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WHITE PAPER

Reading Between the LEAD Lines

How the July 14 LEAD Methodology Paper Rewrites ACOs' Business Case

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EXECUTIVE SUMMARY

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) released the PY 2027 LEAD Alignment and Financial Methodology paper along with a companion policy update. Together, the documents fill in benchmark methodology details left open in the PY 2027 Request for Applications (RFA), published on April 15, 2026. While every LEAD applicant is affected, the most financially material changes are concentrated among ACOs with specific characteristics:

- Those weighing Global versus Professional risk elections
- Lower-spending Global ACOs recruiting newly participating taxpayer identification numbers (TINs)
- Renewing ACOs with complex predecessor histories
- ACOs with skilled nursing facility (SNF) or specialty-heavy billing footprints
- Those with meaningful high needs, voluntarily aligned, or hybrid-aligned populations

Several changes are favorable to participants. The Professional Risk Option's Corridor 1 shared savings rate increases from 50% to 60%, making that track more attractive for ACOs that haven't finalized their risk election. Hybrid alignment benchmarks now incorporate seasonality adjustments for mid-year enrollees, reducing a structural mismatch between partial-year claims and full-year benchmarks. Base-year expenditures will exclude Significant, Anomalous, and Highly Suspect (SAHS) billing and a portion of skin substitute billing, which may raise historical benchmarks for ACOs that modeled more conservative assumptions.

Other changes require careful, ACO-specific modeling rather than being viewed as simply good or bad. The regional efficiency adjustment (REA) now excludes newly recruited, higher-spending TINs from the underlying calculation, but applies a $0 adjustment to those TINs when blending results, which can increase or decrease an ACO's overall REA depending on whether it sits above or below the adjustment cap. The prior savings adjustment (PSA) now requires a predecessor continuity test (40% of TINs at BY3, 30% at BY1/BY2), which could substantially reduce or eliminate PSA credit for ACOs formed from fragments of prior MSSP or REACH entities. Changes in how CMS applies risk adjustment in the benchmark calculation (from a risk ratio approach to a risk score approach) may shift benchmarks up or down. The high needs risk-score cap is finalized at a symmetric 4% (or 3% for aged/disabled and end stage renal disease (ESRD) categories), replacing an uncertain 3%–8% range. New exclusions for SNF-based primary care and an option to exclude specialty-focused NPPs, FQHCs, and RHCs from alignment will reshape aligned populations for affected ACOs, changing both benchmark inputs and performance-year results.

Compounding the urgency, CMS will use CY 2026 completion factors to build preliminary PY 2027 benchmark reports before final BY3 data is available, with a one-time designation election offered if an ACO's higher/lower-spending status shifts between reports. Meanwhile, the roster deadlines for adding (August 5, 2026) and removing (September 8, 2026) participant TINs mean that risk-track decisions, alignment modeling, and TIN-level analysis must be substantially complete well before the final benchmarks are established.

Bottom Line

The July release resolves significant methodology uncertainty, but it does not simplify LEAD. Rather, it makes the model more parameter-dependent on each ACO's specific composition. Organizations should treat this as a mandate to fully refresh PY 2027 financial modeling now, particularly around risk-track election, TIN-level alignment strategy, predecessor continuity, and high/low-spend designation scenarios, given the compressed timeline to the TIN roster deadlines.

BACKGROUND AND SCOPE

LEAD is a CMS Innovation Center total cost of care model for Medicare ACOs. It is built around Global (100% shared savings) and Professional (50% shared savings) risk tracks, three static base years (2024–2026), and several benchmark adjustments layered on top of an adjusted historical benchmark. CMS finalized the PY 2027 Request for Applications on April 15, 2026, but left several financial methodology parameters, including some central to benchmark construction, for later guidance.

On July 14, 2026, CMS published two documents that fill in most of that detail:

1. The PY 2027 LEAD Alignment and Financial Methodology Paper
2. A companion policy update for selected applicants that also previews how certain proposed CY 2027 Physician Fee Schedule changes may interact with LEAD

This paper compares the two July 14 releases with the April 15 RFA.

WHERE THE JULY RELEASES MATTER MOST

The July 14 releases affect every LEAD applicant to some degree. CMS proposes to calculate Accountable Care Prospective Trend (ACPT) on an annual basis for each performance year, rather than fixing it for the full agreement period. The high needs symmetric risk score cap (4%) applies across the model. The companion policy update also previews a proposed CY 2027 Physician Fee Schedule change for HCPCS code G2211, which could affect compensation for ACO participant providers. The most financially material changes, however, are concentrated among a handful of ACO profiles. The table below maps those characteristics to the changes that matter most.

ACO Profile	Most Impactful Changes	Why
Any ACO weighing Global vs. Professional Risk Option	Professional Risk Option Corridor 1 savings rate: 50% to 60%	Materially improves Professional's potential upside
Lower-spending Global ACOs recruiting newly participating TINs	REA exclusion for new, higher-spending TINs	Removing those TINs can increase the REA, but can also decrease REA because of benchmark cap mechanics

ACO Profile	Most Impactful Changes	Why
Renewing ACOs with multiple predecessor MSSP or REACH ACOs	Prior Savings Adjustment (PSA) predecessor continuity test (40% for BY3, 30% for BY1/BY2)	Gross savings from prior ACOs can vary significantly; understanding which ACOs qualify (and for which years) will be critical
ACOs with risk scores significantly different from 1.0	Calculating updated benchmark based on performance-year risk score rather than risk ratio	ACOs' benchmark adjustments (prior savings or regional efficiency) will not be adjusted by dividing out BY3 risk score; this is a favorable impact for ACOs with a BY3 risk score >1.0, and unfavorable impact for ACOs with a BY3 risk score <1.0
ACOs with SNF rounding or post-acute primary care in their footprint	New SNF exclusion from claims-based alignment	Aligned population and associated expenditures/risk scores may decrease for affected TINs
ACOs with significant specialty billing within their TIN	Option to exclude certain specialty-focused NPPs, FQHCs, and RHCs from alignment	Beneficiaries attributed via specialty providers can have significantly different cost and risk profiles than beneficiaries attributed via primary care physicians
ACOs with significant high needs or voluntarily aligned populations	4% high needs cap, quarterly high needs eligibility checks, and BY3 treatment of voluntary aligned (VA) high needs	Clarifies benchmark methodology and risk treatment
ACOs considering hybrid alignment	Seasonality-adjusted benchmarks for beneficiaries added through hybrid alignment	Reduces a mismatch between partial-year claims and a full-year benchmark

ACO Profile	Most Impactful Changes	Why
ACOs with meaningful voluntarily aligned populations	Clarified VA benchmark methodology	Confirms how VA benchmarks are built and when the VA minimum applies
ACOs with meaningful 2024 to 2025 SAHS or skin substitute billing	SAHS and skin substitute carve-outs from BY1/BY2	Base-year expenditures used to set the benchmark will change
ACOs near the higher-spending or lower-spending boundary	CY 2026 completion factors, benchmark report timing, and one-time designation election for PY 2027	High/low spend designation affects the discount rate, REA eligibility, and the Administrative Add-On

THE PROFESSIONAL VS. GLOBAL RISK OPTION COMPARISON NEEDS TO BE REBUILT

The Professional versus Global comparison is changing for several reasons. The higher Professional Corridor 1 savings rate, the REA treatment for newly recruited higher-spending TINs, and the PSA continuity test can all move the economics. These changes need to be viewed together to understand whether an ACO wants to change its risk-track decision.

The Professional Risk Option Becomes More Competitive

CMS raises Corridor 1 shared savings for the Professional Risk Option from 50% to 60% for PY 2027. The shared loss rate remains 50%, so Corridor 1 becomes more favorable to ACOs than it appeared in the RFA. Corridors 2, 3, and 4 remain unchanged.

For applicants that have not yet finalized a Global versus Professional election, this is one of the most important changes in the July release. It improves the expected value of the Professional Option and may lead some ACOs that were previously leaning Global to choose Professional instead. That said, the decision still depends on the full package of benchmark mechanics, and not on the corridor alone.

The Global Benchmark Calculus Has Changed for Regionally-Efficient ACOs

CMS outlined a policy that excludes newly recruited higher-spending TINs from the REA calculation when those TINs have not participated in MSSP or REACH in the prior two years. This policy applies to lower-spending ACOs in the Global track who have new, higher-spending TINs in their provider list.

As outlined in the LEAD Alignment and Financial Methodology Paper, the process works as follows:

1. CMS determines whether an ACO is higher- or lower-spending (as compared to their region in BY3) using all participant TINs.
2. If the ACO is lower-spending, CMS determines whether the ACO has any new, higher-spending TINs within the ACO. CMS uses the same approach to determine this status as is used for the ACO, but using TIN-level data.
3. CMS calculates an REA (at the alignment type and beneficiary category level) for all TINs in the ACO excluding new/higher-spending TINs.
4. CMS applies the REA cap (5% or 3% of adjusted United States Per Capita Costs times PY risk score) to the amount from #3.
5. CMS blends the resulting capped adjustment from #4 (applied to all participant TINs that do not meet the new/higher-spending TIN status) with $0 (applied to all participant TINs that do meet the new/higher-spending TIN status).

While CMS frames this change as a method to avoid penalizing lower-spending ACOs for recruiting higher-spending providers (a positive change for ACOs), this methodology can decrease benchmark adjustments for ACOs with a capped regional efficiency adjustment.

Consider the example outlined by CMS starting on page 42 of the LEAD methodology document for a lower-spending ACO in the high needs category. The ACO has 80% of beneficiaries aligned to TINs that contribute toward the REA and 20% of beneficiaries aligned to TINs that do not contribute (in other words, the new, higher-spending TINs).

- Overall ACO (including all TINs):
    - Uncapped regional efficiency adjustment: $250 PBPM
    - Capped regional efficiency adjustment: $180.25 PBPM
- ACO excluding new, higher-spending TINs:
    - Uncapped regional efficiency adjustment: $350 PBPM
    - Capped regional efficiency adjustment: $180.25 PBPM
        - Note that while this adjustment is the same as the cap for the overall ACO in this example, the cap amount itself could also change as CMS only applies the risk scores from TINs that contribute toward the REA when calculating the cap.

- Final blended regional efficiency adjustment:
    - 80% * $180.25 + 20% * $0 = $144.20

Under the previous methodology outlined in the RFA, this ACO would have received a (capped) REA of $180.25. Under the new methodology, their adjustment drops to $144.20. This happens because CMS only applies the adjustment to TINs that contribute toward the calculation, and applies a $0 adjustment to the new/higher-spending TINs; previously, the capped adjustment applied to all TINs in the ACO. This happens despite an overall greater regional efficiency from the TINs included in the adjustment calculation ($350 vs. $250).

In summary:

- ACOs under the regional efficiency cap can expect **higher** regional efficiency adjustments under this proposal (from the removal of higher-spending TINs)
- ACOs above the regional efficiency cap can expect **lower** regional efficiency adjustments (as CMS applies their capped adjustment to a smaller portion of overall membership)
- ACOs in the Professional risk track, who are higher-spending (overall), or for whom a PSA is greater than their REA should see **no change** to their benchmark

The Prior Savings Adjustment Adds a Predecessor Continuity Test

The July release adds an eligibility gate to the PSA. A predecessor MSSP or REACH ACO can contribute to the PSA only if at least 40% of the LEAD ACO's participant TINs participated in that predecessor, measured at BY3. A lower 30% threshold applies for BY1 and BY2.

The test is not a free choice among predecessors. CMS identifies the predecessor first using the BY3 threshold, then applies the lower thresholds for BY1 and BY2 to that same predecessor. If the continuity threshold is not met, that year's contribution is zero. If two predecessor ACOs qualify, CMS uses a beneficiary-weighted average of their savings.

This is an important change for ACOs formed from fragments of prior MSSP or REACH entities. A small difference in roster continuity can materially change the PSA. For some ACOs, that could mean the difference between a meaningful PSA and no PSA at all.

CMS also clarifies that a given benchmark year can contribute net losses, but the average per-beneficiary-per-month savings across all three years cannot be negative. The proration formula was also corrected from the RFA so that average base-period beneficiary months are divided by current performance-year beneficiary months, capped at 100%.

The Mechanics of Risk Adjustment in Benchmark Calculation Has Changed

When calculating an ACO's historical benchmark, CMS blends the three base years' trended expenditures on a risk-standardized basis. That is, CMS divides by the risk score for each base year so that each year's expenditures are on a 1.0 risk score basis. CMS then adds a benchmark adjustment (either prior savings or regional efficiency) to this risk-standardized, blended historical benchmark.

- Adjusted historical benchmark = Blended historical benchmark (on a 1.0 risk basis) + benchmark adjustment (prior savings or regional efficiency)

Once the adjusted historical benchmark is calculated, CMS applies an adjustment to account for the average risk score of the population aligned in the performance year:

- Risk-adjusted historical benchmark = (Adjusted historical benchmark) * (PY Average Risk Score)

This risk adjustment approach differs from MSSP (and from what many potential LEAD participants were anticipating before the July LEAD methodology paper was released) in that MSSP's calculation adjusts for an ACO's *risk ratio* (or the ratio of the PY risk score and BY3 risk score).

- MSSP risk-adjusted historical benchmark = (Adjusted historical benchmark) * (PY Average Risk Score) / **(BY3 Average Risk Score)**

The MSSP and LEAD approaches are equivalent when it comes to the ACO's blended historical benchmark (the average of BY1-BY3 expenditures risk-adjusted to the performance year). This is because the blended historical benchmarks under both approaches are represented on a PY basis; they just differ on where risk adjustment is applied within the calculation. However, when it comes to the benchmark adjustment (prior savings or regional efficiency), the MSSP approach divides by the BY3 risk score while LEAD simply applies the PY risk score. This means that an ACO that has a BY3 risk score above 1.0 will see a benchmark adjustment higher than MSSP (all else equal), while an ACO with a BY3 risk score below 1.0 will have a lower benchmark adjustment.

ALIGNMENT IS GETTING NARROWER IN SOME PLACES AND MORE FLEXIBLE IN OTHERS

The July release changes alignment in two ways. First, CMS excludes certain SNF-based primary care from claims-based alignment. Second, it adds an option to prospectively exclude specialty-focused nonphysician practitioners, FQHCs, and RHCs from alignment and Primary Care Capitation. The combined effect is a more selective alignment process.

SNF-Based Primary Care No Longer Counts in Attribution

Primary care services (CPT codes 99304 through 99318) billed in a SNF no longer count toward the calculation of plurality for attribution purposes. For ACOs with meaningful post-acute rounding or SNF-based primary care, this can reduce the aligned population and change the mix of beneficiaries who drive benchmark and performance-year results.

For ACOs with little SNF exposure, the impact may be minor. For ACOs that rely on post-acute primary care as part of their alignment footprint, the change can be significant. It is not just a coding technicality; it can change who is aligned and who shows up in the financial model.

Some Specialty-Heavy Providers Can Be Excluded Prospectively

CMS also adds an option to prospectively exclude certain specialty-focused nonphysician practitioners, FQHCs, and RHCs from alignment and Primary Care Capitation. That matters most for ACOs whose participant roster includes a significant presence of specialists billing primary care services.

Because this change is optional, ACO leaders should take an in-depth look at which NPI-level providers (at an NPI level) are driving alignment. Because beneficiaries aligned to specialists often have a different profile of cost and acuity than those aligned to primary care providers, the difference between populations—and therefore the economics of the decision—can be material. ACOs should therefore examine which NPIs may qualify as specialty providers under the CMS definition, pull data at an NPI level for the ACO's participant TINs, and model various scenarios of including or excluding the specialist providers from attribution. This exercise will help ACOs make data-driven decisions regarding specialty alignment.

HIGH NEEDS, VA, AND HYBRID POPULATIONS DESERVE THEIR OWN REVIEW

High Needs Economics Are Clarified

CMS finalized a symmetric 4% high needs risk score growth cap for at least PY 2027 and PY 2028, with 3% caps for the aged/disabled and ESRD categories. This replaces a previously estimated range of 3%–8% for the high needs risk score cap. The cap applies independently to each beneficiary category using combined data from claims aligned and voluntary aligned (VA) beneficiaries. The BY3 high needs reference average used for this comparison includes only beneficiaries who were classified as high needs in BY3. Quarterly eligibility re-checks mean high needs status can be refreshed on a rolling basis.

For ACOs with meaningful high needs populations, the change more clearly defines how risk is measured and when it can move, reducing ambiguity in forecasting and changing the shape of benchmark movement year over year. CMS also noted that this cap may be revisited as the model transitions to AI-inferred risk adjustment beginning in PY 2029, but did not offer additional details on this model or plans for implementation.

CMS Largely Keeps Voluntary Alignment Benchmarks the Same, But Institutes a New Beneficiary Minimum

The July paper clarifies how voluntarily aligned benchmarks are built. A guardrail that limits the difference between voluntary aligned benchmarks to within 10% of claims aligned benchmarks was confirmed as two-sided. This guardrail is applied after the three base years are blended but before the benchmark adjustment is calculated. CMS also set a 500-beneficiary minimum: if an ACO has fewer than 500 VA beneficiaries contributing BY3 expenditures, those beneficiaries revert to a claims-aligned benchmark.

Many in the industry have raised concerns regarding the impact of "survivorship bias" in the calculation of voluntary aligned benchmarks. Because CMS does not have a way to determine individuals who would have been voluntary aligned in the three base years (like they can for claims alignment), they have chosen to calculate historical benchmarks using actual historical claims data for those who are voluntary aligned in the performance year. This means that, by definition, all individuals used to calculate base-year expenditures and risk scores were alive in the base years. However, the performance-year VA population can include individuals who have passed away. Because of the significant cost of end-of-life healthcare, this methodology can cause a mismatch in expenditures and beneficiary acuity between the population used to calculate historical benchmarks and the performance-year expenditures. While CMS's 10% guardrail and 500-beneficiary minimums can serve to mitigate this effect, ACOs may still see an impact from the survivorship bias in voluntary aligned benchmark calculations.

Hybrid Alignment Benchmarks Become More Aligned with Seasonal Risk

CMS clarified that beneficiaries aligned through hybrid alignment will receive a seasonality-adjusted benchmark for beneficiaries added mid-year. That reduces the mismatch between the portion of the year in which a beneficiary is aligned and a benchmark that otherwise would have assumed a full-year relationship. For ACOs considering hybrid alignment, the change can materially improve the alignment between benchmarks and expenditures associated with mid-year TIN additions. ACOs may still face risk to the extent that performance-year claims seasonality for the ACO's population differs from CMS-defined benchmark seasonality factors.

BASE-YEAR SPENDING AND PY 2027 SETUP ARE CLARIFIED

SAHS and Skin Substitute Spending Are Carved Out of the Base Years

For SAHS billing activity, CMS excludes 100% of expenditures for designated codes from Historical Baseline Expenditures and from national and regional expenditure calculations for relevant base years. Separately, CMS excludes 65% of skin substitute expenditures from BY1 and BY2, reflecting the lower payment rates finalized in the CY 2026 rule. Stop-loss reference calculations apply a stricter 100% exclusion for both categories for CY 2023 through CY 2025.

For ACOs with meaningful wound care, skin substitute, or similar high-cost billing, the benchmark can change materially. Depending on what ACOs assumed in previous modeling, benchmarks will either increase or decrease accordingly. In particular, the 65% guidance differs from previous updates from PY 2025 in ACO REACH in which 90% of expenditures are excluded; if ACOs previously used the 90% assumption, they can expect their historical benchmarks to increase.

CY 2026 Now Functions as BY3 Through Completion Factors, with a One-Time Election

The RFA established CY 2024 through CY 2026 as the static base years but did not fully explain how CY 2026 claims would be handled when PY 2027 benchmarks are first calculated. The July release fills that gap. Using LEAD National Reference Population data, CMS will use completion factors and a seasonality adjustment to build the first PY 2027 benchmark reports from incomplete CY 2026 claims data, then refresh those reports on a defined schedule until the full BY3 picture is available.

The December 2026 preliminary benchmark report will be an early indicator of where a given ACO is heading, but it will not be the final word. This matters most for ACOs near the higher-spending or lower-spending boundary. If an ACO's designation changes between the preliminary and final reports, CMS will allow a one-time election of which designation to use for PY 2027. That election can affect the discount rate, REA eligibility, and the Administrative Add-On, so it should be modeled carefully before the final report is released.

Timing matters. CMS's technical FAQ gives selected ACOs until August 5, 2026, to add participant TINs to the 2027 participant TIN list and until September 8, 2026, to remove TINs. This means roster decisions, risk-track analysis, and alignment modeling need to be substantially complete before early September and not after the final benchmark.

QUESTIONS EVERY LEAD ACO SHOULD ANSWER BEFORE PY 2027 DECISIONS

After a careful review of the updated LEAD guidance, ACOs should determine which changes are most impactful, and whether the organization's current business case still holds after the July methodology is applied:

- Would the organization make the same Global versus Professional decision today after modeling the 60% Corridor 1 savings rate and the revised benchmark mechanics?
- How will the ACO be impacted by new, higher-spending TIN exclusions from REA and the new prior savings methodology?
- Which benchmark adjustment controls each scenario, and is the ACO likely to hit the risk-adjusted cap?
- What does the ACO's projected performance look like by NPI? Are there certain specialty-focused NPIs that are driving unfavorable development?
- In light of new seasonality-adjusted benchmarks, is hybrid alignment right for the ACO?
- Do provider incentives, especially where specialty billing or SNF-based care are involved, line up with ACO economics?
- Is the ACO near the higher-spending or lower-spending boundary, and should both designation scenarios be modeled before the final PY 2027 benchmark report is issued?

For many organizations, the answer to these questions will depend on how each policy interacts. ACOs with SNF-heavy primary care, predecessor complexity, newly recruited TINs, meaningful high needs or VA populations, or considering hybrid alignment should expect the interaction effects to matter.

WHAT ACOS SHOULD DO NOW

The July 14 releases call for a full refresh of PY 2027 financial modeling. The most practical next steps are below.

1. Rerun the Global versus Professional Risk Option comparison using the 60% corridor savings rate
2. Quantify SNF-based primary care exposure across participant TINs and rebuild claims-based alignment projections excluding overlapping SNF-date claims
3. Calculate predecessor continuity for every MSSP or REACH relationship in the formation history against the new PSA thresholds
4. Screen newly recruited or newly formed TINs for prior MSSP or REACH history and regional spending status, then rerun REA scenarios with and without those TINs
5. Recalculate BY1 and BY2 base-year expenditures applying the skin substitute and SAHS carve-outs
6. Rework high needs modeling using the finalized 4% cap, quarterly re-check cadence, and BY3-only reference average for high needs beneficiaries
7. Update hybrid modeling to reflect seasonality-adjusted benchmarks for mid-year enrollees
8. Rebuild VA benchmark projections using the clarified two-sided guardrail and the 500-beneficiary minimum
9. Consider modeling sensitivities that would result in either higher- or lower-spend status for the ACO, and determine which status would be more favorable if the ACO could choose

FINAL THOUGHTS

The gap between the April RFA and the July 14 methodology release is significant. Several items changed outright rather than simply being specified for the first time. On balance, that is good news for some ACOs. The Professional Risk Option is more attractive, the ACPT should track reality more closely, and several previously open questions now have concrete answers organizations can plan around.

At the same time, the July release makes clear that LEAD is not a one-size-fits-all model. ACOs with SNF-based primary care, predecessor complexity, new TIN growth, high needs populations, VA populations, or considering hybrid alignment may see very different results than the average applicant.

Wakely's Value-Based Payment team works with ACOs to quantify these provisions and evaluate the implications for current performance and PY 2027 participation strategy. Contact us to discuss what the July changes may mean for your organization.

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Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

CMS SOURCE MATERIALS

- PY 2027 LEAD Alignment and Financial Methodology Paper, July 14, 2026: https://www.cms.gov/priorities/innovation/files/lead-alignment-finance-paper.pdf
- April 15, 2026 PY 2027 LEAD Request for Applications: https://www.cms.gov/priorities/innovation/files/lead-rfa.pdf