

# Long-term Enhanced Accountable Care Organization (ACO) Design (LEAD)

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Application Office Hour

April 21, 2026

Centers for Medicare & Medicaid Services | Center for Medicare & Medicaid Innovation





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# Agenda

- 1** | Welcome and Introductions
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# Welcome and Introductions

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# Today's Presenters



**Emily Bezold**  
Technical Advisor  
*CMS Innovation Center*



**Lucy Sola**  
LEAD Model Co-Lead  
*CMS Innovation Center*



**Meredith Yinger**  
LEAD Model Co-Lead  
*CMS Innovation Center*

# Application Overview



**LEAD Application:** The LEAD Application for the 2027 Performance Year is available at: <https://app.innovation.cms.gov/LEAD/IDMLogin>. **Applications are due by May 17, 2026, at 11:59pm EST.**



**Letter of Interest (LOI):** LEAD's LOI is now available on the LEAD Model Webpage (<https://www.cms.gov/priorities/innovation/innovation-models/lead>).

It will close on May 17, 2026, at 11:59pm EST. The LOI is not binding and is not required to participate in future cohorts for the model.



**Streamlined Application:** Current REACH ACOs (participating in PY2026) are eligible to submit a streamlined application to the LEAD Model. To qualify for the streamlined application, the ACO must either:

1. Use the same ACO Entity Taxpayer Identification Number (TIN) on the LEAD application as is being used in ACO REACH; or
2. If the ACO is creating a new entity TIN for LEAD, they can submit an **attestation** in the ACO REACH 4i platform confirming that the ACO is structured similarly (in parent organization, infrastructure, and leadership team). *Note: The attestation should be uploaded in the 4i platform under the Operations Module --> Document Submission Feature under the Change in Legal Business Name (LBN) or TIN.*

To access the streamlined application, applicants should select that they are a current REACH ACO in the application; the tool will **automatically** load the streamlined application.

# Application Helpful Links

**Helpful Links:** The LEAD Application has a 'Helpful Links' section that has information on the Application Checklist, New Entrant Template, Application FAQs, User Manual, and Attestation Instructions for Current REACH ACOs:

**CMS.gov** Welcome to the Long-Term Enhanced ACO Design (LEAD) Model

## Long-Term Enhanced ACO Design (LEAD) Model Application

CMS will safeguard any information submitted in accordance with applicable federal privacy and security laws, regulations, and CMS policies.

CMS provides no opinion on the legality of any contractual or financial arrangement that the applicant may disclose, propose, or document in this application. The receipt by CMS of any such information in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules, or regulations, and will not preclude CMS, HHS, the HHS Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules, and regulations.

Questions about the application for the LEAD Model should be directed to [LEAD@cms.hhs.gov](mailto:LEAD@cms.hhs.gov).

**NOTE:** Please be sure to save your work before navigating away from each page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity.

### Helpful Links

- [User Manual](#)
- [Application Checklist](#)
- [Application FAQs](#)
- [New Entrant Provider Check](#)
- [Eligibility for Streamlined LEAD Application for Current REACH ACOs](#)

**LEAD Model Upcoming Deadlines:**  
Application Deadline: 03/31/2026 to 05/17/2026 11:59 PM EST

### My Applications

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## Live Q&A: Application Overview

Please type your question about the **application** in the **Q&A box**.

If we do not get to your question, we welcome you to email the LEAD Team at [LEAD@cms.hhs.gov](mailto:LEAD@cms.hhs.gov). We will aim to answer unaddressed questions via emails and upcoming FAQs.

# Eligibility and Participation Requirements

# Eligibility Requirements

## ACO Eligibility



**LEAD is designed for a wide spectrum of health care providers**, including those that have not previously participated in ACOs, current ACO REACH participants, and those serving High Needs and dually eligible beneficiaries.

## Participant Eligibility



**Participant Providers:** Physicians and health care organizations that take direct accountability for cost and quality and drive beneficiary alignment under the model. Participant providers are typically primary care providers, though not required to be. *LEAD will use a whole Tax Identification Number (TIN) approach, which captures all National Provider Identifiers (NPIs) billing under a Participant TIN as Participant Providers.*



**Preferred Providers:** Physicians and health care organizations that can take indirect financial accountability and do not drive beneficiary alignment or quality performance for the ACO. Preferred Providers are typically specialists and institutional providers (e.g., post-acute care) but not required to be. *Preferred Providers will be managed at the TIN-NPI level to allow flexibility for ACOs.*

# Beneficiary Alignment



LEAD introduces a new option for more timely Beneficiary Alignment and more transparency for ACOs.

## LEAD ACOs will receive beneficiary alignment in two ways:



- **Claims-Based Alignment:** Beneficiaries align to ACOs based on their claims history and utilization patterns.
- **Voluntary Alignment:** Beneficiaries voluntarily align to an ACO by choosing a provider affiliated with that ACO as their primary provider, practice, or other source of care. Voluntary alignment can occur in a healthcare setting, or in a patient's home when there is a pre-existing relationship with an ACO provider.

## LEAD ACOs can select one of two alignment approaches:



- **Prospective:** Conducted prior to the start of each performance year, with no alignment updates during the performance year.
- **Hybrid:** Allows ACOs to update their beneficiary list during the performance year (PY). Voluntary alignment would be updated monthly. Claims-based alignment would be updated once a year (prior to the PY). For ACOs that have new Participant TINs during the PY, claims-based alignment will be updated once mid-PY for new additions. *Note: Eligible beneficiaries can only be added mid-year; they cannot be dropped.*

- ✓ What is the criteria to be considered a Newly Entering ACO?  
What about a Renewing ACO?

**Newly Entering ACOs are defined as ACOs that meet all of the following criteria:**

- 1) The ACO entity hasn't participated in the Shared Savings Program or ACO REACH,
- 2) Less than 40% of the ACO's Participant TINs have participated in the Shared Savings Program or ACO REACH in the past 5 years, and
- 3) Less than 50% of the ACO's Participant Providers have participated in Medicare ACO Initiatives in the past 5 years.

**ACOs that do not meet all three of the Newly Entering ACO criteria will be considered a Renewing ACO.**

✓ What is the **claims lookback window** for the initial alignment run? What about for the hybrid alignment update mid-year?

- The claims lookback window for the initial alignment run (effective January 1<sup>st</sup>) will be **October 1 to September 30<sup>th</sup>** prior to the Performance Year.
- For the hybrid alignment update in the middle of the Performance Year, the claims lookback period will be **January 1 to December 31<sup>st</sup>** prior to the Performance Year.
  - The hybrid claims lookback period will only apply to beneficiaries added mid-year.

✓ What is the **final date to add and drop** Participant TINs and Preferred Providers to LEAD for PY2027?

- **August 5, 2026**, is the final date to add Participant TINs and Preferred Providers to LEAD for PY2027.
- **September 8, 2026**, at 11:59pm EST is the final deadline to drop Participant TINs and Preferred Providers from LEAD for PY2027.



# Live Q&A: Eligibility and Participation Requirements

Please type your question about **eligibility and participation requirements** in the **Q&A box**.

If we do not get to your question, we welcome you to email the LEAD Team at [LEAD@cms.hhs.gov](mailto:LEAD@cms.hhs.gov). We will aim to answer unaddressed questions via emails and upcoming FAQs.

# Benchmarking Methodology

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# Benchmarking Methodology

LEAD's benchmarking methodology is designed to work for both ACOs that are new to accountable care and experienced ACOs that have succeeded under previous ACO models. Benchmarks will be calculated according to the following process:



## Calculate Baseline Benchmark Using Historical Expenditures

- **3-year weighted average of historical claims**, from the **3 base years** (BYs) prior to ACO's first performance year (PY). For PY 2027, the BYs are 2024 – 2026.
- BYs will be weighted differently depending on whether the ACO is **new** or **renewing**:

Base Year	New ACOs	Renewing ACOs
BY 1	10%	33%
BY 2	30%	33%
BY 3	60%	33%



## Apply ACO Specific Adjustments

Certain ACOs will be eligible for the following adjustments. ACOs eligible for both will receive the higher adjustment. Both adjustments are subject to a risk-adjusted cap of 5% of U.S. per capita cost\*.

### Prior Savings Adjustment

- **For Professional and Global Risk Options:** Renewing ACOs (Shared Savings Program and REACH) eligible based on savings in 3 BYs.
- Calculation: 50% of average annual savings in 3 BYs.

### Positive Regional Efficiency Adjustment

- **For Global Risk Option only:** ACOs eligible if spending is below average fee-for-service (FFS) spending in their region.
- Calculation: 50% of difference between ACO's historical benchmark and average regional spending in BY 3.

\*Lower-spending ACOs with 40% or more of TINs that participated in the Shared Savings Program in the prior two years will be subject to the 3% cap instead of a 5% cap.

# Benchmarking Methodology (continued)



## **Trend Benchmarks Forward to the Performance Year** *to account for medical cost growth*

Benchmarks will be trended forward from the BYs to the current PY using a 3-way blended trend factor calculated as follows:

### **2/3 national/regional blend:**

A blend of actual national and regional spending trends during the PY.



**1/3 Accountable Care Prospective Trend (ACPT):** A projected growth rate set prospectively before the start of the PY. Subject to **guardrails** to prevent benchmarks from diverging too far from actual national and regional spend.



## **Risk Adjust Benchmarks** *to account for relative illness of ACO's patient population*

LEAD will apply a different risk adjustment model to each beneficiary category (Aged and Disabled (A&D), End-Stage Renal Disease (ESRD), and High Needs). Models will be re-calibrated for use in LEAD based exclusively on beneficiaries in the beneficiary category to which the model applies:

- **High Needs:** CMMI Concurrent Model V2
- **ESRD:** 2023 V28 CMS HCC Prospective Model
- **A&D:** 2024 V28 CMS HCC Prospective Model (Calibrated on a non-High Needs Population)



## **Apply Discount and Quality Withhold**

- **1.75%-3% Discount:** Applicable to ACOs in Global risk; applied as reduction to the PY benchmark before the shared savings/shared losses calculation. Higher-spending ACOs will have a 1.75% discount in PY1 that will increase by 0.25 percentage points annually until it reaches 3% in PY5. Lower-spending ACOs will have a 3% discount beginning PY1.
- **3% Quality Withhold:** Portion of benchmark at risk based on quality performance; ACOs can earn back some or all.

## ✓ What is the definition of a **higher-spending ACO**?

- A **higher-spending ACO** is an ACO whose aligned beneficiaries have higher Medicare costs compared to similar beneficiaries in the same geographic region.
- A **lower-spending ACO** is an ACO whose aligned beneficiaries have lower Medicare costs compared to similar beneficiaries in the same geographic region.
- To determine an ACO's status, CMS will compare the ACO's historical benchmark amount, which reflects a blend of all three base years, to regional spending in the third base year for the alignable beneficiary population.

✓ When is the determination of an ACO being **high-spending or low-spending** made, and can it change over time?

- The higher-or-lower spending designation is made **before the beginning of each PY**. The **determination will not change during the PY**.
- The determination will always be based on comparing the ACO's historical benchmark amount, based on Base Years (BY) 1-3, to regional expenditures in BY3. Annual determinations will only reflect changes to the ACO's participant list for the PY.

- ✓ When is an ACO subject to the **3% cap** on the ACO Specific Adjustments?

The 3% cap on benchmark adjustments applies to lower-spending ACOs when 40% or more of their participant TINs have participated in the Shared Savings Program in the last 2 years.



# Live Q&A: Benchmarking Methodology

Please type your question about **benchmarking methodology** in the **Q&A box**.

If we do not get to your question, we welcome you to email the LEAD Team at [LEAD@cms.hhs.gov](mailto:LEAD@cms.hhs.gov). We will aim to answer unaddressed questions via emails and upcoming FAQs.

# Capitated Payments

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# Key Payment Components

LEAD provides participants with **monthly upfront cash flow to invest in care improvements** and **greater flexibility** to deliver patient-centered care that **does not rely on fee-for-service, volume-based billing**. LEAD offers the following payment options:

## Primary Care Capitation (PCC)

- LEAD ACOs can get predictable, upfront monthly payments for primary care services delivered by ACO Participant and Preferred Providers to help them invest in new care capabilities.

## Total Care Capitation (TCC)

- For those in the Global Risk Option, LEAD also offers the option of capitated payments for all Medicare Parts A and B services delivered by ACO Participant and Preferred Providers, including both primary and specialty care.

## Advanced Payment Option (APO) and Non-Primary Care Capitation (NPCC)

- For ACOs that select PCC, the APO and NPCC are options to enter downstream payment arrangements with non-primary care providers (e.g., specialists and post-acute care facilities). Following ACO REACH, APO is an upfront monthly payment that will be reconciled against actual fee-for-service billing, while NPCC is a new mechanism that acts as a true capitated payment.

## Add-On Capitation Payments

- As noted, LEAD will include an add-on capitated payment to provide an additional source of upfront cash flow for eligible ACOs.

- ✓ What happens to **specialists in a Participant TIN** for an ACO that has elected PCC? Are their claims included in the PCC calculation and subject to claims reductions?

Non-primary care specialists that bill under a Participant TIN are not eligible for PCC.

Their historical claims are not included in the calculation of the Base PCC and their claims filed during LEAD performance will not be reduced.

Non-primary care specialists in a Participant TIN will still be able to participate in upfront or capitated payments through the Advance Payment Option or Non-Primary Care Capitation.

- ✓ How is **Advanced Primary Care Management (APCM)** treated in capitated payments?

In PY2027, APCM will not be included in capitated payments. It will be paid separately via fee-for-service claims.

✓ Will **capitated payments** be updated midyear due to Hybrid Alignment?

Yes, capitated payments will be updated to account for newly aligned beneficiaries added during the mid-year alignment period.



## Live Q&A: Capitated Payments

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# Quality

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# Quality Plans and Measures

## LEAD's Quality Approach

- ACOs can earn back a **quality withhold up to 3%** of their benchmark based on performance on the LEAD quality measures, as well as implementation of a Prevention and Quality Plan (PQP).
- **The High Performers Pool (HPP)** and **Continuous Improvement or Sustained Exceptional Performance (CI/SEP) adjustment** incentivize ongoing, meaningful quality improvement throughout the model.
- Each ACO will choose a **prevention intervention** based on the unique needs of their patient population (e.g., falls prevention, controlling high blood pressure) and implement a PQP.

## New Electronic Clinical Quality Measures (eCQMs)

- LEAD will phase in the **Controlling High Blood Pressure** and **Diabetes: Glycemic Status Assessment >9%** measures during the first four years of the model.<sup>1</sup>
- ACOs will only be required to report eCQM data for **aligned Medicare beneficiaries**.
- CMS expects to provide technical support to those who choose to submit eCQM data in 2027-2028



1. These two new quality measures will be rolled out in phases, initially offering flexible, supported electronic submission options, with the goal of aligning with CMS's digital quality strategy over time.

- ✓ What are the **quality measures** for the LEAD Model, and how do they compare with ACO REACH?

Measure	Submission Type	Included in ACO REACH?
Risk-Standardized All Condition Readmission	Claims-based	Yes
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims-based	Yes
Days at Home for Patients with Complex, Chronic Conditions	Claims-based	Yes
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	Claims-based	Yes
CAHPS® Survey	Patient-Reported	Yes
Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM	No
Controlling High Blood Pressure	eCQM	No

✓ Which **quality score bonus points/adjustments** are LEAD ACOs eligible for in 2027?

Do these include the eCQM bonus, Prevention and Quality Plan, Continuous Improvement/ Sustained Exceptional Performance, and the High Performers Pool?

- Prevention and Quality Plan Adjustment and eCQM Reporting Adjustment are available in PY 2027.
- Continuous Improvement/ Sustained Exceptional Performance (CI/SEP) adjustment and High Performers Pool are not available until an ACO's second PY.



## Live Q&A: Quality

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# High Needs and Dually Eligible Populations

# Medicaid Integration for Dually Eligible Beneficiaries

LEAD aims to expand access to integrated Medicare-Medicaid care for dually eligible beneficiaries while realigning financial incentives to increase accountability and reduce cost shifting between the programs.



## Medicaid Integration

- **LEAD aims to promote Medicare-Medicaid integration for dually eligible beneficiaries in Original Medicare** by creating incentives for ACOs and state Medicaid agencies or Medicaid Managed Care Organizations (MCOs) to coordinate care and improve outcomes.
- **CMS will select two states to partner with to develop a framework for supporting Medicare-Medicaid integration** during a planning phase that will begin with the release of the LEAD Request for Applications. CMS will work with selected states to define how ACOs and Medicaid organizations can work together to share data, coordinate care, and share in savings to improve outcomes. Pending successful completion of the planning phase, ACOs in those states will have the option to enter into partnerships with Medicaid organizations.
- **LEAD Medicare-Medicaid integration will include Medicaid-based alignment**, meaning that CMS will align beneficiaries to a LEAD ACO if they are enrolled for Medicaid benefits in the MCO (or affiliate) or Medicaid fee-for-service (FFS) program that has a partnership agreement with the ACO (and are not already aligned to another ACO).

- ✓ Which two states is CMS planning to partner with for the **Medicare-Medicaid integration** component of LEAD?

CMS is currently engaged in the planning phase for the Medicare-Medicaid integration component. This includes having discussions with interested states about their capacity to participate.

# High Needs and Dually Eligible Populations FAQs

✓ How does LEAD's benchmarking strategy **support organizations** who focus on **providing care for High Needs** beneficiaries, particularly over a 10-year model period?

- LEAD applies the Concurrent Risk Adjustment model for all beneficiaries that meet the High Needs criteria across all ACOs.
- Benchmarks and trend factors are calculated separately for each beneficiary category for each ACO, which will lead to more accurate benchmarks for the High Needs population.



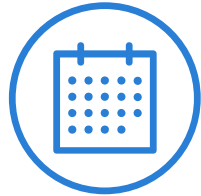
## Live Q&A: High Needs and Dually Eligible Populations

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# Closing and Resources

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## **LEAD Alignment and Financial Methodology Office Hour**

- Tuesday, May 5, at 2:00 PM ET
- Register [here](#)



**Email:** [LEAD@cms.hhs.gov](mailto:LEAD@cms.hhs.gov)



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- LEAD Model [Overview Resource](#) and [Value Factsheet](#)



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