disproportionate share hospitals and inclusion of payments associated with hospice claims.

OACT will calculate annualized growth rates in projected per capita Medicare expenditures for the applicable Performance Year, with separate projections for ESRD and non-ESRD populations. For purposes of the LEAD Model, the non-ESRD ACPT will apply to the High Needs and Aged & Disabled beneficiary categories, while the ESRD ACPT will apply to the ESRD beneficiary category.

Prior to each Performance Year, CMS will publicly report the applicable ACPT values for that Performance Year. Each ACPT value will be based on the most recently available OACT modified USPCC annualized growth projections corresponding to the applicable Performance Year.

Accordingly, ACPT values will be updated and announced annually, rather than fixed for the duration of the agreement period.

ACPT Guardrail Policy

The goal of including the ACPT in the three-way blended trend factor is to trend benchmarks in LEAD at a rate higher than actual, realized Medicare spending, but below what Medicare spending would be in the absence of ACOs. However, the ACPT is subject to potential forecasting errors, which makes it necessary to include a guardrail policy to prevent benchmarks based on ACPT from diverging too far from actual spending.

In PY 2027, CMS will apply a guardrail that limits the three-way blended trend factor to within +0.3/-0.2 percentage points of the two-way regional/national blended trend factor, which represents realized Medicare spending growth. In other words, if the three-way blended trend factor exceeds the two-way regional/national blend by more than 0.3 percentage points, it will be

capped at the two-way regional/national blend plus 0.3 percentage points. Likewise, if the three-way blended trend factor is more than 0.2 percentage points below the regional/national blend, it will be capped at the regional/national blend, minus 0.2 percentage points. In subsequent Performance Years, the upper bound of the guardrail will be widened by 0.3 percentage points per year (e.g., to +0.6 percentage points in PY 2028 and +0.9 percentage points in PY 2029, up to 1.5 percentage points in PY 2031), while the lower bound will be widened by 0.2 percentage points per year (e.g., to -0.4 percentage points in 2029 and -0.6 percentage points in 2030, up to -1.0 percentage points in PY 2031). **Table 3.5.1** illustrates how the size of these guardrails changes by Performance Year.

Table 3.5.1: ACPT Guardrail Policy

ACPT Guardrail	Upper Bound by PY	Lower Bound by PY
PY 1	+0.3%	-0.2%
PY 2	+0.6%	-0.4%
PY 3	+0.9%	-0.6%
PY 4	+1.2%	-0.8%
PY 5–PY 10	+1.5%	-1.0%

The ACPT guardrails will be applied at financial reconciliation for each Performance Year of an ACO's agreement period, and will apply to the cumulative trend from BY 3 to the current Performance Year (e.g., for PY 3, the +0.9 percent/-0.6 percent guardrails will apply to cumulative growth from BY 3 to PY 3). Any guardrail adjustment will apply only for purposes of determining the benchmark update and financial reconciliation for that specific Performance Year and will not be carried forward into subsequent Performance Years. In other words, the guardrail does not modify or replace the underlying ACPT assumptions used in future years.

For example, if an ACO's PY 1 three-way blended trend factor is adjusted under the guardrail policy, CMS will nevertheless continue to use the original prospective PY 1 ACPT value when calculating the cumulative ACPT component of the trend for PY 2 and subsequent Performance Years.

3.5.2 Risk Adjustment

After applying the three-way blended trend factor described in **Section 3.5.1**, CMS will adjust the benchmark to reflect the average risk of the ACO's aligned beneficiary population in the Performance Year. CMS will apply this risk adjustment separately for each beneficiary category and alignment type.

This Performance Year risk adjustment step builds on the risk standardization performed during Historical Benchmark construction. As described in **Section 3.3.1**, CMS risk-standardizes Historical Baseline Expenditures by dividing base year expenditures by the applicable average risk score. As a result, the Adjusted Historical Benchmark, after trending to the Performance Year, is expressed in risk-standardized terms.

To convert the risk-standardized Adjusted Historical Benchmark into a Performance Year Benchmark that reflects the risk of the ACO's aligned Performance Year population, CMS multiplies the Adjusted Historical Benchmark by the ACO's average Performance Year risk score for the applicable beneficiary category and alignment type.

CMS calculates the average Performance Year risk score as a beneficiary month–weighted average risk score for beneficiaries aligned to the ACO in the applicable beneficiary category and alignment type. For each beneficiary, CMS includes only the months in which the beneficiary is eligible for alignment. CMS multiplies each beneficiary's risk score by the beneficiary's eligible months, sums those weighted risk scores across aligned beneficiaries, and divides by the total number of eligible beneficiary months.

> ***Average Performance Year risk score*** *= (sum of each aligned beneficiary's risk score × their eligible months) ÷ total eligible beneficiary months*

CMS then applies the average Performance Year risk score to the trended Adjusted Historical Benchmark:

> ***Risk-adjusted Performance Year Benchmark*** *= trended Adjusted Historical Benchmark × average Performance Year risk score*

For example, assume an ACO's trended Adjusted Historical A&D benchmark is $1,100 PBPM. Assume the ACO's beneficiary month–weighted average Performance Year claims-aligned A&D risk score is 1.02. CMS would calculate the risk-adjusted A&D Performance Year Benchmark as:

> *$1,100 × 1.02 = $1,122 PBPM*

CMS will use the applicable risk adjustment model for each beneficiary category, as shown in **Table 3.5.2**.

Table 3.5.2: Risk Adjustment Model Used by Beneficiary Category

Beneficiary Category	Risk Adjustment Model	Model Description
Aged and Disabled	2024 CMMI HCC Prospective Risk Adjustment Model V1	Modified version of the prospective 2024 CMS-Hierarchical Condition Categories (HCC) Risk Adjustment Model (Version 28) that has been recalibrated solely on a non-High Needs A&D population
End Stage Renal Disease	2023 ESRD CMS-HCC Prospective Risk Adjustment Model	No LEAD-specific modifications
High Needs	CMMI HCC Concurrent Risk Adjustment Model V2	Modified version of the CMMI HCC Concurrent Risk Adjustment Model V1, which was used in ACO REACH, and has been updated to reflect V28 architecture and recalibrated solely on a High Needs population.

Risk Score Normalization

All benchmark calculations are performed with normalized risk scores. Normalization is a mechanism to calibrate a population's mean risk score to equal 1.0. Risk models are initially calibrated using expenditures incurred within a particular year, the denominator year. In Medicare, when risk scores are calculated for beneficiaries in years other than the denominator year, the mean population risk score can diverge from 1.0 because of changes in the demographic composition of the population, the prevalence of conditions/diagnoses in the FFS population, and the reporting of conditions on FFS claims. If applied to expected cost of care in a payment year, these deviations from a 1.0 mean risk score will result in overpayment or underpayment for the population's aggregate expenditures.

Normalized risk scores are obtained by dividing raw risk scores by a normalization factor. For LEAD, the normalization factor is calculated as the mean raw risk score of the universe of LEAD-eligible Medicare beneficiaries. This ensures that the mean normalized risk score among LEAD-eligible beneficiaries is 1.0 in each time period.

Risk Score Growth Cap

CMS will apply a symmetric 3% risk score growth cap for the A&D and ESRD beneficiary categories and a symmetric 4% risk score growth cap for the High Needs beneficiary category. Base Year 3 will be the static reference year for measuring risk score growth for at least the first two Performance Years of LEAD (PY 2027 and PY 2028). This means that an ACO's average risk score for a beneficiary category cannot increase or decrease by more than the applicable risk score growth cap relative to BY 3. CMS intends to phase in a new, AI-inferred risk adjustment model for payment purposes in LEAD beginning in PY 2029 and may adjust or remove the risk score growth cap as part of this transition.

CMS will apply a single risk score growth cap for each beneficiary category and alignment type. For claims-aligned beneficiaries, BY 3 risk scores will be calculated based on beneficiaries who would've been aligned to the ACO in BY 3 (i.e., the same beneficiaries who contribute BY 3 historical baseline expenditures, as described in section 3.2). For voluntarily aligned beneficiaries, in PY 2027, CMS will use the BY 3 risk scores of the beneficiaries who are voluntarily aligned in the Performance Year. In future years, when voluntarily aligned historical baseline expenditures are calculated based on expenditures for voluntarily aligned beneficiaries during the model performance period, the reference year for the voluntarily aligned risk score growth cap will also roll forward and become a year within the model performance period. More information about the timing of this transition will be available in a future version of the Alignment and Financial Methodology Paper.

For the purposes of applying the High Needs risk score growth cap, the average risk score in the reference year (BY 3) will be calculated using only beneficiaries who were classified as High Needs in BY 3. Accordingly, beneficiaries who voluntarily align to an ACO in the Performance Year but were not classified as High Needs in BY 3 will not be included in the calculation of the ACO's BY 3 average risk score for the High Needs beneficiary category.

This approach ensures that the reference-year average is calculated using a consistent High Needs population. Including beneficiaries who were not High Needs in BY 3 would lower the reference-year average by adding beneficiaries who would not have been part of the High Needs cohort at that time, resulting in an inappropriately restrictive cap on allowable risk score growth.

If the ACO's beneficiary month–weighted average Performance Year risk score exceeds the applicable risk score growth cap, CMS will use the capped risk score rather than the uncapped risk score to calculate the risk-adjusted benchmark. For example, assume an ACO's updated Adjusted Historical A&D benchmark is $1,100 PBPM, the ACO's uncapped beneficiary month–weighted average Performance Year A&D risk score is 1.050, and the applicable risk score growth cap limits the ACO's risk score to 1.030. CMS would calculate the risk-adjusted A&D Performance Year Benchmark as:

$$\$1{,}100 \times 1.030 = \$1{,}133 \text{ PBPM}$$

In this example, the benchmark reflects a 3% risk adjustment rather than a 5% risk adjustment because the uncapped Performance Year risk score exceeds the applicable risk score growth cap.

3.5.3 Hybrid Alignment Benchmark Adjustment

Under hybrid alignment, some beneficiaries become newly aligned to an ACO after the beginning of the Performance Year and therefore contribute expenditures for only a portion of the year.

Because Medicare expenditures exhibit seasonal variation, with expenditures generally lowest in the first quarter of the calendar year and highest in the fourth quarter, beneficiaries aligned for only part of the year are expected to contribute a systematically different mix of expenditures than beneficiaries aligned for the full year.

To account for this effect, CMS will apply a Hybrid Alignment Benchmark Adjustment for beneficiaries who become aligned during the Performance Year due to hybrid alignment. The adjustment is intended to ensure that benchmark expenditures appropriately reflect the expected expenditure profile associated with the months during which the beneficiary is aligned.

CMS will calculate model-wide Hybrid Alignment Benchmark Adjustment factors using historical expenditure experience for the LEAD reference population during CY 2024 and CY 2025, calculated as:

$$\text{Adjustment Factor} = \text{Average PBPM during applicable partial-year period} \div \text{Average full-year PBPM}$$

Where:

- Average PBPM expenditures during the applicable partial year period represents average expenditures during the portion of the year for which hybrid-aligned beneficiaries are expected to contribute expenditures; and
- Average Full-Year PBPM expenditures represents average expenditures across all twelve months of the calendar year.

The benchmark for beneficiaries added through hybrid alignment will be multiplied by the applicable adjustment factor.

Claims-Based Hybrid Alignment

For beneficiaries claims aligned through the hybrid alignment process effective April 1, CMS will apply an adjustment factor equal to the ratio of average PBPM expenditures during April through December (Q2–Q4) to average PBPM expenditures during the full calendar year.

Claims-Based Hybrid Alignment Adjustment Factor = Q2–Q4 PBPM ÷ Full-Year PBPM

Voluntary Hybrid Alignment

For beneficiaries who become voluntarily aligned during the Performance Year, CMS will apply an adjustment factor based on the quarter in which the beneficiary's voluntary alignment becomes effective.

Table 3.5.3.1: Adjustment Factor by Voluntary Alignment Effective Date

Voluntary Alignment Effective Date	Adjustment Factor
January 1–March 31	No adjustment (factor = 1.000)
April 1–June 30	PBPM during Q2-Q4 ÷ Full-Year PBPM
July 1–September 30	PBPM during Q3-Q4 ÷ Full-Year PBPM
October 1–December 31	PBPM during Q4 ÷ Full-Year PBPM

For PY 2027, CMS will calculate Hybrid Alignment Benchmark Adjustment factors using national expenditure patterns from the LEAD reference population and will not calculate different adjustment factors by beneficiary category. CMS may evaluate regional or beneficiary category–level adjustment factors or other refinements for future Performance Years based on observed experience.

Table 3.5.3.2: Calculation of the Hybrid Alignment Benchmark Adjustment

Line	Step	Calculation	Value
1	PBPM Benchmark	PBPM PY Benchmark	$1,125.00
2	Beneficiary Alignment	Aligned beneficiary months with effective alignment date of Jan. 1	60,000
3	Beneficiary Alignment	Beneficiary months with effective alignment date of April 1	4,500
4	Calculation of Hybrid Alignment Benchmark Adjustment	Q2 Hybrid alignment adjustment factor	1.0099
5	Calculation of Hybrid Alignment Benchmark Adjustment	Q2 Hybrid alignment adjustment (Line 1 x Line 4)	**$1,136.14**

Line	Step	Calculation	Value
6	Calculation of Hybrid-Alignment-Adjusted PY Benchmark	Total PY Benchmark for Beneficiaries Aligned Effective January 1 (Line 1 x Line 2)	$67,500,000.00
7	Calculation of Hybrid-Alignment-Adjusted PY Benchmark	Total PY Benchmark for Beneficiaries Aligned Effective April 1 (Line 3 x Line 5)	$5,112,618.75
8	Total	Total PY Benchmark (Line 6 + Line 7)	$72,612,618.75

3.5.4 Blending Beneficiary Categories for Total Performance Year Benchmark

As previously described, up until this point benchmarks have been calculated separately for A&D, ESRD, and High Needs populations for both claims-aligned and voluntarily aligned beneficiaries. These separate benchmarks are then combined to arrive at a single Performance Year Benchmark.

Combined Claims-Aligned and Voluntarily Aligned Benchmarks

First, the claims-aligned and voluntarily aligned benchmarks—**after** application of risk adjustment—are combined for each beneficiary category, based on a beneficiary month–weighted average of the two benchmarks within each.

Combined A&D, ESRD, and High Needs Benchmark

The aggregate A&D, ESRD, and High Needs benchmarks are then combined to arrive at the total benchmark expenditure. This is calculated based upon a simple sum of the three benchmarks because both are in aggregate dollars.

See **Table 3.5.4** for an illustration of the combined benchmark calculation.

Table 3.5.4: Combined Benchmark Calculation

Line	Step	Benchmark to Which Experience Accrues: ESRD	Benchmark to Which Experience Accrues: AD	Benchmark to Which Experience Accrues: High Needs	TOTAL
1.	**Claims Alignment Benchmark**	-	-	-	-
2.	PBPM Claims Alignment Adjusted Historical Benchmark	$10,175.00	$796.00	$3,739.00	-
3.	3-Way Blended Trend Factor	1.034	1.042	1.037	-
4.	PY Average Risk Score	1.007	1.045	1.020	-
5.	Full-Year Eligible Months	981	56,677	9,806	-
6.	Hybrid-Aligned Eligible Months	120	11,570	2,864	-
7.	Hybrid Alignment Benchmark Adjustment Factor	1.0099	1.0099	1.0099	-

Line	Step	Benchmark to Which Experience Accrues: ESRD	Benchmark to Which Experience Accrues: AD	Benchmark to Which Experience Accrues: High Needs	TOTAL
8.	**Total PY Claims Alignment Benchmark** Line 2 x Line 3 x Line 4 x [Line 5 + (Line 6 x Line 7)]	**$11,677,237.29**	**$59,252,807.64**	**$50,220,589.89**	**$121,150,634.83**
9.	**Voluntary Alignment Benchmark**	-	-	-	-
10.	PBPM Voluntary Alignment Adjusted Historical Benchmark	$10,175.00	$796.00	$3,739.00	-
11.	3-Way Blended Trend Factor	1.034	1.042	1.037	-
12.	PY Average Risk Score	0.990	0.866	1.061	-
13.	*Eligible Beneficiary Months*	-	-	-	-
14.	Full Year and Q1 VA Months	421	5,514	2,393	-
15.	Q2 VA Months	76	825	734	-
16.	Q3 VA Months	62	753	549	-
17.	Q4 VA Months	51	538	240	-
18.	*Hybrid Alignment Benchmark Adjustment Factors*	-	-	-	-
19.	Q2 Factor	1.0099	1.0099	1.0099	-
20.	Q3 Factor	1.0236	1.0236	1.0236	-
21.	Q4 Factor	1.0352	1.0352	1.0352	-
22.	**Total PY Voluntary Alignment Benchmark** (Line 10 x Line 11 x Line 12) x [Line 14 + (Line 15 x Line 19) + (Line 16 x Line 20) + (Line 17 x Line 21)]	**$6,395,377.16**	**$5,512,772.12**	**$16,227,827.88**	**$28,135,977.16**
23.	**Total Performance Year Benchmark**	-	-	-	-
24.	Performance Year Benchmark for All Aligned Beneficiaries (Line 8 + Line 22)	**$18,072,614.45**	**$64,765,579.76**	**$66,448,417.77**	**$149,286,611.98**

CMS will compare this total Performance Year Benchmark to total Performance Year expenditures to determine the ACO's shared savings or shared losses for the Performance Year.

4. Capitation

The goal of capitated payments is to give health care providers additional flexibility in how they deliver care and to reduce the volume-based incentives of fee-for-service payment. With capitated payments, health care providers get steady, predictable cash flow that is not tied to the number of services they provide. This flexibility frees health care providers to deliver care in innovative and flexible ways, such as non–face to face care management, telehealth, and electronic messaging, without worrying about foregone fee-for-service revenue.

Under LEAD, capitated payments replace Medicare fee-for-service payments for certain services provided by LEAD Participant Providers and Preferred Providers. Instead of paying the full amount on individual claims, CMS will reduce the claim payments for specific services delivered to aligned beneficiaries by Participant Providers and Preferred Providers enrolled in capitated payment mechanisms. Which services are subject to these payment reductions—and by how much— depends on the capitated payment option and reduction percentage selected by the ACO. LEAD Participant and Preferred Providers will continue to submit claims to CMS for all services furnished to aligned beneficiaries, even when those services are covered by a capitated payment.

LEAD offers two main capitation payment mechanisms. All ACOs must select one of the following capitation payment mechanisms:

1. **Total Care Capitation Payment:** A per-beneficiary, per-month (PBPM) capitated payment for all Medicare Parts A and B services provided to aligned beneficiaries by all Participant TINs and those Preferred Providers who have opted to participate in TCC Payment. This capitation payment mechanism is only available to ACOs participating in Global Risk.
2. **Primary Care Capitation Payment:** A PBPM capitated payment for Medicare-covered primary care services provided to aligned beneficiaries by all primary care specialists billing under Participant TINs and those Preferred Providers who have opted to participate in PCC Payment. Both Global Risk and Professional Risk ACOs may choose this capitated payment mechanism.

ACOs that elect PCC will also have two supplemental payment options to enable them to engage in value-based downstream arrangements with non-primary care providers: a Non-Primary Care Capitation (NPCC) and an Advanced Payment Option (APO), described below. Both the NPCC and APO allow ACOs to elect claims reduction percentages for non-primary care services delivered to aligned beneficiaries by Participant and Preferred Providers, and to replace these claims reductions with upfront payments to the ACO, which the ACO can then use to fund alternative payment arrangements with these providers.

Participation rules vary by risk track:

- **Global Risk ACOs** may have primary care specialists in a Participant TIN elect PCC + NPCC, or just PCC. Non-primary care providers in the Participant TIN can only elect NPCC or APO. Eligible Participant Providers and Preferred Providers in a Global Risk

ACO may elect PCC + NPCC, PCC only, NPCC only, or APO, subject to the ACO's entity-level capitation mechanism elections. NPCC and APO are only available when the ACO has elected APO participation at the entity level.

- **Professional Risk ACOs** cannot have the same provider participating simultaneously in both PCC and NPCC. Primary care specialists in Participating TINs can only elect PCC or PCC and APO. Non-primary care specialists can only elect NPCC or APO. Preferred providers can elect PCC, NPCC, or APO.

Table 4.1.1: Payment Mechanism Participation Rules by Provider Type

Capitation Type	Global Risk Option: Primary Care Specialist Participant Providers	Global Risk Option: Non-PC Specialist Participant Providers	Global Risk Option: Preferred Providers	Professional Risk Option: Primary Care Specialist Participant Providers	Professional Risk Option: Non-PC Specialist Participant Providers	Professional Risk Option: Preferred Providers
PCC	Required	Non-eligible	Eligible	Required	Non-eligible	Eligible
NPCC	Non-eligible	Eligible	Eligible	Non-eligible	Eligible	Eligible
APO	Non-eligible	Eligible	Eligible	Non-eligible	Eligible	Eligible
PCC+NPCC	Eligible	Non-eligible	Eligible	Non-eligible	Non-eligible	Non-eligible
PCC+APO	Eligible	Non-eligible	Eligible	Eligible	Non-eligible	Eligible
TCC	Required (if PCC is NOT elected by ACO)	Required (if PCC is NOT elected by the ACO)	Eligible	Non-eligible	Non-eligible	Non-eligible

ACOs elect their applicable capitation payment mechanisms for each Performance Year. Accordingly, an ACO's payment mechanism election may change between Performance Years, subject to the payment mechanism options available under the ACO's selected risk option and other applicable participation requirements.

Finally, higher-spending ACOs in both the Global Risk Option and the Professional Risk Option will receive an additional capitation, the 1.5% Administrative Add-on, to support care delivery investments aimed at improving quality and reducing cost.

The remainder of this section discusses each type of capitation payment in more detail.

4.1 Total Care Capitation (TCC)

For ACOs that elect TCC, the TCC payment will include all Medicare Parts A and B services provided to aligned beneficiaries by all Participant TINs and those Preferred Providers who have opted to participate in TCC Payment.

Participant TINs in ACOs that elect TCC must participate in the TCC payment mechanism with a 100% fee reduction. This means that 100% of Medicare payments for services provided to

aligned beneficiaries by Participant TINs will be paid through the TCC payments to the ACO; Participant TINs will not receive any claims-based payments for these services.

Preferred Providers in ACOs that elect TCC can choose whether to participate in the TCC payment mechanism and the amount of their fee reduction. This means that Preferred Providers can receive some, all, or none of their payments through TCC payments. Providers enrolled in TCC are still required to submit claims for services provided to LEAD-aligned beneficiaries. **Table 4.1.2** summarizes these policies.

Table 4.1.2: Total Care Capitation Payment

Provider Type	Requirements	Fee Reductions
Participant Providers in Participant TINs	Required to participate in TCC payment mechanism	100%
Preferred Providers	Optional to participate in TCC payment mechanism	1–100%, selected by ACO

To support cash flow for value-based activities and downstream provider payments, CMS will make a one-time add-on payment to ACOs, in addition to their regular first monthly payment. The add-on payment will equal 20% of the first monthly payment and will be made only in the first Performance Year. CMS will recover this add-on amount through a corresponding reduction to the December payment.

TCC amounts are derived from the ACO's Performance Year Benchmark, which represents the expected Medicare total cost of care for aligned beneficiaries. Because not all services for these beneficiaries will be furnished by health care providers participating in TCC, CMS will calculate the portion of the benchmark that is attributable to care delivered by TCC-participating providers.

To calculate an ACO's TCC amount, CMS will identify all Parts A and B claims that were billed by Participant TINs and Preferred Providers that have elected to participate in TCC for beneficiaries who would have been aligned to the ACO in the lookback period. To allow for claims run-out, the initial lookback period for the TCC will generally be the first nine months of the prior calendar year. For example, in PY 2027, the initial lookback period would be the first nine months of 2026.

This historical spending is adjusted based on the claims reduction levels elected by Preferred Providers participating in the TCC (e.g., if the ACO has elected a 20% claims reduction for Preferred Providers on average, historical expenditures for claims billed by Preferred Providers will be multiplied by 20%). The claims reduction–adjusted historical amount is then expressed as a percentage of total historical expenditures for all Parts A and Part B covered services received by aligned beneficiaries in the lookback period. This percentage is referred to as the TCC Percentage. CMS then applies this percentage to the ACO's PBPM Performance Year Benchmark to determine the monthly TCC payment. The TCC amount that an ACO receives is the TCC Amount PBPM multiplied by projected eligible beneficiary months for a given month.

During the Performance Year, CMS will update capitation payment amounts on a quarterly basis to incorporate changes in beneficiary alignment, benchmark and risk score updates, and—if applicable—changes in the share of total spending provided by Participant TINs and Preferred Providers. Any remaining under or over payments will be incorporated into final financial settlement. See **Section 4.7** for more information about quarterly adjustments.

4.2 Primary Care Capitation (PCC)

Primary Care Capitation (PCC) is a more targeted form of capitation than Total Care Capitation (TCC). Whereas TCC applies broadly to all services for all provider types that participate in the TCC, PCC applies only to primary care services furnished by primary care specialists. Under PCC, CMS makes prospective monthly payments to the ACO for primary care services delivered to aligned beneficiaries, while services not covered by PCC continue to be paid through fee-for-service.

CMS defines primary care services as claim lines from professional claims for Evaluation and Management (E/M) office visits for both new and established patients using the current procedural terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes described in **Appendix D**. The primary care service must also be provided by a provider whose principal specialty in the Provider Enrollment, Chain and Ownership System (PECOS) is included in **Table 2.3.2.** A provider's specialty is determined based on the CMS Specialty Code recorded on the claim. For institutional claims, only services billed by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), regardless of CPT/HCPCS or provider specialty, are eligible for PCC payments. This flexibility was created for FQHC and RHC facilities because these organizations are specifically designed to provide primary care to the populations they serve.

PCC is mandatory for primary care providers in Participant TINs in LEAD ACOs that have elected the PCC (see **Table 4.2.1**). If a Participant TIN in an ACO that elects PCC includes non-primary care specialists, those non-primary specialists are not included in PCC and claims are not reduced; they may opt into NPCC or APO (discussed below) at the NPI level. This policy is intended to prevent specialists in Participant TINs from being impacted by capitated payments and claims reductions that are meant to be targeted to primary care.

Participation in PCC requires specified levels of fee-for-service claims reduction for primary care services, which vary by provider type and Performance Year, as summarized below.

Table 4.2.1 Primary Care Capitation

Type	Payment Mechanism Participation Requirements	Claims Reduction Requirements
Primary Care Specialist Participant Providers *(Previous ACO REACH Participants*)*	Mandatory participation in PCC payment mechanism	100%

Type	Payment Mechanism Participation Requirements	Claims Reduction Requirements
Primary Care Specialist Participant Providers *(New ACOs & Previous Shared Savings Program Participants)*	Mandatory participation in PCC payment mechanism	PY 2027: 1–100% PY 2028: 5–100% PY 2029: 10–100% PY 2030: 20–100% PY 2031–2036: 100%
Preferred Providers	Optional participation	0–100%

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

The PCC Payment consists of two components: a Base Primary Care Capitation amount and an Enhanced Primary Care Capitation amount. The Base PCC is intended to approximate the expected cost of primary care services furnished by participating primary care providers, while the Enhanced PCC provides additional upfront funding to support investments in primary care infrastructure, access, and care coordination. Together, these components make up the total PCC payment received by the ACO.

4.2.1 Base PCC

As with TCC, PCC payments are derived from the ACO's Performance Year Benchmark. To calculate the Base PCC, CMS uses historical claims data to identify the portion of total spending for aligned beneficiaries that is attributable to primary care services furnished by primary care Participant TIN Providers and those Preferred Providers who elect to participate in PCC (see **Appendix D** for a list of HCPCS codes used to identify services included in the PCC). This historical primary care spending is adjusted based on the claims reduction levels elected by Participant TINs and Preferred Providers (e.g., if the ACO has elected 20% claims reduction, historical primary care expenditures will be multiplied by 20%). The claims reduction–adjusted amount is then expressed as a percentage of total historical expenditures for all Medicare Parts A and B services in the lookback period. This percentage is referred to as the Base PCC Percentage. CMS then applies this percentage to the ACO's PBPM Performance Year Benchmark to determine the monthly Base PCC payment. The Base PCC amount that an ACO receives is the Base PCC Amount PBPM multiplied by projected eligible beneficiary months for a given month.

The Base PCC calculation includes a safeguard for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to ensure ACOs are appropriately funded for beneficiaries aligned through these providers. This "FQHC/RHC True-up" is assessed at the ACO level for all beneficiaries aligned through FQHCs and RHCs. CMS compares base PCC payments to actual FFS fee reductions for these beneficiaries on a quarterly, year to date (YTD) basis, accounting for any prior adjustments in the Performance Year. If PCC payments are lower than the corresponding fee reductions, CMS will make an additional payment to cover the difference, applied in the following quarter. This adjustment can only increase payments, not reduce them. Adjustments will count toward ACOs' Performance Year expenditures for the purpose of calculating Shared Savings/Losses.

4.2.2 Enhanced PCC

The purpose of the Enhanced PCC Amount is to provide an upfront, additional payment for ACOs to invest in and expand their primary care capabilities. ACOs will have some flexibility to choose their Enhanced PCC amount, subject to the limits described below. Specifically, the maximum Enhanced PCC amount equals the greater of (1) the difference between 7% of the ACO's Performance Year Benchmark and the Base PCC amount, or (2) 2% of the Performance Year Benchmark. Although paid prospectively, the Enhanced PCC is subtracted from Shared Savings/Shared Losses at final financial settlement and therefore functions as an advance payment rather than net new payments to the ACO.

At the start of each Performance Year, an ACO will learn of its Base PCC Percentage, and the range of Enhanced PCC percentages from which it can choose. When calculating the maximum Enhanced PCC Amount an ACO can elect, CMS will assume a 100% claims reduction amount for all Participant Providers. This ensures that an ACO's Enhanced PCC Payment is not artificially increased due to lower claims reduction elections by Participant Providers. If 3% of the ACO's historical claims expenditures are determined to be for PCC-eligible services, and that ACO elects 100% claims reduction, its Base PCC Amount will be 3% and its Enhanced PCC Amount will be 4%. However, if that ACO's Participant Providers elect only 50% claims reduction, the Base PCC Payment will be 1.5% and the Enhanced PCC Payment will remain 4%.

If an ACO chooses to receive an Enhanced PCC Amount, it can request an amount no more than the difference between 7% of the Performance Year Benchmark and what the Base PCC Amount would have been with 100% claims reduction for all Participant Providers, unless that amount is less than 2% of the Performance Year Benchmark. In this case, the ACO is allowed to request an Enhanced PCC Amount up to 2% of the Performance Year Benchmark. That means that in cases where an ACO's Base PCC Amount (assuming 100% claims reduction for Participant Providers) is greater than 5% of the Performance Year Benchmark, the ACO may still request an Enhanced PCC Amount up to 2% of the Performance Year Benchmark, even though the sum of the Base PCC Amount and the Enhanced PCC Amount may exceed 7% of the Performance Year Benchmark.

The ACO also has the option to not receive an Enhanced PCC Amount at all, in which case the PCC Payment will equal the Base PCC Amount.

Example: PCC Calculation

Assume that an ACO's Performance Year Benchmark is $1,000 PBPM and that the Base PCC Amount is determined to be $40 PBPM. The $40 PBPM Base PCC Amount is 4% of the monthly Performance Year Benchmark ($40/$1,000). Because 7% of the PBPM benchmark is $70 (7% of $1,000), the ACO may receive an Enhanced PCC Amount no larger than $30 PBPM, which is 3% of the PBPM benchmark (7% minus 4%). The ACO may choose an Enhanced PCC Amount equal to 3%, less than 3%, or may choose not to receive an Enhanced PCC Amount at all, in which case the ACO will receive a monthly PCC payment of $40. In summary, in this example, the Monthly PCC Payment for the ACO has a minimum of $40 and a maximum of $70.

In the scenario where the ACO's Base PCC Amount already exceeds 7% of the monthly Performance Year Benchmark, the ACO may receive an Enhanced PCC Amount no larger than 2% of the monthly Performance Year Benchmark. For example, assume that an ACO's monthly Performance Year Benchmark is $1,000 PBPM and that the Base PCC Amount is determined to be $80 PBPM, as calculated from historical claims. The $80 PBPM Base PCC Amount is 8% of the monthly Performance Year Benchmark ($80/$1,000), which is greater than 7% of the monthly Performance Year Benchmark. In this case, the ACO may still receive an Enhanced PCC Amount no larger than 2% of the monthly Performance Year Benchmark, which is $20. The ACO may choose not to receive an Enhanced PCC Amount at all, in which case the ACO will receive a monthly PCC payment of $80. In summary, in this example, the Monthly PCC Payment for the ACO has a minimum of $80 and a maximum of $100.

Regardless of the Enhanced PCC Amount received, the value of the Enhanced PCC Amount is fully recouped by CMS during financial settlement and is not considered in any Shared Savings/Losses calculations.

4.3 Non-Primary Care Capitation (NPCC)

ACOs that elect PCC may also elect NPCC to extend capitation to non-primary care services for certain eligible Participant Providers billing under Participant TINs and Preferred Providers. Under the NPCC mechanism, CMS would reduce NPCC-eligible FFS claims payments billed by Participant Providers and Preferred Providers participating in NPCC. The reduced claims payments can be between 1% and 100% (integer values only) of the value of the FFS claims payment amount. In return, CMS would make a monthly NPCC payment to the ACO equivalent to the estimated value of the FFS claims reductions for NPCC-eligible services. CMS will continue to pay any remaining non-reduced portion of FFS claims for services furnished by these providers.

The NPCC applies to all Medicare Parts A and B services that are not PCC-eligible services (i.e., that are non-primary care services delivered by primary care providers or any services delivered by non-primary care providers) and that are furnished by Participant Providers and Preferred Providers participating in the NPCC arrangement.

For an ACO participating in NPCC, Participant Providers and Preferred Providers can individually choose whether to participate in NPCC and, if so, at what percent claims reduction. The elected percent reduction may change from year to year, but this information must be submitted by the ACO to CMS prior to each Performance Year (PY). An ACO may also choose not to elect NPCC, in which case no ACO provider will be able to participate in NPCC.

The NPCC payment is calculated to reflect the estimated cost of care for non-PCC services furnished by NPCC-participating providers to aligned beneficiaries. CMS bases this calculation on historical claims for those services, following the same methodology used to determine PCC payments: historical spending for services furnished by NPCC-participating providers to aligned beneficiaries is expressed as a percentage of total historical Medicare Parts A and B expenditures during the lookback period, and the resulting NPCC Percentage is applied to the ACO's PBPM Performance Year Benchmark to determine the prospective monthly NPCC payment.

Unlike the APO described in **Section 4.4**, NPCC payments are not reconciled against actual FFS claims during financial settlement. Like TCC and PCC, NPCC payments are made monthly, and capitation payments are included in the ACO's total cost of care for purposes of financial settlement.

4.4 Advanced Payment Option (APO)

As an alternative to NPCC, ACOs that elect PCC may also elect the APO to extend prospective payments to non-primary care services for certain eligible Participant Providers billing under Participant TINs and Preferred Providers. Under the APO mechanism, CMS would reduce APO-eligible FFS claims payments billed by Participant Providers and Preferred Providers participating in APO. The reduced claims payments can be between 1% and 100% (integer values only) of the value of the FFS claims payment amount. In return, CMS would make a monthly APO payment to the ACO equivalent to the estimated value of the FFS claims reductions for APO-eligible services. CMS will continue to pay any remaining non-reduced portion of FFS claims for services furnished by these providers. The APO applies to all Medicare Parts A and B services that are not PCC-eligible services (i.e., that are non-primary care services delivered by primary care providers or any services delivered by non-primary care providers) and that are furnished by Participant Providers and Preferred Providers participating in the APO arrangement.

For an ACO participating in APO, Participant Providers and Preferred Providers can individually choose whether to participate in APO and, if so, at what percent claims reduction. The elected percent reduction may change from year to year, but this information must be submitted by the ACO to CMS prior to each Performance Year. An ACO may also choose not to elect APO, in which case no ACO provider will be able to participate in APO.

The APO payment is calculated to reflect the estimated cost of care for non-primary care services furnished by APO-participating providers to aligned beneficiaries. CMS bases this calculation on historical spending for services furnished by APO-participating providers to aligned beneficiaries.

Unlike NPCC, APO payments are reconciled against actual FFS claims during financial settlement. In practice, this means the APO functions as an advance on expected FFS spending rather than a fixed prospective payment. If actual claims exceed the prepaid amount, the difference will be reflected as an additional payment to the ACO at reconciliation; if actual claims are lower than the prepaid amount, the difference will be reflected as a repayment obligation owed by the ACO to CMS at reconciliation. The APO may be attractive to ACOs seeking upfront cash flow with lower financial risk, while NPCC may be better suited to ACOs seeking to shift non-primary care providers away from fee-for-service and capture savings from fixed prospective payments.

Example: NPCC vs. APO Final Settlement

ACO A with a benchmark of $1200 PBPM elects NPCC, while ACO B, with the same benchmark amount, elects APO. In both ACOs, the Preferred Providers participating in these payment mechanisms elect 100% claims reduction for NPCC/APO, and the calculated amount paid prospectively for both payments is $20 PBPM. Throughout the year, the Preferred Providers in

both ACOs submit claims for non-primary care services for aligned beneficiaries totaling $30 PBPM.

For ACO A, the total cost of care calculated at final settlement will include $20 PBPM in NPCC payments per beneficiary. The ACO will not receive payment for the additional $10 PBPM billed through claims (resulting in a lower total cost of care for the purposes of calculating Shared Savings/Losses).

For ACO B, the total cost of care calculated in final settlement will include $20 in APO payments per beneficiary plus the additional $10 PBPM fee-for-service costs incurred throughout the year. During final settlement, CMS pays the ACO the additional $10 PBPM billed through claims (in addition to counting this extra spending toward the ACO's total cost of care).

4.5 Administrative Add-On

Higher-spending ACOs will be eligible for an additional capitated payment equivalent to 1.5% of their Performance Year Benchmark (prior to application of any discount, quality withhold, or retention incentive adjustment). This payment is designed as an upfront capitated payment to encourage higher-spending ACOs to invest in primary care and other enhanced services that will ultimately enable them to reduce Medicare expenditures for LEAD-aligned beneficiaries over time. The Administrative Add-On will be paid prospectively in monthly installments alongside the ACO's selected payment mechanism(s). Similar to other LEAD capitation payments, the payment amount may be updated during the Performance Year to reflect changes in beneficiary alignment, benchmark values, and risk scores. However, unlike TCC, PCC, and NPCC, and the APO, the Administrative Add-On is not included in the Performance Year expenditures for purposes of financial settlement, meaning it is not subject to repayment and does not affect the calculation of Shared Savings or Shared Losses. Instead, it functions as a prospective participation incentive that provides higher-spending ACOs with predictable funding to support care transformation activities, including investments in care management, care coordination, primary care infrastructure and other services to improve beneficiary outcomes and reduce long-term Medicare spending.

4.6 Insufficient Claims History to Calculate Payments

CMS expects to be able to establish reliable prospective payment amounts for most LEAD ACOs, including ACOs with limited claims experience in the applicable lookback period. However, some LEAD ACOs may not have sufficient claims history in the lookback period for CMS to calculate one or more of the following amounts before the start of the Performance Year:

- The Total Care Capitation (TCC) Percentage;
- The Base Primary Care Capitation (PCC) Percentage;
- The Non-Primary Care Capitation (NPCC) Percentage; or
- The Advanced Payment Option (APO) Payment.

If CMS determines that a LEAD ACO does not have sufficient claims history to calculate a reliable initial payment amount before the start of the Performance Year, CMS will apply the following approach based on the payment mechanism.

For PCC, CMS will continue to reduce FFS claims for PCC-eligible services furnished to LEAD-aligned beneficiaries by PCC-participating Participant Providers and Preferred Providers, using the PCC fee reduction percentage specified in the applicable payment arrangement. During this period, CMS will make monthly PCC payments to the LEAD ACO equal to 7% of the Performance Year Benchmark. Once sufficient Performance Year claims experience is available, CMS will calculate the LEAD ACO's Base PCC Percentage using claims experience from the first quarter of the Performance Year, with two months of claims run-out. CMS will then use the resulting Base PCC Percentage and the most recent available Performance Year Benchmark to calculate the estimated annual Base PCC payment amount. Based on that amount, CMS will determine what portion of the PCC payments made during the first six months of the Performance Year were Base PCC payments and what portion were Enhanced PCC payments. Base PCC and Enhanced PCC payments will be subject to adjustment in future quarters and during final settlement, as applicable.

For TCC, NPCC, and APO, CMS will not make monthly payments under the applicable payment mechanism, and will not reduce FFS claims subject to the applicable payment mechanism, for the first two quarters of the Performance Year. CMS will use claims experience from the first quarter of the Performance Year, with two months of claims run-out, to calculate the applicable amount (TCC Percentage, NPCC Percentage, or APO amount). Payments and corresponding FFS claims reductions will begin in the third quarter of the Performance Year and will apply for the remainder of the Performance Year.

For TCC, if CMS determines that the LEAD ACO does not have sufficient claims history in the lookback period to calculate a reliable initial TCC Withhold Percentage, CMS will not make the first-month accelerated TCC payment for that Performance Year.

For a LEAD ACO's second Performance Year and each subsequent Performance Year, if CMS determines that the LEAD ACO does not have sufficient claims history to calculate a reliable TCC Percentage, NPCC Percentage, or APO Amount before the start of the Performance Year, CMS may, at its sole discretion, use the corresponding amount from the prior Performance Year as the current Performance Year's estimated amount to avoid a six-month delay in implementation of the payment mechanism. CMS may update the amount during the Performance Year as additional claims experience becomes available.

4.7 Quarterly Updates to Payments

CMS determines beneficiary alignment and calculates the monthly capitated payments to the LEAD ACO in advance of each quarter. Because of the quarterly cycle, the prospective monthly payment the LEAD ACO receives will be for all beneficiaries aligned for the quarter and assumes continued alignment for the entire three months.

However, a beneficiary may lose alignment if the beneficiary loses Part A or Part B coverage, joins a Medicare Advantage plan, loses Medicare as the primary payer, moves out of the ACO's service area, or dies before or during the payment quarter. Beneficiaries failing to meet any of these eligibility criteria on the first day of a month are not eligible for payment reduction in that month. Beneficiaries can also be aligned on a monthly basis if an ACO has elected Hybrid Alignment.

Because the Performance Year Benchmark is first calculated prior to the Performance Year (prospectively), if the changes in aligned beneficiary counts are not accounted for, then the monthly prospective payment amounts (for TCC, PCC, NPCC, or APO) will lose precision.

Additionally, in the case of TCC, the TCC amount is calculated based on the historical baseline period, which may be different than the actual proportion of services subject to the TCC in the Performance Year (for example, if there is an increase in care provided to aligned beneficiaries by Participant Providers or Preferred Providers). If this amount is significantly different between the baseline period and the Performance Year, the monthly TCC payment may be over or underestimated.

Due to these limitations of a purely prospective estimate for monthly capitated payments and to avoid substantial end-of-PY fund transfers, CMS will update the capitated payments prior to every quarter based on the beneficiary experience in the current quarter. To account for the changes in beneficiary alignment and the actual portion of expenditures incurred outside of the capitation arrangement (TCC and NPCC only), before each quarterly payment cycle (starting with the second quarter of each Performance Year), CMS will recalculate the capitated payments for the upcoming quarter.

Table 4.7.1. Prospective and Retrospective Adjustments by Payment Mechanism.

Quarterly Adjustment	Prospective Adjustment for the Number of Aligned Beneficiaries in Next Quarter	Retrospective Adjustment for the Number of Aligned Beneficiaries in Prior Quarter(s)	Update % of Total Cost of Care Subject to Capitation	Update Based on Updated Benchmarks (as risk scores move from interim to final)
TCC	Yes	Yes	Yes (TCC Percentage)	Yes
PCC	Yes	Yes	No (Base PCC Percentage)	Yes
NPCC	Yes	Yes	Yes (NPCC Percentage)	Yes
APO	Yes	Yes	No[1]	No[1]
1.5% Administrative Add-On	Yes	Yes	No	Yes

[1] CMS will monitor for meaningful discrepancies between APO payments and FFS claims reduced under APO (for instance, >5% of payments made). CMS reserves the right (but is not required) to adjust quarterly payments if the amount paid meaningfully diverges from the amount reduced during the year.

4.7.1 Updating the Projected Eligible Months for the Upcoming Quarter

At the end of every quarter in the Performance Year, CMS will have a new alignment file that reflects the actual alignment in each month of that quarter. To continually adjust for the changes in alignment, CMS will assume a "retention rate" that predicts the percentage of eligible months left at the start of the next month, compared with the start of the prior month. The retention rate will be based on the last year of the lookback period used to calculate the capitated payments and is updated annually. It is calculated as the average of the retention rate for each month during the lookback period (January to February, February to March, March to April, etc.). For PY 2027, this will be the average of eight retention rates, as the lookback period spans January–September of the prior year.[6]

Figure 1: Average Retention Rate per Month

$$Average\ retention\ rate\ per\ month = 1/N \sum_{m=1}^{N} (eligible\ months\ at\ start\ of\ m+1)/(eligible\ months\ at\ start\ of\ m)$$

The average monthly retention rate is then multiplied by the actual eligible months in the current month to calculate the updated projected eligible months in the upcoming month.

Projected eligible months in upcoming month = Actual eligible months in current month X retention rate

For example, Q2 payments are updated in March, by which time the actual eligible months in Q1 are known (because eligibility determinations are made monthly, beneficiaries eligible on the first of the month are considered eligible for that month). The updated projected eligible months in April are then equal to the actual eligible months in March multiplied by the monthly retention rate.

For ACOs participating in PCC, if CMS determines that the ACO does not have sufficient claims history for CMS to calculate a reliable retention rate prior to the Performance Year, CMS will use the retention rate for beneficiaries in the LEAD National Reference Population to project the number of beneficiaries for the first two quarters of the Performance Year. For ACOs with a high proportion (> 40%) of High Needs and ESRD beneficiaries, however, CMS will assume a retention rate of 100% due to the small populations and potential impact on cash flow. Once CMS calculates the Base PCC Percentage using experience from the Performance Year, CMS will also calculate a retention rate for the LEAD ACO based on the same lookback period from the Performance Year.

4.7.2 Accounting for the Loss/Gain of Beneficiary Alignment in the Past Quarters

Using the actual eligible months from the current quarter, we can determine whether a beneficiary lost or gained alignment during the current quarter. Using the actual eligible months, CMS will

[6] If CMS uses a full 12-month CY for a subsequent PY, the retention rate will be the average of the 11 retention rates in the lookback period.

calculate how much an ACO was overpaid or underpaid in that quarter due to differences in the actual versus expected number of eligible beneficiary months and apply that amount to the upcoming quarter's payments to reflect previous over- or under-payments.

The over- or under-payment in Q4 will not be applied to Q1 of the upcoming Performance Year, to avoid mixing payments in two different Performance Years. Instead, the over- or under-payment in Q4 will be accounted for during the Financial Settlement of that Performance Year. As a result, there will be three adjustments for over- or under-payments during the Performance Year, and again for the Provisional and Final Financial Settlement.

4.7.3 Updating the TCC Percentage

The TCC Percentage throughout the Performance Year is updated to reflect the changes in the aligned population and the associated changes in utilization in and outside of the ACO. The re-estimation of the TCC Percentage will be based on the most recent claims from the Performance Year, as they become available. For example, at the end of PY Q2, CMS will look at the actual alignment in PY Q1, examine accrued claims from aligned beneficiaries during Q1, and re-estimate the TCC Percentage for PY Q3. Because of the 2-month run-out period of claims, the TCC Percentage will be updated twice in a full PY—at the end of Q2 (Q1 claims would be available) for Q3 payments and at the end of Q3 (Q1–Q2 claims would be available) for Q4 payments.

The updated TCC Percentage can then be used to calculate capitated payments for the upcoming quarter and update any over- or under-payments in the current quarter, which will be deducted or added to the upcoming quarter's payments. A payment floor will be utilized in Q2, Q3, and Q4 to ensure that after accounting for over- or under-payments, monthly payment amounts do not fall below 75% of the prior quarter's average monthly payment. Note that if recoupment of over-payments is constrained by this payment floor, the unrecouped balance is carried forward to be reconciled with any additional under- or over-payments in subsequent quarters and/or with determination of Shared Savings/Losses at Financial Settlement.

4.7.4 Updating the Performance Year Benchmark

The Performance Year Benchmark changes throughout the Performance Year as additional information on alignment and beneficiary risk scores becomes available. CMS will use the Performance Year Benchmark from the most recently available Quarterly Benchmark Report to calculate capitated payments for the upcoming quarter, and to update any over- or under-payments in the current quarter, which will be deducted or added to the upcoming quarter's payments.

Because Quarterly Benchmark Reports are published after each quarter, the Performance Year Benchmark will be updated twice in a full Performance Year—before making Q3 payments (Q1 Benchmark Report would be available) and before making Q4 payments (Q2 Benchmark Report would be available). This is in addition to the benchmark update that will occur before making Q2 payments for ACOs that have elected Hybrid alignment. Capitated payment amounts will be updated alongside benchmarks in each of these cases.

4.7.5 Final Retrospective Adjustments at Financial Settlement

At Final Financial Settlement, CMS will make final retrospective adjustments for the payments made during the Performance Year to determine the Total Monies Owed (TMO), after Shared Savings/Losses calculations. Final retrospective adjustments reflecting actual Performance Year beneficiary alignment will apply to all payment mechanisms. For APO, payments will be reconciled against the actual APO reductions made on claims during the Performance Year at the time of Financial Settlement. For TCC, the actual TCC Percentage will be calculated using all Performance Year claims during Financial Settlement. For PCC, the only retrospective adjustment to the payments made to the ACO will be beneficiary alignment counts.

4.8 Claims Processing

A LEAD ACO selects a Capitation Payment Mechanism, in addition to selecting the risk sharing option. The LEAD ACO then negotiates with individual Participant Providers and Preferred Providers on the percent FFS claims reduction under the capitation. CMS will pay LEAD ACOs monthly capitated payments, and will continue to pay the remaining claims by Participant Providers and Preferred Providers and all claims by non-associated providers on a FFS basis. Upon receiving the monthly capitated payments from CMS, ACOs will reimburse Participant Providers and Preferred Providers based on prior negotiations between the ACO and providers.

4.8.1 Claims Submission

Regardless of payment option, all providers must continue to submit all claims for aligned beneficiaries to the Shared System Maintainers (SSMs) in accordance with standard Medicare FFS claims processing rules and procedures. Claims data supports monitoring, evaluation, and quality measurement.

4.8.2 Claims Excluded from TCC, PCC, NPCC, and APO

Notwithstanding the above, certain services will be excluded from fee reductions under certain circumstances. These include, but are not limited to:

- Claims payments where Medicare is not the primary payer;
- Claims payments for providers enrolled in the Periodic Interim Payments (PiP) program or other Medicare programs or initiatives specified by CMS prior to the start of the Performance Year or relevant subsequent quarter;
- Claims payments that represent a health professional shortage area (HPSA) payment. An HPSA payment will be based on the amount prior to the reduction;
- Claims payments to a home health agency for an episode period for which the home health agency has submitted a Request for Anticipated Payment (RAP);
- Claims payments for beneficiaries who elect to decline data sharing; and
- Claims payments for services related to the diagnosis and treatment of substance use disorder (SUD).

4.8.3 Claims Processing and Reprocessing

When a claim is submitted to the SSMs, the SSMs adjudicate the claim and determine the payment amount to the provider(s). If a claim is for a service rendered to an aligned beneficiary by a Participant Provider or Preferred Provider who has opted into any of the payment mechanisms (for TCC, PCC, NPCC, or APO), based on the monthly updated provider and beneficiary alignment lists that the SSMs receives from CMS, the SSMs will reduce the Otherwise Payable Amount (OPA). The OPA is the amount the provider would have received from Original Medicare, which is the amount after accounting for beneficiary cost-sharing and the application of sequestration that will be subject to alternative payment reductions. This accounts for the percent claims reduction elected by the provider and reimburses the provider the remaining amount after the reduction.

Because the SSMs receive the monthly provider and beneficiary alignment lists prior to the start of a given month, the SSMs do not learn of a beneficiary's actual alignment status during the month until the next provider and beneficiary alignment lists are available. In cases where a beneficiary has lost alignment during that month, the SSMs would be reducing the OPA as if the beneficiary were still aligned, when the provider should have received the total OPA. In these cases, CMS will instruct the SSMs to re-process and re-adjudicate the claim and reimburse the provider the OPA.

This process of claims reprocessing works similarly if the ACO terminates their agreement with the Participant Provider or Preferred Provider during a given month. The services provided to aligned beneficiaries by the provider during this month are still eligible for reduction. Starting the next month, if any claims are erroneously reduced, CMS will instruct the SSMs to re-process and re-adjudicate the claims for services provided to aligned beneficiaries on or after the first day of that next month and reimburse the provider the OPA. In addition, CMS reserves the right to adjust payments for an ACO if a significant number of the Participant Providers or Preferred Providers participating in capitation are removed from the ACO during the Performance Year.

Beneficiaries who are aligned during the Performance Year through hybrid alignment will be included for the purposes of capitation payments and fee reductions as of their effective alignment date.

Finally, through the SSMs, all ACOs will receive a weekly snapshot of all eligible Parts A and B claims reduced and adjudicated in the prior week. This snapshot is known as the Weekly Claims Reduction File (CRF). This file may serve several purposes for ACOs, from helping facilitate tailored payment arrangements between providers and ACOs to improving beneficiary engagement. This file will include fields related to the type and amount of claim reduction, beneficiary cost-sharing amounts, the linkage of an original claim to its adjustment, the source and type of a retrospective adjustment to a claim, and other relevant claim metadata.

4.8.4 Claims Processing Precedence Rules

The CMS Innovation Center operates mandatory and voluntary models that test alternative approaches to provider compensation under the FFS program, including episode-based payments, pay-for-performance, population-based payment, and global budgets. Certain models adjust the OPA, like LEAD, or otherwise take priority in terms of how the claims processing system

adjudicates the claim because they are rendered by providers associated with a mandatory model. While situations where claims overlap with two models are generally rare, it is necessary to proactively create and maintain instructions for how the claims processing system should adjudicate these claims to ensure that both models are carried out as designed. For some CMMI models for which overlap is permitted, including TEAM and ASM, a precedence policy is not required because these models do not reduce claims at the service level.

Table 4.8.4 presents the claims processing rules that correspond to LEAD for PY 2027, where the first column corresponds to the name of an Innovation Center model or CMS demonstration, and the second column indicates whether the other model or LEAD takes precedence. For example, in the event a TIN is simultaneously participating in Primary Care AHEAD and LEAD in 2027 and submits a claim for a primary care service, the claim would be adjusted based on LEAD policies. These rules will be updated as models retire or are subsequently implemented, and CMS will notify LEAD participants of any updates when available.

Table 4.8.4. Claims Processing Precedence Rules with Other Models and Demonstrations

Model	Who Has Precedence?
ACCESS	No claims overlap permitted—ACCESS participants cannot bill ACCESS G-codes and other services for the same beneficiary.
AHEAD Hospital Global Budgets	No claims overlap permitted—LEAD will reduce primary care service claims while AHEAD HGB will reduce hospital claims.
Primary Care AHEAD	LEAD precedence.
GUIDE	No claims overlap permitted—codes reduced by the GUIDE and LEAD models must be submitted on separate claims. Overlapping HCPCS otherwise denied by the GUIDE model will be reduced using LEAD logic when there is simultaneous participation.
EOM	EOM precedence.
Veteran's Medicare Remittance Advice (VA MRA)	VA MRA.

5. Settlement and Risk Mitigation

Financial Settlement is the process by which CMS determines an ACO's Shared Savings or Shared Losses after the end of a Performance Year by comparing the Performance Year Benchmark to actual Medicare expenditures (inclusive of TCC, PCC, NPCC, and APO, as well as FFS claims paid by CMS directly to Medicare providers and suppliers for services rendered to aligned beneficiaries). Financial Settlement is also when CMS applies risk-mitigation mechanisms, such as Stop-Loss Reinsurance and risk corridors. This section details the calculation of total Performance Year expenditures, the application of risk-mitigation methodologies, and Shared Savings/Losses.

5.1 Settlement Timing

Final Financial Settlement

Final Financial Settlement will be conducted for all LEAD ACOs after the Performance Year has ended and sufficient time has passed to allow for claims processing. The Final Financial Settlement process will be conducted in Q3 of the calendar year following the close of the Performance Year. This Final Financial Settlement will include claims run out through the end of Q1 of the calendar year following the Performance Year for expenditures incurred in the Performance Year.

Provisional Financial Settlement

LEAD ACOs will also have the option to select Provisional Financial Settlement. This Provisional Financial Settlement will include ACO expenditures through the end of the Performance Year and will be calculated in Q1 of the following Performance Year. Provisional settlement will include no claims run out; instead, CMS will apply a completion factor to account for the fact that claims run-out is not yet complete. The purpose of the Provisional Financial Settlement is to provide ACOs with a timelier disbursement of provisional Shared Savings and to allow ACOs to more promptly repay CMS provisional Shared Losses.

For purposes of calculating Shared Savings or Shared Losses as part of the Provisional Financial Settlement, CMS may make adjustments to account for anticipated differences between the ACO's expenditures in the Provisional Financial Settlement and those that will be included in the Final Financial Settlement, including the use of an Incurred But Not Reported (IBNR) estimate of Performance Year expenditures. Adjusted expenditures will then be compared to a Provisional Performance Year Benchmark (provisional insofar as several elements of the Performance Year Benchmark are not finalized until well after the end of the Performance Year). For example, the ACO's quality performance and final risk scores are components of the benchmark that will not be available when CMS performs Provisional Financial Settlement. Consequently, CMS may use a default quality score (e.g., the average quality score from a prior year) and a preliminary risk score (e.g., estimated risk score provided in the ACO's Preliminary Benchmark Report before the start of the Performance Year) to calculate the Provisional Performance Year Benchmark. Final risk scores and the ACO's actual quality performance will be incorporated into the Performance Year Benchmark for the Final Financial Settlement.

Table 5.1.1 below summarizes the key differences between Provisional Financial Settlement and the Final Financial Settlement.

Table 5.1.1: Provisional Financial Settlement and Final Financial Settlement

Item	Provisional Financial Settlement	Final Financial Settlement
Target Date for Financial Settlement	Quarter 1 of calendar year following the Performance Year	Quarter 3 of calendar year following the Performance Year
Claims Included in Financial Settlement	Performance year expenditures incurred through December 31 of the Performance Year	Performance year expenditures incurred through December 31 of the Performance Year
Claims Run-Out	Through December 31 of the Performance Year	Through March 31 of the calendar year following Performance Year
Risk Scores	Preliminary risk scores	Final risk scores
Quality Score	Placeholder quality score	Actual Performance Year quality performance
Repayment of EPCC	Optional (though ACOs will not be able to release their financial guarantee for the Performance Year until they have re-paid EPCC)	Required
Stop Loss Applied	Yes	Yes

Termination without Liability

CMS will establish a Termination Without Liability Date for each Performance Year, including PY 2027. If an ACO terminates its participation in LEAD by providing written notice on or before the applicable Termination Without Liability Date, the ACO will not be liable for Shared Losses for that Performance Year.

For each Performance Year, the Termination Without Liability Date will be the later of: (1) February 28 of the Performance Year, or (2) 30 days after CMS distributes the Performance Year Benchmark Report to the ACO.

Termination without liability applies only to the ACO's liability for Shared Losses for the applicable Performance Year; it does not eliminate the ACO's responsibility to repay other monies owed to CMS, including any outstanding payment obligations, overpayments, or amounts otherwise due.

If an ACO terminates after the applicable Termination Without Liability Date, the ACO remains responsible for financial settlement for that Performance Year, including any Shared Losses owed to CMS, in accordance with the model's financial reconciliation and settlement policies.

5.2 Performance Year Benchmark Adjustments

The process for determining an ACO's Performance Year Benchmark is detailed in **Section 3**. During Financial Settlement, CMS will apply several adjustments to the Performance Year Benchmark.

5.2.1 Discount

LEAD's Global Risk Option applies a discount to the benchmark that represents the share of savings that CMS retains when an ACO generates Shared Savings. Specifically, the Performance Year Benchmark is reduced by the discount rate during Financial Settlement, prior to calculating the ACO's Shared Savings or Shared Losses. As illustrated in **Table 5.2.1**, lower-spending ACOs will be subject to a 3% discount for all years that they participate in the Global Risk Option. Higher-spending ACOs will be subject to a 1.75% discount rate in the first year of the model. In subsequent years, the discount rate for higher-spending ACOs will grow by 0.25% annually until it reaches 3% in PY 2032, where it will remain for the rest of the model.

Table 5.2.1: Discount Rate Schedule

Type of ACO	Discount Rate Schedule
Lower-spending ACOs	3.0% static discount rate
Higher-spending ACOs	2027: 1.75% 2028: 2.0% 2029: 2.25% 2030: 2.5% 2031: 2.75% 2032–2036: 3.0%

5.2.2 Quality Withhold

A 3% Quality Withhold will be applied to all ACOs' Performance Year Benchmarks during Financial Settlement. The Quality Withhold represents the portion of the benchmark that is contingent on the ACO's quality performance under the LEAD Model. ACOs will have the opportunity to earn back some or all of the Quality Withhold based on their quality performance.

The Quality Withhold is calculated as 3% of the ACO's total Performance Year Benchmark, prior to the application of the discount for ACOs participating in the Global Risk Option. This calculation results in a single dollar amount representing the ACO's total Quality Withhold.

To determine the amount of the Quality Withhold an ACO is eligible to earn back, CMS will calculate a quality score based on the ACO's performance on the LEAD Model's seven quality measures,[7] as well as whether the ACO successfully submits and maintains a Prevention and Quality Plan. The quality score will be expressed as a percentage ranging from 0 to 100%. CMS

[7] The seven LEAD quality measures are Risk-Standardized All-Condition Readmission; 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; CAHPS Survey; Controlling High Blood Pressure electronic clinical quality measure (eCQM); and Diabetes: Glycemic Status Assessment Greater Than 9% eCQM. During PY 1 and PY 2, the two eCQM measures will be optional, and ACOs will receive bonus points to their quality score for reporting them. During PY 3 and PY 4, they will become pay-for-reporting, before transitioning to pay-for-performance in PY 5. The other measures will be pay-for-performance beginning in PY 1.

will then multiply the ACO's quality score by the Quality Withhold dollar amount to calculate the ACO's Quality Earn Back.

Accordingly, the net impact of quality performance on the Performance Year Benchmark equals the Quality Withhold minus the Quality Earn Back. **Table 5.2.2** illustrates this calculation.

During Financial Settlement, the Quality Withhold is applied after the Discount (for ACOs participating in the Global Risk Option) and after the Retention Incentive Adjustment.

Table 5.2.2: Calculation of Performance Year Benchmark after Discount and Earned Quality

Line	Step	Calculation of Performance Year Benchmark	Global	Professional
1	Performance Year Benchmark with Initial Adjustments	Performance Year Benchmark for All Aligned Beneficiaries	$150,000,000	$150,000,000
2	Calculation of Discount Rate	Discount Rate	3.00%	0.00%
3	Calculation of Discount Rate	Total Discount	$4,500,000	N/A
4	Calculation of Discount Rate	**Performance Year Benchmark for All Aligned Beneficiaries After Discount (Line 1-Line 3)**	**$145,500,000**	**$150,000,000**
5	Calculation of Earned Quality Withhold	Quality Withhold (0.03 x Line 1)	$4,500,000	$4,500,000
6	Calculation of Earned Quality Withhold	Quality Score	95%	95%
7	Calculation of Earned Quality Withhold	Earned Quality Withhold (Line 5 x Line 6)	$4,275,000	$4,275,000
8	Calculation of Earned Quality Withhold	Net Impact of Quality Withhold (Line 5-Line 7)	$225,000	$225,000
9	Calculation of Earned Quality Withhold	**Performance Year Benchmark for All Aligned Beneficiaries After Discount and Earned Quality (Line 4-Line 8)**	**$145,275,000**	**$149,775,000**

5.2.3 Retention Incentive Adjustment

To determine whether ACOs can succeed in improving quality and reducing costs over a longer time period, ACOs will be incentivized to participate in LEAD for a minimum of two Performance Years (e.g., PY 2027 and PY 2028 for ACOs starting LEAD participation in PY 2027). ACOs that terminate participation after one Performance Year (by providing written notice to CMS on or before the Termination Without Liability Date of the ACO's second Performance Year) will have their Performance Year Benchmark reduced by 2% at Final Settlement for the ACO's first Performance Year. ACOs that do not terminate participation on or before the Termination Without Liability Date of the ACO's second Performance Year will "earn back" the retention incentive during Final Settlement for their first Performance Year, meaning the 2% benchmark reduction will not be applied.

For ACOs that terminate participation after their first Performance Year, the retention incentive is applied after the application of the Discount (for ACOs in the Global Risk Option) and before the Quality Withhold during Final Settlement.

CMS will also offer ACOs a Termination Without Liability Date in PY 2027. ACOs that provide written notice to CMS on or before the Termination Without Liability date specified for PY 2027 will not be subject to the retention incentive.

5.3 Performance Year Expenditures

The Performance Year expenditure (PY expenditure) is the total payment that Medicare has made for services provided to ACO-aligned beneficiaries during months in which they were aligned to the ACO. The PY expenditure is the sum of the capitation payments made to the ACO for services within the scope of their respective capitation arrangement and the fee-for-service (FFS) payments made to all Medicare-enrolled providers and suppliers for covered services delivered to aligned beneficiaries. Because the Performance Year Benchmark is calculated on a pre-sequestration basis, the PY expenditure will also be calculated on a pre-sequestration basis for the purposes of calculating Shared Savings/Losses. Sequestration will be applied in the calculation of Shared Savings/Losses (see **Section 5.4**).

5.3.1 Capitation Payments

All ACOs are required to participate in either Total Care Capitation (TCC) or Primary Care Capitation (PCC). The TCC or Base PCC Payments made to the ACO during the Performance Year, including any adjustments to those payments made during or after the Performance Year, will be included as capitation payments in the calculation of the PY expenditure. More details on the Capitation Payment Mechanisms can be found in **Section 4**.

5.3.2 Claims Payments to Participant, Preferred, and Non-ACO Providers

Beneficiaries aligned to an ACO will continue to receive services not covered by capitation. For those services, the total amount of FFS claims for a given provider type is inclusive of the total claim payment amounts, plus amounts withheld due to sequestration, minus reductions made to provider payments due to participation in any of the capitated payment options, minus Uncompensated Care Payments to hospitals under the Inpatient Prospective Payment System. This section describes the claims payments to each type of provider and illustrates an example calculation in **Table 5.3.2.**

Payments to Participant Providers

In an ACO that has elected TCC, Participant Providers will continue to receive FFS payment on eligible claims that are exempt from the TCC reduction, generally because the beneficiary opted out of data sharing or the claim contains data related to substance abuse.

In an ACO that has elected PCC, Participant Providers will continue to receive FFS payments for any portion of eligible Primary Care claims billed by Primary Care Specialists that are not subject to PCC reduction, as well as FFS payments on eligible claims that are not for PCC services.

In an ACO that has also elected NPCC, Participant Providers will continue to receive FFS payments for any portion of eligible non-Primary Care claims billed by Participant Providers that are not subject to PCC reduction.

In an ACO that has also elected the Advanced Payment Option (APO), the amounts of FFS claims reductions associated with APO payments are included in the PY expenditure. Providers participating in APO will continue to receive FFS payment for any portion of claims not reduced as well as for claims not eligible for APO, such as those for beneficiaries electing to opt-out of claims sharing or those related to substance abuse.

Payments to Preferred Providers

Because Preferred Providers are not required to participate in capitation and those that do have the option to reduce any portion of claims (1–100%), any unreduced claims for services provided by a Preferred Provider will be included in FFS payments.

Payments to Other Providers

Payments made to non-ACO providers (providers who are not Participant Providers or Preferred Providers and are by definition not participating in the capitation arrangement) are also included in the PY expenditure.

Table 5.3.2: PY Expenditure Example

Line	PY Expenditure	Global	Professional
10	**Capitation Payments**	$10,000,000	$10,000,000
11	Participant Provider Claim Payments	$1,003,442	$1,003,442
12	Preferred Provider Claim Payments	$33,435,084	$33,435,084
13	Non-ACO Provider Claim Payments	$91,355,457	$91,355,457
14	**Total FFS Payments (Sum Lines 11, 12, and 13)**	$125,793,983	$125,793,983
15	**PY Expenditure (Line 10 + Line 14)**	**$135,793,983**	**$135,793,983**

5.3.3 Stop-Loss Reinsurance

Stop-Loss Reinsurance is a risk-mitigation strategy that is optional for all ACOs, regardless of their selected risk sharing option. If chosen, Stop-Loss reinsurance must be selected by an ACO during the applicable election window established by CMS. For PY 2027, the Stop-Loss Reinsurance Election deadline is April 30, 2027, at 11:59 PM ET. ACOs may change their Stop-Loss Reinsurance election during the applicable election window for a subsequent Performance Year. Stop-Loss is designed to protect ACOs from financial liability for individual beneficiaries with extremely high, outlier expenditures. LEAD's Stop-Loss Reinsurance will use a residual approach that compares beneficiary PY expenditures to Predicted expenditures (PY expenditure less Predicted expenditure is referred to as the "Residual Expenditure"). ACO protection from expenditures begins once a beneficiary's Residual Expenditure passes a prospectively developed Attachment Point. Once the beneficiary's Residual Expenditure exceeds the Attachment Point, the amount that is paid out by CMS under Stop-Loss Reinsurance will increase as the

expenditure incurred by the beneficiary increases, according to a set schedule referred to as Stop-Loss bands.

At Financial Settlement, ACOs that have elected Stop-Loss Reinsurance will have their Performance Year expenditures adjusted to account for the net effect of Stop-Loss charges (the per-beneficiary per-month amount that CMS charges ACOs for electing Stop-Loss Reinsurance) and any Stop-Loss payout that the ACO has earned, adjusted for a model-wide Stop-Loss neutrality factor if applicable. **Box 5.3.3** provides a more detailed explanation of LEAD's Stop-Loss Reinsurance arrangement, including its impact on financial settlement.

Box 5.3.3 Overview of Stop-Loss Reinsurance Arrangement

The Stop-Loss Reinsurance arrangement is comprised of four components: Residual Expenditure, Attachment Point, Payout, and Charge, all of which will be detailed in this section.

Shared Experience Between ESRD, AD, and High Needs Months

For every beneficiary, Residual Expenditures, Attachment Points, and Charges will be estimated for the ESRD, High Needs, and A&D benchmarks and will then be combined together via month-weighted averaging to arrive at a single, beneficiary-level value for each of the above variables. A single payout amount will then be calculated using these beneficiary-level values.

Stop-Loss Residual Expenditure

The Stop-Loss Residual Expenditure comprises two components: the PY expenditure a beneficiary accrues over the course of the performance year, and the Predicted Expenditure for the beneficiary in the performance year. In PY 2027, the Predicted Expenditure will be calculated as PY 2027 regional expenditures (based on the beneficiary's county of residence), times the beneficiary risk score, times the beneficiary's total months of enrollment in the performance year.

Predicted Expenditures = the LEAD Regional Expenditures X Beneficiary Risk Score X Months of Alignment in PY

For purposes of developing Stop-Loss predicted expenditures, Attachment Points, and Charges, CMS will adjust reference year expenditures to exclude spending associated with significant, anomalous, and highly suspect (SAHS) billing activity and skin substitute products. For more background on SAHS billing and skin substitute expenditures, see Section 3.2.1. Specifically, CMS will exclude 100% of expenditures associated with HCPCS codes A4352 and A4353 for CY 2023; HCPCS codes A4353 and A5057 for 2024; HCPCS codes A4352, A4353, A6197, L0486, L1852, and L3916 for CY 2025; and any additional HCPCS or CPT codes subsequently designated by CMS as SAHS billing activity. CMS will also exclude 100% of expenditures associated with the specified set of skin substitute product codes for CY 2023 through CY 2025. These exclusions will be applied consistently in the development of reference year expenditures, Attachment Points, Stop-Loss Charges, and Stop-Loss Payouts.

Stop-Loss Attachment Point

A Stop-Loss Attachment Point will be prospectively established for the entire model prior to the beginning of the performance year. The Attachment Point is calculated by simulating the Stop-Loss model for the LEAD National Reference Population in each of the three Stop-Loss reference years. The Stop-Loss reference years will be the most recent three years before the performance year, with a one-year gap between the most recent reference year and the performance year (e.g., 2023, 2024, and 2025 for PY 2027).

In each simulation, the Attachment Point is set such that the total model payout for each year is equal to 2% of total Medicare expenditures for the year. After the Attachment Points in each base year are determined, the Attachment Point from the most recent reference year is trended to performance year dollars using a national trend factor (calculated using the same methodology as the national trend factor used to develop Performance Year Benchmarks) to arrive at the PY Attachment Point.

Stop-Loss Charge

After the Attachment Points in each of the three reference years are determined, each ACO will have Stop-Loss simulated for each reference year, using the respective Attachment Point for that year and the beneficiaries that would have been aligned to the ACO in each reference year. The ACO's payout percentages (equivalent to the total Stop-Loss payout divided by the total reference year expenditure) from each base year are then simple- averaged together to arrive at the Average Payout Percentage, which will be multiplied by the risk adjusted, performance year–trended reference year expenditure and performance year ACO-aligned beneficiary months to determine the total Stop-Loss Charge.

If CMS determines that an ACO's historical claims experience is insufficient for determining a Stop-Loss Charge in the performance year, then the 3-year Average Payout Percentage will instead be calculated based on the historical experience of beneficiaries in the LEAD Reference Population in the counties where the ACO's aligned beneficiaries reside in the performance year. CMS will calculate a 3-year Average Payout Percentage and average reference year expenditure for each county using the same 3-year reference period. For counties with insufficient claims experience to determine a historical Stop-Loss payout percentage and reference year expenditure, CMS will use the cumulative experience of beneficiaries in the state across counties with insufficient claims experience to calculate the Stop-Loss Charge.

Calculation of Stop-Loss Charge

Line	Calculation	Value
1	Average Reference Year Expenditure PBPM, Trended	$946.97
2	Number of ACO-Aligned Beneficiary Months in PY	132,000
3	ACO Average Risk Score in PY 1	1.160
4	Total Trended, Risk-Adjusted Reference Year Expenditure	$145,000,046.40
5	3-Year Average Payout Percentage	2.03%
-	RY1 Aggregate Payout Percentage	1.96%
-	RY2 Aggregate Payout Percentage	2.09%
-	RY3 Aggregate Payout Percentage	2.05%
6	PY Stop-Loss Charge (Line 4 x Line 5)	**$2,948,334.28**

[1] The Stop-Loss Charge will be calculated using the final PY risk scores for aligned beneficiaries. For quarterly reporting, interim risk scores will be used based on the most recently available risk scores at the time. PBPM = Per beneficiary per month; PY = Performance year; RY = Reference Year

Stop-Loss Payout

ACOs will receive Stop-Loss payouts for beneficiaries who accrue enough expenditure in the performance year that their Residual Expenditure is greater than the Attachment Point.

CMS will apply a band schedule to all payouts from Stop-Loss Reinsurance. Stop-Loss bands are a progressive coinsurance schedule in which CMMI will cover a certain percentage of the expenditure within the band, increasing as beneficiary spending moves into higher bands.

Stop-Loss Payment Schedule

Stop-Loss Band	Start Band	End Band	Stop-Loss Payout Rate
1	Beneficiary Attachment Point	200% of Beneficiary Attachment Point	80%
2	200% Beneficiary Attachment Point	No Upper Limit	100%

These calculations are progressive and occur only once the beneficiary has passed their Attachment Point. For example, assume an ACO with a beneficiary with $400,000 of Residual Expenditure and a combined AD, HN, and ESRD Attachment Point of $150,000. There will be no Stop-Loss coverage on the first $150,000. The Residual Expenditure between $150,000 and $300,000 will be covered at 80%, meaning CMS will cover $120,000. The remaining Residual Expenditure between $300,000 and $400,000 will be covered at 100%, which means CMS will cover the entire $100,000.

Illustration of the Calculation of the Stop-Loss Payout for an Individual Beneficiary

Line	Calculation of Stop-Loss Payout for Individual Beneficiary	Value
1	Attachment Point (AP)	$150,000
2	Predicted Spend	$100,000
3	Actual Spend	$500,000
4	**Residual Expenditure (Line 3 - Line 2)**	**$400,000**
-	Below Attachment Point	$150,000
-	Risk Band 1 (100% to 200% of AP)	$150,000
-	Risk Band 2 (Beyond 200% of AP)	$100,000
5	**Total Payout**	**$220,000**
-	Risk Band 1 (80% Payout)	$120,000
-	Risk Band 2 (100% Payout)	$100,000

Stop-Loss Payout Adjustment Factor

To ensure that the Stop-Loss is budget neutral across the model, CMS will apply a retrospective adjustment factor to Stop-Loss payouts called the Stop-Loss Neutrality Factor.

At Final Settlement, CMS will calculate the Stop-Loss Neutrality Factor as the sum of all LEAD Stop-Loss charges divided by all LEAD Stop-loss Payouts across all ACOs in the performance year. This factor is then directly applied to the Stop-Loss payout of each ACO. This factor is symmetric in its adjustment; when total payouts are greater than total charges for a given performance year, the Stop-Loss Neutrality Factor will serve as a reduction factor to bring down payouts to be equivalent to charges at the model level; alternatively, in years where total charges are greater than total payouts, the Stop-Loss Neutrality Factor will amplify Stop-Loss payouts.

The table below shows the application of Stop-Loss to the PY expenditure. Stop-Loss is a virtual payment—no actual cash flows are made to/from CMS for Stop-Loss charges and payouts. Instead, the charge will be represented as an increase to the PY expenditure, and the payout will be represented as a reduction to the PY expenditure.

Application of Stop-Loss

Line	Calculation	Global	Professional
16	PY Expenditure	$135,793,983	$135,793,983
17	Stop-Loss Charge	$2,948,334.28	$2,948,334.28
18	Total Stop-Loss Payout	$2,900,000.00	$2,900,000.00
19	Stop-Loss Neutrality Factor*	0.930	0.930
20	Adjusted Stop-Loss Payout	$2,697,000.00	$2,697,000.00
21	Net Impact of Stop-Loss (Line 17-Line 20)	$251,334.28	$251,334.28
22	PY Expenditure after Stop-Loss (Line 16+Line 21)	$136,045,317.28	$136,045,317.28

*Calculated in aggregate for all ACOs with stop-loss

5.4 Gross Savings/Losses and Shared Savings/Losses

Gross Savings/Losses are calculated by subtracting an ACO's PY expenditure, adjusted for Stop-Loss, from its total Performance Year Benchmark.

Gross Savings/Losses will then have Risk Corridors applied to arrive at Shared Savings/Losses. Under both Global and Professional risk arrangements, Risk Corridors (bands) are applied to

Gross Savings/Losses to mitigate the risk of large savings or losses to CMS and participants. As Gross Savings/Losses increase as a percentage of the ACO's Performance Year Benchmark, the ACO will retain a progressively smaller portion of the total savings or will be responsible for a progressively smaller portion of the total losses. Risk Corridor thresholds will be based on percent of the ACO's Performance Year Benchmark after application of the discount, Quality Withhold, and Quality Earn Back.

After the application of risk corridors, CMS adjusts the final Shared Savings amount for sequestration by reducing by 2% the Shared Savings amount retained by the ACO, as required by the Budget Control Act of 2011.

5.4.1 Risk Corridors: Global Option

Under the Global Option, an ACO will be responsible for a higher portion of Shared Losses but will also retain a higher portion of Shared Savings. **Table 5.4.1** shows the Risk Corridors applied to an ACO that has selected the Global Risk Option.

Table 5.4.1: Risk Corridor Percentage Savings/Losses, Global Option

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

*For all aligned beneficiaries after the application of the Discount, Quality Withhold, and Quality Earn Back

Table 5.4.2 shows an example of the application of Risk Corridors in the calculation of Shared Savings/Losses.

Table 5.4.2: Calculation of Shared Savings/Losses, Global Risk Option

Line	Step	Calculation	Global
23	Calculation of Gross Savings (Losses)	PY Expenditure after Stop-Loss	$136,045,317.28
24	Calculation of Gross Savings (Losses)	PY Benchmark After Discount, Earned Quality	$145,275,000
25	Calculation of Gross Savings (Losses)	**Gross Savings (Losses) (Line 24-Line 23)**	**$9,229,682.72**
26	Calculation of Shared Savings (Losses)	Savings (Losses) Retained by ACO	$9,229,682.72
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 1	$9,229,682.72
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 2	$ -
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 3	$ -
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 4	$ -
27	Calculation of Shared Savings (Losses)	Sequestration Amount (2% x Line 26)	$184,593.65
28	Calculation of Shared Savings (Losses)	Savings (Losses) Retained by ACO, net of Sequestration (Line 26–Line 27)	**$9,045,089.07**

In this example, the ACO had Gross Savings of $9,229,683. Because the Shared Savings for the period is entirely within the first corridor, the ACO's Shared Savings for the year will be 100% of their Gross Savings.

5.4.2 Risk Corridors: Professional Option

Under the Professional Option, an ACO will be responsible for a lower portion of Shared Losses but will also retain a lower portion of Shared Savings. **Table 5.4.3** shows the Risk Corridors applied to an ACO that has selected the Professional Risk Option. As discussed in **Section 1.3**, the savings rate in Corridor 1 is 60%, while the losses rate is 50%; for all other corridors the savings and losses rates are equal.

Table 5.4.3: Risk Corridor Percentage Savings/Losses, Professional Risk Option

Corridor	Corridor 1	Corridor 2	Corridor 3	Corridor 4
Percent of Benchmark *	Up to 10%	10–15%	15–20%	More than 20%
Savings/Losses Rate	60% savings rate 50% losses rate	35%	15%	5%

*For all aligned beneficiaries after the application of the Quality Withhold and Quality Earn Back.

Table 5.4.4 shows the same example of the application of Risk Corridors in the calculation of Shared Savings/Losses, this time for an ACO participating in the Professional Risk Option.

Table 5.4.4: Calculation of Shared Savings/Losses, Professional Option

Line	Step	Calculation	Professional
26	Calculation of Shared Savings (Losses)	Savings (Losses) Retained by ACO (60% x Line 25)	$8,237,809.63
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 1	$8,237,809.63
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 2	$ -
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 3	$ -
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 4	$ -
27	Calculation of Shared Savings (Losses)	Sequestration Amount (2% x Line 26)	$164,756.19
28	Calculation of Shared Savings (Losses)	Savings (Losses) Retained by ACO, net of Sequestration (Line 26-Line 27)	**$8,073,053.44**

In this example, the ACO had Gross Savings of $13,729,683. Because gross savings are entirely within the first corridor (10% of benchmark after earned quality), the ACO's Shared Savings (pre-sequestration) will be calculated as 60% of gross savings, equaling $8,237,810.

5.5 Settlement and Calculation of Total Monies Owed

After the calculation of Shared Savings/Losses is completed, CMS will calculate the Total Monies Owed, which represents an ACO's portion of Shared Savings/Losses, adjusted for any additional over/underpayments. In the calculation of Total Monies Owed at Provisional Settlement, CMS will adjust the preliminary Shared Savings/Losses amount by the following:

- **Under (over) payments from capitation:** Differences in final beneficiary alignment and risk scores, shifts in utilization patterns, and claims processing errors may lead to significant over or underpayments throughout the Performance Year. Any (over) payments not adjusted for throughout the Performance Year will be adjusted for here. For more

information on the calculation of capitation payments and year-end payment adjustments, see **Section 4**.

- **Adjustments for ACOs participating in EPCC and/or APO:** CMS will recoup the EPCC payment amount in full. For ACOs also electing the APO, the APO payment will be reconciled against actual claims reductions for the year. If the reduction in FFS claims was greater than the APO payment made, the difference will be credited to the ACO. If the reduction in FFS claims was less than the APO payment made, the difference will be recouped by CMS.

At Final Settlement, CMS will adjust the Final Shared Savings/Losses amount by the following:

- **Money already distributed to (received from) the ACO at the time of Provisional Settlement:** At the time of Provisional Settlement, incomplete claims, alignment, and quality data will be used in the calculation of Shared Savings/Losses and Total Monies Owed. As such, the estimate of Provisional Shared Savings/Losses and Total Monies Owed may be materially different than the Final Shared Savings/Losses amount. Consequently, Final Shared Savings/Losses will be settled as if it were an "adjustment" to the amount already paid out to, or received from, the ACO at the time of Provisional Settlement.
- **Contributions from the High-Performers Pool incentive**, if applicable.

Table 5.5.1 shows an example of the calculation of Total Monies Owed at Final Financial Settlement in which CMS will pay Total Monies Owed to the ACO. Under different circumstances (e.g., an ACO has capitation overpayments, or Final Settlement Shared Savings are less than Provisional Settlement Shared Savings), an ACO could also owe Total Monies Owed to CMS.

Table 5.5.1: Calculation of Total Monies Owed

Line	Step	Calculation of Total Monies Owed	Professional
1	Shared Savings Adjustments	Provisional Settlement Shared Savings (Losses)	$6,456,540.00
2	Shared Savings Adjustments	Final Settlement Shared Savings (Losses)	$8,073,053.43
3	Shared Savings Adjustments	Shared Savings (Losses) Owed (Line 2–Line 1)	$1,616,513.43
4	Additional Adjustments	Under (Over) Payments from Payment Arrangements	$160,700.00
-	Additional Adjustments	Capitation Under (Over) Payment	$160,700.00
-	Additional Adjustments	Enhanced PCC Repayment[1]	-
-	Additional Adjustments	APO Adjustment[1]	-
5	Additional Adjustments	High-Performers Pool Incentive	$100,000.00
6	Additional Adjustments	Adjustments Owed	$260,700.00
7	Additional Adjustments	Total Monies Owed (Line 3 + Line 6)	$1,877,213.43

[1] The example in Table 5.5.1 is that of an ACO electing the TCC Capitation Mechanism. As a result, no adjustments need be made for Enhanced PCC or APO.

5.6 Full Settlement Calculation Example

Table 5.6.1 shows the entire Final Settlement process for the same ACO for both the Professional and Global Risk Sharing Options.

Table 5.6.1: Full Settlement Calculation

Line	Step	Full Settlement Calculation	Global	Professional
1	PY Benchmark for All Aligned Beneficiaries	**PY Benchmark for All Aligned Beneficiaries**	$150,000,000.00	$150,000,000.00
2	Calculation of Discount Rate	Discount Rate	3.00%	0.00%
3	Calculation of Discount Rate	Total Discount	$4,500,000.00	N/A
4	Calculation of Discount Rate	**PY Benchmark for All Aligned Beneficiaries After Discount (Line 1-Line 3)**	**$145,500,000.00**	**$150,000,000.00**
5	Calculation of Earned Quality Withhold	Quality Withhold (0.030 x Line 1)	($4,500,000.00)	($4,500,000.00)
6	Calculation of Earned Quality Withhold	Quality Score	95%	95%
7	Calculation of Earned Quality Withhold	Earned Quality Withhold (Line 5 x Line 6)	$4,275,000.00	$4,275,000.00
8	Calculation of Earned Quality Withhold	Net Impact of Quality Withhold (Line 5 – Line 7)	($225,000.00)	($225,000.00)
9	Calculation of Earned Quality Withhold	**PY Benchmark for All Aligned Beneficiaries After Discount and Earned Quality (Line 4 + Line 8)**	**$145,275,000.00**	**$149,775,000.00**
10	PY Expenditure	Capitation Payments	$10,000,000	$10,000,000
11	PY Expenditure	Participant Provider Claim Payments	$1,003,442	$1,003,442
12	PY Expenditure	Preferred Provider Claim Payments	$33,435,084	$33,435,084
13	PY Expenditure	Non-ACO Provider Claims	$91,355,457	$91,355,457
14	PY Expenditure	**Total FFS Payments (Sum Lines 11:13)**	**$125,793,983**	**$125,793,983**
15	PY Expenditure	**PY Expenditure (Line 10 + Line 14)**	**$135,793,983**	**$135,793,983**
16	Application of Stop-Loss	PY Expenditure	$135,793,983	$135,793,983
17	Application of Stop-Loss	Stop-Loss Charge	$2,948,334.28	$2,948,334.28
18	Application of Stop-Loss	Total Stop-Loss Payout	$2,900,000.00	$2,900,000.00
19	Application of Stop-Loss	Stop-Loss Neutrality Factor	0.930	0.930

Line	Step	Full Settlement Calculation	Global	Professional
20	Application of Stop-Loss	Adjusted Stop-Loss Payout	$2,697,000.00	$2,697,000.00
21	Application of Stop-Loss	Net Impact of Stop-Loss (Line 17-Line 20)	$251,334.28	$251,334.28
22	Application of Stop-Loss	**PY Expenditure after Stop-Loss (Line 16 + Line 21)**	**$136,045,317.28**	**$136,045,317.28**
23	Calculation of Gross Savings (Losses)	PY Expenditure after Stop-Loss	$136,045,317.28	$136,045,317.28
24	Calculation of Gross Savings (Losses)	PY Benchmark After Discount and Earned Quality	$145,275,000.00	$149,775,000.00
25	Calculation of Gross Savings (Losses)	**Gross Savings (Losses) (Line 24-Line 23)**	**$9,229,682.72**	**$13,729,682.72**
26	Calculation of Shared Savings (Losses)	Savings (Losses) Retained by ACO	**$9,229,682.72**	**$8,237,809.63**
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 1	$9,229,682.72	$8,237,809.63
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 2	$ -	$ -
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 3	$ -	$ -
-	Calculation of Shared Savings (Losses)	Retained Savings (Losses) in Corridor 4	$ -	$ -
27	Calculation of Shared Savings (Losses)	Sequestration Amount (2% x Line 26)	$184,593.65	$164,756.19
28	Calculation of Shared Savings (Losses)	Savings (Losses) Retained by ACO, net of Sequestration (Line 26-Line 27)	**$9,045,089.07**	**$8,073,053.44**

5.7 Settlement Adjustment for Late Fee Reductions

After the calculation of Total Monies Owed at Final Settlement, CMS will calculate a Settlement Adjustment to account for any claims that were reduced by the claims processing systems after the run-out for the Performance Year. CMS shall calculate the Late Fee Reduction Adjustment for each ACO as an adjustment to the Capitation or Advanced Payment Mechanism elected by the ACO in that Performance Year. For ACOs that elect TCC, NPCC, or APO, CMS shall calculate the Late Fee Reduction Adjustment as the difference between the amount of TCC/APO Fee Reductions based on March 31 of the subsequent Performance Year, and a claims run-out period. For ACOs that elect PCC, CMS shall calculate the Late Fee Reduction as the difference between the PCC Fee Reductions based on March 31 of the subsequent Performance Year, and a claims run-out period that is multiplied by the marginal risk sharing rate elected by the ACO (i.e., Global or Professional). If the absolute value of the net amount of Late Fee Reductions calculated is greater than or equal to $1,000, then CMS shall calculate a new component of Other Monies Owed to adjust Final Financial Settlement.

CMS shall calculate the Late Fee Reduction at most two times, and application will be contingent on the $1,000 threshold. The first time will occur one year after Final Financial Settlement for a Performance Year, coinciding with the issuance of the subsequent Performance Year's Final Financial Settlement. The second time will occur two years after the Final Financial Settlement for a Performance Year, coinciding with the subsequent Final Financial Settlement for PY+2. These adjustments shall be applied to all ACOs. **Table 5.7.1** shows the timing of these adjustments, and the run-out period for each adjustment, for the first five Performance Years of the model. CMS anticipates that PY 2032–2036 will follow a similar timeline.

Table 5.7.1: Tentative Timing of First and Second Post-Settlement Adjustments

Performance Year	First Settlement Adjustment		Second Settlement Adjustment	
	Timing of Adjustment	Anticipated Run-out	Timing of Adjustment	Anticipated Run-out
2027	Fall 2029	01/01/2027–05/31/2029 ~29 months	Fall 2030	01/01/2027–05/31/2030 ~ 41 months
2028	Fall 2030	01/01/2028–05/31/2030 ~29 months	Fall 2031	01/01/2028–05/31/2031 ~41 months
2029	Fall 2031	01/01/2029–05/31/2031 ~29 months	Fall 2032	01/01/2029–05/31/2032 ~41 months
2030	Fall 2032	01/01/2030–05/31/2032 ~29 months	Fall 2033	01/01/2030–05/31/2033 ~41 months
2031	Fall 2033	01/01/2031–05/31/2033 ~29 months	Fall 2034	01/01/2031–05/31/2034 ~41 months

5.8 Significant Anomalous and Highly Suspect Billing Activity and Reopening Policies

In addition to the historical SAHS adjustments described in **Section 3.2.1**, CMS intends to implement prospective SAHS billing activity and reopening policies under LEAD, similar to those currently present in ACO REACH and the Shared Savings Program. These policies are meant to protect ACOs that see significant expenditures that may be related to misuse, fraud, waste, or abuse.

SAHS billing is defined at 42 CFR § 425.672. The regulation stipulates that CMS, at its sole discretion, may determine that the billing of one or more specified HCPCS or CPT codes represents significant, anomalous, and highly suspect billing activity for a calendar year that warrants adjustment to calculations made under this part. For example, CMS may make a SAHS determination when a given HCPCS or CPT code exhibits a level of billing 1) that represents a significant claims increase, either in volume or dollars (e.g., dollar or claims volume significantly above prior year), 2) with national or regional impact (e.g., not only impacting one or few ACOs), and 3) represents a deviation from historical utilization trends that is unexpected and is not clearly attributable to changes in policy or the supply or demand for covered items or services. The billing level is significant and represents billing activity that would cause significantly inaccurate and inequitable payments and repayment obligations in LEAD if not addressed. When CMS

determines that a SAHS billing activity has occurred, we will adjust LEAD ACOs' final financial settlement.

The Reopening policy will allow LEAD ACOs to submit a request in writing to have their final Financial Settlement reconsidered by CMS. Reopening could result in a reconsideration of a LEAD ACO's Final Settlement because of overpayments to Medicare providers or suppliers with significant individual ACO impact. More information about both policies will be made available in future guidance documents.

5.9 Financial Guarantee

LEAD ACOs must have the ability to repay all Shared Losses, accrued interest, and Other Monies Owed for which it may be liable under this Model and shall secure a financial guarantee to ensure CMS is able to recoup any Shared Losses and Other Monies Owed. ACOs who select the Global Risk Option and/or the Enhanced Primary Care Capitation (EPCC) will be required to maintain a larger financial guarantee.

The financial guarantee amount is calculated by applying the percentages in **Table 5.9.1** to Medicare Parts A and B expenditures from the 12-month period ending three months before the start of the Performance Year, adjusted to reflect the ACO's expected aligned population for the upcoming Performance Year. To estimate these expenditures, CMS will:

1. Calculate average monthly Medicare Parts A and B expenditures for beneficiaries aligned to the ACO during the 12-month period ending three months before the start of the Performance Year, with a completion factor;
2. Estimate the number of beneficiary alignment months expected during the Performance Year based on the Preliminary Alignment Estimate Report for the upcoming Performance Year; and
3. Multiply the average monthly expenditures from Step 1 by the projected beneficiary alignment months from Step 2.

This approach uses recent historical expenditures while adjusting for expected changes in ACO size for the upcoming Performance Year. The applicable percentage depends on the ACO's selected risk sharing option and capitation payment mechanism election, as shown in **Table 5.9.1**.

Financial guarantees cover Shared Losses, accrued interest, as well as Other Monies Owed, including capitated payments. In the case of an ACO that elects Primary Care Capitation and opts to receive EPCC, the financial guarantee covers the requirement for the ACO to repay the EPCC amount to CMS during financial settlement. ACOs that elect to receive the EPCC may choose to secure two separate financial guarantees (one to cover the EPCC and another to cover Shared Losses and all Other Monies Owed excluding the EPCC) or one combined financial guarantee based on the percentages displayed in **Table 5.9.1**. If an ACO elects EPCC and chooses to secure two separate financial guarantees, the two financial guarantees may be different mechanisms (e.g., Escrow for Shared Losses and applicable Other Monies Owed and Surety Bond for EPCC). ACOs that elect TCC must secure only one financial guarantee.

Table 5.9.1: Financial Guarantee Requirement by Risk Sharing Option and Capitation Payment Mechanism Election

Risk Sharing Option	Shared Losses and Base PCC Payment Only	Enhanced PCC Only *(optional)*	Combined Shared Losses, Base PCC, and Enhanced PCC Payment *(optional)*	Shared Losses and TCC Payment
Professional	2.0% of Previous Year's Parts A & B Expenditures	1.5% of Previous Year's Part A & B Expenditures	3.5% of Previous Year's Part A & B Expenditures	N/A
Global	2.5% of Previous Year's Parts A & B Expenditures	1.5% of Previous Year's Part A & B Expenditures	4.0% of Previous Year's Part A & B Expenditures	4.0% of Previous Year's Part A & B Expenditures

Previous Year's Parts A and B expenditures refer to the expenditure amount used to calculate the financial guarantee. This amount is determined by calculating average monthly Medicare Parts A and B expenditures during the 12-month period ending three months before the start of the Performance Year and multiplying those expenditures by the projected beneficiary alignment months for the upcoming Performance Year. This financial guarantee must be in one of the following three forms:

1. Funds placed in escrow,
2. A line of credit as evidenced by a letter of credit upon which CMS may draw; or
3. A surety bond.

CMS will annually notify the ACO of the amount that must be funded by its financial guarantee for the relevant Performance Year. The ACO must submit documentation of its compliance with the financial guarantee requirements by December 31 prior to the start of the Performance Year. If the ACO fails to submit such documentation, CMS will withhold monthly payments to the ACO under the ACO's selected capitation payment mechanism until the ACO has submitted the required documentation. LEAD ACOs that do not have an executed financial guarantee by the Termination Without Liability date may be terminated from participation in LEAD.

CMS uses the final Participant TIN list, after the close of the provider drop window on September 11, 2026, at 5:00 pm ET, to calculate a final financial guarantee amount for PY 2027. The amount reflects the ACO's potential liability to CMS for Shared Losses, accrued interest, and any Other Monies Owed under the terms of the Agreement. Final financial guarantee amounts are made available to ACOs during the fourth quarter of each PY.

For ACOs that select Hybrid Alignment and add new Participant TINs during the Hybrid Alignment add window (December 14 – January 14), CMS will recalculate the financial guarantee amount to incorporate expenditures associated with newly aligned beneficiaries. If the recalculated amount is more than $500,000 higher than the ACO's original financial guarantee, the ACO must update its existing financial guarantee document or obtain a new financial guarantee document within 90 calendar days of notification.

LEAD will have a mandatory draft period for financial guarantees, meaning LEAD ACOs will be required to submit draft financial guarantees for CMS to review. The due date for draft financial guarantees is September 30, 2026, at 11:59 pm ET. The purpose of the draft is to correct any deficiencies in language ahead of the deadline. A template with the draft financial guarantee language will be made available to accepted ACOs by mid-August 2026.

5.10 Extended Repayment Option

To support the participation of independent practices and ensure CMS's ability to recoup Shared Losses and payments, LEAD would include an Extended Repayment Option (ERO) that would allow ACOs that are continuing in the model and not terminating to request, subject to CMS approval and satisfaction of ERO eligibility requirements, repayment of Shared Losses or Other Monies Owed to CMS over time. The ERO would be similar to the Extended Repayment Schedule that Medicare-enrolled health care providers/suppliers are able to request.

Appendix A. PQEM Codes Used for Claims-Based Alignment

(Subject to slight modifications ahead of each Performance Year.)

HCPCS	Long Descriptor
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
99304	Initial Nursing Facility Care
99305	Initial Nursing Facility Care
99306	Initial Nursing Facility Care
99307	Subsequent Nursing Facility Care
99308	Subsequent Nursing Facility Care
99309	Subsequent Nursing Facility Care
99310	Subsequent Nursing Facility Care
99315	Nursing Facility Discharge Services
99316	Nursing Facility Discharge Services
99318	Other Nursing Facility Care
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
99339	Brief
99340	Comprehensive
99341	New Patient, brief

HCPCS	Long Descriptor
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
99354	Prolonged visit, first hour
99355	Prolonged visit, additional 30 mins
G2212	Prolonged visit, additional 15 mins
99421	Online digital, Established Patient, 5–10 mins
99422	Online digital, Established Patient, 10–20 mins
99423	Online digital, Established Patient, 21+ mins
99424	Principal Care Management (PCM)
99425	Principal Care Management (PCM)
99426	Principal Care Management (PCM)
99427	Principal Care Management (PCM)
99437	Principal Care Management (PCM)
99441	Phone, Established Patient, 5–10 mins
99442	Phone, Established Patient, 10–20 mins
99443	Phone, Established Patient, 21+ mins
GFCI1	Post-Discharge Telephonic Follow-up Contacts Intervention
G2010	Remote evaluation, Established Patient
G2012	Brief communication technology-based service, 5-10 mins of medical discussion
G2252	Brief communication technology-based service, 11-20 minutes of medical discussion
99457	Remote Physiologic Monitoring
99458	Remote Physiologic Monitoring
G9481	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology or just “Remote e/m new pt 10mins” for short, used in medical care.

HCPCS	Long Descriptor
G9482	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9483	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9484	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9485	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.
G9486	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires at least 2 of the following 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9487	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires at least 2 of the following 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology

HCPCS	Long Descriptor
G9488	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires at least 2 of the following 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
G9489	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center demonstration project, which requires at least 2 of the following 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology
98016	Virtual Check-in Service
99439	Non-complex chronic care management services, additional 30 min
99487	Extended care coordination time for especially complex patients (first 60 mins)
99489	Additional care coordination time for especially complex patients (30 mins)
99490	Comprehensive care plan establishment/implementations/revision/monitoring
99491	Chronic care monitoring service, moderate
G0506	Additional work for the billing provider in face-to-face assessment or CCM planning
G2058	Non-Complex Chronic Care Management Service
G2064	Comprehensive care management, physician
G2065	Comprehensive care management, clinical staff
GCDRA	Cardiovascular Risk Assessment and Risk Management Services
GCDRM	Cardiovascular Risk Assessment and Risk Management Services
99483	Cognitive assessment and care plan services
99484	Monthly services furnished using BHI models
99492	Initial psychiatric collaborative care management, first 70 mins
99493	Subsequent psychiatric collaborative care management, first 60 mins
99494	Initial or subsequent psychiatric collaborative care management, additional ’30 mins
G2214	Psychiatric collaborative care management
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
G2001	Brief (20 minutes) in-home visit for a new patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary’s home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)

HCPCS	Long Descriptor
G2002	Limited (30 minutes) in-home visit for a new patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2003	Moderate (45 minutes) in-home visit for a new patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2004	Comprehensive (60 minutes) in-home visit for a new patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2005	Extensive (75 minutes) in-home visit for a new patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2006	Brief (20 minutes) in-home visit for an existing patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2007	Limited (30 minutes) in-home visit for an existing patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2008	Moderate (45 minutes) in-home visit for an existing patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2009	Comprehensive (60 minutes) in-home visit for an existing patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2013	Extensive (75 minutes) in-home visit for an existing patient post-discharge. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
99497	ACP first 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
99498	ACP additional 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
G0076	Brief (20 minutes) care management home visit for a new patient.
G0077	Limited (30 minutes) care management home visit for a new patient.
G0078	Moderate (45 minutes) care management home visit for a new patient.
G0079	Comprehensive (60 minutes) care management home visit for a new patient.
G0080	Extensive (75 minutes) care management home visit for a new patient.
G0081	Brief (20 minutes) care management home visit for an existing patient.
G0082	Limited (30 minutes) care management home visit for an existing patient.

HCPCS	Long Descriptor
G0083	Moderate (45 minutes) care management home visit for an existing patient.
G0084	Comprehensive (60 minutes) care management home visit for an existing patient.
G0085	Extensive (75 minutes) care management home visit for an existing patient.
G0086	Limited (30 minutes) care management home care plan oversight.
G0087	Comprehensive (60 minutes) care management home care plan oversight.
G0317	Prolonged nursing facility evaluation and management service
G0318	Prolonged home or residence evaluation and management
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
G0463	Professional Services Provided in ETA Hospitals
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis;
G3003	Additional 15m pain management
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time
99406	Counseling to Prevent Tobacco
99407	Counseling to Prevent Tobacco
G0101	Cervical or Vaginal Cancer Screening
G0136	Cervical or Vaginal Cancer Screening
G2086	Office Based Opioid Use Disorder Services
G2087	Office Based Opioid Use Disorder Services
G2088	Office Based Opioid Use Disorder Services
96202	Caregiver Behavior Management Training CPT
96203	Caregiver Behavior Management Training CPT
97550	Codes for caregiver training services
97551	Codes for caregiver training services
97552	Codes for caregiver training services
GCTD1	Direct Care Caregiver Training Services
GCTD2	Direct Care Caregiver Training Services
GCTD3	Direct Care Caregiver Training Services
GCTB1	Individual Behavior Management/Modification Caregiver Training Services
GCTB2	Individual Behavior Management/Modification Caregiver Training Services
G0023	Principal Illness Navigation (PIN) services

HCPCS	Long Descriptor
G0024	Principal Illness Navigation (PIN) services
99446	Interprofessional Consultation Services
99447	Interprofessional Consultation Services
99448	Interprofessional Consultation Services
99449	Interprofessional Consultation Services
99451	Interprofessional Consultation Services
99452	Interprofessional Consultation Services
G0019	Community Health Integration services HCPCS
G0022	Community Health Integration services HCPCS
GPCM1	Behavioral health integration add-on when furnished with advanced primary care management services
GPCM2	Behavioral health integration add-on when furnished with advanced primary care management services
GPCM3	Psychiatric collaborative care model add-on when furnished with advanced primary care management services
G2014	Limited (30 minutes) care plan oversight. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)
G2015	Comprehensive (60 mins) home care plan oversight. for use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility.)
G0519	Management of new patient-caregiver dyad with dementia, low complexity, for use in CMMI Model
G0520	Management of new patient-caregiver dyad with dementia, moderate complexity, for use in CMMI Model
G0521	Management of new patient-caregiver dyad with dementia, high complexity, for use in CMMI Model
G0522	Management of a new patient with dementia, low complexity, for use in CMMI Model
G0523	Management of a new patient with dementia, moderate/severe complexity, for use in CMMI Model
G0524	Management of established patient-caregiver dyad with dementia, low complexity, for use in CMMI Model
G0525	Management of established patient-caregiver dyad with dementia, moderate complexity, for use in CMMI Model
G0526	Management of established patient-caregiver dyad with dementia, high complexity, for use in CMMI Model
G0527	Management of established patient with cognitive impairment with dementia, low complexity, for use in CMMI Model
G0528	Management of established patient with cognitive impairment, moderate/high complexity, for use in CMMI Model
GSPI1	Safety Planning Interventions
G2211	Complex Evaluation and Management Services Add-on
G0537	Administration of a standardized, evidence-based atherosclerotic cardiovascular disease (ascvd) risk assessment, 5-15 minutes, not more often than every 12 months

HCPCS	Long Descriptor
G0538	Atherosclerotic cardiovascular disease (ascvd) risk management services; clinical staff time; per calendar month
G0539	Caregiver training in behavior management or modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540	Caregiver training in behavior management or modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; initial 30 minutes
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; each additional 15 minutes
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face with multiple sets of caregivers
G0544	Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month
G0556	Advanced primary care management services for a patient with one chronic condition or fewer, per calendar month
G0557	Advanced primary care management services for a patient with multiple (two or more) chronic conditions, per calendar month
G0558	Advanced primary care management services for a patient that is a qualified Medicare beneficiary with multiple (two or more) chronic conditions, per calendar month
G0560	Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of personalized elements of a safety plan

Appendix B. Codes Related to High Needs Eligibility Criteria

The following diagnoses for mobility-related conditions are drawn primarily from the list of Other Chronic or Potentially Disabling Conditions in the CMS Chronic Condition Data Warehouse. Per the Chronic Condition Data Warehouse guidelines, a beneficiary will qualify as meeting the mobility impairment High Needs eligibility criteria during the applicable lookback window if they have one inpatient claim (claim type 60) or two or more non-inpatient claims with different dates of service with a diagnosis from Table B.1.

Table B.1: Mobility Impairment ICD-10 Codes for High Needs Eligibility

Category	ICD-10 Codes
Cerebral Palsy	G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9
Cystic Fibrosis and Other Metabolic Developmental Disorders	D81.810, D84.1, E00.0, E00.1, E00.2, E00.9, E03.0, E03.1, E25.0, E25.8, E25.9, E56.9, E70.0, E70.1, E70.20, E70.21, E70.29, E70.30, E70.310, E70.311, E70.318, E70.319, E70.320, E70.321, E70.328, E70.329, E70.330, E70.331, E70.338, E70.339, E70.39, E70.5, E70.8, E70.81, E70.89, E70.9, E71.0, E71.110, E71.111, E71.118, E71.19, E71.2, E71.310, E71.311, E71.312, E71.313, E71.314, E71.318, E71.32, E71.41, E72.10, E72.11, E72.12, E72.19, E72.20, E72.21, E72.22, E72.23, E72.29, E72.3, E72.4, E72.50, E72.51, E72.59, E72.8, E74.20, E74.21, E74.29, E74.810, E74.818, E74.819, E74.89, E84.0, E84.11, E84.19, E84.8, E84.9
Mobility Impairments	G04.1, G11.4, G81.00, G81.01, G81.02, G81.03, G81.04, G81.10, G81.11, G81.12, G81.13, G81.14, G81.90, G81.91, G81.92, G81.93, G81.94, G82.20, G82.21, G82.22, G82.50, G82.51, G82.52, G82.53, G82.54, G83.0, G83.10, G83.11, G83.12, G83.13, G83.14, G83.20, G83.21, G83.22, G83.23, G83.24, G83.30, G83.31, G83.32, G83.33, G83.34, G83.4, G83.5, G83.81, G83.82, G83.83, G83.84, G83.89, G83.9, I69.031, I69.032, I69.033, I69.034, I69.039, I69.041, I69.042, I69.043, I69.044, I69.049, I69.051, I69.052, I69.053, I69.054, I69.059, I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.131, I69.132, I69.133, I69.134, I69.139, I69.141, I69.142, I69.143, I69.144, I69.149, I69.151, I69.152, I69.153, I69.154, I69.159, I69.161, I69.162, I69.163, I69.164, I69.165, I69.169, I69.231, I69.232, I69.233, I69.234, I69.239, I69.241, I69.242, I69.243, I69.244, I69.249, I69.251, I69.252, I69.253, I69.254, I69.259, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.331, I69.332, I69.333, I69.334, I69.339, I69.341, I69.342, I69.343, I69.344, I69.349, I69.351, I69.352, I69.353, I69.354, I69.359, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.831, I69.832, I69.833, I69.834, I69.839, I69.841, I69.842, I69.843, I69.844, I69.849, I69.851, I69.852, I69.853, I69.854, I69.859, I69.861, I69.862, I69.863, I69.864, I69.865, I69.869, I69.931, I69.932, I69.933, I69.934, I69.939, I69.941, I69.942, I69.943, I69.944, I69.949, I69.951, I69.952, I69.953, I69.954, I69.959, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969
Multiple Sclerosis and Transverse Myelitis	G35, G36.0, G36.1, G36.8, G36.9, G37.1, G37.2, G37.3, G37.4, G37.8, G37.9
Muscular Dystrophy	G71.0, G71.00, G71.01, G71.02, G71.09, G71.11, G71.2, G71.20, G71.21, G71.220, G71.228, G71.29
Spina Bifida and Other Congenital Anomalies of the Nervous System	G90.1, Q00.0, Q00.1, Q00.2, Q01.0, Q01.1, Q01.2, Q01.8, Q01.9, Q02, Q03.0, Q03.1, Q03.8, Q03.9, Q04.0, Q04.1, Q04.2, Q04.3, Q04.4, Q04.5, Q04.6, Q04.8, Q04.9, Q05.0, Q05.1, Q05.2, Q05.3, Q05.4, Q05.5, Q05.6, Q05.7, Q05.8, Q05.9, Q06.0, Q06.1, Q06.2, Q06.3, Q06.4, Q06.8, Q06.9, Q07.00, Q07.01, Q07.02, Q07.03, Q07.8, Q07.9

Category	ICD-10 Codes
Spinal Cord Injury	G96.11, S12.000A, S12.001A, S12.100A, S12.101A, S12.200A, S12.201A, S12.300A, S12.301A, S12.400A, S12.401A, S12.500A, S12.501A, S12.600A, S12.601A, S12.9XXA, S12.000B, S12.001B, S12.100B, S12.101B, S12.200B, S12.201B, S12.300B, S12.301B, S12.400B, S12.401B, S12.500B, S12.501B, S12.600B, S12.601B, S14.0XXA, S14.0XXS, S14.101A, S14.102A, S14.103A, S14.104A, S14.105A, S14.106A, S14.107A, S14.108A, S14.109A, S14.111A, S14.112A, S14.113A, S14.114A, S14.115A, S14.116A, S14.117A, S14.118A, S14.119A, S14.121A, S14.122A, S14.123A, S14.124A, S14.125A, S14.126A, S14.127A, S14.128A, S14.129A ,S14.131A, S14.132A, S14.133A, S14.134A, S14.135A, S14.136A, S14.137A, S14.138A, S14.139A, S14.141A, S14.142A, S14.143A, S14.144A, S14.145A, S14.146A, S14.147A, S14.148A, S14.149A, S14.151A, S14.152A, S14.153A, S14.154A, S14.155A, S14.156A, S14.157A, S14.158A, S14.159A, S14.101S, S14.102S, S14.103S, S14.104S, S14.105S, S14.106S, S14.107S, S14.108S, S14.109S, S14.111S, S14.112S, S14.113S, S14.114S, S14.115S, S14.116S, S14.117S, S14.118S, S14.119S, S14.121S, S14.122S, S14.123S, S14.124S, S14.125S, S14.126S, S14.127S, S14.128S, S14.129S, S14.131S, S14.132S, S14.133S, S14.134S, S14.135S, S14.136S, S14.137S, S14.138S, S14.139S, S14.141S, S14.142S, S14.143S, S14.144S, S14.145S, S14.146S, S14.147S, S14.148S, S14.149S, S14.151S, S14.152S, S14.153S, S14.154S, S14.155S, S14.156S, S14.157S, S14.158S, S14.159S, S22.009A, S22.019A, S22.029A, S22.039A, S22.049A, S22.059A, S22.069A, S22.079A, S22.089A, S22.009B, S22.019B, S22.029B, S22.039B, S22.049B, S22.059B, S22.069B, S22.079B, S22.089B, S24.0XXA, S24.101A, S24.102A, S24.103A, S24.104A, S24.109A, S24.111A, S24.112A, S24.113A, S24.114A, S24.119A, S24.131A, S24.132A, S24.133A, S24.134A, S24.139A, S24.141A, S24.142A, S24.143A, S24.144A, S24.149A, S24.151A, S24.152A, S24.153A, S24.154A, S24.159A, S24.0XXS, S24.101S, S24.102S, S24.103S, S24.104S, S24.109S, S24.111S, S24.112S, S24.113S, S24.114S, S24.119S, S24.131S, S24.132S, S24.133S, S24.134S, S24.139S, S24.141S, S24.142S, S24.143S, S24.144S, S24.149S, S24.151S, S24.152S, S24.153S, S24.154S, S24.159S, S32.009A, S32.019A, S32.029A, S32.039A, S32.049A, S32.059A, S32.009B, S32.019B, S32.029B, S32.039B, S32.049B, S32.059B, S32.10XA, S32.2XXA, S32.10XB, S32.2XXB, S34.01XA, S34.02XA, S34.101A, S34.102A, S34.103A, S34.104A, S34.105A, S34.109A, S34.111A, S34.112A, S34.113A, S34.114A, S34.115A, S34.119A, S34.121A, S34.122A, S34.123A, S34.124A, S34.125A, S34.129A, S34.131A, S34.132A, S34.139A, S34.3XXA, S34.01XS, S34.02XS, S34.101S, S34.102S, S34.103S, S34.104S, S34.105S, S34.109S, S34.111S, S34.112S, S34.113S, S34.114S, S34.115S, S34.119S, S34.121S, S34.122S, S34.123S, S34.124S, S34.125S, S34.129S, S34.131S, S34.132S, S34.139S
Functional Quadriplegia	R53.2
Heart Failure	I50.84
Alpers Disease	G31.81
Pressure Ulcers	L89.013, L89.014, L89.023, L89.024, L89.103, L89.104, L89.113, L89.114, L89.123, L89.124, L89.133, L89.134, L89.143, L89.144, L89.153, L89.154, L89.203, L89.204, L89.213, L89.214, L89.223, L89.224, L89.303, L89.304, L89.313, L89.314, L89.323, L89.324, L89.43, L89.44, L89.503, L89.504, L89.513, L89.514, L89.523, L89.524, L89.603, L89.604, L89.613, L89.614, L89.623, L89.624, L89.813, L89.814, L89.893, L89.894
Ventilator Dependence	Z99.11

The following list of codes is used to identify beneficiaries who meet the DME-based frailty High Needs eligibility criteria. A beneficiary will qualify as meeting these criteria if they have a claim with a HCPCS code from Table B.2 during the applicable lookback window.

Table B.2: Frailty Codes for High Needs Eligibility Criteria

Category	ICD-10 Code	Long Descriptor
Transfer Equipment	E0172	Seat lift mechanism placed over or on top of toilet, any type
Transfer Equipment	E0621	Sling or seat, patient lift, canvas, or nylon
Transfer Equipment	E0625	Patient lift, bathroom or toilet, not otherwise classified
Transfer Equipment	E0627	Seat lift mechanism, electric, any type
Transfer Equipment	E0628	Separate seat lift mechanism for use with patient owned furniture-electric
Transfer Equipment	E0629	Seat lift mechanism, non-electric, any type
Transfer Equipment	E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)
Transfer Equipment	E0635	Patient lift, electric with seat or sling
Transfer Equipment	E0636	Multi-positional patient support system, with integrated lift, patient accessible controls
Transfer Equipment	E0637	Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
Transfer Equipment	E0638	Standing frame/table system, one position (e.g., upright, supine, or prone stander), any size including pediatric, with or without wheels
Transfer Equipment	E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories
Transfer Equipment	E0640	Patient lift, fixed system, includes all components/accessories
Transfer Equipment	E0641	Standing frame/table system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels
Transfer Equipment	E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric
Transfer Equipment	E0700	Safety equipment, device or accessory, any type
Transfer Equipment	E0705	Transfer device, any type, each
Transfer Equipment	E0710	Restraints, any type (body, chest, wrist, or ankle)
Transfer Equipment	E0910	Trapeze bars, aka patient helper, attached to bed, with grab bar
Transfer Equipment	E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
Transfer Equipment	E0912	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
Transfer Equipment	E0940	Trapeze bar, free standing, complete with grab bar
Transfer Equipment	E1035	Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs
Transfer Equipment	E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs.
Hospital Bed	E0194	Air fluidized bed

Category	ICD-10 Code	Long Descriptor
Hospital Bed	E0250	Hospital bed, fixed height, with any type side rails, with mattress
Hospital Bed	E0251	Hospital bed, fixed height, with any type side rails, without mattress
Hospital Bed	E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
Hospital Bed	E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress
Hospital Bed	E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
Hospital Bed	E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
Hospital Bed	E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
Hospital Bed	E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
Hospital Bed	E0270	Hospital bed, institutional type includes oscillating, circulating and stryker frame, with mattress
Hospital Bed	E0271	Mattress, innerspring
Hospital Bed	E0272	Mattress, foam rubber
Hospital Bed	E0273	Bed board
Hospital Bed	E0274	Over-bed table
Hospital Bed	E0277	Powered pressure-reducing air mattress
Hospital Bed	E0280	Bed cradle, any type
Hospital Bed	E0290	Hospital bed, fixed height, without side rails, with mattress
Hospital Bed	E0291	Hospital bed, fixed height, without side rails, without mattress
Hospital Bed	E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
Hospital Bed	E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
Hospital Bed	E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
Hospital Bed	E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
Hospital Bed	E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress
Hospital Bed	E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress
Hospital Bed	E0301	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
Hospital Bed	E0302	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
Hospital Bed	E0303	Hospital bed, heavy duty, extra-wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress

Category	ICD-10 Code	Long Descriptor
Hospital Bed	E0304	Hospital bed, extra heavy duty, extra-wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
Hospital Bed	E0305	Bed side rails, half length
Hospital Bed	E0310	Bed side rails, full length
Hospital Bed	E0315	Bed accessory: board, table, or support device, any type
Hospital Bed	E0316	Safety enclosure frame/canopy for use with hospital bed, any type
Hospital Bed	E0370	Air pressure elevator for heel
Hospital Bed	E0371	Nonpowered advanced pressure-reducing overlay for mattress, standard mattress length and width
Hospital Bed	E0372	Powered air overlay for mattress, standard mattress length and width
Hospital Bed	E0373	Nonpowered advanced pressure-reducing mattress
Hospital Bed	E0462	Rocking bed with or without side rails

Appendix C. Skin Substitute HCPCs Codes

Table C.1: List of Skin Substitute HCPCs Codes Used in Applicable LEAD Financial Calculations

A2001, A2002, A2005, A2006, A2007, A2008, A2009, A2010, A2011, A2012, A2013, A2015, A2016, A2018, A2019, A2021, A2022, A2024, A2027, Q4101, Q4102, Q4103, Q4104, Q4105, Q4106, Q4107, Q4108, Q4110, Q4111, Q4115, Q4116, Q4117, Q4121, Q4122, Q4123, Q4124, Q4125, Q4126, Q4127, Q4128, Q4130, Q4132, Q4133, Q4134, Q4135, Q4136, Q4137, Q4138, Q4140, Q4141, Q4142, Q4143, Q4146, Q4147, Q4148, Q4150, Q4151, Q4152, Q4153, Q4154, Q4156, Q4157, Q4158, Q4159, Q4160, Q4161, Q4163, Q4164, Q4165, Q4166, Q4167, Q4169, Q4170, Q4173, Q4175, Q4176, Q4178, Q4179, Q4180, Q4181, Q4182, Q4183, Q4184, Q4186, Q4187, Q4188, Q4190, Q4191, Q4193, Q4194, Q4195, Q4196, Q4197, Q4198, Q4199, Q4200, Q4201, Q4203, Q4204, Q4205, Q4208, Q4209, Q4211, Q4214, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4222, Q4225, Q4226, Q4227, Q4229, Q4232, Q4234, Q4235, Q4236, Q4237, Q4238, Q4239, Q4247, Q4248, Q4249, Q4250, Q4251, Q4252, Q4253, Q4254, Q4255, Q4256, Q4257, Q4258, Q4259, Q4260, Q4261, Q4262, Q4263, Q4264, Q4265, Q4266, Q4267, Q4268, Q4269, Q4270, Q4271, Q4272, Q4273, Q4274, Q4275, Q4276, Q4278, Q4279, Q4280, Q4281, Q4282, Q4283, Q4284, Q4285, Q4286, Q4287, Q4288, Q4289, Q4290, Q4291, Q4292, Q4293, Q4294, Q4295, Q4296, Q4297, Q4298, Q4299, Q4300, Q4301, Q4302, Q4303, Q4304, Q4305, Q4306, Q4307, Q4308, Q4309, Q4311, Q4312, Q4313, Q4314, Q4315, Q4316, Q4317, Q4318, Q4319, Q4320, Q4321, Q4322, Q4323, Q4324, Q4325, Q4326, Q4327, Q4328, Q4329, Q4330, Q4331, Q4332, Q4333, Q4334, Q4335, Q4336, Q4337, Q4338, Q4339, Q4340, Q4341, Q4342, Q4343, Q4344, Q4345, Q4346, Q4347, Q4348, Q4349, Q4350, Q4351, Q4352, Q4353, Q4354, Q4355, Q4356, Q4357, Q4358, Q4359, Q4360, Q4361, Q4362, Q4363, Q4364, Q4365, Q4366, Q4367, Q4368, Q4369, Q4370, Q4371, Q4372, Q4373, Q4375, Q4376, Q4377, Q4378, Q4379, Q4380, Q4382

Appendix D HCPCS Codes Used to Calculate Primary Care Capitation (PCC) Payment

Codes used to calculate the Base PCC Amount are subject to sufficient claims history and are subject to change.

HCPCS Code	Long Descriptor
96160	Administration of patient-focused health risk assessment instrument
96161	Administration of caregiver-focused health risk assessment instrument
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
99304	Initial Nursing Facility Care
99305	Initial Nursing Facility Care
99306	Initial Nursing Facility Care
99307	Subsequent Nursing Facility Care
99308	Subsequent Nursing Facility Care
99309	Subsequent Nursing Facility Care
99310	Subsequent Nursing Facility Care
99315	Nursing Facility Discharge Services
99316	Nursing Facility Discharge Services
99318	Other Nursing Facility Care
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
99339	Brief

HCPCS Code	Long Descriptor
99340	Comprehensive
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
99354	Prolonged visit, first hour
99355	Prolonged visit, additional 30 mins
G2212	Prolonged visit, additional 15 mins
99421	Online digital, Established Patient, 5–10 mins
99422	Online digital, Established Patient, 10–20 mins
99423	Online digital, Established Patient, 21+ mins
99424	Principal Care Management (PCM)
99425	Principal Care Management (PCM)
99426	Principal Care Management (PCM)
99427	Principal Care Management (PCM)
99437	Principal Care Management (PCM)
99441	Phone, Established Patient, 5–10 mins
99442	Phone, Established Patient, 10–20 mins
99443	Phone, Established Patient, 21+ mins
G2010	Remote evaluation, Established Patient
G2012	Brief communication technology-based service, 5-10 mins of medical discussion
G2252	Brief communication technology-based service, 11-20 minutes of medical discussion
98016	Virtual Check-in Service
99439	Non-complex chronic care management services, additional 30 min
99487	Extended care coordination time for especially complex patients (first 60 mins)
99489	Additional care coordination time for especially complex patients (30 mins)
99490	Comprehensive care plan establishment/implementations/revision/monitoring
99491	Chronic care monitoring service, moderate
G0506	Additional work for the billing provider in face-to-face assessment or CCM planning
G2064	Comprehensive care management, physician
G2065	Comprehensive care management, clinical staff

HCPCS Code	Long Descriptor
G0537	Cardiovascular Risk Assessment and Risk Management Services
G0538	Cardiovascular Risk Assessment and Risk Management Services
99483	Cognitive assessment and care plan services
99484	Monthly services furnished using BHI models
99492	Initial psychiatric collaborative care management, first 70 mins
99493	Subsequent psychiatric collaborative care management, first 60 mins
99494	Initial or subsequent psychiatric collaborative care management, additional ’30 mins
G2214	Psychiatric collaborative care management
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
99497	ACP first 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
99498	ACP additional 30 mins (subject to exclusion if beneficiary has an overlapping inpatient stay, per proposed Medicare Shared Savings Program regulation)
G0076	Brief (20 minutes) care management home visit for a new patient.
G0077	Limited (30 minutes) care management home visit for a new patient.
G0078	Moderate (45 minutes) care management home visit for a new patient.
G0079	Comprehensive (60 minutes) care management home visit for a new patient.
G0080	Extensive (75 minutes) care management home visit for a new patient.
G0081	Brief (20 minutes) care management home visit for an existing patient.
G0082	Limited (30 minutes) care management home visit for an existing patient.
G0083	Moderate (45 minutes) care management home visit for an existing patient.
G0084	Comprehensive (60 minutes) care management home visit for an existing patient.
G0085	Extensive (75 minutes) care management home visit for an existing patient.
G0086	Limited (30 minutes) care management home care plan oversight.
G0087	Comprehensive (60 minutes) care management home care plan oversight.
G0317	Prolonged nursing facility evaluation and management service
G0318	Prolonged home or residence evaluation and management
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
G0442	Annual alcohol misuse screening
G0443	Annual alcohol misuse counseling
G0444	Annual depression screening
G0463	Professional Services Provided in ETA Hospitals
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis;
G3003	Additional 15m pain management

HCPCS Code	Long Descriptor
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time
G0136	Cervical or Vaginal Cancer Screening
97550	Codes for caregiver training services
97551	Codes for caregiver training services
97552	Codes for caregiver training services
G0023	Principal Illness Navigation (PIN) services
G0024	Principal Illness Navigation (PIN) services
99446	Interprofessional Consultation Services
99447	Interprofessional Consultation Services
99448	Interprofessional Consultation Services
99449	Interprofessional Consultation Services
99451	Interprofessional Consultation Services
99452	Interprofessional Consultation Services
G0019	Community Health Integration services HCPCS
G0022	Community Health Integration services HCPCS
G0537	Administration of a standardized, evidence-based atherosclerotic cardiovascular disease (ASCVD) risk assessment, 5-15 minutes, not more often than every 12 months
G0538	Atherosclerotic cardiovascular disease (ASCVD) risk management services; clinical staff time; per calendar month
G0539	Caregiver training in behavior management or modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540	Caregiver training in behavior management or modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; initial 30 minutes
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; each additional 15 minutes
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face with multiple sets of caregivers
G0544	Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month
G0560	Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of personalized elements of a safety plan