



COMPARISON CHART





ACO Comparison Chart

This chart details key elements of: Medicare Shared Savings Program (MSSP); Realizing Equity, Access, and Community Health (REACH) ACOs; and Long-term Enhanced ACO Design Model (LEAD).

Reflects current/anticipated policies in effect for 2026/2027 (announced by CMS as of March 2026).

	MSSP Basic Level A/B	MSSP Basic Level C/D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global	LEAD Professional	LEAD Global
Number of ACOs	121	12	82	296	9	65	TBD	TBD
Length of contract	Five years				2021 starters = 5 years + 9 months 2022 starters = 5 years 2023 starters = 4 years		2027 starters = 10 years	
Participation opportunities	Annual MSSP application cycle opens each spring. ACOs must submit a notice of intent to apply (NOIA) in order to be eligible to submit a full application.				No future application cycles planned at this time.		Application cycle #1 in 2026 to begin participation January 2027. Abbreviated application for current REACH ACOs. CMS to offer pre-implementation period. Future application cycles likely but timing and frequency not announced. ACO should submit LOI (to be released around 4/20/2026).	
Status under MACRA	MIPS APM				Advanced APM		Advanced APM	
Governance requirements	ACO participants must hold at least 75% control over the governing board. Each ACO's governing board must include at least one Medicare FFS beneficiary who is served by the ACO, and this beneficiary representative must have full voting rights.				Participant providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a separate consumer advocate, each with full voting rights.		Participant providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a separate consumer advocate, each with full voting rights. 2 options for beneficiary representation: 1 beneficiary on the board; OR A beneficiary and consumer advisory committee (min. 5 members)	

FINANCIAL STRUCTURE

	MSSP Basic Level A/B	MSSP Basic Level C/D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global	LEAD Professional	LEAD Global				
Risk-sharing arrangement	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 75% 1st dollar losses at 40– 75%	1st dollar savings and losses at 50%	1st dollar savings and losses at 100%	1st dollar savings and losses at 50%. 1% of benchmark required to be passed on to Participant providers. ACO choosing Professional risk must remain in that option for at least four years. After four years, may – but is not required to – move to Global.	1st dollar savings and losses at 1% of benchmark required to be passed on to Participant providers. 100%				
Shared savings cap	10% of updated benchmark			20% of updated benchmark	<u>Gross (S/L):</u> < 5%	<u>Cap (S/L):</u> 50%	<u>Gross (S/L):</u> < 25%	<u>Cap (S/L):</u> 100%	<u>Gross (S/L):</u> < 10%	<u>Cap (S/L):</u> 50%	<u>Gross (S/L):</u> < 15%	<u>Cap (S/L):</u> 100%
Shared losses cap	Not applicable	Lesser of 2%/4% of total Medicare Parts A & B FFS revenue or 1%/2% of updated benchmark	Lesser of 8% of total Medicare Parts A & B FFS revenue or 4% of updated benchmark	15% of updated benchmark	5%-10% 10%-15% > 15%	35% 15% 5%	< 25% 25%-35% 35%-50% > 50%	50% 25% 10%	< 10% 10%-15% 15%-20% > 20%	35% 15% 5%	< 15% 15%-35% 35%-50% > 50%	50% 25% 10%
Discount or MSR/MLR	MSR will be 2% to 3.9% depending on number of assigned beneficiaries. Smaller ACOs have higher MSR (5,000 assigned beneficiaries = 3.9% MSR) and larger ACOs have lower MSR, (2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.		Prior to entering a two-sided model, the ACO must select its MSR/ MLR as part of the application cycle. The choices are: <ul style="list-style-type: none"> 0% MSR/MLR Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0% Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO. 		<ul style="list-style-type: none"> No MSR/MLR No discount 		<ul style="list-style-type: none"> No MSR/MLR Discount applied to the PY benchmark: 3% (PY2023-2024) 3.5% (PY2025-2026) 		<ul style="list-style-type: none"> No MSR/MLR No discount 		<ul style="list-style-type: none"> No MSR/MLR Discount applied to the PY benchmark: • Lower-Spending ACOs: 3% • Higher-Spending ACOs: 1.75%, increasing .25% annually up to 3% in PY6 	
Beginning in 2024, low revenue ACOs in the Basic Track may share in a portion of savings if the MSR is not exceeded; Levels A & B at 20%; Levels C, D, & E at 25%												
Transition to two-sided model	New, inexperienced ACOs may participate in Basic Level A for a full 5-year agreement period. In a subsequent agreement period, inexperienced ACOs that remain eligible are permitted to progress through Basic Levels A-E, which provides 2 additional years under upside-only (7 years total before downside risk). If ineligible to continue in the glidepath for the second agreement period, ACOs can participate in Level E for all 5 years of the agreement period.			Optional for all ACOs. ACOs may transition back to Level E from Enhanced.	No one-sided model under ACO REACH.				No one-sided model under LEAD.			
Benchmark	CMS establishes and rebases MSSP ACO benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual, and aged/non-dual). CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year. ACOs with spending higher than their region have a regional adjustment weight of 15%, ACOs with spending lower than their region receive a weight of 35% in the first agreement year. If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement. Beginning in 2024, CMS will: <ul style="list-style-type: none"> Incorporate a prospective administrative growth factor based on US per capita cost to update an ACO's benchmark each performance year, creating a new three-way blend. The new update factor would look as follows: <ul style="list-style-type: none"> Two-way blend = (National Update Factor x National Weight) + (Regional Update Factor x (1 – National Weight)) Three-way blend = [PY1 ACPT x (1/3)] + [PY1 Two-Way Blend x (2/3)] Account for an ACO's prior savings when establishing benchmarks for renewing and re-entering ACOs. Reduce the cap on negative regional adjustments from -5 to -1.5 percent. 				Prospective blend of historical spending and adjusted Medicare Advantage Rate Book <ul style="list-style-type: none"> Standard ACOs using claims-based alignment: fixed 3-year baseline period (2017-19), with application of a trend adjustment and geographic adjustment Standard ACOs using voluntary alignment, New Entrant ACOs, & High Needs ACOs: only regional expenditures through PY2024 (historical expenditures incorporated beginning PY2025) 				<ul style="list-style-type: none"> Base Years = 2024-2026; No rebasing over the 10-year performance period; Newly Entering: weighted 10-30-60; All other ACOS: equally weighted Benchmark initially based only on historical costs, plus an additional capitated payment incentive for higher spending ACOs. Use of standardized, rate book-based benchmarks in the second half of the model. ACO-Specific Benchmark Adjustments <ul style="list-style-type: none"> Regional Efficiency Adjustment (Global only): Lower Spending ACOS receive 50% positive regional adjustment. Prior Savings Adjustment: Based on savings generated in Base Years; 50% of prorated average per-capita savings. 1.5% Administrative Add-On Capitation: For Higher-Spending ACOs; not reconciled and not repaid. Adjustment Cap: 3% for ACOs coming from MSSP; 5% for all other ACOs Annual benchmarks updated using a blend of actual national and regional spending trends and ACPT prospective trend with guardrails. <ul style="list-style-type: none"> Separate calculations for A&D, ESRD, High Needs ACPT guardrails: limits update factor to within +.2/- .2 percentage points of regional/national blended update factor; guardrail increases over time. High needs patients will have a separate benchmark and trend 			

				factor, using concurrent risk adjustment.	
Risk Adjustment	<p>CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year. Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent for each agreement period.</p> <p>Beginning in 2024, CMS will account for changes in demographic risk scores before applying the 3 percent cap and the +3 percent cap will apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual, and aged/non-dual)</p>	<p>CMS will risk adjust historical baseline, regional expenditures, and capitated payments</p> <ul style="list-style-type: none"> For Standard & New Entrant ACOs: CMS-HCC prospective risk adjustment model High Needs ACOs: CMMI-HCC concurrent risk adjustment model for aged & duals, CMS-HCC prospective risk adjustment model for ESRD <p>To control potential increases in coding intensity and risk score growth, CMS will use a normalization factor, a Coding Intensity Factor, and a risk score cap. Additional details on risk adjustment</p>		<p>CMS will risk adjust historical baseline, regional expenditures, and capitated payments. CMS will use CMMI-HCC concurrent risk adjustment for all high needs patients and prospective CMS-HCC prospective risk adjustment for others.</p> <ul style="list-style-type: none"> Growth Cap <ul style="list-style-type: none"> For A&D and ESRD: 3% growth cap on A&D using BY 3 as a static reference year For High Needs: TBD, 3%-8% AI-Inferred Risk Adjustment (for A&D population only) <ul style="list-style-type: none"> 2028: shadow test 2029: blend of AI-inferred and HCC 2031: full AI-inferred 	
Payment options	CMS makes all FFS payments	<p>Primary Care Capitation (PCC) = monthly payments for primary care services ~2-7% of TCOC (CMS pays claims for all other services)</p> <ul style="list-style-type: none"> Fee reduction required for Participant Providers, optional for Preferred Providers Optional Advanced Payment up to 100% of benchmark w/ reconciliation 	<ul style="list-style-type: none"> Fee reduction required for Participant Providers, optional for Preferred Providers 	<ul style="list-style-type: none"> Primary Care Capitation (PCC), with base PCC (true capitation) and optional Enhanced PCC (reconciled at settlement). Non-Primary Care Capitation (NPCC) and Advanced Payment Option (APO): ACOs may elect capitation for specialists and post-acute facilities. NPCC = payments will act as true capitation and will not be reconciled; APO = a cash flow mechanism reconciled against FFS gilling. Advanced Payment Option (APO): ACOs may elect capitation for Add-On Capitation Payments: LEAD will offer an add-on capitated payment to provide an additional upfront cash-flow. 	<ul style="list-style-type: none"> TCC for Participant Providers. Add-On Capitation Payments: LEAD will offer an add-on capitated payment to provide an additional upfront cash-flow.
				<p>CMS-Administered Risk Arrangements (CARA) = voluntary episodic payment arrangements with specialists. ACO can choose between traditional CMS episodes or create its own episode. Administered by CMS.</p>	
Reconciliation	Full performance year reconciliation following full claims run out period	<p>Capitation payments not reconciled against actual claims. APO payments reconciled against actual claims. For ACOs electing TCC, CMS will reconcile TCC with-hold against actual expenditures incurred by aligned beneficiaries for services</p>		<p>Capitation payments not reconciled against actual claims. APO payments reconciled against actual claims. For ACOs electing TCC, CMS will reconcile TCC with-hold against actual expenditures incurred by aligned beneficiaries for services</p>	

BENEFICIARIES AND ALIGNMENT

	MSSP Basic Level A/B	MSSP Basic Level C/D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global	LEAD Professional	LEAD Global		
Minimum number of beneficiaries	5,000				<p>Standard ACOs: 5,000 (≥ 3,000 “alignable” beneficiaries in at least one base year)</p> <p>New Entrant ACOs: 2,000 in PY23, 3,000 in PY24, 5,000 in PY25-26 (max. 3,000 “alignable” beneficiaries in any base year)</p> <p>High Needs Population ACOs: 500 in PY23, 750 in PY24, 1,200 in PY25, 1,400 in PY26</p>	<p>In General: 5,000, including 3,000 claims-aligned benes in at least one base year</p> <p>High Needs: starts at 800 (total)/500(claims) transitions to 1600/1000</p> <p>Newly Entering: starts at 1,000/600 transitions to 3,000/5,000 “Newly Entering ACOs”:</p> <ol style="list-style-type: none"> 1. The ACO entity does not have any prior performance in a Medicare ACO initiative,; 2. Fewer than 40% of the ACO’s Participant TINs have participated in a Medicare ACO Initiative in the past 5 years; and 3. Fewer than 50% of the ACO’s Participant Providers have participated in a Medicare ACO Initiative in the past 5 years. 				
Beneficiary alignment	<ul style="list-style-type: none"> • Prospective or preliminary prospective with retrospective reconciliation (elected annually) • Claims-based and voluntary <ul style="list-style-type: none"> ◦ Voluntary alignment takes precedence over claims-based 				<ul style="list-style-type: none"> • Prospective • Claims-based and voluntary (may market voluntary alignment) <ul style="list-style-type: none"> ◦ Voluntary alignment takes precedence over claims-based ◦ Voluntary alignment through MyMedicare.gov takes precedence over Attestation-Based Voluntary Alignment ◦ Option to add voluntarily aligned beneficiaries quarterly 			<ul style="list-style-type: none"> • Prospective or hybrid; Hybrid allows updates during a PY (monthly VA updates; one mid-year claims-based update for newly joined provider TINs); only adds beneficiaries, does not remove • Claims-based and voluntary (may market voluntary alignment) <ul style="list-style-type: none"> ◦ Voluntary alignment takes precedence over claims-based ◦ Voluntary alignment through MyMedicare.gov takes precedence over Attestation-Based Voluntary Alignment ◦ Option to VA to either TIN or NPI ◦ VAs carry over from ACO REACH ◦ Allows home-based VA 		
Beneficiary notification requirements	<p>ACOs must include posted signs in all ACO participant facilities notifying beneficiaries that its providers are participating in MSSP. Each agreement period, ACOs must furnish a written notice to beneficiaries prior to or at the first primary care visit:</p> <ul style="list-style-type: none"> • For ACOs under preliminary prospective assignment—send to all FFS beneficiaries prior to or at the first primary care visit during the first performance year that the beneficiary is seen by an ACO participant. • For ACOs under prospective assignment—send to all assigned beneficiaries prior to or at the first primary care visit. <p>Within 180 days of providing the notice or at the next primary care visit, ACOs must follow-up with beneficiaries and offer a meaningful opportunity to ask questions and engage with an ACO representative.</p>				<p>Each performance year, ACOs must send CMS-drafted and/or approved letters to all prospectively aligned patients by the date specified by CMS.</p>			<p>Each performance year, ACOs must send CMS-drafted and/or approved letters to all prospectively aligned patients by the date specified by CMS.</p>		

QUALITY

	MSSP Basic Level A/B	MSSP Basic Level C/D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global	LEAD Professional	LEAD Global
Measures	<p>GPRO Web Interface (WI) reporting will sunset after PY 2024. Now through PY 2024, ACOs may report WI, eCQMs/MIPS CQMs, or both (those reporting both will receive the higher of the two scores). The WI will no longer be a reporting option for PY 2025 or later.</p> <ul style="list-style-type: none"> WI reporting: 10 total measures (7 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) eCQMs/MIPS CQMs: 6 total measures (3 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) <p><i>Note: CMS may suppress certain measures in certain performance years</i> NAACOS remains concerned with the timeline and strategy to shift to all payer/eCQM reporting and the NAACOS Digital Quality Measurement Task Force has provided recommendations to CMS on this issue.</p>				<ul style="list-style-type: none"> Standard & New Entrant ACOs: assessed on 4 measures (3 administrative claims measures and the ACO CAHPS Survey) High Needs ACOs: Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions 		<ul style="list-style-type: none"> 3 categories: <ul style="list-style-type: none"> The same 4 claims-based measures from ACO REACH, CAHPS; and 2 digital measures (eCQMs) (Diabetes Glycemic Status Assessment >9%, Controlling high blood pressure); eCQMs optional PY 1-2, then pay-for reporting PY 3-4. ACOs must also implement a Prevention and Quality Plan 	
Scoring	<p>In order to earn maximum shared saving, an ACO must meet or exceed the 30th percentile among all MIPS quality performance category scores in 2021-2023 and meet or exceed the 40th percentile each year after. ACOs that do not meet this threshold may share in a portion of savings by achieving a quality performance score equivalent to the 10th percentile (individual measure performance benchmark) or higher on at least one outcome measure. The ACO's final sharing rate would be scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score, which includes any health equity bonus points.</p>				<ul style="list-style-type: none"> 2% benchmark withhold can be earned back through quality scores Total Quality Score (0-100%) = initial quality score adjusted for continuous improvement/sustained exceptional performance (CI/SEP) and health equity data reporting (HEDR) Highest performers eligible for a bonus 		<ul style="list-style-type: none"> 3% benchmark withhold can be earned back through quality scores and implementation of a Prevention and Quality Plan (PQP) Total Quality Score (0-100%) = initial quality score adjusted for continuous improvement/sustained exceptional performance (CI/SEP) and health equity data reporting (HEDR) Highest performers eligible for a bonus. 	
EHR use	<p>At least 75% of ACOs' eligible clinicians as defined under MACRA must use Certified EHR Technology (CEHRT), using an annual attestation process.</p>				<p>ACOs must document that at least 75% of Participant Providers that are eligible clinicians use Certified EHR Technology (CEHRT)</p>		<p>ACOs must document that at least 100% of Participant Providers that are eligible clinicians use Certified EHR Technology (CEHRT) or request targeted (3-year) exception for providers with advanced, custom, or home-grown health IT systems.</p>	

COMPLIANCE AND WAIVERS

	MSSP Basic Level A/B	MSSP Basic Level C/D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global	LEAD Global	LEAD Professional
Compliance programs	ACO must have a compliance plan that meets the requirements of 42 C.F.R. § 425.300, including: a designated compliance official who is not legal counsel to the ACO; anonymous reporting of suspected compliance violations, both by ACO members, employees and contractors regarding internal ACO matters and to law enforcement where the law may be violated; and compliance training.							
Monitoring efforts	CMS monitors and assesses the performance of ACOs, their ACO participants, and ACO providers/ suppliers through: <ul style="list-style-type: none"> • Analysis of financial and quality data reported by the ACO as well as aggregate annual and quarterly reports • Analysis of any beneficiary/provider complaints • Audits (i.e., analysis of claims, chart review, beneficiary survey reviews, coding audits, on-site compliance reviews) 				In addition to MSSP monitoring, CMS will monitor REACH ACOs for: <ul style="list-style-type: none"> • Beneficiaries being shifted to MA • Excessive risk score growth/ inappropriate coding practices • Service use over time Full list of monitoring efforts		TBD; Compliance plan required.	
Available waivers	Not applicable		<ul style="list-style-type: none"> • SNF 3-day Rule—Waives 3-day inpatient stay requirement prior to SNF admission. CMS waives 3-star quality rating requirement for providers under swing bed arrangements. • Telehealth—Waives typical geographic restrictions count patients’ homes as originating sites. (Only available to ACOs under prospective assignment) 		<ul style="list-style-type: none"> • SNF 3-day Rule—SNF must be Participant or Preferred Provider and have quality rating of 3+ stars • Telehealth—Same as MSSP • Home visits – care management and post-discharge • Chronic Disease Management Reward Program • Provision of home health services to beneficiaries not “homebound” • Nurse Practitioner Services Benefit • **Hospice Benefit—Waive requirement to give up curative care (**only for Global) 		<ul style="list-style-type: none"> • All existing BEs from ACO REACH • Medical Nutrition - Expanded access to medical nutritional therapy to beneficiaries with pre-diabetes and hyperlipidemia. • Part D Premium Reductions - ACOs sharing savings with beneficiaries through Part D premium reductions (beginning at a date TBD, before 2029). Opportunity to integrate Rapid Randomized Controlled Trials (RRCTs) to test impact of BEs. 	
Allowable beneficiary incentives	Not applicable		<ul style="list-style-type: none"> • Beneficiary Incentive Program —Allows ACOs to provide a limited “cash equivalent” incentive to eligible beneficiaries who receive qualifying primary care services. May not be limited to a subset of beneficiaries or services. • In-kind incentives — There must be a reasonable connection between items/services and beneficiary’s medical care; must be preventive care items/services or advance a clinical goal of the beneficiary; must not be a Medicare-covered item/service 		<ul style="list-style-type: none"> • Cost sharing support for Part B services tailored to specific categories of services and/or beneficiaries • In-kind items or services—may include home blood pressure monitors, vouchers for OTC medications, transportation vouchers, wellness programs, etc. 		<ul style="list-style-type: none"> • All existing BEIs from ACO REACH • Substance Access for Hemp 	
Policies to promote health equity	Health equity quality adjustment: Beginning PY2023, CMS will award up to 10 bonus points to the quality performance score for ACOs delivering high quality care to underserved populations. Bonus points are only available to ACOs reporting eCQMs/MIPS CQMs. Additional details on the bonus calculation can be found on p. 14-15 here . Advance Investment Payments (AIPs): Beginning PY2024, CMS will provide advance shared savings payments to new, inexperienced, low revenue ACOs, modeled after the ACO Investment Model (AIM). AIPs will consist of a one-time upfront payment \$250,000 and quarterly payment calculated per beneficiary over the first 2 years of an ACO’s agreement period. ACOs will be able to apply for AIPs as part of the MSSP application cycle. More information can be found on p. 9-12 here .				<ul style="list-style-type: none"> • Health Equity Plan requirement • Health equity benchmark adjustment • Requirement to collect and report beneficiary-reported demographic and SDOH data • Application scores include ACOs’ demonstrated ability to provide high quality care to underserved communities 		<ul style="list-style-type: none"> • Healthy Living Strategy: <ul style="list-style-type: none"> - Prevention and Quality Plan Requirement - Tech Enabler Initiative 	

ADDITIONAL RESOURCES

	MSSP Basic Level A/B	MSSP Basic Level C/D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global	LEAD Professional	LEAD Global
NAACOS resources	<ul style="list-style-type: none"> • NAACOS MSSP webpage • NAACOS Analysis of the 2023 MPFS • NAACOS Quality webpage 				<ul style="list-style-type: none"> • NAACOS ACO REACH webpage • Summary of REACH Financial Specifications • REACH FAQs 			
CMS resources	<ul style="list-style-type: none"> • Shared Savings Program webpage • Information for ACOs • Information for Providers • Program Guidance & Specifications • Program Data • MSSP News 				<ul style="list-style-type: none"> • REACH Model webpage • Model Factsheet • Financial operating guide • Quality measurement methodology • Provider management guide 		<ul style="list-style-type: none"> • LEAD Model Overview Slides • LEAD Model Overview • LEAD Model Value Factsheet 	

