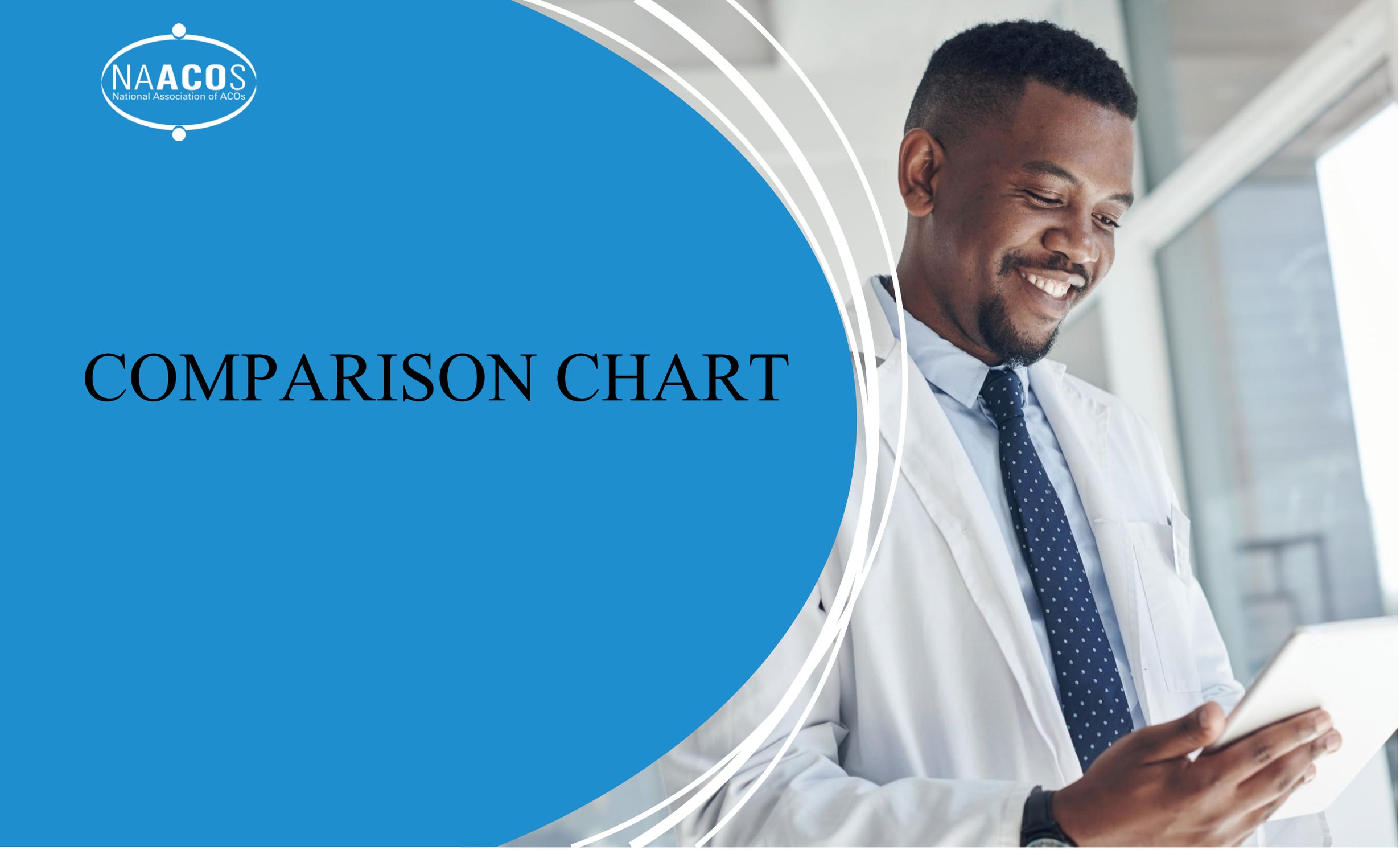
NAACOS
National Association of ACOs

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.		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 yet announced. ACOs should submit LOI (to be released around 4/20/2026).	
Status under MACRA	MIPS APM		MIPS APM or Advanced 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.				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	Gross (S/L): < 5% 5%-10% 10%-15% > 15% Cap (S/L): 50% 35% 15% 5%	Gross (S/L): < 10% 10%-35% 35%-50% > 50% Cap (S/L): 100% 50% 25% 10%	Gross (S/L): < 10% 10%-15% 15%-20% > 20% Cap (S/L): 50% 35% 15% 5%	Gross (S/L): < 15% 15%-35% 35%-50% > 50% Cap (S/L): 100% 50% 25% 10%
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				
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: • 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.			• No MSR/MLR • No discount	◦ No MSR/MLR ◦ Discount applied to the PY benchmark: 3% (PY2023-2024) 3.5% (PY2025-2026)	• No MSR/MLR • No discount	• No MSR/MLR • Discount applied to the PY benchmark: • Lower-Spending ACOs: 3% • Higher-Spending ACOs: 1.75%, increasing by .25% annually up to 3% in PY6
	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. If these ACOs are determined to become experienced during the agreement period, they will be required to move to Level E the following PY.			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: • 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: ◦ 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 • 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)		• Base Years = 2024-2026; No rebasing over the10-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 - 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. - 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	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. 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)	CMS will risk adjust historical baseline, regional expenditures, and capitated payments
		• 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
		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
				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 CMS-HCC prospective risk adjustment for others.
				• Growth Cap
				  ○ 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)
				  ○ 2028: shadow test
				  ○ 2029: blend of AI-inferred and HCC
				  ○ 2031: full AI-inferred

Payment options	CMS makes all FFS payments	Primary Care Capitation (PCC) = monthly payments for primary care services ~2-7% of TCOC (CMS pays claims for all other services) • Fee reduction required for Participant Providers, optional for Preferred Providers • Optional Advanced Payment up to 100% of benchmark w/ reconciliation	May select between PCC and Total Care Capitation (TCC), which covers all Parts A and B services delivered by ACO Participant and Preferred Providers • Fee reduction required for Participant Providers, optional for Preferred Providers	• PCC required, 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 billing. • Administrative Add-On: capitated payment for higher-spending ACOs, not included in expenditures • May select between PCC and TCC for Participant Providers. • Optional fee reductions for Preferred Providers • NPCC and APO only available to ACOs that select PCC • Administrative Add-On: capitated payment for higher-spending ACOs, not included in expenditures CMS-Administered Risk Arrangements (CARA) = voluntary episodic payment arrangements with specialists. ACO can choose between traditional CMS episodes or custom episodes. Administered by CMS.
Reconciliation	Full performance year reconciliation following full claims run out period	Capitation payments not reconciled against actual claims. APO payments reconciled against actual claims. For ACOs electing TCC, CMS will reconcile TCC withhold against actual expenditures incurred by aligned beneficiaries for services		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

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				**Standard ACOs:** 5,000 (≥ 3,000 "alignable" beneficiaries in at least one base year) **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) **High Needs Population ACOs:** 500 in PY23, 750 in PY24, 1,200 in PY25, 1,400 in PY26		**In General:** 5,000, including 3,000 claims-aligned benes in at least one base year **High Needs**: starts at 800 (total)/500(claims) transitions to 1600/1000 **Newly Entering**: starts at 1,000/600 transitions to 5,000/3,000 *"Newly Entering ACOs":* 1. ACO entity has no past experience 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. *"High Needs ACOs":* 1. At least 40% of the ACO's beneficiary population meets High Needs criteria and 2. Required care delivery capabilities: 24/7 provider access, trained in advanced care planning, ability to deliver care in the home.	
Beneficiary alignment	• Prospective or preliminary prospective with retrospective reconciliation (elected annually) • Claims-based and voluntary ◦ Voluntary alignment takes precedence over claims-based ◦ Voluntary alignment only through MyMedicare.gov				• Prospective • Claims-based and voluntary (may market voluntary alignment) ◦ 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		• 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) ◦ 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 or MSSP ◦ Allows home-based VA	
Beneficiary notification requirements	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: • 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 firs primary care visit. • Within 180 days of providing the notice, ACOs must follow-up with beneficiaries and offer a meaningful opportunity to ask questions and engage with an ACO representative.				Each performance year, ACOs must send CMS-drafted and/or approved letters to all prospectively aligned patients by the date specified by CMS.		Each performance year, ACOs must send CMS-drafted and/ or approved letters to all prospectively aligned patients by the date specified by CMS. ACOs must include posted signs in all ACO participant facilities notifying beneficiaries that its providers are participating in LEAD.	

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	ACOs may report eCQMs, Medicare CQMs, or MIPS CQMs (MIPS CQMs sunset after PY26), or a combination (those reporting multiple will receive the higher of the two scores on a measure-by-measure basis). • eCQMs/MIPS CQMs: 8 total measures (5 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) *Note: CMS may suppress certain measures in certain performance years* 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.				• 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		• 3 categories: - 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	In order to earn maximum shared saving, an ACO must meet or exceed the 40th percentile among all MIPS quality performance category scores. 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 bonus points.				• 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		• 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 CI/SEP and applicable reporting adjustments (PQP, eCQM for PY 1 and 2) • Highest performers eligible for a bonus.	
EHR use	At least 75% of ACOs' eligible clinicians as defined under MACRA must use Certified EHR Technology (CEHRT), using an annual attestation process.				ACOs must document that at least 75% of Participant Providers that are eligible clinicians use CEHRT		ACOs must document that at least 100% of Participant Providers that are eligible clinicians use CEHRT or request targeted (3-year) exception for providers with advanced, custom, or home-grown health IT systems.	

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: • 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: • 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	• **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)			• **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*)		• All existing BEs from ACO REACH • ****Medical Nutrition Therapy**- Expanded access to medical nutritional therapy to beneficiaries with pre-diabetes and hyperlipidemia. (*only for Global*) • **Part D Premium Reductions** - ACOs sharing savings with beneficiaries through Part D premium reductions (beginning 2029, for "High-value Care Champion" ACOs). Opportunity to integrate Rapid Randomized Controlled Trials (RRCTs) to test impact of BEs.	
Allowable beneficiary incentives	Not applicable	• **Beneficiary Incentive Program —A**llows 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			• **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.		• All existing BEIs from ACO REACH • Substance Access for Hemp	
Policies to promote health equity	Population Adjustment to benchmark upwardly adjusts an ACO's historic benchmark based on the proportion of assigned beneficiaries who are duals or enrolled in the Part D low income subsidy. ACOs receive the higher of the population adjustment, prior savings adjustment, or regional adjustment. 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.				• 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		• Healthy Living Strategy: - 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	• NAACOS MSSP webpage • Analysis of the 2026 MPFS • NAACOS Quality webpage				• NAACOS ACO REACH webpage • Summary of REACH Financial Specifications • REACH FAQs			
CMS resources	• Shared Savings Program webpage • Information for ACOs • Information for Providers • Program Guidance & Specifications • Program Data • MSSP News				• REACH Model webpage • Model Factsheet • Financial operating guide • Quality measurement methodology • Provider management guide		• LEAD Model Overview Slides • LEAD Model Overview • LEAD Model Value Factsheet	