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

Request for Applications (RFA) Webinar

April 9, 2026

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

Housekeeping and Logistics

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Agenda

1. Welcome and Introductions
2. Eligibility and Participation Requirements
3. Financial Methodology
4. Quality and Healthy Living Strategy
5. CMS-Administered Risk Arrangements (CARA)
6. Application Process and Timeline
7. Q&A
8. Closing and Resources

Welcome and Introductions

Today’s Presenters

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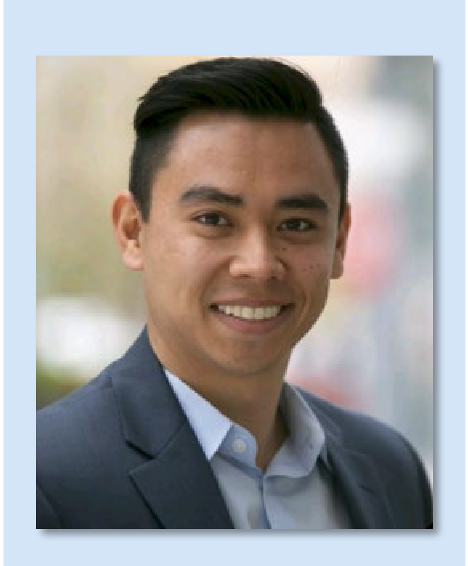

Harland McGee

LEAD Model Finance Lead, CMS Innovation Center

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CARA Initiative Legal Lead, CMS Innovation Center

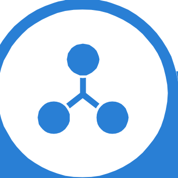
LEAD Model Overview

The LEAD Model is a nationwide, **10-year voluntary Innovation Center ACO model** that will run from January 1, 2027, through December 31, 2036.

Model Goals

Increase the scope of ACOs to include more small, rural, and independent health care providers and community health centers

Enhance evidence-based prevention and care coordination for more patients, including those with High Needs and dually eligible individuals



Empower patients to be more actively involved in their care

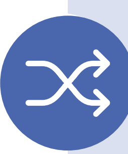
The Innovation Center's goal is to test innovative health care payment and service delivery models that have the potential to lower Medicare spending while maintaining or improving the quality of care for beneficiaries.

Eligibility and Participation Requirements

What is a LEAD Accountable Care Organization (ACO)?

An **ACO is a group of health care providers** that has chosen to come together to take **accountability** for the quality and Medicare total cost of care for their aligned beneficiaries.

ACOs can be formed by a **broad range of Medicare-enrolled providers and suppliers*** working together, including primary care and specialist physicians, nurse practitioners, physician assistants, clinics and group practices, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).



If the ACO includes Medicare-enrolled providers and suppliers billing under more than one Tax Identification Number (TIN), the ACO must be a **distinct legal entity** identified by its own TIN, formed under applicable state, federal, or Tribal law, and authorized to conduct business in each state in which it operates.

Governing Body

ACOs must have a governing body with sole, exclusive authority to execute functions and make final decisions for the ACO. The governing body must have 75% voting control held by Participant or Preferred Providers and a mechanism for incorporating beneficiary representation.

Service Area

A LEAD ACO's service area will consist of the **Core Service Area** (counties in which the ACO has physical office locations) and the **Extended Service Area** (contiguous counties). An ACO may propose an alternative service area definition, e.g. if its providers do not have a physical office location.

*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, ambulance suppliers, and drug manufacturers are not eligible to participate

Participant and Preferred Provider Participation

Medicare-enrolled providers and suppliers may participate in LEAD ACOs as a **Participant TIN** or **Preferred Provider.** LEAD ACOs must submit a Participant TIN list and Preferred Providers list before each Performance Year, and have written agreements in place with Participant TINs and Preferred Providers.

Participant TIN	Preferred Provider
Based on LEAD's whole TIN approach, all providers billing under a Participant TIN must agree to participate in LEAD	Participation as a Preferred Provider is at the TIN-NPI level
Usually (but not required to be) primary care providers	Usually (but not required to be) specialists or post-acute care providers
Used for alignment	Not used for alignment
Direct accountability for care quality	Does not contribute to quality performance
Mandatory participation in capitated payments*	Optional participation in capitated payments
Quality reporting requirements	No quality reporting requirements
Not CARA eligible	CARA eligible
Optional access to Benefit Enhancements and Patient Incentives	Optional access to Benefit Enhancements and Patient Incentives

*Non-primary care providers that bill under a Participant TIN that has elected primary care capitation (PCC) will not be required to participate in PCC. They will have the option, but are not required, to participate in Non-Primary Care Capitation or the Advance Payment Option

Beneficiary Alignment

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

LEAD ACOs will receive beneficiary alignment in two ways:

- **Claims-Based Alignment:** Beneficiaries align to ACOs based on their claims history and utilization patterns.
- **Voluntary Alignment:** Beneficiaries voluntarily align to an ACO by choosing a provider affiliated with that ACO as their primary provider, practice, or other source of care.

LEAD ACOs can select one of two alignment approaches:

- **Prospective:** Conducted prior to the start of each performance year, with no alignment updates during the performance year.
- **Hybrid:** Allows ACOs to update their beneficiary list during the performance year (PY). Voluntary alignment will be updated monthly. Claims-based alignment will be updated prior to the PY; for ACOs that add new Participant TINs during the PY, claims-based alignment will be updated once mid-PY for new additions.

Note: Eligible beneficiaries can only be added mid-year, they cannot be dropped.

High Needs and Newly Entering ACO Eligibility

New ACOs and those serving a high proportion of High-Needs beneficiaries and will benefit from lower alignment minimums and other model flexibilities.

LEAD ACOs serving many High-Needs beneficiaries and offering specialized care will have lower alignment minimums.

LEAD ACOs will be designated as High Needs if:

- **At least 40%** of their total aligned beneficiary population meets High Needs eligibility criteria.
- The ACO has required **care delivery capabilities**, including 24/7 access to a health care provider with access to the patient's electronic record; providers with training in advanced care planning conversations; and the ability to deliver care in patients' homes.

Newly Entering ACOs will be eligible to receive lowered alignment minimums.

Lowered alignment minimums will be available to Newly Entering ACOs defined as ACOs meeting the following criteria:

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

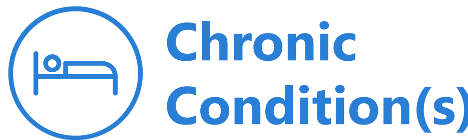
Beneficiary Alignment Minimums

ACOs will maintain a minimum number of beneficiaries so that CMS can reliably calculate capitation payments (for both risk options) and financial benchmarks.

PY	LEAD PY Alignment Minimum	LEAD Claims-Based Alignment Minimum in BY	LEAD PY Alignment Minimums for Newly Entering ACOs	Claims-Based Alignment Minimum in BY for Newly Entering ACOs	High Needs Eligible ACO PY Alignment Minimum	Claims-Based Alignment Minimum in BY for High Needs Eligible ACOs
1	5,000	3,000	1,000	600	800	500
2	5,000	3,000	2,000	1,200	1,000	625
3	5,000	3,000	3,000	1,800	1,200	750
4	5,000	3,000	4,000	2,400	1,400	825
5-10	5,000	3,000	5,000	3,000	1,600	1,000

High Needs Beneficiary Eligibility Criteria

A beneficiary must meet **at least one** of the following criteria to be considered high needs:



≥1 significant chronic condition or serious illness, identified as Aged and Disabled (A&D) **prospective or concurrent risk score ≥ 3.0 or End-Stage Renal Disease (ESRD) risk score ≥ 0.35**

Condition(s) **that impair a beneficiary's mobility** (identified through Mobility Impairment ICD-10 Codes)

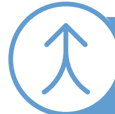
A&D **Hierarchical Condition Category (HCC) prospective risk score** 2.0–3.0 or **ESRD risk score** 0.24–0.35, and **≥ 2 unplanned hospital admissions** in the past 12 months

Kim Claims-based Frailty Index of ≥ 0.35 (Moderate–Severely Frail) **or** evidence of frailty via certain DME claims including **home-use hospital beds and transfer equipment**

Have qualified for and received at **least 45 Medicare-covered days** in a Skilled Nursing Facility within the **past 12 months**

Medicaid Integration for Dually Eligible Beneficiaries

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



Medicaid Integration

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

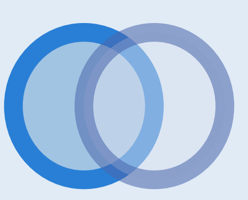
Program Overlaps

Below is a summary of program overlaps permitted and not permitted for LEAD Participants.

Overlaps Not Permitted

*LEAD Participant TINs **may not** simultaneously participate in:*

- The **Medicare Shared Savings Program.**
- The **AHEAD Model**, including Hospital Global Budget and Geo AHEAD.
- Another Innovation Center model that involves **Shared Savings**, such as Kidney Care Choices (KCC).
- Cannot be a **Preferred Provider** in the same LEAD ACO.



Overlaps Permitted

*Participant TINs **may** simultaneously participate in*

- Select Innovation Models including **GUIDE, TEAM, ACCESS, ASM, EOM, and,** in certain cases, **Primary Care AHEAD**.
- **Preferred Providers** can be Preferred Providers for more than one **LEAD ACO**, a **Participant TIN in another LEAD ACO**, or a **Medicare Shared Savings Program Participant.**

Note: NPIs billing under a Participant TIN may participate in other models and programs through a different TIN.

Financial Methodology

Risk Sharing Options

LEAD ACOs will have two risk sharing options: the Professional Risk Option and the Global Risk Option. ACOs in either risk option will be eligible to receive Shared Savings or be required to repay Shared Losses, subject to a series of risk corridors outlined below.

Professional Risk Option – 50% Risk

- For all savings and losses up to and including 10% of the Performance Year Benchmark, the **ACO is responsible for 50% of the savings or losses** and **CMS is responsible for the remaining 50%.**
- ACOs will be responsible for a progressively smaller portion of additional savings or losses.

Corridor	1	2	3	4
% of Benchmark	≤10%	10-15%	15-20%	>20%
ACO's Savings/Loss Rate	50%	35%	15%	5%

Global Risk Option – 100% Risk

- For all savings and losses up to and including 15% of the Performance Year Benchmark, the **ACO is responsible for 100% of the savings or losses.**
- ACOs in this option are subject to a **discount (1.75% for higher-spending ACOs in PY1, 3% for lower-spending ACOs)** that is subtracted from the benchmark before shared savings/losses are calculated.

Corridor	1	2	3	4
% of Benchmark	≤15%	15-35%	35-50%	>50%
ACO's Savings/Loss Rate	100%	50%	25%	10%

Optional stop-loss will be available to mitigate ACOs' risk for very high cost beneficiaries. ACOs that elect it will have a stop-loss charge deducted from their benchmark. CMS will adjust payments to keep the program budget-neutral (no net payouts beyond collected charges).

Benchmarking Methodology

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

Calculate Baseline Benchmark Using Historical Expenditures

- **3-year weighted average** of **historical claims**, from the **3 base years** (BYs) prior to ACO's first performance year (PY). For PY 2027, the BYs are 2024 – 2026.
- Base benchmarks will be calculated for each beneficiary category (**Aged and Disabled** (A&D), **End-Stage Renal Disease** (ESRD), and **High Needs**
- Within each category, baseline benchmarks will be calculated separately for **voluntarily aligned** and **claims aligned** beneficiaries.
- BYs will be weighted differently depending on whether the ACO is **new** or **renewing**:

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

Apply ACO Specific Adjustments

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

Prior Savings Adjustment

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

Positive Regional Efficiency Adjustment

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

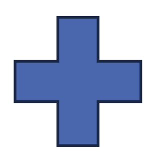
*Lower-spending ACOs with 40% or more of TINs that participated in the Shared Savings Program in the prior two years will be subject to the 3% cap instead of a 5% cap.

Benchmarking Methodology *(continued)*

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

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

2/3 national/regional blend:
A blend of actual national and regional spending trends during the PY.



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

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

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

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

Apply Discount and Quality Withhold

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

Prospective Payments

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

Primary Care Capitation (PCC)

Who: LEAD ACOs in both the Global and Professional Risk Options

What: Receive predictable monthly payments for primary care services delivered by ACO Participant and Preferred Providers to help them invest in new care capabilities. To calculate the **Base PCC**, CMS determines historical spending on primary care services as a percentage of total historical utilization and then applies that percentage to the ACO's benchmark.

LEAD also has an **optional Enhanced Primary Care Capitation (EPCC) to provide ACOs with additional upfront funding support.** The EPCC must be paid back at the end of the year and equals the greater of:

- The difference between 7% of the Performance Year Benchmark and the estimated Base Primary Care Capitation Amount; or
- 2% of the Performance Year Benchmark

Total Care Capitation (TCC)

Who: LEAD ACOs in the Global Risk Option

What: LEAD offers the option of capitated payments for all Medicare Parts A and B services delivered by ACO Participant and Preferred Providers, including both primary and specialty care.

Prospective Payments *(continued)*

In addition to PCC and TCC, LEAD offers the payment options described below.

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

For ACOs selecting PCC, APO and NPCC are options to support downstream payment arrangements with non-primary care providers.

- **APO** is an **upfront monthly payment** that will be reconciled against actual fee-for-service (FFS) billing.
- **NPCC** is a new mechanism that acts as a **true capitated payment**. NPCC is paid monthly, and capitation payments are included in the ACO's Medicare total cost of care for reconciliation purposes.

Administrative Add-On Payment

Higher-spending ACOs will be eligible for an Administrative Add-On equivalent to 1.5% of their benchmark , paid as a monthly capitated payment. This payment does not impact Shared Savings calculations and does not have to be repaid.

Claims Fee Reduction and Payment Operations: ACO providers will continue to submit claims to Medicare as normal for aligned beneficiaries. CMS will reduce payments for certain claims to account for capitated payments.

Financial Guarantee

ACOs must be able to repay all Shared Losses and Other Monies Owed for which it may be liable. Financial guarantee requirements differ by risk sharing option and capitation payment mechanism election, as detailed in the table below. **ACOs that select the Global Risk Option and/or the Enhanced PCC will be required to maintain a larger financial guarantee.**

	Primary Care Capitation (PCC) Payment			Total Care Capitation Payment
	Shared Losses and Base PCC	**Enhanced Primary Care Capitation Payment (Optional)**	**Combined Shared Losses, Base PCC, and Enhanced PCC**	
Professional Risk Option	2.0% of Previous Year's Part A & B Expenditures	1.5% of Previous Year's Part A & B Expenditures	3.5% of Previous Year's Part A & B Expenditures	N/A
Global Risk Option	2.5% of Previous Year's Part A & B Expenditures*	1.5% of Previous Year's Part A & B Expenditures	4.0% of Previous Year's Part A & B Expenditures	4.0% of Previous Year's Part A & B Expenditures

Retention Incentive

CMS will also apply a 2% “Retention Incentive” to the ACO’s Performance Year benchmark for PY 1. ACOs must remain in the model for PY2 (i.e., do not drop out before the PY2 termination without liability deadline) to earn back the withhold in their PY1 final settlement.

*Previous year’s Part A & B Expenditures in the table above refers to the ACO’s total Medicare Part A and B expenditures from the previous calendar year for the expected aligned population for the upcoming Performance Year.

Quality & Healthy Living Strategy

Quality Plans and Measures

LEAD's Quality Approach

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

New Electronic Clinical Quality Measures (eCQMs)

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

2027-2028

Reporting eCQM data is optional and ACOs can earn bonus quality points for doing so.

2029-2030

Quality points are awarded for successfully reporting each eCQM.

2031 onwards

Quality points are awarded based on performance results for each eCQM.

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

LEAD Quality Measures

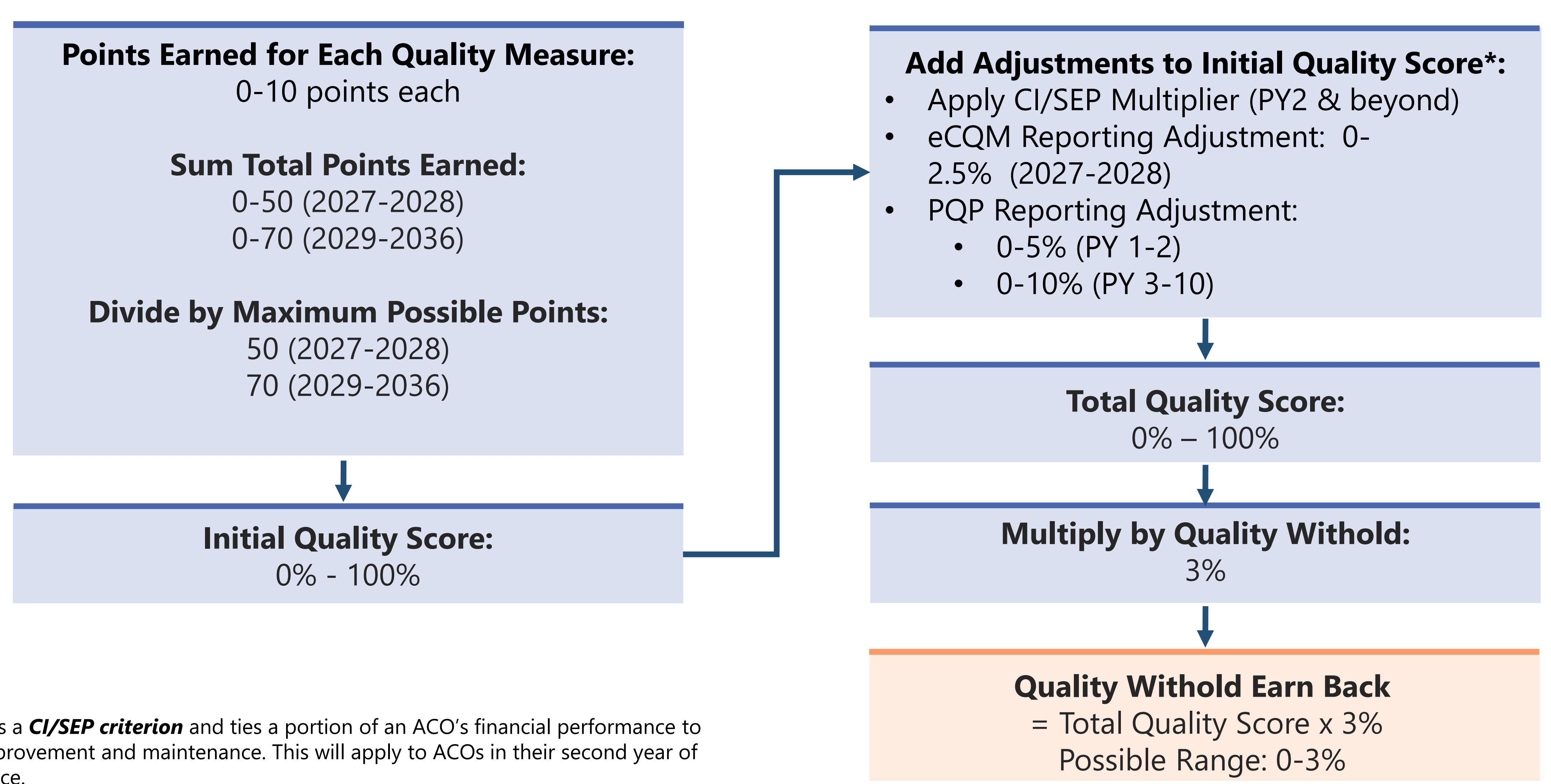
The following quality measures will be used in LEAD:

Measure	Submission Type	Scoring
Risk-Standardized All Condition Readmission	Claims-based	10 points
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims-based	10 points
Days at Home for Patients with Complex, Chronic Conditions	Claims-based	10 points
Timely Follow-Up After Acute Exacerbations of Chronic Conditions	Claims-based	10 points
CAHPS® Survey	Patient-Reported	10 points
Diabetes: Glycemic Status Assessment Greater Than 9%[2]	eCQM	10 points
Controlling High Blood Pressure[2]	eCQM	10 points

1. Consumer Assessment of Healthcare Providers and Systems
2. New eCQMs will be optional in 2027-2028, then pay-for-reporting in 2029-2030 to allow ACOs time to prepare for implementation and CMS technical assistance. See next slide for information on scoring in those two years.

Quality Scoring Approach

LEAD ACO quality scoring is a point-based system where ACOs earn points across a required set of measures, and their overall quality result is expressed as the percent of total points achieved. Over time, LEAD expands the number of measures and refines how points are awarded, including a reporting-based approach for certain electronic measures.



*LEAD uses a ***CI/SEP criterion*** and ties a portion of an ACO's financial performance to quality improvement and maintenance. This will apply to ACOs in their second year of performance.

Healthy Living Strategy

LEAD will incorporate several model features designed to promote a healthy lifestyle while empowering beneficiaries to take greater control of their health. LEAD's Healthy Living Strategy includes the key components below.

Prevention and Quality Plan (PQP)

Create or expand on at least one prevention intervention to engage beneficiaries and improve health outcomes.

Tech Enabler Initiative

Streamline technology adoption by working with ACOs to identify high value technology needs and offering vendors a chance to share how their applications meet those core needs.

Benefit Enhancements

Enable ACOs to offer more preventive services, tailored support, and rewards that empower beneficiaries to achieve their health goals and manage their care.

Patient Incentives

Give LEAD ACOs additional flexibilities to encourage beneficiaries to seek care from high value providers and ACOs, e.g. a Part B cost sharing waiver.

Certified Electronic Health Record Technology (CEHRT) flexibility: LEAD includes a one-year transitional pathway allowing ACOs to grant temporary, targeted CEHRT exceptions for clinicians not previously required to use CEHRT; CMS may extend limited exceptions beyond the first PY. In addition, providers using advanced or custom health IT systems may qualify for up to a three-year CEHRT deferral if they meet specified capabilities upfront; eCQM requirements will still apply on the standard timeline.

CMS-Administered Risk Arrangements (CARA)

CARA Overview

LEAD tests new structures for payment arrangements with specialists through CMS-Administered Risk Arrangements (CARA).

About CARA

Global Risk Option ACOs can participate in CARA to contract directly with specialists (Preferred Providers) for specific quality and cost outcomes, reducing barriers for ACOs to establish meaningful **episode-based risk arrangements (EBRAs)** with specialists.

CARA includes the following:

Data Initiative

- In 2027, LEAD ACOs will receive reports similar to those provided in the **shadow bundles** data initiative in ACO REACH to support **identification** of Preferred Providers and potential episodes of care for EBRAs.
- Shadow bundles data are **episodic data and pricing information** that CMS provides to ACOs to facilitate setting up their own bundled payment arrangements or to help inform high-value referrals.

Quality Measures

- **Performance adjustments will be based on quality measures** – Q484 Risk-Standardized Admissions or other Merit-Based Incentive Payment System (MIPS)-comparable measures. Adjustments range 10-100%, **negotiated between ACOs and specialists**.

Resilience and Independence in a Safe Environment (RISE) to Age in Place Episode

- The RISE to Age in Place Episode aims to increase **activities of daily living** (ADLs) and decrease acute events for Medicare beneficiaries.
- Provides a **bundled payment** for an **interdisciplinary care team** (Occupational Therapists (OTs) and Registered Nurses (RNs)) to deliver comprehensive **fall prevention** interventions.

CARA Episode Options

Episode Options

CARA will offer acute medical and procedural episode-based cost measures (EBCMs) at the onset and will phase in chronic condition EBCMs in the early years of CARA. These include:

- **Acute Inpatient Medical Conditions:** Sepsis, psychoses and related conditions, intracranial hemorrhage, etc.
- **Common Chronic Conditions:** Diabetes, heart failure, chronic kidney disease (CKD), end-stage renal disease (ESRD), etc.
- **General Surgery Procedures**: Melanoma resection, colon and rectal resection, hernia repair, lumpectomy, etc.
- **Other Conditions** include musculoskeletal/rheumatologic chronic conditions, oncology chronic conditions, and kidney transplant management and more.
- **Other Procedures** include orthopedic, cardiovascular, urologic, ophthalmologic, gastroenterology, and more.

Participation Options

Default Approach

- Allows ACOs to select EBCMs based on CMS's methodology.
- ACOs cannot change episode construction, but can specify discounts/premiums to target prices, select quality measures for performance adjustment, and performance adjustment specifications, all subject to CMS review.

Maximal Flexibility (Max Flex) Option

- Allows ACOs to select existing EBCM category and customize the episode by specifying modifications (e.g., episode trigger codes, length).
- ACOs selecting Max Flex may partner with external vendors to assist with the alternative episode construction methodologies.

How to Participate in CARA

CARA will include the following steps:

1. **ACOs access CARA module in the 4i platform**, and select episodes for participation, identify specialists, and enter negotiated episode target prices with specialists.

2. **CMS provides episodic data and pricing information**, as applicable, to ACOs to facilitate setting up their own EBRAs.

3. **ACOs and specialists enter into an EBRA**.

4. **Specialists deliver care**, billed through Medicare fee-for-service (FFS).

5. **CMS reconciles concurrently with LEAD settlement**:
   - If FFS < target price, the specialist receives payment.
   - If FFS > target price, the specialist owes repayment.

Application Process and Timeline

Application Overview

The application is now available at https://app.innovation.cms.gov/LEAD/IDMLogin. Applications are due on **May 17 by 11:59 PM Eastern Time.**

PY 2026 ACO REACH participants can submit an abbreviated application. Eligibility to submit an abbreviated application **does not guarantee acceptance** into LEAD.

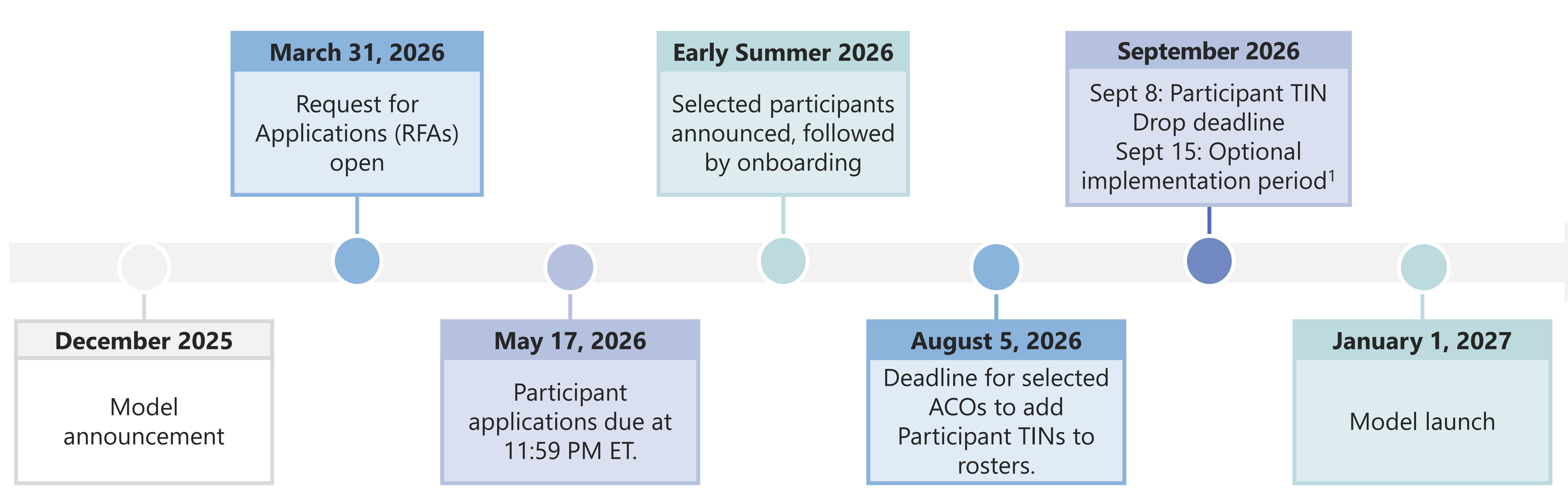
Organizations interested in future cohorts but not prepared to apply during this application window can submit a **Letter of Interest (LOI)** by **May 17 by 11:59 PM Eastern Time.**

Organizations that would like a preliminary assessment of how they will score on the Newly Entering ACO criteria (as defined on slide 11) may submit the **New Entrant tool**. The New Entrant Tool is due by **April 27 by 11:59 PM Eastern Time**, via the LEAD help desk.

Questions may be directed to LEAD@cms.hhs.gov with the subject "Application Question."

Application Process and Timeline

The LEAD Request for Applications is now available. **Participants will be selected in early summer 2026**, and the LEAD Model will **launch on January 1, 2027,** and run for **10 years**. Please visit the LEAD website for the latest timeline updates.



[1]The purpose of the optional implementation period is to allow ACOs to start voluntary alignment.

Q&A

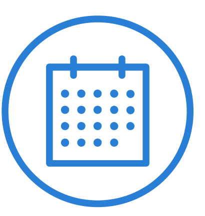
Live Q&A

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

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

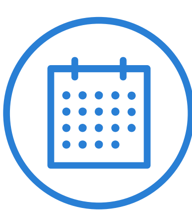
Closing and Resources

Upcoming Events



LEAD Application Office Hour

- Tuesday, April 21, 1:00 PM – 2:00 PM ET
- Register here



LEAD Alignment and Financial Methodology Office Hour

- Tuesday, May 5, 2:00 PM – 3:00 PM ET
- Registration forthcoming

Resources

Email: LEAD@cms.hhs.gov

Visit: LEAD Model Webpage, where you can view the:

- LEAD Model Overview Webinar Slides
- LEAD Model Overview Resource and Value Factsheet

Listserv: Sign up for updates via the LEAD Model Listserv

Thank You

We appreciate your time and interest!

Please share your feedback via the survey following this event.

Questions? Email LEAD@cms.hhs.gov