Will ACOs LEAD the way in 2027?

Last Thursday, January 29th, CMS hosted a webinar on the much-anticipated ACO LEAD model. It did not disappoint. CMS will post a recording of the webinar on the ACO LEAD website (not yet posted as release of today's newsletter). Since we have already covered the initial CMS announcement of LEAD, we will focus this installment on the new details that emerged from Thursday's webinar and insights gleamed.

As the name implies, Long-term Enhanced ACO Design (LEAD) will offer many new innovations to ACOs, attempting to solve some of the shortcomings of the Medicare Shared Savings Program (MSSP) and previous models from the Center for Medicare and Medicaid Innovation (CMMI). While the Request for Application (RFA) is not expected until sometime in March, there were many new details that were shared in last week's webinar. Here are some of those details:

Scope and Model Design

The LEAD model will be much like REACH in many ways but with a combined population approach. We find elements of the High-needs, New Entrant and Standard ACO REACH models combined into a single contracting entity. As CMS continues to move toward the goal of 100% of traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships, it makes sense to include all rather than to exclude certain populations from ACOs based on model features or rules. LEAD will include all aligned populations into the same ACO while accommodating adequate benchmarks for high-needs and special care patients.

High Needs beneficiaries will have their own population category much like Aged & Disabled (AD), or End Stage Renal Disease (ESRD) in REACH today. This will facilitate its own benchmark and trend factors along with the use of concurrent risk adjustment for this population. Prospective risk adjustment will still apply for AD and ESRD populations. Organizations who specialize in the care of high-need beneficiaries (defined as greater than 40%) and new ACOs will have access to lower beneficiary alignment minimums. There will be other care capability requirements to qualify for this lower minimum for the High-Needs exception.

The intent is to provide an attractive option for providers who are currently participating in ACO REACH, provide improved incentives for those who found participation in the MSSP or previous other models difficult, and a more favorable path for small, rural and independent health care providers and community health centers. Also, since the LEAD model will run for a duration of 10 years without rebasing, many current MSSP ACO might find the model an attractive alternative.

Another new feature announced on the webinar was the Tech Enabler Initiative. CMS will work with LEAD ACOs to identify important technology use cases, such as care navigation and condition management, and then create standardized business requirements to facilitate vendor support for these use cases. This process is intended to reduce the burden of tech adoption for ACOs, particularly small, provider-led ACOs.

Participants & Alignment

One departure from the REACH model is in the way participant providers will align to LEAD ACOs. The previous Tax Identification Number (TIN) and National Provider Identifier (NPI) selection will not apply in this model. Rather LEAD ACOs will align all NPIs that are credentialed to a TIN, the same way it is done in the MSSP. While the rationale for this alignment rule was not communicated in the webinar, it does better align to the goal of including all traditional Medicare beneficiaries in accountable care relationships. One significant new feature is the ability to add new TINs during the performance year.

Preferred Provider relationships will be defined in this model much like they currently are in REACH. In LEAD, the selection and management of preferred providers will be at the TIN-NPI level to allow flexibility for ACOs. Since they do not drive beneficiary alignment this flexibility remains consistent with the goal above.

LEAD will utilize both Claims-Based and Voluntary Alignment much like the REACH model. ACOs will be able to select either Prospective or Hybrid alignment methodologies. The Prospective option will align population prior to the beginning of each year with no alignment updates during the performance year. The Hybrid option allows ACOs to update their beneficiary list during the performance year in two ways, with voluntary alignment monthly and with new participant TIN additions via an additional claims-based alignment mid-year.

BE/BEIs

LEAD will include all the Benefit Enhancements (BEs) of REACH, plus expanded access to medical nutrition therapy for beneficiaries with pre-diabetes and hyperlipidemia. There is also a plan to share savings with beneficiaries through Part D premium reductions beginning in 2029.

Additionally, LEAD will include some of the Beneficiary Engagement Incentives (BEIs) and several new or expanded BEIs particularly those involving Part B Cost Sharing and Chronic Disease Prevention Rewards. Apparently CMMI is aligning features of this and other new models with the Innovation Center's Making America Healthy Again strategy.

Risk Sharing Options

The risk participation options in LEAD will be similar to REACH with some modifications. There will be a Global Risk option with savings and losses of up to 100%. The Global Risk option will include a discount to generate savings for Medicare. This is consistent with the methodology of REACH, however, the precise discount has not yet been disclosed. There will also be a Professional Risk option capping savings and losses up to 50%. ACOs electing this option must remain in the Professional Risk option for at least 4 years. The risk corridors will be modified from the REACH model; details will be included in the RFA. Similar to REACH, CMS sponsored stop loss will be available to protect against outliers.

Capitation

LEAD will provide participants with monthly upfront cash flow to invest in care improvement and greater flexibility to deliver patient-centered care that does not rely on fee-for-service, volume-based billing. To that end LEAD will offer the following payment options:

- PCC - Primary Care Capitation: Upfront monthly payments for primary care services delivered by ACO Participants and Preferred Providers.
    For ACOs that select PCC, they may also select the following options:
    - APO – Advanced Payment Option is an upfront monthly payment that will be reconciled against actual fee-for-service billing.
    - NPCC – Non-Primary Care Capitation is a new mechanism that acts as a true capitated payment.
- TCC - Total Care Capitation: Capitated payments for all Part A & B services delivered by ACO Participants and Preferred Providers, including both primary and specialty care.
- Add-On Capitation: LEAD will include an add-on capitated payment to provide an additional source of upfront cash flow for eligible ACOs.

CARA – CMS Administered Risk Arrangements

CARA is a new feature being tested by this model. It is an episode-based risk arrangement between ACOs and their specialists and provider organizations. CMS will design templates with the framework of these arrangements and then help facilitate the negotiated terms.

Most details will be forthcoming in the RFA. It was alluded that the current shadow bundles made available in REACH will be used in this model. The webinar did include the mention of an episode-based Falls Prevention Program that will feature time-limited services to boost independence in daily home and community-based activities for Medicare beneficiaries.

Quality

LEAD will use the quality measures currently included in REACH, plus some additional components. They will be comprised of the four claims-based measures utilized in REACH (the two shared and two model specific measures), along with CAHPS, and two digital measures (eCQMs) phased in over the next several years. Those measures involve controlling diabetes and high blood pressure. In addition, each ACO will choose a prevention intervention based on the unique needs of their population and develop a Prevention and Quality Plan (PQP) to help keep patients healthy. The LEAD model, just as in REACH, will also include a High Performers Pool (HPP) and the Continuous Improvement or Sustained Exceptional Performance (CI/SEP) features. Finally, a quality withhold methodology, as used in REACH, will be applied at a rate of 3% of benchmark in LEAD.

Benchmarking Methodology

LEAD's benchmarking methodology builds on ACO REACH and the Shared Savings Program to create a pathway towards sustainable, long-term benchmarks and savings for different types of ACOs. Key features will include:

- A stable, 10-year performance period without re-basing.
- ACOs will start with a benchmark based on historical costs (plus an additional capitated payment incentive for higher spending ACOs) transitioning to a regional rate book-based benchmarking approach as the model matures.
- Global risk ACOs will be eligible for the higher of positive-only regional adjustments, or prior savings adjustments, based on risk adjusted spending.
- Annual benchmarks are updated using a blend of actual national and regional spending trends and a prospective growth factor with guardrails.

Specific details to come in the RFA

Duration, Timelines and Future Application Cycles

LEAD will be a 10-year model, the longest ACO model introduced by the Innovation Center to date. The RFA will come in early Spring with the application cycle closing in late Spring. Applicants will be notified of selection decisions in early Summer. Participants will then have an onboarding period. There is also an optional pre-implementation period beginning

in the Fall of 2026. The first performance year begins January 1, 2027. Future application cycles are likely but not assured. LEAD staff indicated that future applicants could face different criteria for selection.

Key Takeaways:

ACO LEAD is an innovative new model designed to expand access to ACOs for the providers who serve Medicare beneficiaries. It is an exciting attempt to address some of the shortcomings found in the Shared Savings Programs and prior CMMI ACO models. Features like the 10-year, no re-basing benchmarking methodology, mid-year claims alignment for new TIN additions, combined population approach with high-needs accommodations such as concurrent risk adjustment and add-on capitation payments, lower minimum beneficiary alignment requirements for certain ACOs, the CARA initiative, the expansion of BEs/BEIs, future Medicaid integration, and renewed emphasis on beneficiary engagement and preventive services make LEAD a model that all ACOs should stop and take notice.

ACOs should not wait for the RFA to be released in March but should evaluate and prepare their 2027 plan now. That plan should include an option A and B. The RFA will then either contradict or validate the assumptions made and confirm an option as the optimal course of action. In the hyper competitive ACO landscape, there is no time to wait and see.