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WHITE PAPER

Risks Facing 2027 LEAD Model Participants

Understanding First-Year Full Risk Exposure Amid Critical Data Gaps

Pete Arsenault

Andy Large, FSA, CERA, MAAA

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SUMMARY

The Centers for Medicare & Medicaid Services (CMS) Innovation Center's Long-term Enhanced ACO Design (LEAD) Model introduces a fundamentally different risk paradigm for Medicare accountable care organizations (ACOs), particularly for participants entering in Performance Year (PY) 2027. While LEAD offers compelling long-term strategic advantages - including no rebasing and a prospective trend "savings wedge" - it also introduces significant first-year risk exposure under conditions of data uncertainty.

This white paper outlines the material risks facing 2027 LEAD participants, with a focus on three critical data gaps:

- 2026 as a benchmark year with limited credible data
- Uncertainty around risk score model changes
- Use of prospectively set ACPT values without empirical validation

These three factors collectively create a high-risk environment for Year 1 participation, particularly for organizations electing Global Risk or those with limited previous experience with two-sided risk models.

1. STRUCTURAL CONTEXT: WHY YEAR 1 RISK IS UNUSUALLY HIGH

LEAD requires ACOs to assume downside risk from the first dollar, with no minimum loss rate protections, consistent with the financial structure of the REACH ACO program. This type of ACO model significantly raises the stakes for initial-year participants.

Key Structural Risk Factors
• Benchmarks are locked for 10 years with no rebasing
• Risk corridors allow significant downside exposure early in the model
• Participants must commit provider lists and structure prior to having complete data visibility

This creates a fundamental asymmetry: Organizations must commit to risk before fully understanding their benchmark, population, or potential performance drivers. The irreversibility of these early decisions, particularly given the 10-year benchmark lock, amplifies the cost of miscalculation in Year 1.

2. DATA GAP #1 – 2026 AS A BENCHMARK YEAR

2.1 The Problem

LEAD uses calendar year (CY) 2024–2026 as baseline years for PY 2027 benchmarks. However, 2026 data will be very immature at the time of participant list submission, creating a structural information disadvantage at the moment of commitment. Organizations contemplating participation will need to make assumptions based on data from 2024 and 2025 to fill in a critical benchmark year. This approach may result in a much larger range of possible historical benchmark outcomes than in subsequent performance years, which will have the benefit of full 2026 data visibility.

2.2 Implications

a. Benchmark Misestimation Risk

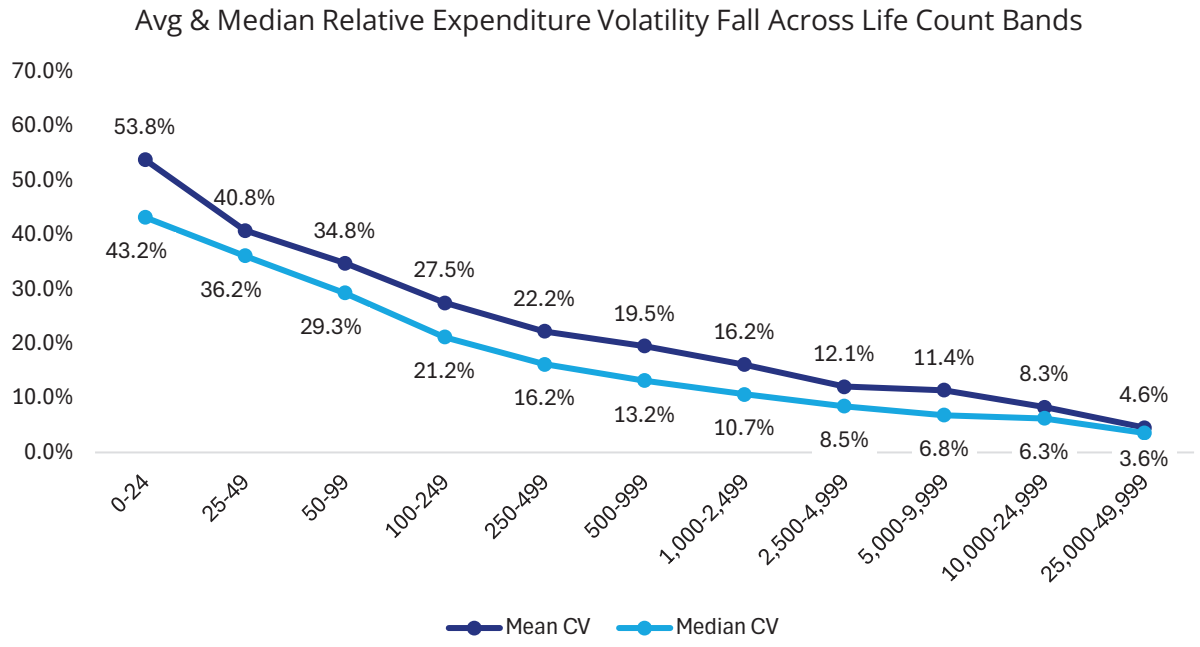
Participants will be able to neither estimate their true baseline costs, case mix, and acuity accurately nor calculate trend-adjusted benchmark levels with confidence. This uncertainty pervades the economic foundation of the participation decision.

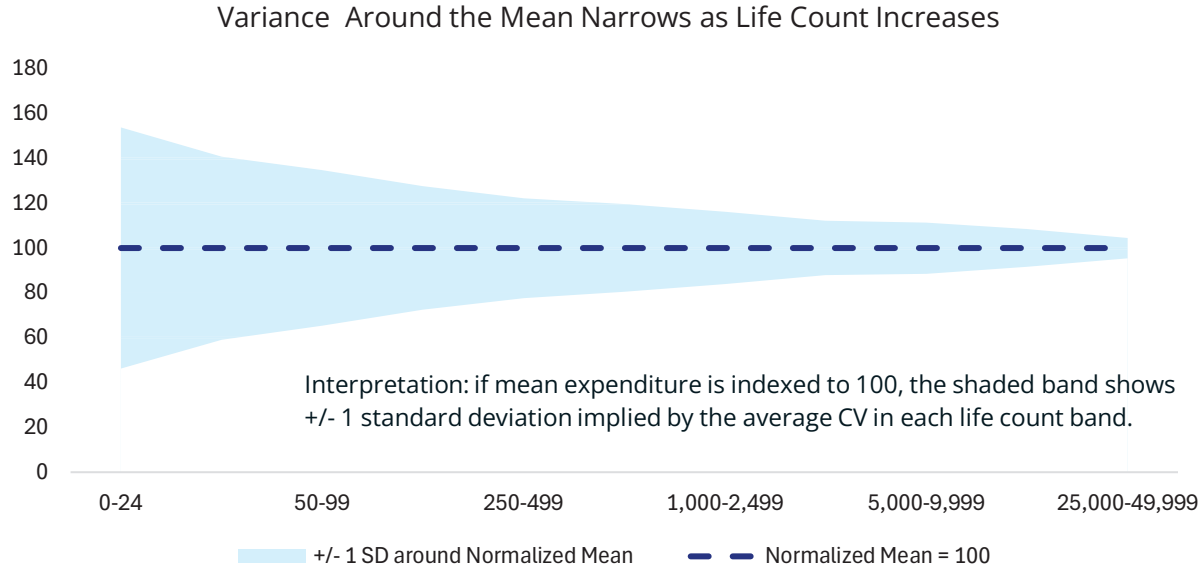
b. Provider Selection Risk

ACO participant lists must be finalized before full 2026 utilization is known or provider performance variability is understood, which increases the likelihood of including high-cost and volatile providers or inadvertently excluding providers critical for attribution stability. A recent study of 2022–2025 fee-for-service (FFS) expenditures shows that lower membership numbers often create significant volatility in year-to-year expenditures.

Figure 1 (next page) shows that practices that deliver services to 100–249 FFS lives have a 27.5% average standard deviation of expenditures in their four-year mean. In simple terms, this means that if an ACO is making 2027 network decisions while blind to the 2026 benchmark Year 3, the risk that a certain practice's benchmark will change significantly when 2026 becomes available is extremely high. ACOs should be aware of that reality and weigh that appropriately when making practice level decisions.

Figure 1. Medicare Expenditure Volatility at Various Practice Sizes





*Study conducted using 2022–2025 FFS data from the 100% Medicare database. Over 31,000 taxpayer identification numbers (TINs) with 11.3 million 2025 attributed beneficiaries were analyzed in the dataset. Expenditures are risk adjusted to a 1.0 using the v28 model.

c. Alignment Volatility

Because LEAD uses a shorter, one-year lookback window, attribution is more sensitive to recent utilization changes, which results in unstable beneficiary panels and reduced predictability of attributed lives - complicating financial forecasting and care management planning alike. Unlike ACOs in REACH, which used a two-year lookback window, LEAD participants will need to ensure their beneficiaries have seen their primary care provider (PCP) within the last year.

3. DATA GAP #2 – RISK SCORE MODEL UNCERTAINTY

3.1 Structural Changes in LEAD

LEAD introduces multiple new and evolving risk adjustment methodologies, each of which introduces a layer of uncertainty. These new frameworks include:

- Modified CMS-HCC V28-based prospective model (Prospective Risk Adjustment Model V1)
- New Concurrent Risk Adjustment Model for High Needs populations (Concurrent Risk Adjustment Model V2)
- Planned transition to AI-inferred risk scores beginning in PY 2028

Specifically, the Innovation Center announced that the new Prospective Risk Adjustment Model v1 used for beneficiaries who are classified as aged/disabled will be recalibrated to reflect the removal of the high needs population to avoid overpredicting the risk of beneficiaries who are non-high needs.

The Concurrent Risk Adjustment Model V2 will be a modified version of the HCC Concurrent Risk Adjustment Model V1, which was used in ACO REACH. It will be modified to reflect the 2024 CMS-HCC Prospective Risk Adjustment Model architecture and recalibrated to reflect only the high needs population.

Final model specifications are unlikely to be published prior to participant commitment deadlines. Calibration details and model coefficients will be unknown at the time decisions must be made, leaving participants unable to validate their own risk score projections.

3.2 Implications

a. Inability to Forecast Risk Scores

Without details of the risk models being used, participants cannot reliably estimate RAF levels, coding elasticity, or the impact of documentation improvement initiatives. Without these inputs, financial planning for Year 1 rests on a foundation of assumptions rather than evidence.

b. Misalignment Between Population and Benchmark

If models underpredict high-acuity populations, participants face downside loss risk from the outset. Conversely, if models overpredict healthier populations, apparent savings potential may prove illusory, leading to misallocated care management investment.

c. Coding Strategy Risk

Traditional coding strategies may be less effective under recalibrated models and could be further disrupted by the transition to AI-based risk scoring approaches beginning in PY 2028, creating meaningful strategic uncertainty in care management investment decisions.

The use of a static reference year for risk score capping in LEAD further constrains the long-term effectiveness of coding strategies. Because risk scores are anchored to a fixed baseline year (2026), ACOs will have limited ability to increase their relative risk position over time, with growth effectively capped at approximately 3% above their 2026 level. This approach introduces a structural "risk score ceiling" that persists throughout the model.

As a result, if an ACO's 2026 risk score is understated because of incomplete coding, documentation gaps, or data immaturity, that inaccuracy becomes effectively locked in. Participants will have few opportunities to correct or recapture missed acuity beyond the capped growth threshold, creating a long-term structural disadvantage relative to peers with more accurate baseline coding.

4. DATA GAP #3: ACCOUNTABLE CARE PROSPECTIVE TREND (ACPT)

4.1 Role of ACPT

ACPT represents a prospectively set growth factor incorporated into benchmarks. One-third of the benchmark update is driven by ACPT based on CMS Office of the Actuary projections. This approach makes the benchmark materially dependent on the accuracy of forward-looking national spending estimates.

4.2 Core Risk: Forecast vs. Reality

ACPT is set before actual spending is observed, creating an irreducible forecasting risk:

- If ACPT exceeds actual cost growth → participants benefit from a favorable "savings wedge"
- If ACPT falls short of actual cost growth → participants face systematic losses unrelated to their own performance

4.3 Guardrail Limitations

Although guardrails exist (+0.3%, -0.2% in PY 2027), they do not eliminate directional error and still allow material financial impact at scale. Organizations with large, attributed populations face proportionally greater absolute exposure even when percentage deviations appear to be modest.

4.4 Implications

a. Uncontrollable Trend Risk

Participants are exposed to national and regional cost variation, as well as policy-driven utilization shifts that fall entirely outside their spheres of influence. This is a form of systematic risk that cannot be diversified away within a single ACO.

b. First-Year Disadvantage

Unlike what will be the case in later years, PY 2027 participants will have no empirical validation of ACPT accuracy and cannot calibrate expectations based on prior LEAD experience. The first cohort effectively bears the modeling risk that subsequent cohorts can assess with the benefit of historical performance data.

5. COMPOUNDING RISK: INTERACTION EFFECTS

The most significant concern is not any single data gap operating in isolation, but rather the compounding effect of their interaction. When baseline uncertainty, risk model ambiguity, and trend risk occur simultaneously, the cumulative exposure is greater than the sum of individual risks.

5.1 Combined Risk Dynamics

Risk Factor	Effect	Interaction Impact
Incomplete 2026 data	Uncertain baseline cost and acuity	Amplifies ACPT misestimation risk
Unknown risk model	RAF and coding uncertainty	Distorts benchmark adequacy
ACPT variability	Prospective trend risk	Compounds baseline estimation error

5.2 Resulting Exposure

Participants face simultaneous uncertainty across spend, benchmark, and risk adjustment mechanisms. This three-dimensional uncertainty leads to increased levels of risk compared to more mature programs, and participants have limited ability to hedge or diversify in Year 1 given the structural requirements of program entry.

6. FINANCIAL RISK UNDER LEAD STRUCTURE

6.1 First-Dollar Loss Exposure

LEAD eliminates minimum loss thresholds, meaning losses begin immediately when spend exceeds benchmark. Unlike MSSP's graduated risk structure, there is no buffer period during which organizations can adapt before financial consequences materialize.

6.2 Risk Corridor Limitations

Even with corridors in place, Global Risk participants face up to 100% loss sharing in initial bands. Organizations that underestimate their exposure profile may find themselves committed to loss repayment obligations that were not adequately anticipated in capital planning.

6.3 Capital and Liquidity Risk

Organizations must demonstrate the ability to repay losses and provide financial guarantees at entry - before performance certainty exists. This creates balance sheet exposure at a time when the organization is simultaneously investing in care management infrastructure and operational scaling.

7. STRATEGIC RISKS FOR PARTICIPANTS

7.1 Adverse Selection Risk

Without full data visibility, ACOs may inadvertently attract or retain higher-cost populations. Voluntary alignment mechanisms may also introduce selection bias that is difficult to anticipate or counteract, particularly in Year 1.

7.2 Operational Readiness Risk

Organizations must scale care management capabilities, data analytics infrastructure, and provider engagement programs without knowing whether benchmarks are achievable or the investments will yield a positive return on investment. This creates a difficult planning environment in which resource allocation decisions must be made without substantial certainty.

7.3 Long-Term Lock-In Risk

Because LEAD locks benchmarks for 10 years, poor Year 1 positioning may persist as a structural disadvantage throughout the contract term. Early miscalculations in provider selection, population management, or coding strategy can have long-term financial consequences that are difficult or impossible to reverse with the model framework.

8. RISK MITIGATION CONSIDERATIONS

Although the risks described in this paper cannot be fully eliminated, participants can take meaningful steps to reduce their exposure and improve Year 1 resilience.

8.1 Conservative Participation Strategy

- Carefully evaluate professional risk vs. global risk entry points based on organizational risk tolerance and capital position
- Consider phasing in provider participation to limit initial exposure while maintaining flexibility

8.2 Rigorous Scenario Modeling

- Stress test financial projections under low RAF scenarios
- Model adverse ACPT scenarios with sensitivity analysis across a range of trend assumptions
- Evaluate high-cost outliers and their potential impact on shared losses

8.3 Provider Selection Discipline

- Focus on providers with stable utilization patterns and low year-over-year variability
- Prioritize providers with demonstrated value-based performance and existing care management engagement
- Avoid providers whose inclusion is driven primarily by attribution volume rather than performance profile

8.4 Capital Planning

- Ensure adequate reserves for worst-case Year 1 loss scenarios, not just expected-case projections
- Budget for operational ramp-up costs that may precede financial performance improvements
- Establish clear governance and risk tolerance thresholds at the board level prior to commitment

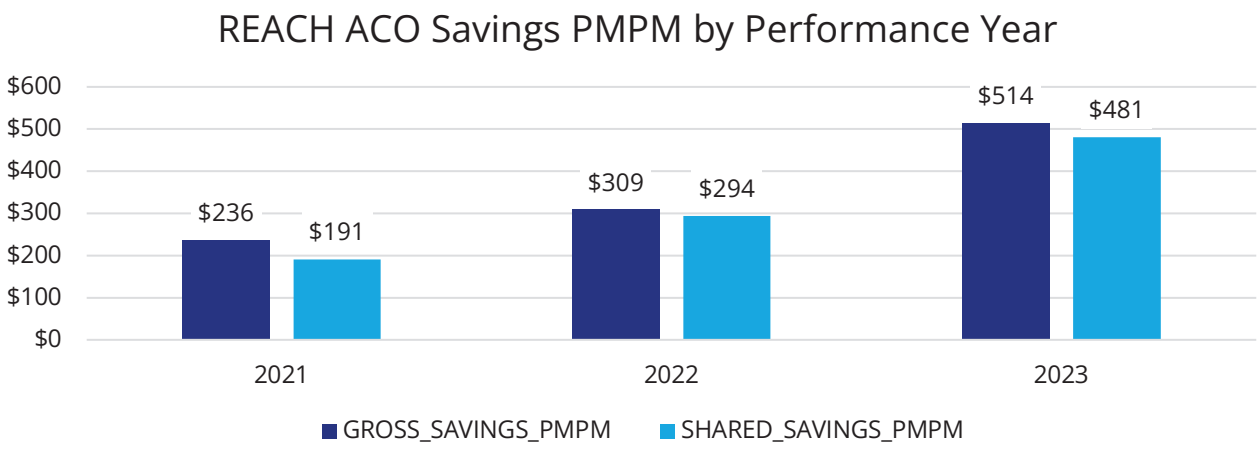
9. EVIDENCE FROM ACO REACH: PERFORMANCE IMPROVEMENT OVER TIME

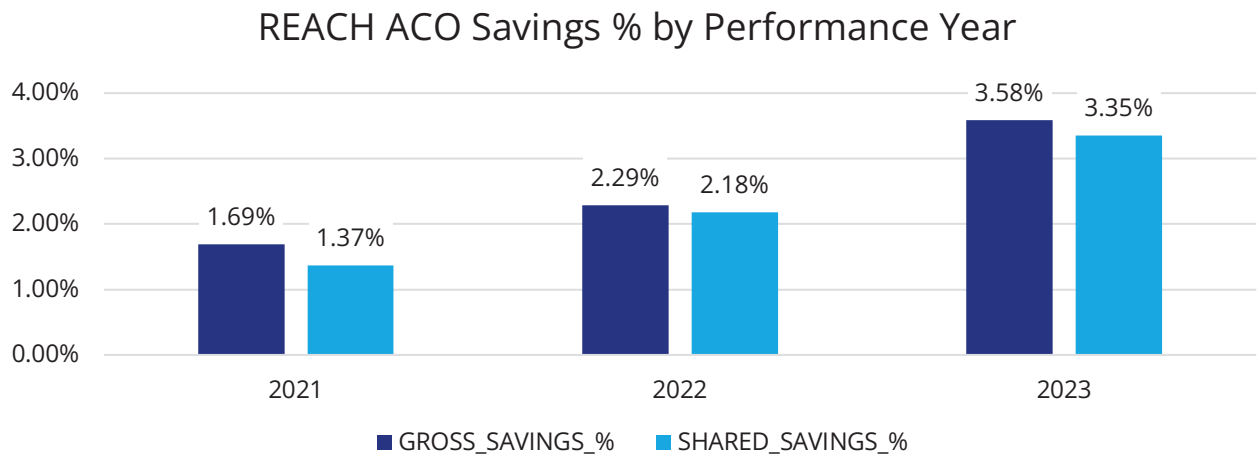
Experience from the ACO REACH model provides important empirical evidence that first-year participation in emerging risk models carries elevated performance risk, with outcomes improving meaningfully as organizations accumulate operational and analytical experience.

9.1 Observed Improvement in Financial Performance

Available CMS data for the REACH program demonstrates a compelling maturation trajectory (see **Figure 2**).

Figure 2. REACH ACO Savings by Performance Year





This trajectory represents a greater than 2x increase in shared savings on both a per beneficiary and percentage of benchmark basis. For providers considering LEAD participation, the REACH trajectory carries a clear message: Early-year financial performance should not be mistaken for a signal of long-term viability. Organizations that entered ACO REACH and sustained participation through the learning curve consistently achieved stronger savings. The same pattern is likely to hold - and may be even more pronounced - in LEAD, given the model's added complexity. Providers should calibrate their Year 1 expectations accordingly.

9.2 The Learning Curve

The REACH experience illustrates a consistent learning curve pattern across financial performance, care management maturity, and data and analytics capability as shown below.

Stage	Year 1	Years 2–3	Mature State
Financial Performance	Lower savings, higher variability	Improving savings, stabilizing	Optimized, predictable outcomes
Care Management	Building infrastructure	Refining protocols	Highly effective programs
Data & Analytics	Limited visibility	Improving accuracy	Full attribution intelligence

9.3 Implications for LEAD Participants

The REACH experience suggests that Year 1 performance is nonindicative of steady-state performance. Organizations need time to optimize attribution and provider networks, refine care management strategies, and improve coding and risk capture accuracy.

Given that LEAD introduces greater benchmarking complexity, new risk adjustment methodologies, and more dynamic alignment rules, it is reasonable to conclude that the Year 1 learning curve in LEAD is likely to be at least as significant, and potentially more pronounced, than that observed in ACO REACH.

10. CONCLUSION

The LEAD Model represents a transformative opportunity in Medicare accountable care, but PY 2027 participation carries uniquely elevated risk resulting from significant data gaps at the point of commitment. Participants must make irreversible strategic commitments in the absence of the following:

- Complete and mature baseline data for the 2026 benchmark year
- Finalized risk adjustment methodologies and model coefficients
- Validated trend assumptions or empirical ACPT calibration

Year 1 LEAD participation should be approached not as a standard program entry, but as a highly uncertain, high-stakes financial decision requiring rigorous modeling, governance, and risk tolerance alignment at the board level.

Organizations that invest in scenario planning, conservative provider selection, and robust capital reserves will be better positioned to weather the inherent uncertainty of Year 1 while building toward the sustained performance improvement that the model's long-term structure is designed to reward.

Prepared using Wakely analysis and CMS LEAD RFA and methodology documentation.

ABOUT THE AUTHORS

Pete Arsenault
Senior Consultant I
pete.arsenault@wakely.com

Andy Large
Senior Consulting Actuary, FSA, CERA, MAAA
andy.large@wakely.com

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