Long-term Enhanced ACO Design (LEAD) Model Overview Webinar

January 29, 2026

>>Benita Lee, Deloitte: Hello everyone, and welcome to the Long-term Enhanced Accountable Care Organization Design, or LEAD, Model Overview Webinar. 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. The information to dial in is available on the screen. Today's presentation is also being recorded. If you have any objections, please hang up now. Closed captioning is also available at the bottom of your screen. Additionally, at the end of the webinar, 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. First, we will start off with a welcome and introductions. Then, the LEAD team will provide an overview of the model. Then, we will discuss LEAD's payment approach. Afterwards, we will answer common questions you submitted in your registration forms. Please feel free to submit any questions you have in the Q&A box as well. You can also email the LEAD team at LEAD@cms.hhs.gov. We will share this email address in the chat. This slide deck, along with a recording and transcript of today's event, will be available on the LEAD Model webpage in the coming weeks.

I will now pass it over to Meghan Elrington-Clayton, Director of the Division of Financial Risk at the CMS Innovation Center, for a welcome and introductions. Next slide, please.

>> Meghan Elrington-Clayton, CMS: Thank you, Benita. Good afternoon, everyone.

As Benita said, my name is Meghan Elrington-Clayton, and I am the Director of the Division of Financial Risk, here at CMS's Innovation Center. On behalf of the Center for Medicare and Medicaid Services, or CMS, we would like to welcome you to today's session. We are absolutely thrilled to have so many of you join us today to learn about our newest ACO model. At the Innovation Center, we develop and test new health care payment and service delivery models aiming to improve patient care and lower costs. We are excited to announce the Long-term Enhanced Accountable Care Organization Design, or LEAD, Model.

LEAD is a nationwide, ten-year, voluntary Innovation Center model. The LEAD Model will launch on January 1st, 2027, following the conclusion of the ACO REACH Model. The LEAD Model builds upon the Innovation Center's earlier accountable care work. It utilizes improved benchmarking to appeal to a broad mix of health care providers, including those with specialized patient populations, and those new to accountable care organizations, or ACOs. Historically, we know that many health care providers have not participated in, or have dropped out of ACOs, because of financial administrative challenges. LEAD is specifically designed to address these barriers by offering enhanced, flexible cash flow payments and greater freedom and tools to

support ACOs and their providers in spending time with patients and meeting patients' needs, including specialized care needs. Next slide, please.

I want to take a moment to introduce you to the rest of today's speakers, members of our LEAD Model Team. First, Emily Bezold will start off with an overview of the LEAD Model. Emily is a technical advisor for the Seamless Care Models Group here at the Innovation Center. Lucy Sola and Meredith Yinger are the co-leads for the LEAD Model. We are also joined by Harland McGee, the model's finance lead. With that, I will now hand it over to Emily for an overview of the LEAD Model. Next slide, please.

>>Emily Bezold, CMS: Thank you, Meghan.

I want to echo Meghan and thank everyone for joining us today. We are really excited about the level of interest in LEAD, and I am excited to be able to share more about the model. Before we jump in though, I do just want to acknowledge that we are holding this webinar before the release of the model's Request for Applications. Our goal in doing that is to share as much information as we can, as soon as we can, to help you start to understand and assess the opportunity.

That said, the Request for Applications is typically where we share technical model details, which I expect many of you are here today hoping to learn more about. I just want to acknowledge that we likely will not be able to address all of your technical methodology questions, and instead, we are going to be focused on providing an overview of the model framework and outlining the core design elements. And then that next level of technical methodology detail will be available when the RFA is released in early spring. But we still hope that you will be able to walk away from today's presentation with a much better understanding of the model design and what makes LEAD unique. If we could go to the next slide, with that disclaimer, we will go ahead and jump in.

We want to first ground the discussion in the goals of the LEAD Model. In addition to the goals of reducing costs and improving quality of care, which of course are the goals of all Innovation Center models, LEAD is specifically designed with three goals in mind. The first of those is to increase the scope of ACOs to include more small, rural, and independent health care providers and community health centers. These are the provider types that have often been underrepresented in earlier models, even though they often have the most significant opportunity to achieve savings and improve quality. There are a number of model features that are focused on reducing barriers to participation for these types of providers.

Secondly, LEAD is designed to enhance evidence-based prevention and care coordination for more patients, including those with High Needs and beneficiaries who are dually eligible for Medicare and Medicaid. LEAD does this by incorporating prevention-focused quality incentives and benefit enhancements and by integrating policies for High Needs and dually eligible beneficiaries across all ACOs.

Then third, LEAD aims to empower patients to be more actively involved in their own care, through policies like making it easier for patients to voluntarily align through their primary care provider and also allowing ACOs to share savings with patients through beneficiary engagement

incentives like cost-sharing support. We will get into the details of all of those policies that I've mentioned throughout this presentation. Next slide, please.

Before we do get into more of those details, we do just want to provide a quick refresh of what accountable care organizations, or ACOs, are. An ACO is a group of health care providers that have chosen to come together to take accountability for the quality and costs of their patients' care. ACOs are different from Original Medicare because they do not just get paid for the volume of services that they provide. Instead, they get paid for improving quality of care and reducing costs. Specifically, ACOs have a Medicare cost target, called a benchmark, for their patients. If they are able to reduce costs below that benchmark, they get to keep some of those savings. How much of those savings they get to keep is tied to their quality outcomes. In exchange for taking on this accountability, ACOs receive a few benefits. These include greater flexibility in care delivery and novel payment systems that improve financial stability.

ACOs are different from other value-based models in the Innovation Center because they take accountability for Original Medicare patients' total Medicare costs, rather than for specific episodes or procedures. They are also not limited to beneficiaries with specific health conditions, like dementia or kidney disease. Because of this, ACOs generally have greater opportunities for shared savings, compared to other value-based models. Next slide.

Now, turning back to LEAD, I want to start by highlighting what makes LEAD different and the unique benefits of participation. One of the primary benefits that you will hear us talking about is a benchmarking methodology that works both for experienced ACOs and ACOs who are new to value-based care. This means the benchmark, which Harland will discuss in more detail later, supports both experienced ACOs (who have already been successful at reducing costs for their patients) and, at the same time, makes sure that new ACOs (that have not yet focused on cost reduction and care improvement) are not penalized by the benchmarking methodology and have the resources to be able to invest in care improvements.

LEAD also offers long-term stability with that ten-year performance period, which is the longest that CMS has ever tested in an ACO model. Our hope is that a ten-year performance period allows time for participants to make care delivery investments, adapt, and then actually see those investments pay off.

Third, LEAD is designed to make it easier to integrate specialists into ACOs. The model will offer several different flexible payment mechanisms for engaging specialist providers. This includes voluntary episode-based risk arrangements that ACOs can elect to have CMS administer, which is meant to dramatically reduce the administrative barriers of establishing these relationships.

Another central feature of the model is integrated support for patients with High Needs and dually eligible beneficiaries. And as we will talk about in just a moment, policies that support these patient populations will now be integrated across all ACOs, rather than limited to certain ACO types.

Finally, the model introduces new flexibilities for engaging patients to support preventive care and healthy living. These new flexibilities are meant to drive consumer demand for high-value, accountable care. Next slide, please.

Now we will start to get into some of the details of these specific model components, beginning with LEAD support for High Needs and dually eligible beneficiaries. In ACO REACH, CMS tested a unique benchmarking and risk adjustment methodology for High Needs beneficiaries, but only for ACOs that participated in the High Needs Track. This meant that High Needs beneficiaries and standard ACOs were left out of efforts to set more accurate risk adjustment and benchmarking. LEAD builds on those unique risk adjustment and benchmarking methods that were tested in the High Needs Track of ACO REACH but implements them for High Needs beneficiaries across all ACOs in LEAD.

LEAD's approach to integrating High Needs policies is meant to both increase incentives and support for standard ACOs to care for these patients, while at the same time allowing High Needs organizations to care for all of their Original Medicare patients under one accountable care model. LEAD will accomplish this by treating High Needs beneficiaries as a distinct population type, like aged and disabled patients, or patients with end-stage renal disease, who are currently treated in ACO REACH with their own historical benchmark, trend factor, and risk adjustment model. Specifically, concurrent risk adjustment will be applied to all High Needs beneficiaries, regardless of ACO type. This means that all ACOs will receive High Needs methodologies for patients who meet the High Needs definition and standard methodologies for any patients who do not.

That said, LEAD will retain some important flexibilities for organizations that specialize in High Needs care, specifically lower beneficiary alignment minimums. This policy recognizes that these organizations provide more specialized and intensive care and therefore typically have smaller patient panels. To qualify for lower beneficiary alignment minimums, at least 40% of an ACO's aligned population must be High Needs beneficiaries. ACOs must also have certain care capabilities, like 24/7 patient access to a provider, staff training, advanced care planning, and the ability to deliver care in the home. Next slide, please.

Medicare and Medicaid integration is a wholly new feature of LEAD that has not been tested in prior ACO models. Existing integration efforts for dually eligible beneficiaries typically focused on beneficiaries enrolled in managed care plans like Dual Eligible Special Needs Plans. The goal of this element of LEAD is to create incentives, where currently none exist, to focus on integrating and coordinating care for dual eligible beneficiaries in Original Medicare.

Because this type of ACO Medicaid integration has not been tested before, CMS will start with a planning phase to work with states on designing the details of ACO Medicaid partnership. During the planning phase, CMS will select two states to partner with initially, aiming for both a fee-for-service Medicaid state, and a managed care state. CMS will work with those selected states to define how ACOs and Medicaid organizations can collaborate to share data, coordinate care, and share in savings to improve outcomes. Pending successful completion of this planning phase, ACOs in these two states will have the option to enter into partnerships with Medicaid organizations.

LEAD Medicare and Medicaid integration will also include a new form of alignment, Medicaid-based alignment. Under this mechanism, if a beneficiary is receiving Medicaid benefits from a Medicaid organization partnered with a LEAD ACO and is not already aligned to another ACO, they will be aligned to the Medicaid organization's partner ACO. This alignment mechanism is intended to connect dual eligible beneficiaries to a source of accountable integrated care if they do not have one already.

With that, I am going to pass it over to Lucy to talk about the provider eligibility.

>>Lucy Sola, CMS: Thanks, Emily.

Now we are going to talk about eligibility requirements for the LEAD Model. As stated previously, the LEAD Model is designed for a wide spectrum of health care providers, including those who have not previously participated in ACOs, current ACO REACH participants, and those serving High Needs and dually eligible beneficiaries. LEAD ACOs are formed by providers that voluntarily choose to assume accountability for the cost and quality of their beneficiaries.

A key feature of LEAD is its adoption of a whole Tax Identification Number, or TIN, approach for participant management. Under this model, all eligible providers billing under a participant TIN are encompassed in the ACO's operations, similar to how it is used in the Medicare Shared Savings Program. This is aimed to serve to simplify administrative processes and ensure consistency and alignment.

Within eligible health care organizations, there are two principal categories for provider participation, similar to what you see in the ACO REACH. The first category is Participant Providers, which include physicians and organizations that assume direct accountability for patient care. They drive beneficiary alignment under LEAD. The whole Tax Identification Number approach means all billing National Provider Identifiers, or NPIs, under the participant TIN are Participant Providers. Participant Providers are typically, but not required to be, primary care providers.

The second type of provider participation is Preferred Providers. These Preferred Providers can take indirect financial accountability, and they do not drive beneficiary alignment or quality performance for the ACO. Preferred Providers may share in risk with the ACO and access incentives and flexibilities offered under the model. They may be specialists or institutional providers, such as post-acute providers, but they are not required to be. Preferred Providers will continue to be managed at the TIN-NPI level to allow for maximum flexibility for ACOs. Next slide, please.

Now we will talk a little bit more about LEAD's beneficiary alignment policy. LEAD innovates on the alignment approach in ACO REACH by introducing a new option for more timely alignment and more transparency for ACOs. LEAD ACOs receive beneficiary alignment in two ways. The first is claims-based alignment, where patients are aligned to ACOs based on their claim's history and utilization patterns. Second, is voluntary alignment, where patients can actively choose to align to an ACO by choosing a provider affiliated with that ACO as their primary provider, practice, or other source of care.

Additionally, ACOs can select one of two alignment approaches. The first is prospective alignment, which may be familiar from ACO REACH, where the beneficiary list is set before the start of each performance year, and there are no additional alignment updates during the performance year (aside from drops due to the loss of eligibility). Second is the hybrid alignment approach, which is a new innovation within the LEAD Model, where the beneficiary list can be updated during the performance year. It can be updated through voluntary alignment on a monthly basis, and claims-based alignment will be run once prior to the start of the performance year. Then, if the ACO adds new Participant TINs during the performance year, claims-based alignment will be updated one additional time mid-performance year for new additions. Eligible beneficiaries can only be added mid-year and cannot be dropped, and they must not have an overlap with another initiative.

Finally, as Emily mentioned previously, ACOs serving a high proportion of High Needs patients (more than 40% of their patients) and newly entering ACOs will have lower minimums for alignment. For a beneficiary to count towards that 40% threshold, they would need to meet High Needs eligibility criteria. That is all I have for today on beneficiary alignment, and I will now pass it on to Meredith. Next slide, please.

>>Meredith Yinger, CMS: Thanks so much, Lucy.

Now we are going to talk a little bit about some of the flexibilities that are available to ACOs who participate in the LEAD Model. Benefit Enhancements and Beneficiary Engagement Incentives, or BEs and BEIs, enable ACOs to offer more preventive services, tailored support, and rewards to beneficiaries to empower them to achieve their health goals. By offering these, ACOs can attract more beneficiaries, improve care quality, and finally, unlock greater savings. LEAD will include the existing BEs from ACO REACH, which many folks on the phone are probably familiar with. But additionally, LEAD will also include an expanded set of BEs and BEIs. Examples of some of the new BEs include expanding access to medical nutrition therapy to beneficiaries with pre-diabetes and hyperlipidemia to prevent the progression of disease. Additionally, by 2029, we expect to allow ACOs to share savings with Medicare beneficiaries through Part D premium reductions. Next slide, please.

Here on the slide, you will see some examples of the expanded BEIs that we expect to offer to ACOs participating in the LEAD Model. These include Part B cost-sharing support, as well as a chronic disease prevention reward, which involves offering healthy food products to beneficiaries to support their engagement in healthy living activities.

Finally, the LEAD Model will include the Tech Enabler Initiative, which will support ACOs in adopting innovative technology tools by providing standard contracting support and other support to LEAD ACOs. I am going to now pass it to Harland to talk about LEAD's payment methodology.

>>Harland McGee, CMS: Thank you, Meredith.

Hello everyone. My name is Harland McGee, and I am the finance lead for the LEAD Model. Before we get into some of the model design features, I just wanted to emphasize something that Emily had alluded to earlier in the presentation. A key goal of LEAD's new financial strategy is

to create long-term, sustainable incentives. Additionally, these policies are aimed at reducing ratchet effects and strengthening incentives to save over time, while also creating some new incentives for providers to take on beneficiaries who have higher costs associated with more complex care needs. Next slide, please.

I imagine many people on the call are already familiar with the risk-sharing options from ACO REACH. LEAD will feature the same risk-sharing options that we feature today in ACO REACH. The first being the Global Risk Option, which is full risk. ACOs can earn up to 100% of their savings but are also responsible for 100% of their losses. LEAD will also be featuring the Professional Risk Option, where ACOs can earn up to 50% of their savings, while capping potential losses at 50%.

One note that I would like to make about the Professional Risk-Sharing Option is that LEAD will feature a four-year lock-in period for selecting that particular risk-sharing option. ACOs that do select into the Global Risk-Sharing Option have access to a few broader capitated payment options as well as some beneficiary engagement tools. Next slide, please.

Just to emphasize again, the overall goal is long-term, sustainable benchmarking, which should in turn lead to sustainable savings for the participants. LEAD will establish new benchmarks based on historical spend for all ACOs in their first performance year. These benchmarks will not be re-based for the full ten-year performance period.

With the goal of attracting providers with higher cost patients, LEAD will not have any negative adjustments to ACOs with higher costs compared to their regional peers. In fact, LEAD will also feature additional capitated payment incentives for these higher cost ACOs. For many ACOs that have already achieved cost efficiency relative to their regional peers, the model will feature positive-only regional efficiency adjustments similar to the one offered in Shared Savings Program today. ACOs that have previously participated in accountable care will also be eligible for a prior savings adjustment, once again, similar to what is featured in the Shared Savings Program today.

In an effort to make growth trends more predictable and sustainable, we will also update annual benchmarks with a blend of national and regional spending trends with a prospective growth factor that will be guardrailed to protect against any potential forecasting errors. As I mentioned previously, LEAD will not re-base benchmarks at any point over the full ten-year period. Instead, LEAD will move away from historical benchmarks, towards a rate book-based benchmark in the second half of the model, allowing for a convergence of spend between the high and the low spending beneficiaries. Next slide, please.

Capitated payments will be a key element of the LEAD Model. These payment mechanisms are designed to add flexibility while creating upfront cash flow that ACOs can use to build and expand their care programs. Primary Care Capitation and Total Care Capitation will be featured in LEAD, similar to the way they have been designed in ACO REACH today. As the name suggests, the Primary Care Capitation provides capitation for primary care services only, while the Total Care Capitation provides capitation for primary and specialty care services.

To double click into this a little bit, for those that select the Primary Care Capitation, there are also flexibilities for downstream arrangements with non-primary care providers. LEAD will feature the Advanced Payment Option, again similar to how it is deployed in REACH today. LEAD will also feature a new Non-Primary Care Capitation Option. Both will provide upfront cash flow for non-primary care services. But the difference lies in how those payments get reconciled. APO will be reconciled against actual fee-for-service billing, while the Non-Primary Care Option will act as a true capitated payment, reconciled only against total cost of care.

The last capitation on this slide is in reference to the administrative Add-On Capitation Payments. This is a new incentive that LEAD will be providing only to higher cost ACOs and higher costs relative to their regional peers. This payment mechanism is designed to offer an additional incentive for these ACOs that historically have not participated in accountable care, providers that specialize in those complex care beneficiaries.

With that, I am going to pass the mic back over to Meredith. Thank you.

>>Meredith Yinger, CMS: Thanks, Harland.

Let's talk a little bit about CMS-Administered Risk Arrangements, or CARA. CARA is an optional initiative within the LEAD Model, available to ACOs that select the Global Risk Option that Harland just reviewed. CARA will test new payment structures that allow ACOs to engage specialists in episode-based risk arrangements, promoting accountability. We at CMS have heard from ACOs that having episode data is helpful, but the real challenge they face is using that data to create actual financial arrangements with specialists they are working with. CARA bridges that gap by providing both the data and the payment infrastructure that ACOs need to negotiate meaningful accountability with their specialist partners.

CARA includes a wide range of episode options, including acute medical, procedural, and chronic condition episodes using episode-based cost measures. CARA also includes a targeted falls prevention episode designed to improve independence for Medicare beneficiaries through time-limited home and community-based services.

ACOs that elect to participate in CARA will negotiate with specialists to determine a target price for episodes. Specialists then share in savings when they deliver efficient care below the target price or share in losses when costs exceed the target price. Before we move on, I want to acknowledge that we have heard a lot of excitement and interest about CARA from stakeholders, and this is not a ton of information. We are happy that you are excited about this and promise that more information is forthcoming.

Let's move on and talk about LEAD’s quality strategy. LEAD’s quality strategy is really built on some of the key learnings and successes from ACO REACH. For example, you will note that LEAD’s quality measurement list is small, targeted, and meaningful, similar to ACO REACH’s quality list. We will be using four claims-based measures from ACO REACH, the Consumer Assessment of Health Care Providers and Systems (or CAHPS) patient-reported measure, and two new digital eCQMs (or electronic clinical quality measures). These eCQMs will be optional for the first two years of the model, pay-for-reporting for the following two performance years, before transitioning to full pay-for-performance in the fifth performance year. We have purposely

implemented this phased approach to the eCQMs to provide ACOs with time and support to adjust to this new reporting requirement. But these measures closely align with goals of the model to address and support beneficiaries who have chronic disease challenges.

Finally, ACOs will be able to earn back a quality withhold of up to 3% of their benchmark based on performance on LEAD quality measures. ACOs will also implement a Prevention and Quality Plan to better support beneficiaries and close gaps in care. Similar to ACO REACH, LEAD will have a high-performers pool and opportunities to earn additional quality points through continuous improvement. Let's go ahead and go to the next slide. Thanks so much.

We have discussed that LEAD will operate for ten years, starting on January 1st, 2027, through December 31st, 2036. The LEAD Request for Applications will be available early this spring, and applications will be due later this spring. Applicants will be notified of selection decisions in early summer, and onboarding will take place from then through the fall, when an optional pre-implementation period will begin for folks who would like to participate. Next slide, please.

We are going to move into the Q&A portion of today's webinar. But before we do, we want to take a few minutes to hear from you all. We are going to pull up two different Zoom polls that we hope that you will participate in. Let's go ahead and bring up the first one. This one asks: "What are the top two factors that will determine whether your organization applies to the LEAD Model?" Please select two. I am going to pause for a couple of seconds here while we let these responses come in.

Okay, I think we can move on to our next poll. This next question asks: "What additional resources or information would your organization need to support a final decision to apply for or participate in the LEAD Model?" Please type your answer in here. This information is really helpful to us at CMS as we are creating resources and planning other events to support you all. Thank you for offering this information to us. I think we can go ahead and move on whenever our answers have started to slow down here. I want to make sure we are offering enough time since this is a free response question. Let's go to the next slide, please.

We are going to move into the Q&A portion here. The team is going to answer a series of questions that we received both before the webinar and during the webinar here. We have been watching your questions come in through the Q&A box. Please go ahead and continue submitting those and reach out to our email and help desk here with those questions. Again, those are really helpful for us as we continue to develop additional materials.

I am going to go to Harland first. I have seen a lot of questions in the chat about how LEAD's benchmarking methodology differs from ACO REACH and other models that folks are familiar with. Harland, could you provide additional information there beyond what you discussed earlier?

>>Harland McGee, CMS: I think it is an important question, and I do appreciate the comments in the chat. In some ways, LEAD's methodology builds on what worked well in previous model designs, and we have borrowed some of those features. In a lot of ways, what makes the methodology for LEAD different is that it is somewhat of an amalgamation of what has worked

in previous model designs. Then there are a couple of new key innovations that will truly be unique, and this will be the first time CMMI will be testing some of these features.

Just to rattle off some examples, I think purely historical baseline benchmarks with the regional adjustment as well as the prior savings adjustment – these are features that we have borrowed from the Shared Savings Program. The use of the concurrent model for the High Needs beneficiaries as well as the full risk-sharing option – these are some features that we have borrowed from ACO REACH.

I think some of the features that are unique truly to LEAD would be the removal of rebasing. I would like to emphasize – for the full ten-year period, we will not be re-basing benchmarks. I think that is a key innovation that is featured in LEAD that no model design has ever attempted before. I think additionally, removing barriers to entry for providers that focus on high-cost beneficiaries, as well as providing additional incentives for their participation – that is the other side of where LEAD will be testing new, innovative features that have not existed before. Thank you for the question.

>>Meredith Yinger, CMS: Thanks, Harland. That was really helpful.

I am going to turn to Emily next. Emily, you mentioned a bit in your remarks about the High Needs Track and ACO REACH, but there are some questions in the chat here, sort of asking to reiterate: "Is there a High Needs Track in LEAD? How will risk adjustment be conducted for beneficiaries who meet High Needs criteria?" Could you talk more about that?

>>Emily Bezold, CMS: It is a good question. There will not be a distinct High Needs Track within LEAD. Unlike ACO REACH, where we differentiated whether ACOs could be High Needs or not, in LEAD, we are instead going to make that differentiation at the beneficiary-level. Regardless of what type of organization or ACO a beneficiary is aligned to, if they are High Needs, they will all be treated the same way. We are essentially creating a High Needs beneficiary category that is going to have its own historical benchmark calculation, its own trend factor, and its own risk adjustment methodology.

Again, all ACOs will receive those methodologies for their High Needs patients, specifically, which we think is beneficial for all organization types. More standard types of organizations now will get extra support and more accurate payments for their High Needs beneficiaries, and those organizations that focus on High Needs beneficiaries will still be able to bring in their Medicare patients who do not meet those High Needs criteria. We think this is really an improvement from the ACO REACH methodology.

Just to speak to the risk adjustment a little bit more, for those of you who are familiar with the concurrent risk adjustment that was pioneered in ACO REACH: the idea here is that for High Needs beneficiaries, their health status changes more quickly than a sort of average risk patient, so the prospective risk adjustment methodology that is used in the Shared Savings Program does not appropriately capture the risk for this population. So, a concurrent methodology that actually looks at and takes into account diagnoses that happened within the performance year does a better job of tracking changes in health status for the High Needs population. That methodology

is going to be carried over from REACH into LEAD, and again, applied to all High Needs beneficiaries across all ACOs.

>>Meredith Yinger, CMS: Thanks, Emily. That was really helpful. I think several additional examples you mentioned show how we are really taking the learnings from ACO REACH and other models and refining them and applying them to a new methodology.

Next, let's go to Lucy. Lucy, can you clarify how LEAD's beneficiary alignment differs from ACO REACH, and sort of reiterate some of the points you made earlier? I am seeing a lot of questions about beneficiary alignment in the chat.

>>Lucy Sola, CMS: In the ACO REACH model, we allow voluntary alignment on a quarterly basis, and in LEAD, we will be allowing voluntary alignment to occur on a monthly basis if the ACO has selected to participate in the hybrid alignment methodology. In addition to that, they would have the ability to do one more claims-based alignment addition run mid-year, where, for newly added providers or Participant TINs to that ACO in the middle of the performance year, they would be able to add claims-based aligned beneficiaries for those newly added TINs. That was not in ACO REACH, and we did not do any claims-based alignment updates during the performance year in ACO REACH.

I will quickly reiterate just how beneficiary alignment works. It is either through claims-based alignment, which is where we are looking at the claims history and utilization patterns for a Medicare beneficiary. The second is through voluntary alignment, where the beneficiary is choosing to align to the ACO by choosing a provider affiliated with that ACO as their primary source of care.

>>Meredith Yinger, CMS: Thanks so much. I have seen a couple of specific questions about LEAD's quality methodology and some specific measures in the Q&A box, so let me provide a little bit of additional clarity there.

LEAD is going to include four claims-based measures from ACO REACH. These include Risk Standardize All-Condition Readmission, All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions, Days at Home for Patients with Complex Chronic Conditions, and Timely Follow-up After Acute Exacerbations of Chronic Conditions. We expect right now that those will apply to all ACOs. I saw a couple questions about that in the Q&A.

It is also going to include the CAHPS measure that was in ACO REACH, and then we are adding those two new eCQM measures. Those are diabetes, Glycemic Status Assessment Greater Than 9%, and controlling high blood pressure. As I mentioned earlier, those two eCQMs will be phased in over the first half of the model, in recognition that it is a new reporting requirement for a lot of ACOs. That will give us time to provide technical assistance and support as folks adapt to that new requirement.

Let me take another here. Harland, I am going to come back to you. There are several questions in the Q&A about capitated payments. Could you review the options in LEAD, particularly? Probably some of those new options?

>>Harland McGee, CMS: Sure thing, Meredith. Just once again to review, we are borrowing again from REACH. We will feature the Primary Care Capitation – again, it is the upfront monthly capitated payments for primary care services only that are delivered by ACO Participant and Preferred Providers. We will also have the Total Care Capitation, which is an option for all Medicare Part A and B services delivered by Participant and Preferred Providers, including primary and specialty care. The Advanced Payment Option will be for those that select the Primary Care Capitation but still want some downstream payment arrangements for their non-primary care providers, and that again will be borrowed from ACO REACH.

What I think will be new for the non-primary care providers is the Non-Primary Care Capitation, which works similarly, but is quite different. It is really a true capitation, similarly to the way Primary Care Capitation, PCC, works today, but for non-primary care providers. The upfront cash flow is sent monthly, and we do the reconciliation towards the end of the year at final settlement. Whereas the Advanced Payment Option is the reconciliation against the actual fee-for-service billing, and they have that true up. That is the major difference between those two. Again, there will be an Add-On Capitation Payment that will only be eligible to ACOs with costs compared to their regional average. That is the new incentive for ACOs to participate and bring in providers looking after the higher cost beneficiaries with higher risk profiles. Thank you.

>>Meredith Yinger, CMS: Thanks again.

Lucy, I am coming back to you. You mentioned in your remarks earlier that LEAD is going to use a full TIN approach to participation, and we have gotten several questions about that. Can you speak more about how that will work, as well as anything else eligibility related you think would be helpful for the folks on the line?

>>Lucy Sola, CMS: Sure thing. The difference here from ACO REACH is – in ACO REACH, we managed the provider roster for providers that were contributing to alignment at the TIN/NPI level. ACOs were putting in individual providers that were participating in the model. LEAD will use a TIN level for adding providers to the roster. It will be added at the group practice level, and that is for participant TINs. Then, the Participant Providers are the providers that are billing underneath that TIN. Then our Preferred Providers will still be managed at the TIN/NPI level, similar to ACO REACH, and that is intended to give ACOs more flexibility in their contracting with Preferred Providers.

>>Meredith Yinger, CMS: Thanks again. Hopefully, that provides a little bit of additional clarity.

I think one last question here. I am going to come to Emily for this one. There are many, many questions in the Q&A box about whether there will be additional application opportunities for future performance years. Could you offer some thoughts on that?

>>Emily Bezold, CMS: We do expect that there will be future opportunities to apply for the model. We are not prepared to offer all of the details of what that is going to look like at this moment. As we do across other models, the sort of participation parameters and expectations may change as we progress based on what we are seeing in the early years of the model. We do strongly encourage – if you think you are interested in participating – you really consider

applying for this first cohort. But we do expect future application windows and more information about those to come as the model progresses.

>>Meredith Yinger, CMS: Thanks, Emily. Hopefully, that is good news for some folks.

That is all of the Q&A we are going to be able to address today. I do acknowledge there are many, many, many questions you all have submitted in the Q&A. We really appreciate that. It will be helpful to us as we move forward. As a reminder, there will be a lot more information available in the coming weeks and months about the model. Please continue to check back on the model webpage. Let's go ahead and do some brief closing remarks.

As a reminder, we have lots of resources online, and we are going to continue adding to those. To learn more about the model, please visit the LEAD webpage. It has important information and resources about the model and that is where we post new information. That is where the materials from this event will also be posted for folks who have been asking that question. We welcome additional questions to be submitted to us via the help desk email listed here. Like I mentioned before, we always use your questions to develop FAQs and other guidance materials.

Lastly, please take a couple of minutes to fill out the post event survey that your browser will connect you to after this event. We look forward to connecting with you soon and providing additional information about LEAD. Thank you for joining us. This concludes today's event.