The Accountable Alliance

LEAD ACO Model: Frequently Asked Questions

The Long-term Enhanced ACO Design (LEAD) Model is the newest accountable care model from the Centers for Medicare & Medicaid Services (CMS), scheduled to begin in 2027

This FAQ is intended to help providers understand the basics of the LEAD Model, how participation may affect their operations and payments, and what questions they may want to consider prior to joining a LEAD ACO.[1]

Contents

1. What is value-based care?

Value-based care aligns payment with quality, outcomes, and cost efficiency, incentivizing providers to keep patients healthy and reduce avoidable utilization. Value-based care is often

[1] This document was created using CMS-published documents about the LEAD Model and is current as of June 25, 2026.

contrasted with fee-for-service payment, where compensation is provided for individual services, with no connection to outcomes.

Value-based care models tie compensation to patient health outcomes and de-emphasizes payment for the volume of care provided. In general, value-based care involves:

- Incentivizing improved quality of care, better health outcomes, and lower cost of care.
- Tying compensation to performance and patient outcomes.
- Team-based patient panel management.
- Proactive, preventive care models.
- Coordination with specialist care.
- Shared accountability for quality and cost.

2. What is an ACO?

An Accountable Care Organization (ACO) is a group of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated services and health care, improve health outcomes, and manage costs. The term ACO can be used across lines of business (Traditional Medicare, Medicare Advantage, Commercial, Medicaid) but in this context we are referring to ACOs that serve patients with Traditional Medicare.

Medicare ACOs sign a contract with CMS to take on accountability for the total cost of care and quality of care of an attributed patient population. CMS set a financial target and if the ACO succeeds in keeping costs below that amount, the group can earn financial bonuses from CMS. If the ACO's patient spending exceeds the target amount, the group may owe money to CMS (see: "What are shared savings and losses?" below).

3. What are the types of Medicare ACO programs?

CMS offers several ACO programs. In addition to LEAD, several of the most well-known ACO models include:

- The Medicare Shared Savings Program (MSSP), which was established by the Affordable Care Act (ACA) and first began in 2012. The oldest, only permanent, and only ACO program codified in federal law, MSSP offers several options (or "tracks") for participation. These include "upside only" tracks that provide modest financial bonuses to ACOs when they achieve shared savings; as well as "downside risk" tracks that provide greater financial bonuses when they achieve shared savings, but require ACOs to pay CMS back if they incur shared losses.

- The Realizing Equity, Access, and Community Health (REACH) Model, a pilot program established by CMMI and ending after 2026. REACH places a greater emphasis on downside risk, managing care for patients with chronic conditions, and compensating providers with capitated rather than fee-for-service payments.
- The Kidney Care Choices (KCC) Model, a pilot program established by CMMI and running through 2027, brings together nephrologists and other kidney care providers and practices to take financial accountability for patients with kidney disease. KCC provides incentives to delay the need for dialysis, encourage kidney transplants, and to improve the quality of patients with late-stage chronic kidney disease.

4. Can I be in more than one ACO program at a time?

You may be able to participate in more than one ACO program, but your patients generally cannot be attributed to more than one program at the same time. Whether participation is allowed depends on the specific program and the provider's role (for LEAD specifically, see "Can I be in more than one LEAD ACO?").

In addition, CMS has released several non-ACO value-based care programs, such as the Guiding an Improved Dementia Experience (GUIDE) model, or the Transforming Episode Accountability Model (TEAM). Providers may be able to participate in an ACO program and a non-ACO value-based care program at the same time. Whether this is allowed depends on the specific program rules.

In general, CMS permits some overlap between value-based care programs (both ACO and non-ACO) but tries to avoid duplicative payments or conflicting accountability for the same patients.

5. What type of providers are eligible to participate in LEAD?

Most Medicare-enrolled providers are eligible to participate in LEAD. The only ineligible provider types are Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers; ambulance suppliers, device manufacturers, and those are excluded or otherwise prohibited from participation in Medicare or Medicaid.

6. What specialties are eligible for attribution?

Most patients are attributed under claims-based alignment based on services delivered by primary care providers. If a patient receives more than 10% of their qualifying Evaluation and Management (E&M) services from specialists, however, those providers' claims are also used in attribution. The specialties used under each of these are listed below.

Note that all services patients receive at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are treated as primary-care services due to the comprehensive nature of

care delivered in those settings. In other words, all services received at FQHCs and RHCs are treated as qualifying E&M services for purposes of LEAD attribution.

CMS defines primary care specialists as providers with the following specialties:

- General Practice
- Family Medicine
- Internal Medicine
- Pediatric Medicine
- Geriatric Medicine
- Nurse Practitioner
- Clinical Nurse Specialist
- Physician Assistant

CMS defines non-primary care specialists as providers with the following specialties:

- Cardiology
- Gastroenterology
- Osteopathic manipulative medicine
- Neurology
- Obstetrics/gynecology
- Hospice and palliative care
- Sports medicine
- Physical medicine and rehabilitation
- Psychiatry
- Geriatric psychiatry
- Pulmonology

7. What are shared savings and losses?

Medicare determines how much an ACO's patients are expected to cost annually—known as a "benchmark"—based largely on historical spending for the providers in the ACO and adjusted for factors such as regional efficiency and changes in acuity in the patient population. If the ACO keeps total Medicare spending for the attributed population below the benchmark, the ACO receives a portion of the difference. This is known as shared savings.

Conversely, ACOs in LEAD are required to pay back a portion of the difference if patient costs are *higher* than the benchmark—known as shared losses.

Shared savings or losses are typically calculated at the ACO level, not at the individual provider level, although the ACO may have internal arrangements that affect how funds are distributed or losses are managed.

8. What does it mean to take on risk?

In some ACO programs, ACOs have the option for "upside only", or "one-sided" risk. In these arrangements (such as BASIC Tracks A and B of MSSP), ACOs are eligible to earn a portion of shared savings, but do not have to pay back any shared losses.

Other ACO programs, including LEAD, only include "downside risk", or "two-sided" risk options. In these arrangements, ACOs are still eligible to earn a portion of shared savings—usually a higher portion than in one-sided risk options—but have to pay back a portion of shared losses if spending exceeds the benchmark

9. How is LEAD different from previous ACO programs?

To understand how LEAD is evolving the ACO model, it's useful to compare it to the Medicare Shared Savings Program (MSSP) as well as ACO REACH (its predecessor), which is ending at the end of 2026.

LEAD is a temporary, but lengthy program: it will last ten years, through 2036. In contrast, ACO REACH spanned five years while MSSP is a permanent program but with five-year agreement periods.

Providers participate at the TIN level, just as they do in MSSP, meaning that all providers within a participating TIN automatically participate in the program. In contrast, providers participated in ACO REACH at the TIN/NPI level, meaning that an ACO could create its participating network at the individual NPI level – this option is not available in LEAD.

There are two risk options that require taking on downside risk, similar to ACO REACH. The LEAD Professional Risk option allows ACOs to retain 50% of shared savings and are held liable for 50% of shared losses; the LEAD Global Risk option allows ACOs 100% of shared savings while also holding them accountable for 100% of shared losses. MSSP has several risk options, several of which are upside-only, meaning that ACOs benefit from shared savings but do not owe any portion of shared losses.

LEAD provides prospective payments to ACOs to allow for more upfront cash flow. ACO REACH provided similar upfront payments, while MSSP does not have this option.

LEAD embeds high-needs beneficiaries across all ACOs rather than treating them as a separate ACO type. MSSP generally evaluates an ACO's population as a whole, while LEAD separately identifies High Needs beneficiaries so ACOs are not penalized for serving more clinically complex

patients. By contrast, ACO REACH has a separate High Needs track; LEAD allows organizations to treat High Needs beneficiaries alongside their broader Medicare population within a single ACO.

10. How am I assigned patients?

In LEAD, patients can be attributed in two ways:

- **Claims-based alignment**, which looks at a patient's claims over the past year and attributes the patient to the ACO if the ACO's providers have rendered a plurality of their primary care services.
- **Voluntary alignment,** in which a patient designates a provider as their main source of care via Medicare.gov or signed attestation.

11. Do I still need to report MIPS if I join LEAD?

Joining LEAD does not automatically exempt every provider from MIPS. Providers are only exempt from reporting MIPS if they meet Qualifying Participant (QP) status or qualify for other exemptions. To achieve QP status and exemption from MIPS, providers must participate to a sufficient degree in an Advanced Alternative Payment Model (APM). LEAD is expected to qualify as an Advanced APM.

LEAD participating providers that meet a certain threshold of either their Medicare patients or Part B payments during a given calendar year are exempted from reporting MIPS for that year. Either of the following thresholds must be met for providers to achieve QP status and qualify for this exemption:

- Payment Amount Threshold: 75% of the provider's Medicare Part B payments must come through LEAD.
- Patient Count Threshold: 50% of the provider's Medicare patients must be attributed to LEAD.

LEAD participating providers that do not achieve QP status in LEAD for a given calendar year generally remain subject to MIPS and would typically be evaluated through the Alternative Payment Model Pathway (APP)/MIPS APM pathway unless they qualify for another MIPS exclusion (e.g., for low-volume providers).

12. What are capitated payments and how do they work?

LEAD provides several options for **capitated payments**, which are a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a given patient over a period of time (often a month). There are two primary capitation options in

LEAD: Primary Care Capitation and Total Care Capitation. The Accountable Alliance is a Primary Care Capitation ACO.

Primary Care Capitation

CMS reduces fee-for-service claim payments for covered primary care services furnished to aligned beneficiaries by participating providers and replaces those payments with prospective monthly PCC payments to the ACO.

Providers continue to submit claims to CMS, but claim payments are reduced according to the PCC claims reduction percentages (selected by the ACO).

The PCC Payment consists of two components:

- **Base Primary Care Capitation:** this intends to approximate the expected cost of primary care services furnished by participating primary care providers
- **Enhanced Primary Care Capitation:** this provides additional upfront funding to support investments in primary care infrastructure, access, and care coordination.

Enhanced PCC is subject to shared savings settlement reconciliation and is reconciled as an advance payment through the shared savings and shared losses calculation. This is essentially a zero-interest loan from Medicare and will be accounted for as an expense prior to paid out shared savings.

Base PCC is calculated quarterly based upon changes in alignment, benchmark, risk score, or other payment calculations.

13. What quality measures will I be evaluated on in LEAD?

LEAD ACOs will be evaluated on seven quality measures, which include five carried over from ACO REACH:

- **Risk-Standardized All-Condition Readmission,** a claims-based measure that measures how many hospital stays result in a readmission within 30 days after a patient discharge.
- **All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions**, a claims-based measure that measures unplanned hospital admissions among beneficiaries who are 66 years of age or older with multiple chronic conditions.
- **Days at Home for Patients with Complex, Chronic Conditions,** a claims-based measure that measures the number of days that adults with complex, chronic disease spend at home or in community settings (rather than acute and post-acute care settings).

- **Timely Follow-Up After Acute Exacerbations of Chronic Conditions,** a claims-based measure that measures the percentage of acute events related to chronic conditions where follow-up care was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting.
- **CAHPS Survey,** a patient-reported measure based on the ACO CAHPS Survey, which measures patient experiences with care.

In addition, there are two new measures that derive data from electronic medical records (note that these will be optional to report for the first two performance years):

- **Controlling High Blood Pressure,** which measures the percentage of adult patients with hypertension that are subsequently able to control their blood pressure within a set time period.
- **Diabetes: Glycemic Status Assessment Greater Than 9%,** which measures the percentage of adult patients with diabetes who had a glycemic status assessment greater than 9%.

14. Can I be in more than one LEAD ACO?

Generally, providers in LEAD are not allowed to be in more than one LEAD ACO at a time.

Links to resources:

LEAD Model Page

LEAD Model Overview

LEAD Model RFA

LEAD, ACO REACH, and MSSP Comparison Document