

WHITE PAPER

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# **The LEAD Model: A New Chapter in Medicare Accountable Care**

## Overview of LEAD with Comparison to ACO REACH and MSSP

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## SUMMARY

On March 31, 2026, the Center for Medicare and Medicaid Innovation (Innovation Center) released the Request for Applications (RFA) for the Long-term Enhanced ACO Design (LEAD) Model. This framework is a successor to the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model and will run for 10 performance years (PY)—2027 to 2036.

Based on our review of the RFA, LEAD represents a significant evolution in Medicare's accountable care strategy, introducing several foundational changes to the financial methodology that distinguish it from both ACO REACH and the Medicare Shared Savings Program (MSSP). The LEAD Model is designed to resolve key limitations of those prior models, while advancing the broader value-based care agenda at Centers for Medicare & Medicaid Services (CMS).

By eliminating rebasing, incorporating the High Needs population into a general ACO, expanding capitation and specialist engagement mechanisms, and introducing greater flexibility in alignment and incentives, LEAD creates a more durable and scalable pathway for provider participation. At the same time, its evolving benchmarking approach and increased emphasis on quality, prevention, and technology adoption signal a continued transition toward population-based, administratively informed payment models in Original Medicare. Thus, organizations considering participation will need to carefully assess their readiness for sustained risk, care model transformation, and strategic alignment with this next generation of accountable care.

This white paper provides an overview of LEAD's programmatic design and compares the components side-by-side with ACO REACH and MSSP. It also offers considerations to help health systems and provider organizations evaluate whether LEAD participation aligns with their strategic priorities.

## KEY MODEL COMPONENTS

The following list highlights the most significant innovations in LEAD's financial methodology, alignment approach, quality framework, and care delivery capabilities, and illustrate how the model seeks to create a more flexible, sustainable, and scalable accountable care environment.

- LEAD locks in base years for the duration of the 10-year model (no rebasing), directly addressing the "ratchet effect" that has limited ACO participation in prior models.

- LEAD creates a dedicated High Needs beneficiary category with a separate concurrent risk adjustment model, distinct from Aged and Disabled (A&D) and End-Stage Renal Disease (ESRD). ACOs can cover the High Needs population without having to create a separate ACO for people with High Needs.
- LEAD adopts risk corridors with graduated sharing rates, similar to REACH but with wider first risk corridors, allowing ACOs to retain savings (and cover losses) across a wider range of performance. It replaces the simpler percentage-based savings/losses structure used in MSSP.
- Capitation payment options expand beyond ACO REACH to include Non-Primary Care Capitation (NPCC) and an Advanced Payment Option (APO), enabling downstream specialist risk arrangements.
- LEAD adds a Hybrid Alignment option allowing monthly voluntary alignment additions and mid-year claims-based updates for new participant Tax Identification Numbers (TINs).
- CMS intends to have LEAD plans transition to a regional rate book-based benchmark beginning in PY 2032 or thereafter. This marks a long-term shift toward administratively set rates in Original Medicare.
- LEAD's quality measurement shifts to a graduated Continuous Improvement/Sustained Exceptional Performance (CI/SEP) approach, replacing ACO REACH's pass/fail. It phases in two electronic clinical quality measures (eCQMs) over five years and introduces a Prevention and Quality Plan (PQP) requirement with dedicated quality points.
- LEAD includes a Healthy Living Strategy, which provides new benefit enhancements (including Part B cost-sharing support and chronic disease prevention incentives) and a Tech Enabler Initiative to accelerate adoption of digital health tools.
- LEAD introduces the CMS-Administered Risk Arrangements (CARA) initiative, enabling downstream episode-based risk arrangements between ACOs and specialists, with both a default and "maximal flexibility" customization option.
- LEAD incorporates a framework to test Medicare-Medicaid integration features, where two states will be identified for ACOs and state Medicaid agencies or Medicaid managed care organizations (MCOs) to collaboratively serve dual-eligible beneficiaries.

## **COMPARATIVE SUMMARY: LEAD VERSUS ACO REACH VERSUS MSSP**

This section provides a high-level comparison of the LEAD Model with its predecessors—ACO REACH and the MSSP—highlighting key differences in design, financial methodology, and operational features. By examining these models side-by-side, it clarifies how LEAD builds on previous frameworks while introducing new approaches to benchmarking, risk sharing,

alignment, and care delivery, which may materially impact provider strategy and participation decisions (see Table 1).

**Table 1. Comparison of LEAD, ACO REACH, and MSSP Features**

Dimension	LEAD	ACO REACH	MSSP
Performance Period	10 years (PY 2027–2036)	6 years (PY 2021–2026)	5-year agreement periods, renewable
Rebasing	No rebasing; static base years (BYs) for the life of the model	No rebasing during model period; static BYs	Rebased at start of each new agreement period (AP)
Base Years (Renewing)	Equal (33/33/33%); static CY 2024–CY 2026	Recency weighted (10/30/60%); static CY 2017–CY 2019	Equal (33/33/33%) for 2nd+ agreements; previous 3 years to start of AP
Base Year Weighting (New Entrants)	Weighted (10%/30%/60%)	Weighted (10%/30%/60%)	Weighted (10%/30%/60%) for 1st agreement
Alignment Method	Prospective; claims-based + voluntary; hybrid option + monthly voluntary alignment updates	Prospective; claims-based + voluntary	Prospective with retrospective reconciliation or prospective-only; voluntary alignment
Beneficiary Categories	A&D, ESRD, High Needs (separate benchmarks)	A&D, ESRD (High Needs ACOs as separate ACO type)	ESRD, disabled, aged/dual, aged/non-dual
Benchmark Trending	Three-way blend: 2/3 national/regional + 1/3 accountable care prospective trend (ACPT) with guardrails	Prospective trend (US per capita costs [USPCC]-Based) with retrospective trend adjustment (RTA) Corridors	National/regional blend with ACPT (for AP starting 1/1/2024+)

Dimension	LEAD	ACO REACH	MSSP
Regional Rate Blend	Phased in rate book after year 5; starts with historical-only	Historical/regional blend (60%/40% by PY 2026)	Regional adjustment incorporated into benchmark; increases with APs
Benchmark Adjustments	Regional efficiency adjustment (50% of gap, global only) + prior savings adjustment + 1.5% add-on for higher spending ACOs	Regional adjustment + population adjustment (health equity); no prior savings adj.	Regional adjustment + prior savings adj. (for AP starting 1/1/2024+); population health adj.
Benchmark Adjustment Caps	Capped at 3% of USPCC for prior MSSP ACOS and 5% for all other ACOS	Capped at 5% of USPCC (standard ACOS)	Capped at 5% of USPCC
Risk Tracks	Global (up to 100%) or professional (up to 50%)	Global (100%) or professional (50%)	Basic (levels A-E, one-sided through two-sided glide path) or enhanced (up to 75% savings)
Discount Rate	Global only: 1.75%–3.0% (higher spending) or 3.0% (lower spending)	Global only: 3.5% (PY 2025); 4.0% (PY 2026)	No discount; minimum savings/loss rate (MSR)/(MLR) thresholds instead
Quality Withhold	3%	5%	No withhold; quality score determines savings rate
MSR/MLR	None; first-dollar savings/losses	None; first-dollar savings/losses	Variable MSR (one-sided); selectable MSR/MLR (two-sided)

Dimension	LEAD	ACO REACH	MSSP
Risk Corridors	Graduated 4-tier corridors for both global and professional, widening the first corridor compared to REACH	Graduated corridors for both global and professional	Savings cap (10% or 20% of benchmark); loss cap varies by track
Stop-Loss	Optional; residual-based reinsurance	Optional; residual-based reinsurance	Truncation automatically applied
Capitation Options	Total care capitation (TCC), primary care capitation (PCC), NPCC, APO, administrative add-on	TCC, PCC, APO	None (FFS-only, except for the PC Flex Option for low-spending ACOS)
Settlement Timing	Provisional (optional, ~Q1+1); final (~Q3+1)	Provisional (optional, ~FEB+1); final (~JUL/AUG+1)	Single final settlement (~Q3+1)
Specialist Engagement	CARA Initiative (episode-based risk arrangements with preferred providers)	Shadow bundles data; no formal episode-based mechanism	No formal specialist risk sharing mechanism
Minimum PY Membership Requirement	Standard – 5,000 Newly entering – 1,000 High needs eligible (>40% High Needs) – 800	Standard – 5,000 Newly entering – 5,000 High needs – 1,250	5,000 at all participation levels

Several of these components are explored in greater detail in the following sections.

## ATTRIBUTION AND ALIGNMENT

MSSP, ACO REACH, and LEAD all use claims-based and voluntary alignment but differ in timing and flexibility. MSSP allows either prospective or retrospective reconciliation, whereas ACO REACH uses fully prospective, claims-based alignment determined before the performance year, with ongoing voluntary alignment quarterly. LEAD introduces a hybrid alignment approach, enabling monthly voluntary alignment updates and a mid-year claims-based refresh when new participant TINs are added. This reduces alignment errors and lowers barriers for smaller providers. LEAD also expands voluntary alignment to the TIN level and allows carryover of previous ACO REACH attestations.

## BENCHMARKING AND INCENTIVES

The models differ materially in how benchmarks evolve over time. MSSP rebases every five years, which can penalize successful ACOs through the “ratchet effect,” whereas ACO REACH avoids rebasing but is limited to a shorter model period. LEAD extends the no rebasing approach across 10 years, locking in base years (CY 2024–2026) and allowing ACOs to retain savings over time.

LEAD also introduces a “savings wedge” through a blended trend approach, allowing benchmarks to grow faster than actual expenditures but slower than counterfactual spending. Over time, this approach creates a measurable gap between benchmarks and actual costs, sustaining incentives for participation. Unlike MSSP and ACO REACH, LEAD initially relies on historical benchmarks but projects a transition to a regional rate book after year five, supporting long-term convergence.

## RISK ADJUSTMENT

All three models use hierarchical condition category (HCC)-based risk adjustment, but LEAD expands the framework. MSSP uses the standard CMS-HCC prospective model, whereas ACO REACH introduced a concurrent model for High Needs ACOs. LEAD applies a distinct High Needs category across all ACOs, supported by a recalibrated concurrent model, with plans to introduce AI-inferred risk scores for A&D populations (phased in from PY 2029 - 2031). In LEAD, the CMS-HCC prospective model will be recalibrated to reflect the removal of the High Needs population—a potential shift in how Medicare measures risk and complexity.

## FINANCIAL SETTLEMENT AND RISK SHARING

MSSP relies on thresholds (MSR/MLR) before savings or losses are realized, whereas both ACO REACH and LEAD use first-dollar savings/losses. Similar to REACH, LEAD maintains graduated

risk corridors in which initial savings/losses are fully shared (up to 100%) with reduced exposure at higher levels, balancing incentives and downside protection. REACH's Global Option allows ACOs to retain 100% of savings/losses only within +/-10% of benchmark (PY2026). Beyond the +/-10%, CMS shares in the savings/losses. LEAD's Global Option widens the first corridor to +/-15%, which presents greater savings opportunities and risks under LEAD.

LEAD and ACO REACH also offer optional stop-loss reinsurance, providing protection against high-cost outliers, while MSSP relies on automatic truncation of outlier expenditures at the 99th percentile.

## **PAYMENT MECHANISMS AND SPECIALIST INTEGRATION**

MSSP remains fully fee-for-service (FFS) with retrospective reconciliation. ACO REACH introduced capitation through PCC and TCC, along with advanced payment options. LEAD builds on this methodology, adding NPCC, extending capitation to specialist services and enabling more MA-like sub-capitation arrangements.

LEAD also introduces CARA, allowing ACOs to establish episode-based risk arrangements with specialists, including customizable episode definitions. This addition significantly expands downstream risk sharing capabilities and strengthens specialist engagement in accountable care.

## **STRATEGIC IMPLICATIONS FOR PROVIDERS**

LEAD's structural and financial changes have important implications for health systems and provider organizations considering participation. Beyond program mechanics, these design elements influence how providers will manage risk, structure care delivery, engage specialists, and invest in population health capabilities. This section outlines key strategic considerations, helping organizations assess their readiness for LEAD and identify opportunities to align the model's incentives with their broader clinical, financial, and operational goals.

### **For Health Systems Considering LEAD Participation**

LEAD's 10-year performance period without rebasing represents a fundamentally different value proposition than MSSP's five-year cycles. Provider organizations that have successfully reduced costs in the LEAD program's benchmark years can carry the benefit of those reductions forward indefinitely, rather than seeing that efficiency eroded at rebasing.

However, the commitment is substantial. ACOs that select the Global Risk Option face full upside and downside risk from day one, with a financial guarantee requirement. The retention incentive (2% benchmark reduction for ACOs that leave after one year) reinforces CMS's expectation that participation entail a long-term commitment.

### **For Higher Spending Provider Organizations**

LEAD is explicitly designed to attract higher spending ACOs that have historically been reluctant to participate in accountable care models. The 1.5% administrative add-on provides upfront capital for care transformation, and the ramped discount rate (starting at 1.75% versus 3.0% for lower spending ACOs) provides financial runway during the critical early years. This arrangement makes LEAD particularly attractive for organizations that are ready to make significant investments in care transformation infrastructure. Higher spending organizations should evaluate whether the combination of these incentives, the no rebasing structure, and the 10-year horizon creates sufficient opportunity to reduce costs.

### **For Organizations Currently in MSSP**

MSSP participants face a strategic decision: remain in MSSP (which continues to operate) or transition to LEAD. Participant TINs cannot simultaneously participate in both LEAD and MSSP. Organizations should model the financial impact of LEAD's static BYs versus MSSP's rebasing cycle, the effect of the different discount rates, and the relative value of LEAD's capitation options versus MSSP's FFS-only structure.

Notably, renewing ACOs with more than 40% of participant TINs from a recent MSSP ACO are subject to a lower benchmark adjustment cap (3% versus 5%) to discourage opportunistic switching solely to access LEAD's more favorable savings structure.

### **For Organizations Currently in ACO REACH**

ACO REACH participants face a strategic decision to either transition to LEAD or enter MSSP. The abbreviated application process for ACO REACH participants lowers the barrier to entering LEAD. LEAD offers continuity in two-sided risk and capitation, along with advantages such as no rebasing and expanded specialist engagement, but introduces new features, including hybrid alignment, TIN-level attribution, evolving benchmarks, and enhanced quality requirements. Participants may need to add infrastructure and make care model adjustments. Organizations must assess their readiness to sustain long-term risk, leverage new payment mechanisms, and align with LEAD's broader shift toward population-based and specialist-integrated care.

## For Specialty-Focused Organizations

LEAD's CARA initiative and NPCC payment mechanism create new pathways for specialist engagement in accountable care. Specialty practices that have been excluded from ACO financial arrangements can now participate as preferred providers with episode-based risk arrangements or sub-capitated payment. This represents a meaningful shift toward the total cost of care accountability model that has been discussed in policy circles for years but rarely operationalized in Original Medicare.

## CONCLUSION

The LEAD Model represents a significant evolution in Medicare's accountable care landscape, offering a more stable, flexible, and comprehensive framework for managing total cost of care. By addressing long-standing challenges such as the ratchet effect, expanded payment and alignment options, and heightened support for High Needs populations and specialist engagement, LEAD creates new opportunities for providers to deliver value-based care at scale. At the same time, its increased complexity and long-term commitment to risk require thoughtful evaluation and strategic alignment. As organizations consider participation, success in LEAD will depend on their ability to adapt care models, invest in data and care coordination capabilities, and effectively navigate a more integrated, population-based approach to healthcare delivery.

## DISCLAIMER

This white paper is based on the LEAD Model RFA published March 31, 2026, the ACO REACH PY 2026 Financial Operating Guide and related methodology documents, and the MSSP Shared Savings and Losses Methodology Specifications (Version 13, June 2025). CMS may modify model policies prior to the start of any performance year. This document is provided for informational purposes only and does not constitute legal, actuarial, or regulatory advice.

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