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What is the CMS LEAD Model?

Understanding LEAD and Preparing for Medicare's 10-Year Accountable Care Model

Executive Summary

On December 18, 2025, CMS announced the Long-term Enhanced ACO Design (LEAD) Model, launching January 1, 2027, to replace ACO REACH. This is CMS's boldest commitment to accountable care. A 10-year model with stable benchmarks, eliminating the ratchet effect that penalized high performers. LEAD targets small practices, rural providers, and organizations serving high-needs populations with lower participation thresholds, infrastructure payments, and streamlined specialist integration through CARA (CMS Administered Risk Arrangements). Organizations have until March 2026 to apply, giving them roughly 13 months to decide between transitioning to LEAD, moving to MSSP, or exiting ACO models entirely. Success requires financial reserves, care coordination infrastructure, and data analytics capabilities. This isn't incremental change. It's a redesign that levels the playing field and signals Medicare's permanent shift toward value-based care. Organizations that start planning now will enter LEAD prepared. Those that wait will scramble. The clock is ticking.

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What is the LEAD Model?

On December 18, 2025, CMS announced the Long-term Enhanced ACO Design (LEAD) Model, a 10-year voluntary program launching January 1, 2027. This isn't just another ACO iteration. It's the longest commitment CMS has ever made to an accountable care model, and it's designed to fix the basic problems that have plagued ACO REACH and its predecessors.

The Bottom Line: LEAD replaces ACO REACH when it expires on December 31, 2026. Organizations have roughly 13 months to decide their path forward and prepare for the transition.

WHY LEAD EXISTS

1. Unstable Benchmarks

High-performing ACOs were penalized. Every time costs were reduced, benchmarks got harder. The "ratchet effect" made long-term success impossible.

2. High Barriers to Entry

Small, rural, and independent practices were locked out. Only large health systems had the resources to participate successfully.

3. Administrative Complexity

Specialist integration was nearly impossible. The administrative burden of creating preferred provider arrangements was overwhelming.

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HOW LEAD WORKS

The Structure

- Total cost of care model with accountability for quality and spending
- Flexible capitated payments upfront (not just fee-for-service)
- Shared savings when costs are reduced while maintaining quality
- Predictable benchmarks that don't reset for 10 years

Two Risk Tracks

GLOBAL RISK

100%

Keep 100% of savings
Liable for 100% of losses

For organizations with strong infrastructure and risk tolerance

PROFESSIONAL RISK

50%

Keep 50% of savings
Liable for 50% losses

For organizations building toward full risk

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WHO LEAD TARGETS

Small & Independent Practices

Couldn't compete with large health systems. Now, have lower barriers and infrastructure support.

Rural Providers

Facing resource constraints. LEAD offers infrastructure payments and lower patient minimums.

Community Health Centers

FQHCs serving underserved populations. Get support to build ACO capacity.

High-Needs Specialists

Focus on dually eligible, homebound patients, and complex chronic conditions.

Current ACO REACH

Direct transition path with long-term stability and improved benchmarking.

Specialists

Can participate through CARA without building their own ACO infrastructure.

NEW TO ACOs?

LEAD offers lower beneficiary alignment minimums and infrastructure add-on payments to help you build capacity.

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What Makes LEAD Different?

1

The 10-Year Timeline

No rebasing. No moving targets. A full decade to invest, learn, and optimize your care model. This is unprecedented.

2

CARA (CMS Administered Risk Arrangements)

Specialists can finally participate through episode-based arrangements, and CMS handles the administrative burden. ACOs can partner with specialists without drowning in paperwork.

3

Medicaid Integration Pilot

CMS will select two states to test ACO-Medicaid partnerships. Transformative for care coordination of dually eligible patients.

4

Infrastructure Support

Rural and small providers get add-on payments (that aren't reconciled) to build the systems they need to succeed. This levels the playing field.

5

Patient Engagement Tools

Part B cost-sharing support, Part D premium buy-down (by 2029), expanded medical nutrition therapy, and chronic disease prevention rewards.

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THE TIMELINE THAT MATTERS

MARCH 2026

RFA Opens
Request for Applications released

DEC 31 2026

ACO REACH Ends
Official conclusion of predecessor model

JAN 1 2027

LEAD Launches
10-year performance period begins

DEC 31 2036

LEAD Concludes
End of 10-year model

CRITICAL WINDOW

Organizations have approximately 9 months (March through December 2026) between RFA release and LEAD launch to apply, get approved, and operationalize.

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WHAT LEAD IS NOT

NOT ACO REACH 2.0

This is fundamentally redesigned with new incentives and structure

NOT Mandatory

Participation is completely voluntary for all organizations

NOT Just for Large Health Systems

Explicitly designed to help smaller players compete

NOT a Short-Term Experiment

This is a decade-long commitment from CMS

LEAD represents CMS's longest-ever commitment to accountable care and signals the permanent shift to value-based payment models.

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Here's How to Prepare for LEAD

LEAD's 10-year timeline rewards organizations that can manage risk, cost, quality, and utilization in real time. Most ACOs struggle because they operate on fragmented systems. Ten different tools, no unified view, and claims data that arrives too late to act on. CareSpace® solves this with one platform that consolidates analytics, care management, quality tracking, risk stratification, documentation, and referrals into a single AI-ready foundation. No integration headaches. No data silos. Just predictive and real-time insights that let clinical and financial teams manage performance seamlessly. Success in LEAD starts with having the operational foundation to execute.

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