PrimaryCareAlliance LLC

NAACOS Spring 2026

Decision 2027: Is LEAD a Reach?

ACO LEAD Trivia: Here's how to play:

- Engage and have fun throughout the presentation!
- Jot down your responses
- Extract wisdom from the panelists
- It's an honor system, so keep track of your own score!
- Participate and share your thoughts at the conclusion of each round!?

Panelist:

- Moderator: Jordan Hall, Consulting Advisor (Primary Care Alliance ACO)

- Purva Rawal, Managing Principal Health Transformation Strategies, Advisor Duke Margolis Institute for Health Policy

- Brian Sikora, VP, VBC Analytics, Duly Health & Care (MSSP)

- Chris Smith, Consulting Actuary, Milliman

Primary Care Alliance: Our ACO Experience

• Duly is an independent care delivery system for patients & employers

Overview

- **Leading & diversified delivery system with density** across Chicagoland, Quincy, IL & South Bend, IN
- **Trusted brand** with **30+ year reputation** for **affordable, high-quality** patient care
- **Highly engaged provider community with 94% retention rate,** underpinned by unique shareholder model
- **Best-in-class patient access** across our specialties & ancillary services
- **Multifaceted, high performing** value-based care platform
- **World class customer satisfaction and experience** performance

Geographic Footprint

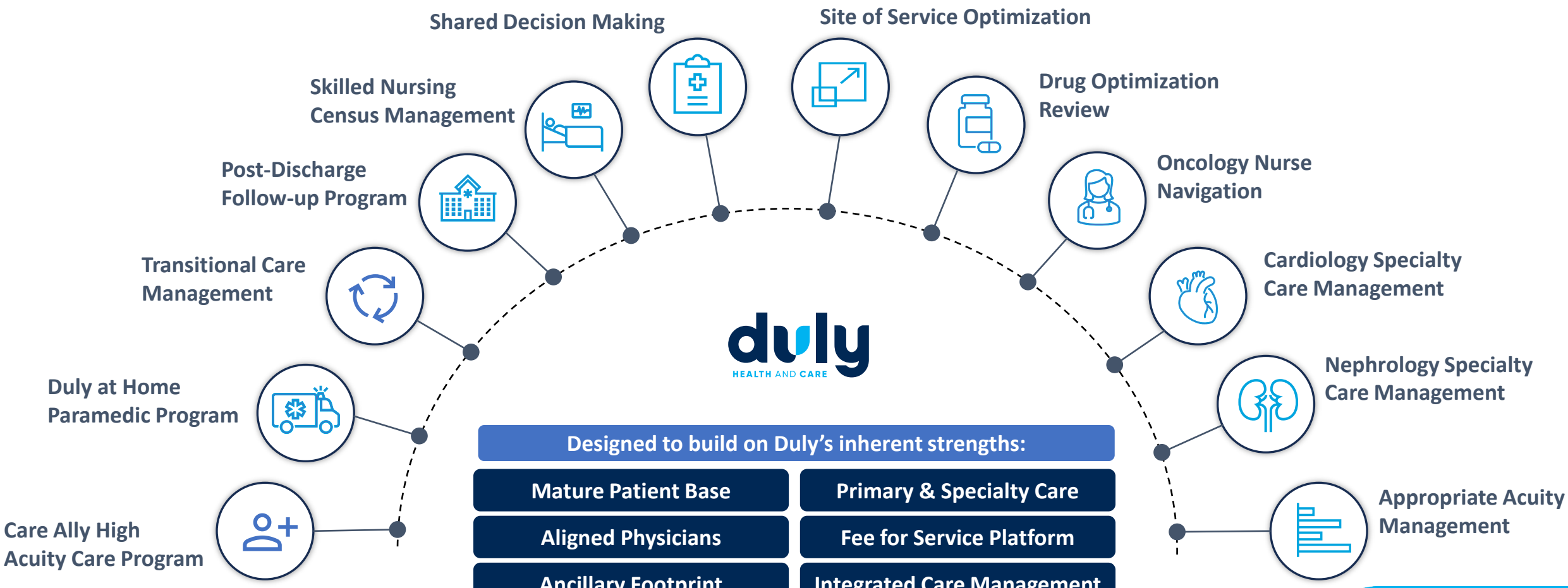
- **190** *Sites of Service*
- **15** *Medical Office Buildings*
- **7** *Ambulatory Surgery Centers*
- **11** *Immediate Care Centers*
- **17** *Imaging Centers*
- **30** *Lab draw sites*
- **40** *Physical Therapy Locations*
- **100** *Ambulatory Infusion Chairs*

Key Metrics

- **1,800+** Employed Clinicians
- **~$3.0bn+** '25E Revenue
- **1.2M** FFS Patients
- **390k+** Value-Based Care Lives
- **76** Net Promoter Score *(+ 6 pts since 2023)*
- **9 .5m+** Annual Patient Visits
- **30+** Physician Specialties

- Our VBC model wraps services around the strengths of our foundation

Patient-centered initiatives driving at-scale impact



Evolution of ACO Models

Medicare Shared Savings Program (MSSP)

- **2012:** MSSP launches with 220 ACOs in its first year
- **2015:** Track 3 established with prospective beneficiary assignment and higher risk/reward parameters
- **2016:** 21st Century Cures Act required assignment based on additional provider types
- **2019:** Introduction of Regional Efficiency Adjustment and Pathways to Success; replaced Tracks 1, 1+, 2 and 3 with BASIC and ENHANCED
- **2024:** Introduction of ACPT, Prior Savings Adjustment, Population Adjustment, Advance Investment Program (based on CMMI ACO Investment Model)

CMMI *Stand-Alone* ACO Model Tests

- **Pioneer ACO (2012-2016)***
  Higher Sharing Rate & Downside Risk
- **Next Gen ACO (2016-2021)**
  Population-Based Payments, higher sharing rates, prospective alignment, SNF 3-day prior stay waiver
- **GPDC (2021-2022)**
  PCC, ePCC, TCC capitation, Ratebook, High Needs, Concurrent Risk Adjustment Model, Quality Program
- **ACO REACH (2023-2026)**
  Modification of GPDC to add health equity features, including HEBA
- **LEAD (2027-2036)**
  10-Year Model, supports for specialty integration (CARA), participation incentives for less efficient orgs and rural providers

CMMI Model Tests *on MSSP Chassis*

- **ACO Investment Model (2015-2020)*** – prepaid shared savings for early investment that was codified as the Advance Investment Model (AIP)
- **ACO PC Flex (2025-2029)** – primary care capitation in SSP with enhancements

HEALTH TRANSFORMATION STRATEGIES

*Denotes models that were certified or expanded via regulation into MSSP

Future Path for Accountable Care

- **Over half of beneficiaries (14.3 M) in Traditional Medicare (TM) are in ACOs in 2026**
  - MSSP is the largest care coordination program in Medicare FFS, and the program has achieved modest cost savings over the last decade
- **Despite promising results, broader reforms are needed to achieve 100% in accountable care in TM**

Increase Provider Participation in ACOs	Community-Level Integration for ACOs	Level the Playing Field Between TM and MA
• Move benchmarks to administrative trends or set growth factors to decouple from historical FFS spending • Increase shared savings levels, prospective payments to fund care delivery, and downstream payment arrangements to integrate specialty, PAC	• Increase safety net participation – low or no-risk tracks, social risk adjustment • Data, payment supports, attribution changes to integrate specialty • Work systematically with community-based organizations to address health related social needs	• Choose outcomes measures that drive population health and align across TM and MA • Make ACOs an active enrollment choice for beneficiaries • Reduce out-of-pocket costs for TM beneficiaries in ACOs

LEAD's Potential to Drive Long-term ACO Reform

- **Longer Model:** 10-year Performance Period without rebasing, likely with multiple cohorts
- **Path for "High Needs":** Incorporation of "High Needs" benchmarking (incl. Concurrent Risk Adjustment) into all LEAD ACOs for HN beneficiaries
- **New Features:**
  - Introduction of Prior Savings Adjustment
  - Introduction of Hybrid Alignment & option for monthly VA
  - Additional funding for "inefficient" organizations and rural organizations – not clawed back at settlement
- **Multi-Payer Alignment:** plan to test integration of dually eligible beneficiaries through agreement with two states
- **Quality:** similar to REACH but with two eCQMs phased in over time
- **Specialty Care Integration:** New supports for specialist integration through CMS-Administered Risk Arrangements (CARA)
- **Benefit Enhancements & Beneficiary Engagement Incentives Include:**
  - Part B Cost Sharing
  - Part D Premium Buydown (starting in 2029)
  - Chronic Disease Prevention Reward (healthy food)

ACO LEAD Trivia: Let Play!

Round 1: Applications and Operations

Question 1: When is the application due for the first cohort of participants?	A. May 17, 2026, 11:59 PM Eastern Time (E.T.)
	B. June 23, 2026, at 12:00 p.m. (noon) ET
	C. August 5, 2026, at 12:00 p.m. (noon) ET
	D. May 15, 2026, 11:59 AM Eastern Time (E.T.)
	E. May 23, 2026, 11:59 AM Eastern Time (E.T.)

Round 1: Applications and Operations

Question 2: How are applications submitted?

- A. Eligible ACOs must complete and submit the CMS application through the ACO Management System (ACO-MS) by deadline.
- B. Only MSSP and Reach ACOs may initially apply for the Model, organizations must follow the Request for Applications (RFA) process outlined by the Centers for Medicare and Medicaid Services (CMS).
- C. Via the CMS Innovation Center portal at https://app.innovation.cms.gov/LEAD/IDMLogin
- D. Delayed (No surprise) CMMI to announce application process and cycle in Late April 2026

Round 1: Applications and Operations

Question 3:

Will there be future application cycles?

- A. Similar to ACO Reach, CMMI is designed to permit only a single application cycle. It seems we need to make a decision promptly…
- B. MSSPs and Reach ACOs that wish to apply to LEAD are strongly urged to submit their applications in the initial cohort, but they can transition at any point throughout the 10-year model.
- C. ACOs must receive an invitation from CMMI to apply for ACO LEAD, given its highly awaited launch.
- D. CMMI anticipates that there will be additional chances to apply for the model, although specifics are currently unavailable.

Round 1: Applications and Operations

Question 4:

Who can apply to become an ACO LEAD entity?

- A. MSSP and Reach ACOs
- B. Smaller, independent ACOs
- C. Rural, and safety-net providers including FQHCs, CINs, and IPAs
- D. Experienced ACOs looking to better engage specialists
- E. All of the above

Round 1: Applications and Operations Panel Q&A

Answers

1) A
2) C
3) D
4) E

Round 2: Financial Methodology and Benchmarking

Milliman

Question 1: Which of these statements is NOT true?

A. A REACH ACO's prior savings can contribute to a benchmark adjustment in LEAD

B. A REACH ACO's prior savings can contribute to a benchmark adjustment in MSSP

C. An MSSP ACO's prior savings can contribute to a benchmark adjustment in LEAD

D. An MSSP ACO's prior savings can contribute to a benchmark adjustment in MSSP

Round 2: Financial Methodology and Benchmarking

Question 2:

Which of the following are NOT true of Newly Entering ACOs?

A. Lower alignment minimum
B. Higher benchmark adjustment ceiling
C. 10/30/60 baseline year weighting
D. Lower discount

Round 2: Financial Methodology and Benchmarking

Question 3:

LEAD features the same risk sharing options as ACO REACH: global risk (full risk), professional risk and geographic (Geo) options

A.True

B.False

C.I need more coffee

Round 2: Financial Methodology and Benchmarking

Question 4:

LEAD uses what calendar years as baseline years for PY 2027 benchmarks.

A. (CY) 2023–2025
B. (CY) 2024–2026
C. (CY) 2022–2024
D. (CY) 2025–2027 (Projected)

Round 2: Financial Methodology and Benchmarking

Answers

1) A
2) D
3) A
4) B

Round 2: Financial Methodology and Benchmarking Panel Q&A

- CMMI is incentivizing REACH ACOs to continue into LEAD (and avoid MSSP where their prior savings are not recognized).
- What are the criteria for newly entering ACOs?
  - Not participated in Medicare ACO
  - 40% of TINs haven't been in ACO in last 5 years
  - 50% of NPIs haven't been in ACO in last 5 years
- Alignment minimum (1,000 vs 5,000 in PY1)
- Benchmark adj ceiling (5% vs 3%)
- Renewing ACOs get a 33/33/33 baseline year weighting
- (ACOs) have the ability to transition from a Global model to a Professional model following Performance Year 1; however, it is important to note that the Professional risk-sharing option entails a commitment period of four years.
- Global ACOs that opt for this model benefit from a wider array of capitated payment alternatives as well as enhanced tools for engaging beneficiaries.

Round 2: Financial Methodology and Benchmarking Panel Q&A

- LEAD benchmarking addresses the “shared savings" issue that has adversely affected the top-performing ACOs in MSSP/REACH
- LEAD introduces new benchmarks derived from historical expenditures for all ACOs during their initial performance year, without any rebasing throughout the entire 10-year performance span.
- NO negative adjustments on ACOs that incur higher costs in comparison to their regional counterparts
- Model offers additional capitated payment incentives for these higher-cost ACOs.
- ACOs that demonstrate cost efficiency relative to regional peers are granted positive-only regional efficiency adjustments akin to those in the Shared Savings Program.

Round 2: Financial Methodology and Benchmarking Panel Q&A

- High Needs is no longer its own track - LEAD ACOs will have separate per-beneficiary per-month (PBPM) benchmarks for three beneficiary categories: Aged & Disabled (A&D), End-Stage Renal Disease (ESRD), and **High Needs.**
- Baseline Readjustment: LEAD secures the baseline until 2036, potentially posing difficulties for ACOs that have invested years in reducing their MSSP baseline, as their baseline could be significantly elevated compared to present expenditures.
- LEAD's obligatory discount within the Global track, along with the new stipulations such as the increased financial guarantee, necessitates thorough financial evaluation. How should I approach my decision-making? What inquiries should I be making?

Round 3: Quality

Question 1: ACOs will be evaluated on what common set of quality measures?

A. Same measure set as MSSP

B. Set of 7 measures, including claims-based metrics, CAHPS patient experience, and two eCQMs to be phased in

C. Same Measure set as Reach

D. Quality reporting is optional for ACO LEAD – bonus points only

Round 3: Quality

Question 2:
What quality withhold percentage is applied to the benchmark that ACOs can earn back based on performance?

A. 5% quality withhold applied to the benchmark that ACOs can earn back based on performance.
B. 5% with High-performing ACOs also eligible for a "High Performer Pool" bonus
C. Initial 3% but increases to 5% midway of model
D. 3% quality withhold applied to the benchmark that ACOs can earn back based on performance.

Round 3: Quality

Question 3: Participants must use Certified EHR Technology?

A. True, Participants must use Certified EHR Technology and be able to report electronic clinical quality measures by the later years of the model.

B. False

C. True, Participants must use Certified EHR Technology only if they intend to report electronic clinical quality measures.

Round 3: Quality

Question 4: New clinical outcome measures will be optional?

A. True.

B. True, for the first two years and pay for reporting for years three and beyond allowing time for ACOs to prepare reporting.

C. False.

Round 3: Quality

Answers

1) B

2) D

3) A

4) B

Round 3: Quality Panel Q&A

- eCQMs are introduced too rapidly
- The quality payments of the model will rely on a concise, focused selection of well-known quality measures.
- LEAD will incorporate the same four claims-based measures from ACO Reach, CAHPS, along with two new digital measures (eCQMs).
- For the initial two years, these new measures will be optional, transitioning to a pay-for-reporting structure in years three and four, thus providing ACOs with adequate time to prepare for reporting.
- Additionally, ACOs will continue to have the 3% quality withhold earn back
- Its back! - all participants must submit Prevention and Quality Plan (PQP).

Round 4: Participants and Alignment

Question 1: ACOs may only select what alignment methodology

A. Prospective alignment

B. Retrospective alignment

C. ACOs have the option to choose between prospective alignment, where the beneficiary list is established prior to the performance year and only modified to reflect eligibility drops, or hybrid alignment, which introduces a new possibility for mid-year updates.

D. Prospective Alignment Plus (+)

Round 4: Participants and Alignment

Question 2:
The Hybrid alignment refreshes beneficiary lists via voluntary alignment quarterly updates seen in ACO REACH.

A. True

B. False

Round 4: Participants and Alignment

Question 3:
Claims-based alignment occurs once prior to the commencement of the performance year, along with an additional mid-year alignment if the ACO incorporates new participant TINs before the midyear deadline.

A. True

B. False

Round 4: Participants and Alignment

Question 4: Does claims-based alignment occur midyear for all TINs?

A. Yes

B. No

C. Yes, if the ACO elects this option

D. Is it lunch yet?!

Round 4: Participants and Alignment

Answers

1) C

2) B

3) A

4) B

Round 4: Participants and Alignment Panel Q&A

- LEAD implements a comprehensive TIN strategy from MSSP for managing participants, which includes all billing NPIs associated with the participant TIN within the ACO's operations.
- Preferred providers continue to be managed at the TIN NPI level, ensuring that ACOs retain maximum flexibility.
- Similar to historical models, an ACO must be a legal entity that can assume risk and typically requires a minimum of 5,000 aligned Medicare beneficiaries (although ACOs that focus on high-needs populations may qualify with a smaller number).

Round 4: Participants and Alignment Panel Q&A

Table 3: Alignment Minimums

Performance Year	LEAD PY Alignment Minimum	LEAD Claims-Based Alignment Minimum in BY	LEAD PY Alignment Minimums for Newly Entering ACOs	Claims-Based Alignment Minimum in BY for Newly Entering ACOs	High Needs Eligible ACO PY Alignment Minimum	Claims-Based Alignment Minimum in BY for High Needs Eligible ACOs
1	5,000	3,000	1,000	600	800	500
2	5,000	3,000	2,000	1,200	1,000	625
3	5,000	3,000	3,000	1,800	1,200	750
4	5,000	3,000	4,000	2,400	1,400	825
5	5,000	3,000	5,000	3,000	1,600	1,000
6	5,000	3,000	5,000	3,000	1,600	1,000
7	5,000	3,000	5,000	3,000	1,600	1,000
8	5,000	3,000	5,000	3,000	1,600	1,000
9	5,000	3,000	5,000	3,000	1,600	1,000
10	5,000	3,000	5,000	3,000	1,600	1,000

Panel reactions and comments. Questions?

What steps can I take to get ready for Decision 2027?

How do MSSP and LEAD compare, and what data or resources can I access to assist my organization in making the most informed decision?