Long-term Enhanced Accountable Care Organization (ACO) Design (LEAD)
Application Office Hour
April 21, 2026

>>Maiya MacAlpine, Deloitte: Hello, and welcome to the Long-term Enhanced Accountable Care Organization (ACO) Design, or LEAD Model Application Office Hour. Next slide, please.

Before we get started, we will share some brief housekeeping remarks. During today's presentation, all participants will be in listen-only mode. We recommend that you listen via your computer speakers, but we also have the option to dial in from your phone. Dial-in information is available on the screen. Today's presentation is being recorded. If you have any objections, please disconnect from the call at this time. Closed captioning is also available at the bottom of your screen. And additionally, at the end of the event, you will be directed to a brief survey to collect your feedback on the event. Next slide, please.

Now we will review our agenda for today. So first, we will start with a welcome and introductions. Then, the LEAD Model Team will provide an overview of the model's application, including when applications are due. Then, we'll discuss LEAD's eligibility and participation requirements, benchmarking methodology, capitated payments, quality, and High Needs and dually eligible populations. We will have a few minutes for Q&A for each topic, before moving on to the next section. Please feel free to submit any questions you have in the Q&A box. We also welcome you to e-mail the LEAD Team at LEAD@cms.hhs.gov. We will share this e-mail address in the chat.

This slide deck will be available on the LEAD Model webpage in the coming weeks. I will now pass it over to Lucy Sola, the LEAD Model Co-Lead, for welcome and introductions. Next slide, please.

>>Lucy Sola, CMS: Hello everyone. As Maiya mentioned, my name is Lucy Sola, and I am the Co-Model Lead for the LEAD Model, here at CMS. As part of the CMS Innovation Center, we develop and test new health care payment and service delivery models, aiming to improve patient care and lower cost. We are excited to launch the Long-term Enhanced Accountable Care Organization Design Model, or LEAD Model, a nationwide 10-year, voluntary Innovation Center model, launching on January 1st, 2027, following the conclusion of the ACO REACH Model.

Now, I will introduce the rest of today's speakers. First, I am joined by Meredith Yinger, and we are both the Model Co-Leads for the LEAD Model. And then, we're also joined by Emily Bezold, a Technical Advisor at the CMS Innovation Center, specifically on ACO models. We can go to the next slide.

So, we're going to go ahead and just jump right into the office hours for today. The first set of slides, and as Maiya mentioned in her opening remarks, the way we structured this for today, we're going to have a couple slides on material, and then we'll have a targeted section of

answering questions, as related to that topic. So, the first section will be on some of the more technicalities of the application. So, we just wanted to review some of those technical details with you all.

To start off, the LEAD application for the 2027 Performance Year is available. The link for it is available here, and the team will drop it in the chat as well. Applications are due by May 17th at 11:59 PM Eastern. The Letter of Interest, or LOI, as we call it, is also now available on the LEAD Model webpage. And we do have a direct link that we sent out to the listserv on Monday. And it will also close on May 17th at 11:59 PM Eastern.

The LOI is not required if you are planning to apply for PY 2027. It is really intended for folks that are interested in potentially participating in future cohorts of the model to submit their Letter of Interest. So that way, we are able to stay in touch with you all, on future application deadlines, and things like that. It is not required to be able to participate in those future cohorts. So, it's non-binding, optional, not required. Just wanted to answer some of those questions, because we've been seeing them come in via the help desk.

Then another core component, that we have been getting communication and questions about, is streamlining the application from ACO REACH, for current ACO REACH participants, into LEAD. So, current REACH ACOs do have the ability to submit a streamlined application to LEAD. To qualify for that, they either, the ACO either needs to be using the same ACO entity Tax Identification Number, or TIN, on the LEAD application, as is used in ACO REACH, or they are required to submit an attestation in the ACO REACH 4i platform, that confirms a variety of details about the ACO. Confirming, that if they have formed a new entity, they still largely are operating with similar infrastructure, a similar executive team, things like that.

To submit that attestation, ACOs should go into the 4i platform, navigate to the Operations Module in the Document Submission Feature, and then up upload that attestation under the Change in Legal Business Name or TIN category. And then we will receive those, and confirm that you're eligible for that streamlined application, on our side of things.

And then to access that streamlined application, applicants should select that they are a current REACH ACO in that application, and the tool will automatically populate that streamlined application. It's basically shortened, it's a shortened application compared to the overall LEAD application. So, it will just be a shorter set of questions. And the ACO should assume that everything is all set regarding their attestation, unless you hear otherwise from us as a team. We can go ahead and go to the next slide.

Another piece that we wanted to point this group's attention towards, are the "Helpful Links" that we have available in the application. So, this is a screenshot of the actual application home page for the LEAD Model. And you'll see on that right-hand side, what we've outlined in that red box, are a variety of links that are meant to be helpful to you all as applicants. So, we have things like the User Manual for navigating Salesforce, an Application Checklist with helpful tips and tricks

to complete the application, FAQs that are more technical in nature, not as policy-focused. And the policy-focused FAQs are on the LEAD website.

The New Entrant Provider Check, which is an Excel document that ACOs that are interested in applying to the model and want to see how they may be scoring on that new entrant criteria. They can submit that information with their ACO entity TIN, and the TINs, or the Participant TINs, that they are looking to bring in. And that is due to us on April 27th. And then we will go and assess and see if that ACO entity and if that TIN have participated previously. It's important to note, that is not like a final determination of if your ACO is considered a Newly Entering ACO. But it's meant to give you all information on how you're scoring on that criteria, so you can make informed decisions, especially around beneficiary alignment minimums, and whether or not you are meeting them. And then finally, we also have that PDF on the eligibility for that streamlined LEAD application. And that's also available in 4i, on the ACO REACH 4i platform.

Okay, I think that's everything we had in terms of slide content here. But now we can move into some application questions. Are there any questions that we can help answer? Meredith, I see you.

>> Meredith Yinger, CMS: Yeah, we're getting several of the same questions in the chat. Lucy and I think we can address several of these.

So the first one is: “Whether folks need to have a final Participant TIN List and their agreements with those participants in place in order to submit an application? And if not, what the timeline for that looks like?” Could you speak to that a bit?

>>Lucy Sola, CMS: Yes. And so, I'll have a couple more slides on this shortly, but Participant TIN rosters are not required for the LEAD application. We are not collecting them as part of the application. And we will plan to, once folks are accepted into the model, then we will onboard folks onto the 4i platform, and that is the process, when they can start adding Participant TINs to their roster. That will be in late June, early July, that we're hoping to do that onboarding on to 4i. And then the window will close for adding Participant TINs on August 5th. And then the final date to drop TINs, is September 8th of 2026.

>> Meredith Yinger, CMS: Thanks so much, Lucy. We've gotten a couple other questions about the New Entrant Tool, and where folks can find the template that they need to submit for us. Could you talk about that? And then could you talk about the deadline, and how they should submit it to us, and all that helpful stuff?

>>Lucy Sola, CMS: Yeah. So under that “Helpful Links” that should pull down the template for you all. And then it is due April 27th at 11:59 PM Eastern. And then, we will return results within the following two weeks after that, before applications are due. And I would anticipate that what will be returned is information on whether the ACO entity has participated in the Medicare Shared Savings Program, or the ACO REACH Model, and then same for the Participant TINs that are included. Folks should submit that via the help desk. And there are more, there are more

instructions on that, and the password to include, in the document. And if you have any questions, please feel free to reach out to the LEAD help desk. And we are monitoring it closely, and will continue to answer questions there too.

>> Meredith Yinger, CMS: Perfect, thanks so much, Lucy. I also see that a number of our other colleagues on the LEAD Model Team are providing helpful answers in the chat. So, encourage folks to continue submitting questions to the chat and we'll get to those in writing, as we have time. But I think we should probably move on to our next section, so we can address all the questions across the different components of the model.

>>Lucy Sola, CMS: Awesome, thanks Meredith. So next we'll move into the eligibility and participation requirements section of the office hours. So we can go ahead, and go to the next slide.

So LEAD is designed for a wide spectrum of healthcare providers and folks in the healthcare system, including those who haven't participated in ACOs previously, and those who have, and then including organizations that also have a focus on High Needs or dually eligible beneficiaries. We have two different types of participants in LEAD. The first is Participant TINs, which are the TINs that we are actually having uploaded to us on the roster. And then all the NPIs billing under that TIN would be considered Participant Providers. Participant Providers and Participant TINs are the ones that are driving alignment under the model, and responsible for quality outcomes. They must participate in capitation, things like that.

And then Preferred Providers are typically like more specialist type providers or facilities. And they are not driving beneficiary alignment in the model. And they do not drive beneficiary alignment, which also means that they are not driving quality outcomes. And they are also not required to participate in capitation, but it is optional to them. We can go ahead and jump to the next slide.

So, this one goes over beneficiary alignment. So, this should, this slide should look familiar if others have been on the other webinars that we've been on. LEAD is introducing a new option for more timely beneficiary alignment, and more transparency for ACOs. So, ACOs will receive beneficiary alignment through claims-based alignment and voluntary alignment. Claims-based alignment is looking at claims utilization patterns, and determining where the beneficiary is receiving care. Voluntary alignment is when a beneficiary is attesting to who their primary provider is, or where they consider their main source of care.

In LEAD, we do have a novel concept, Hybrid Alignment, which is allowing ACOs to update their beneficiary list during the Performance Year. Voluntary alignment will now be able to be updated on a monthly basis. And then, claims-based alignment will be updated once prior to the Performance Year. And then, if the ACO adds new TINs during the Performance Year, we will go ahead and update claims-based alignment for those newly added TINs. And that is meant to be

really only adding beneficiaries in, and not pulling them away from other models, or other shared savings initiatives.

So that's just a little bit of background, to help tee up some of the questions. And then, I think we can go to the next slide, where we'll go over some of the FAQs that we've been getting. So, the first that we've been hearing a lot is: "Confirmation on what the criteria is to be considered a Newly Entering ACO, and then what is the criteria for Renewing ACO?"

So, Newly Entering ACOs must meet all of the following criteria. So, the ACO entity must not have participated in the Shared Savings Program, or ACO REACH previously. Fewer than 40% of their Participant TINs have participated in the Shared Savings Program or ACO REACH in the last five years. And then, fewer than 50% of the ACO's Participant Providers have participated in Medicare ACO initiatives in the past five years. If all three of those criteria are met, then the ACO would be considered a Newly Entering ACO.

And that's also what we're trying to assess in that Newly Entering, in that New Entrant Tool that I was talking about, in the application. So, trying to help ACOs understand how they're scoring on these different criteria. And then, any ACOs that do not meet all three of those Newly Entering ACO criteria will be considered a Renewing ACO. We can go ahead and jump to the next slide.

And then another common question that we have gotten is: "What the claims look-back window is for the initial alignment run, and then also for the Hybrid Alignment update?"

So, the claims look-back period is the time frame that we're looking for claims history, a beneficiary's claims history, to determine who was providing the plurality of care in that time frame. So, the look-back window for January 1st alignment is going to be from October 1st to September 30th prior to the Performance Year. So for PY 2027, that would be October 1st, 2025 to September 30th, 2026, and then the Performance Year would start January 1st, 2027. And then for Hybrid Alignment, which is the update in the middle of the Performance Year, the claims look-back period will match the calendar year prior to the Performance Year. So for PY 2027, that would look like January 1st, 2026 to December 31st, 2026. And that look-back period would only be applied to beneficiaries that are added mid-year.

And then I think there are more questions in here. And then we did talk about this on the prior slide, so just reiterating, the final dates to add and drop Participant TINs. So, for adding Participant TINs, ACOs have until August 5th to add Participant TINs and Preferred Providers to LEAD. And then September 8th, 2026 is the final drop deadline to drop Participant TINs and Preferred Providers. If an ACO was pursuing an application with the Medicare Shared Savings Program and with LEAD, then all those overlaps must be resolved by September 8th of 2026. And we do anticipate that some of you all are applying to both as you assess LEAD.

Okay, I think we can go to open Q&A for a couple minutes.

>>Emily Bezold, CMS: Yeah, and Lucy, I'm seeing a couple of questions in the chat here consistently, where I think some clarification would be helpful. One is a topic you were just touching on, so with that Hybrid Alignment, where people are able to add Participant TINs mid-year. The question is: "Will claims-based alignment still occur throughout the year for all beneficiaries and all TINs, or will that be limited just to the newly added TINs?"

>>Lucy Sola, CMS: It's limited to the newly added TINs.

>>Emily Bezold, CMS: Great. And then there's a question here: "For claims-based alignment, does that only look at professional fee claims?" So, I'm wondering if you could talk just a little bit about what types of claims, and what types of services feed into the claims-based alignment.

>>Lucy Sola, CMS: Yeah, I would point you to, I believe it's Appendix C, in the RFA. There's a list of codes that we kind of consider those Primary Care Qualified Evaluation and Management services, or PQEM, services. But we are looking for certain services that we would think that beneficiaries would have with their main provider, that is providing the main source of care. And there is a comprehensive list that is available in the LEAD RFA.

>>Emily Bezold, CMS: Perfect, thanks Lucy. All right, last question, and then I think we're going to have to move on to our next section. So: "Will the LEAD Model require Participant TINs or Providers to execute fee reduction agreements, similar to those required under REACH? And any information that we can provide yet about the timing and guidance for those agreements?"

>> Lucy, Sola, CMS: Yeah, more guidance will be forthcoming, and we do anticipate that fee reduction agreements will stay in place. And I don't think that we are going to, for folks who are familiar with the Shared Savings Program, there wouldn't be a requirement to have a full Participation Agreement signed with providers by September 8th. It would only by like, end of year. And more guidance will be forthcoming on that one, in the participant management methods papers.

>> Emily Bezold, CMS: Perfect, thank you Lucy. And I think with that we can move on to our next section.

>> Lucy, Sola, CMS: Awesome, thank you.

>> Emily Bezold, CMS: All right, so I'm going to take us through a few background slides on the benchmarking methodology, and then we'll open it up to questions here.

So to start, as we've said, I think across every webinar we've had now, our benchmarking methodology is really designed to work both for ACOs that are new to accountable care models, and experienced ACOs, that have maybe had some success under previous models. And so, the benchmarking approach has different features, that are designed for both of those types of organizations.

So for all ACOs, we'll start by calculating a baseline benchmark that is based purely on historical expenditures. And that baseline will be a three-year average of historical claims, from the three base years that are immediately prior to the ACO's first Performance Year. So for 2027, that means the base years are 2024, 2025, and 2026. And base years will be weighted differently depending on whether an ACO is a Newly Entering ACO or a Renewing ACO.

So for new ACOs, we'll put the most weight on the most recent base year, so 60% on Base Year 3, 30% on Base Year 2, and 10% on Base Year 1. The idea is that we're putting more weight on the most recent year, because that most accurately represents the ACO's current population. For Renewing ACOs, which could have past experience in either SSP or ACO REACH, we'll be putting an equal weight on each of those base years. And that, we want to avoid ratcheting down the benchmark by putting more weight on a more recent year, where maybe an ACO has had the opportunity to generate more savings.

So, we'll start with those base years, and then we'll apply some ACO-specific adjustments. And in particular, the two adjustments here are specific to ACOs who likely have had some success in past models or already been able to generate some efficiencies. So, the two potential adjustments for those types of ACOs are: A prior savings adjustment, and ACOs are eligible for this, whether they're in the Professional or the Global Risk Track. And they'll be eligible based on savings in the three base years, so that 24, 25, 26 that I just mentioned for 2027. And it'll be equal to 50% of the average annual savings in the three base years.

And I just want to say up front, we've been getting a number of questions about how exactly that will work, in particular for ACOs that maybe have participants who are coming from different ACOs. So maybe some, 50% of ACOs were in one prior ACO, and 50% were in another, how are we going to handle that? I'll say that more detail, that level of detail will be available in our methodology papers, available this summer. But we are, in general, intending to align with the SSP approach to this adjustment, as much as possible. So would recommend checking out the SSP guidance on how this adjustment is calculated in the Shared Savings Program, to get a sense of how this policy is likely to shape up.

The second possible adjustment here, is a positive regional efficiency adjustment. So, this is for ACOs in the Global Risk Option only. So, ACOs who are regionally efficient, meaning that the average fee-for-service spending for their aligned beneficiaries is lower than average spending in their region. And to calculate this, we'll be comparing the ACO's historical benchmark, so the amount that I talked about in that step one that's the blend of the three base years, we'll be comparing that amount to average regional spending in Base Year 3 of the model. And it'll be equal to 50% of the difference between those two. Again, our intent here is to align with the Shared Savings Program. So, for those of you who are familiar with this methodology, this should look similar.

ACOs who qualify for both of these, will receive the higher of the two. And they'll both be subject to a risk adjusted cap of 5% of U.S. Per Capita Costs. And that risk adjustment is

important. This feature isn't available for the prior savings adjustment in SSP. So, this is an innovation in LEAD, that the cap will actually reflect the relative risk of your population. And so, it won't disadvantage ACOs that have a higher risk population.

And the last thing to say here, is that lower-spending ACOs, with 40% or more of their TINs that were in the Shared Savings Program in the prior two years, we'll have a 3% cap instead of a 5% cap. So, we've gotten some questions about that. And so that is, the really specific definition of who that 3% cap will apply to, is there on the bottom of the slide. All right, next slide, please.

Okay, so once we've applied those ACO-specific adjustments, then we'll be trending benchmarks forward to the Performance Year. And that trend factor will be a two-thirds, one-thirds blend. Two-thirds is actually a blend of national and regional trends, and it will be, the weight of national versus regional will depend on the ACO's market share in its region. So, for ACOs who have a greater market share in their region, they'll have more weight on the national blend. ACOs that have a lower market share will have more weight on the regional. And the idea is that if an ACO is contributing a lot to its regional blend, because it's one of the biggest players in the market, that we don't want to put so much weight on that trend, that it is already influencing with its own performance.

And then one-third is the Accountable Care Prospective Trend, which is a prospective amount, set before the start of the Performance Year. This is also used in the Shared Savings Program, but it will in LEAD, be subject to guardrails. So, to make sure that, let's say the forecasting of this trend ends up being far different from how spending growth actually trends in the year, the guardrails will ensure that this factor doesn't diverge too far from actual national and regional spend.

Then, after trending, we will risk-adjust benchmarks to account for the relative severity of each ACO's patient population. And will have a different risk adjustment model for each of the three beneficiary categories. So Age & Disabled, End-Stage Renal Disease, and High Needs will each have a distinct risk adjustment model. And the High Needs and A&D models will be recalibrated specifically for use in LEAD, just for the beneficiaries in that beneficiary category. So the Concurrent Model for High Needs will be based just on High Needs patients. The Prospective Model for A&D will be calibrated just on a non-High Needs population. And we expect that this recalibration will ensure that each model is more accurate for the beneficiary category that it's applying to.

And then the last step here in the methodology, is to apply the discount and the quality withhold. So, the discount is just for ACOs in Global Risk, and it represents CMS's portion of shared savings. So, CMS kind of takes the discount off the top, and then the ACO shares in 100% of remaining savings. ACOs who are higher-spending will have a 1.75% discount in the first Performance Year, that will ramp up slowly over time, until it reaches 3% in PY 5. Lower-spending ACOs will have a 3% discount from the start of the model, and that will remain static throughout the life of the model.

And then finally, the 3% quality withhold is the portion of the benchmark that's at risk, based on the ACO's quality performance. We won't actually withhold that money from payments, so you won't see that sort of held back from your capitation. It'll just be at risk, and then in your financial settlement, you'll have the opportunity to earn back some, none, or all of that 3%, based on performance. All right, next slide, please.

So this is a question we get a lot: "What is the definition of a higher-spending ACO?" It's really important, because it does affect some of those policies that I just described.

So at its highest level, a higher-spending ACO is an ACO whose aligned beneficiaries have higher total Medicare costs than similar beneficiaries in the same geographic region. And we'll be defining region at the county-level, so where the ACO service-level or service area at the county-level is. And of course, the flip side of that, a lower-spending ACO is one whose aligned beneficiaries have lower Medicare costs, compared to similar beneficiaries in the same region.

And to actually make that determination, we will be comparing the ACO's historical benchmark amount, the amount the average spending in the three base years before the start of the Performance Year, we'll be comparing that to regional spending in the third base year, for a population that is eligible to be aligned in that region. So again, this should look familiar to those of you who are familiar with the Shared Savings Program approach to the regional efficiency adjustment. This is following a very similar methodology here. All right, next slide, please.

Another question we get a lot is: "When is the determination made, and can it change over time?"

So, we'll be making this designation before the start of each Performance Year, and then it will be fixed. So, it won't change during the Performance Year, even if for example, you dropped TINs, or you add TINs through Hybrid Alignment. We'll just be locking in that designation at the beginning of each Performance Year. And as we recalculate each Performance Year, the base years that it's based on will not change. So, we won't be rolling through the, rolling forward the base period over the model performance period. We don't want to penalize ACOs or change their status if they become more efficient over the life of the model.

But what we will be calculating for, is changes to the ACO's Participant List for the Performance Year. So if, for example, you were low-spending, and you add a bunch of new high-spending providers, we would recognize that in the designation. So, it's meant to avoid penalizing ACOs that really changed their composition over the life of the model.

I think we might have one more question, if we could go to the next slide. Okay, this question is: "When is an ACO subject to a 3% cap on the ACO-specific adjustments?"

So like I mentioned, those adjustments, the prior savings adjustment, the regional efficiency adjustment, are generally subject to a 5% cap. But, for a specific subset of ACOs coming from the Shared Savings Program, that will be a 3% cap. And the specific subset of ACOs, is lower-

spending ACOs who have 40% or more of their Participant TINs who were in the Shared Savings Program, in the last two years. So really specific set of criteria. All other ACOs will be subject to a 5% cap.

Okay, and with that, I think we might have time for a few questions from the chat on benchmarking.

>>Meredith Yinger, CMS: Thanks so much, Emily. That was very comprehensive.

I will start by saying that there are a lot of questions in the chat that are extremely detailed, and so if you're not getting an answer from us today, please know that we've taken note of your question. We will provide more information as soon as we're able to, and oftentimes that's going to be in the financial methodology paper. That will be available over the summer.

I'm just looking quickly through the Q&A, so bear with us. I think, Emily, that there's one question about, for the higher or lower spending designation, that you've talked about extensively. If we can discuss whether we're comparing risk-standardized costs?

>>Emily Bezold, CMS: Good question. Yes, they will be risk-standardized. So we'll be taking into account differences in risk between the ACO's population and the general, regional population, and accounting for those in the comparison.

>>Meredith Yinger, CMS: Awesome, thanks so much. I think that given the time, we should probably move on to the next section. But if folks have additional questions about the benchmarking methodology, feel free to put them in the chat, and we will try to get to those in writing.

Okay, so I'm going to slide right into the capitated payment section here. So, I think folks have heard us talk on a couple of additional webinars about the prospective payment options that are available to participants under LEAD. And the real goal with these prospective payment options, is to provide ACOs and their Participant Providers with predictable, stable monthly cash flow, that they can use to invest in care improvements, and have greater flexibility in the way that they deliver care to their aligned beneficiary population, instead of being locked into some of the requirements that we see in the fee-for-service system.

There are a couple of different options for capitated payments for LEAD ACOs. I'll walk through those briefly, understanding that we've discussed them in some of these previous events. So, all ACOs will be required to choose between either Primary Care Capitation, or Total Care Capitation. Total Care Capitation is only available to those ACOs that are enrolled in LEAD's Global Risk Option. And so, Total Care Capitation is the sort of full capitation option that includes all Medicare Parts A and B spending, delivered to align beneficiaries by providers who are enrolled in this payment mechanism.

ACOs that are not in Global Risk, or do not choose TCC, will be enrolled in the Primary Care Capitation option. And the Primary Care Capitation option focuses on providing monthly,

capitated payments for those primary care services being delivered by the participant organizations in the ACO. It includes that Base PCC, as well as an Enhanced PCC. And the Enhanced PCC is calculated basically by taking the difference between 7% of an ACO's benchmark and subtracting out the percentage of the Base PCC.

And so really what we're doing, is we're providing cash flow through the Enhanced PCC, that ACOs can use to invest in care transformation. And you don't have to wait for your shared savings to come through after the end of the Performance Year to make those investments. The EPCC does have to be repaid at the end of the Performance Year, and so it gets netted out of the ACO's shared savings.

Very quickly, those ACOs that do participate in Primary Care Capitation have the option of choosing either the Advanced Option, or Non-Primary Care Capitation, in order to receive prospective payments for non-primary care services.

And higher-spending ACOs will be automatically eligible for the administrative add-on. So, the administrative add-on is a monthly capitated payment that is provided to those higher-spending ACOs, that's equal to 1.5% of their Performance Year benchmark. And the add-on does not have to be repaid at the end of the Performance Year, nor does it count towards the calculations for an ACO's shared savings. And so, it really provides an additional level of cash flow for these organizations, so that they can immediately begin investing in enhanced care services. And that that is meant to really supercharge their ability to succeed in the model over time. Let's go ahead and go to the next slide.

Okay, so we're going to walk through a couple of the most common questions we've gotten about LEAD's prospective and capitated payments. The first one is: "What happens to specialists that are in a Participant TIN for an ACO that has elected PCC, or Primary Care Capitation? Are their claims included in the PCC calculation or subject to claims reductions?"

So, we've discussed that LEAD takes a full Participant TIN approach to participation. And the way that this is going to work for capitated payments, is that we will automatically enroll the primary care specialists billing under that Participant TINs into PCC. So primary care specialists will have their claims included in the calculation of PCC, and they will see claims reductions as a result of the fact that we are paying for those services through capitation.

Non-primary care specialists that are billing under a Participant TIN are not going to be eligible to participate in PCC. So, we're going to automatically exclude them. And as a result of that, those specialists' historical claims are not included in the calculation of the Base PCC, and they, the claims for those specialists also won't be reduced during LEAD performance. ACOs will have the option to enroll those non-primary care specialists in our other capitation options. So that includes for an ACO that's participating in PCC, the Non-Primary Care Capitation or Advanced Payment Option, if there is an interest in having those non-primary care services flow through a prospective payment. Let's go to the next slide, please.

We've also been asked a couple of times how the Advanced Primary Care Management codes are being treated, for the sake of participation in LEAD. And we did want to clarify that for Performance Year 2027, Advanced Primary Care Management codes will not be included in LEAD's capitated payments. APCM will be paid separately, via fee-for-service claims, and those claims won't be reduced.

I'm going to answer one more question that we've gotten several times in the chat. Folks would like to know: "Whether they will be able to change the capitation selections that they make in their LEAD application before the Performance Year starts in 2027, or if they're locked into the selections that they're making in the application?"

The answer to that is: You will have the option to change those if you are selected for participation. So, once we begin onboarding selected ACOs over the summer, folks will gain access to the 4i platform, where we manage ACO's participation in the model. And you will be able to elect, sort of your final choice of capitation options then. So, you're not locked in. But it's helpful for us to understand what options folks are interested in and looking at. And so, we do want you to give us your best guess on the application.

Do we have one, maybe two questions in the live chat, we're able to answer?

>>Emily Bezold, CMS: Yeah Meredith, I'm seeing a question here, that also ties to alignment: "So what about alignment to the specialist? Will non-PCP specialists under a TIN be given alignment, and I think receive the capitation as well?" If you could speak to that.

>>Meredith Yinger, CMS: Yeah, sure. So, there's a list in the appendix of the RFA that describes the specialist that can potentially contribute to alignment for LEAD ACOs. But I think you heard Lucy talk earlier about LEAD's alignment methodology, which really first considers whether an aligned beneficiary has a primary care relationship. And then, if we're not seeing a primary care relationship in the claims, we will consider whether there is a specialist who is serving as that usual source of care. And so, beneficiaries can get aligned to certain types of specialists, that are in Participant TINs. And we encourage you to look at the RFA for more information there. But those non-primary care specialists will not be enrolled in PCC.

>>Emily Bezold, CMS: And I'm not seeing a lot of other capitated payment questions at this time. So maybe we can go ahead and move on to our next section.

>>Meredith Yinger, CMS: Excellent. Okay, let's talk a little bit about LEAD's quality strategy. Let's go ahead and go to the next slide.

This is probably a familiar slide to folks that are on the phone today. LEAD includes a 3% quality withhold, which essentially means that 3% of a LEAD ACO's benchmark is held at risk, based on ACOs performance on the LEAD quality measure set. There are a number of opportunities for LEAD ACOs to earn additional bonus points on top of that quality measure set. And so those include the development and reporting on a Prevention and Quality Plan, or PQP.

And then, in an ACO's second year of performance and beyond, they can also earn additional points through the High Performers Pool, and the Continuous Improvement/Sustained Exceptional Performance. And these are for ACOs who show year-over-year improvements in quality, and even for those folks who are sort of at the highest levels.

Folks have also heard us talk about how LEAD is introducing two new electronic clinical quality measures. These are the Controlling High Blood Pressure measure and the Diabetes: Glycemic Status Assessment measure. We will be introducing these in a phased approach, so in 2027 and 2028, reporting of these eCQMs will be optional for LEAD ACOs that are participating, and those who do report them can earn bonus points to your quality score. In 2029, we will transition to paying ACOs for successful reporting of these measures, and we're only going to be looking at ACOs to report on their aligned Medicare beneficiaries. And then in 2031 and onward, we will be paying based on performance on these measures.

The goal of this approach is to give ACOs a lot of time and notice to begin transitioning their EHR capabilities, and other sort of important capabilities in the practices, to be able to reliably report this data to us. But it is important and aligns closely with LEAD's prevention strategy. Let's go to the next slide and answer a couple of questions we've gotten on the quality strategy. So the first is: "What are the quality measures for the LEAD Model, and how do they compare with ACO REACH?"

So we've included a table here. This is all of the measures that are included in the LEAD Model. You'll see that we have four claims-based measures, one patient-reported measure, and two eCQMs, that we just talked about. The first five measures were all included in ACO REACH. The two eCQMs are the new ones here. Let's go to the next slide, please.

Okay, and then there've been some questions that have come through about which quality score, bonus points, or adjustments that eligible, that ACOs will be eligible for in 2027. And so, we wanted to clarify that folks will be eligible to get an adjustment for both their Prevention and Quality Plan, as well as eCQMs reporting, in PY 2027. And these will essentially help you earn bonus points. But the CI/SEP, or Continuous Improvement/Sustained Exceptional Performance, adjustment and High Performers Pool won't be available until PY 2028, or an ACO's own second performance period.

All right. I think we have time for one or two quality questions, if we're getting any in the chat.

>>Emily Bezold, CMS: Yup. So, Meredith, one question I see is: "To confirm until 2031, ACOs can submit eCQMs for bonus points, regardless of the performance. Is that correct, or does performance in any way affect the bonus score?"

>>Meredith Yinger, CMS: Yeah, that's correct. So, any kind of reporting is going to sort of provide bonus points to the ACO's score until 2031, when we transition to full pay-for-performance on those eCQMs.

>>Emily Bezold, CMS: Great. And then I'm seeing a question about reporting eCQMs on ACO-aligned beneficiaries versus all payers, all patient populations. Can you just confirm that detail?

>>Meredith Yinger, CMS: Yeah. So one of the things, one of the strategies that's really driving the way that we are implementing these eCQMs, is to ensure that ACOs have time to implement whatever they need to be able to successfully report these electronic clinical quality measures. And this is partially a learning from other CMS programs, where we've heard from ACOs that the implementation process for reporting eCQMs is burdensome, but it also just takes a lot of time to work through. And so, want to make sure we're providing sufficient time. But one of the other things we are doing, to try to alleviate some of that burden, is reducing down the population that we're asking folks to report on, to only those Medicare LEAD-aligned beneficiaries.

>>Emily Bezold, CMS: Great. Thank you, Meredith. I think that was the last quality question we have at the moment. So, I'll go ahead and take us into the our High Needs or dually eligible population section.

And I'll start with just a little bit of background on the Medicaid integration component of LEAD. So, this is an element of the model that is really new to LEAD, that hasn't been tested in prior ACO models. And therefore, we'll be starting out piloting it in two states to begin with. And with those two states, we'll be engaging in a planning period. That planning period will kick off from about now, through the end of 2027. And during that time, we'll be working with states to define expectations for the partnership agreements between participating ACOs and the state, or the managed care organization that is the state's designee. So, we'll be developing that framework.

And then beginning in 2028, ACOs will actually have the opportunity to enter into those partnership agreements with Medicaid entities. And really, the goal of these partnership agreements is to integrate Medicare and Medicaid benefits for dually eligible beneficiaries who are in Original Medicare. So traditionally, integration efforts have focused on beneficiaries who are in managed Medicare, and no one has been taking accountability for the Medicare aspect of benefits for these beneficiaries who still have Original Medicare.

So, the idea is that the ACO becomes the accountable entity, that then partners with the Medicaid entity in order to promote greater integration and coordination between the Medicare and Medicaid sides. So ideally, this will lead to better care coordination. And ACOs and their partners will define how they'll be coordinating care for beneficiaries, how they'll be sharing data, so they have line of sight into both sides of the house. And then also, how they'll share in savings that might be generated by this coordination. So whether that's investments on the Medicaid side that are generating savings on the Medicare side, or vice versa.

And then finally, we'll have this Medicaid-based alignment element. Which means that if a beneficiary is enrolled to receive Medicaid benefits with a Medicaid entity partnered with an

ACO, and they don't already have alignment to an ACO or are not already in an accountable primary care relationship, they'll be aligned to that partner ACO. So, the idea is that we're finding beneficiaries who are maybe falling through the cracks, don't have an accountable care provider, and connecting them to that accountable care relationship. Next slide, please.

So the question that we get most often here is: “Which two states are we planning to partner with?”

And we have not announced this yet. We are currently in talks with states who are interested in this component. And we’re hoping to be able to select states and announce selected states by the end of 2026.

One question that we get asked a lot is: “Do we have a way to influence the states that are selected, or what should we do if we're in a state and we really want our state to participate?”

And what we're saying is that we really encourage you to make sure that your state, and in particular your state Medicaid agency, is aware of your interest in the model. States have a lot of competing demands, when they're trying to decide what initiatives they want to partner in, or not. And so, I think it's really helpful for them to know that if they were to engage in the work, to set up this component, that they'd have organizations in their state that are interested. So again, really encourage you, if you are interested, to start having those conversations with your state Medicaid agency.

And I think with that, we have one more question about: “How LEAD’s benchmarking approach supports organizations who focus on High Needs beneficiaries?”

And there are a couple of components here. So, as we talked about, High Needs beneficiaries will be treated as a distinct beneficiary category in LEAD, across all ACO types. And all beneficiaries in this High Needs category will use the Concurrent Risk-Adjustment Model. And this is a model that uses diagnosis for beneficiaries from the current Performance Year, rather than looking at the prior Performance Year, in order to predict the future Performance Year.

And the reason for that, is we know that High Needs beneficiaries often have exacerbations or events that lead to sudden spending spikes during the year, that aren't appropriately captured by the Prospective Model. And so, the Concurrent Model ends up being much more accurate in predicting risk and predicting costs for High Needs beneficiaries. So, we tested this approach in REACH, for High Needs ACOs, and we're now expanding it to High Needs beneficiaries across all ACOs.

And then to complement that, will also be calculating distinct benchmarks and distinct trend factors. So, the trends that we use to increase benchmarks from the base year to the Performance Year will be distinct for High Needs beneficiaries. And the reason for that, is that we realize they often have different utilization that lead to different trend factors. And so, breaking it out and

doing it separately is another way to ensure that benchmarks here are more accurate for this population.

And I think with that, we may have time for a few questions both on the High Needs component and on the dually eligible population component.

>>Lucy Sola, CMS: Yeah, Emily, there is one question here on the dually eligible component, and they asked: "If dually eligible beneficiaries, would they be eligible for attribution outside of the two states that will be selected for collaboration with CMMI?" Would you be able to answer that?

>> Emily Bezold, CMS: Yes, good question. So absolutely, dually eligible patients will be able to be attributed to ACOs anywhere in the country. So, that won't be limited to the two states. It'll just be this aspect of partnership between ACO and Medicaid entities that is limited to two states. But dually eligible beneficiaries are widely eligible to be attributed to a LEAD ACO.

>>Lucy Sola, CMS: Awesome, thank you. I think that was everything I saw about dually eligibles. Are there any questions, Meredith that we should bring forward on High Needs that you're seeing?

>>Meredith Yinger, CMS: Yeah, I'm looking at the chat right now. I think one thing we've been asked a couple of times, Emily is: "Once a patient becomes High Needs, can they move back to being a traditional or Aged & Disabled beneficiary? And what are sort of our rules for that in LEAD?"

>>Emily Bezold, CMS: Yeah. So in LEAD, like in REACH, once a beneficiary meets the High Needs criteria, they'll continue to be High Needs for the life of the model, or as long as they're eligible for attribution. So, a beneficiary wouldn't move back from High Needs, back into the A&D category. Once they're High Needs, they're always High Needs.

And I also saw a question about how often we'll be checking whether beneficiaries are High Needs. And so, we'll be doing that on a quarterly basis in LEAD. And so, what that means is, on a quarterly basis, we'll be running your whole population against the High Needs criteria, and seeing if any beneficiaries newly qualified for those criteria. And at that point, they would then flip over into the High Needs beneficiary category in the next quarter, after they meet those criteria.

>>Meredith Yinger, CMS: I think those were all of the questions I saw. So, I think we could probably go ahead and move on.

>>Emily Bezold, CMS: Okay, great. Well, I see we answered a lot of questions today, but we also have a number of questions that we weren't able to get to. A lot of those questions are around the alignment and financial methodology, so we're excited to share that we'll be hosting an Alignment and Financial Methodology Office Hour on May 5th, at 2:00 PM. The registration link is available here.

Also, if you're not already signed up for the LEAD listserv, we'd encourage you to do that. That's where we send out additional information and registration links for future webinar events. And then if we could go to the next slide, we just want to highlight a couple of resources that are available.

So, the first is the help desk, which is LEAD@cms.hhs.gov. Any questions that you didn't get answered today, you're welcome to send to the help desk, and we will also respond to questions that way. We also have a number of resources that we've been adding to the webpage over time. And again, if you're signed up for the listserv, we try to send out send out notifications when we post new resources.

But this is definitely not static. We're adding new FAQs, we're adding new factsheets. So, encourage you to keep tabs on the LEAD Model webpage. We've highlighted a couple of resources here, but there are many more to come. We just recently posted the slides and the transcript from the RFA deep dive webinar that we had. And slides for this webinar will also be posted shortly. And then finally, again, a plug for that listserv. It is a great way to stay up to date on all the things that we're doing and posting and putting out.

And with that, we just want to say thank you so much for your time and your interest in LEAD. We are here to answer your questions. We appreciate hearing what's on your mind, what you're considering, what potential barriers to participation might be. So, we just really hope that you'll continue to keep sending those questions in, and encourage you to attend that upcoming Alignment and Financial Methodology Webinar.

And with that, thank you so much. And there will be a survey as we close. We appreciate your feedback on that as well.