LEAD: CMS' next ACO model

What is the LEAD model?

The Long-term Enhanced ACO Design (LEAD) model is the Centers for Medicare and Medicaid Services' (CMS) next-generation accountable care model and the formal successor to ACO REACH, beginning January 1, 2027. LEAD is a voluntary, 10-year model designed to support long-term participation in total cost-of-care accountability while also improving financial sustainability for organizations serving complex and high-needs Medicare populations. It's also the longest running ACO model in the history of the Center of Medicare and Medicaid Innovation (CMMI).

Like ACO REACH, LEAD is a two-sided risk model offering prospective, population-based payments and accountability for quality and cost outcomes in traditional Medicare. However, LEAD places a stronger emphasis on predictability, scalability, and durability, with design features intended to reduce churn, stabilize benchmarks over time, and better support rural providers and organizations caring for high-needs and dually eligible beneficiaries. By lowering financial and administrative hurdles, CMMI hopes to draw in both new and experienced ACOs.

Expected LEAD participants:

- Current ACO REACH participants seeking a long-term successor model
- Smaller and rural providers looking for reduced participation barriers
- Community health centers
- Federally qualified health centers
- Rural health clinics
- Independent physician practices

What is new about LEAD?

Risk tracks and benchmarking

Unlike other Medicare ACO models, LEAD eliminates benchmark rebasing over its 10-year duration, preserving incentives for ACOs to generate savings year after year. LEAD offers two voluntary risk tracks, Global and Professional, consistent with ACO REACH. Organizations entering the Professional track must remain there for four years before becoming eligible to switch to the Global track. Benchmarking will initially rely on historical experience with regional or prior savings adjustments, resembling the Medicare Shared Savings Program (MSSP). CMMI has indicated that the model will-transition to a rate-book-based benchmark in the latter half of its duration. CMMI expects costs to begin converging across higher and lower spending ACOs over time, and therefore, will transition to the use of standardized, rate-book based benchmarks.

Participation, alignment, and population design

LEAD enhances ACO REACH by integrating high-needs beneficiaries across all ACOs, strengthening risk adjustment and benchmarking, supporting Medicaid coordination, and improving payment accuracy for complex-care providers. Under LEAD, participants are defined at the Taxpayer Identification Number (TIN) level, aligning closer to the Medicare Shared Savings Program (MSSP) and replacing ACO REACH's TIN and National Provider Identifier (NPI) structure. Beneficiaries may be aligned through claims-based or voluntary alignment, with ACOs choosing between prospective alignment or a new hybrid option that allows monthly voluntary alignment additions and a mid-year opportunity to add participant TINs. High-needs beneficiaries are treated as a distinct cohort within all ACOs alongside aged/disabled (AD) and end-stage renal disease (ESRD) populations, with LEAD continuing to apply prospective risk adjustment for AD and ESRD and concurrent risk adjustment for the high-needs cohort.

Payment model and care delivery tools

LEAD continues to offer total cost of care (TCC) and primary care capitation (PCC) and introduces a new non-primary care capitation (NPCC) option for organizations electing PCC. NPCC will not be reconciled against fee-for-service billing, offering greater payment stability. The model also introduces CMS-Administered Risk Arrangements (CARA), an optional platform designed by CMMI to support episode-based downstream risk arrangements between ACOs and contracted specialists.

Quality performance and beneficiary supports

LEAD will initially include seven quality measures, five carried over from ACO REACH and two electronic clinical quality measures (eCQMs) phased in over time. There's also a reduced 3% quality withhold (compared to 5% in ACO REACH in PY2026) that ACOs may earn back based on performance in those five measures. Participants must implement a prevention and quality plan (PQP) tailored to their population. The LEAD model will also retain the high performers pool (HPP) that awards a bonus to high-performing ACOs providing exceptional quality of care. The model also expands beneficiary engagement and prevention supports, including future Medicare Part D premium buydowns, expanded medical nutrition therapy, chronic disease prevention rewards, and new beneficiary engagement incentives. Additionally, CMS plans to test Medicaid integration through partnerships with two states focused on care coordination for dually eligible beneficiaries.

How does LEAD compare to ACO REACH?

Element	ACO REACH	LEAD
Participation requirements	Voluntary	Voluntary
Duration	4 years (2023-2026)	10 years (2027-2036)
Risk options (tracks)[1]	Global: Up to 100% shared savings/losses Professional: Up to 50% shared savings/losses	Global: Up to 100% shared savings/losses Professional: Up to 50% shared savings/losses
Benchmark window and adjustments	Benchmark years: 2017-2019 Historical data blended with prospective rate book	CMMI suggested a predictable benchmark window without rebasing, though further specifics are to be determined
Quality assessment and withhold[2]	5% withhold in 2026; eligible to be earned back based on four claims-based measures and one survey-based measure	3% withhold in 2027; earned back based on performance in five of the same measures in REACH, two additional, gradually phased-in eCQMs as well as in the PQP
Prospective payment philosophy[2]	TCC or PCC	TCC, PCC, and NPCC
Program focus[2]	Closing disparities and improving quality and care coordination in traditional Medicare	Builds on REACH with a center of gravity on long-term, scalable participation and better-fitting economics for complex/high-needs populations
High-needs orientation[2]	Explicitly includes a high-needs ACO participant type	Incorporates high-needs population as a separate cohort in addition to AD and ESRD

1. LEAD ACOs must remain in professional track for four years before being eligible to switch to global track.
2. Elements that differ between the two programs; both programs focus on TOTC improvement.

What are the unknowns about LEAD?

While CMS has outlined LEAD's core structure, several critical details remain unresolved and are expected to be clarified in the forthcoming Request for Applications (RFA), anticipated in March.

Area	What remains unknown
Benchmark mechanics	How historical data will be constructed, how regional and prior savings adjustments will be calculated and applied, how risk scores will be normalized, how benchmark will be trended, and utility of floors, ceilings, and trend factors
Risk mitigation and settlement	The structure and parameters of risk corridors, stop-loss provisions, truncation thresholds (if any), and discounts
Support for rural providers	Which ACOs will qualify for add-on payments, how those payments will be calculated, and how reduced beneficiary alignment minimums will be applied
CMS-Administered Risk Arrangements (CARA)	Eligible episodes, participating specialties, contracting structures, payment flow, and the extent to which CARA can scale beyond early use cases
Benefit enhancements and Medicaid integration	Eligibility criteria and compliance guardrails for benefit enhancements, funding mechanisms, which two states will participate in Medicaid integration, and the timeline for implementation following the planning period

Hands-on support to realize your full potential

Optum Advisory is here to work side-by-side with you to help you realize your full potential under LEAD. Our actuaries can help you evaluate whether LEAD or another CMS program is the right fit, then support the strategy, capabilities, and analytics needed to perform.

For additional assistance, get in touch at advisory.com/optum-support

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655 New York Avenue NW, Washington DC 20001 | **advisory.com**