PY 2027 LEAD Financial Methodology and Actuary Perspectives

August 6, 2026

12:00pm ET

Q&A will take place at the end of the program

You can submit written questions using the **“Questions” tab** (not chat) at any time during the webinar.

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

PY 2027 LEAD Financial Methodology

Speakers: Financial Methodology

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Risk Sharing Options

	Professional	Global
Shared savings potential	Up to 60%	Up to 100%
Shared losses liability	Up to 50%	Up to 100%
Discount applicability	N/A	1.75 - 3%
Ability to switch tracks	Renewing ACOs: After at least 4 PYs Newly Entering ACOs*: After at least 4 PYs	Renewing ACOs: switching is not allowed for the duration of the model Newly Entering ACOs*: may switch after completing the PY covered by their Global Agreement

LEAD ACOs have until September 11 to switch tracks

**An ACO is considered a "Newly Entering" if they meet all of the following criteria:*

1. *The ACO legal entity has not previously participated, and is not currently participating, in a Medicare ACO initiative;*
2. *Less than 40 percent of the ACO's Participant TINs have participated in a Medicare ACO initiative in the past five years; and*
3. *Less than 50 percent of the ACO's Participant Providers have participated in a Medicare ACO initiative in the past five years.*

Key Benchmark Definitions

Historical Baseline Expenditures

- ACO's Medicare Parts A & B expenditures for aligned beneficiaries in three base years, calculated using the current PY Participant TIN List and:
  - Beneficiary category (A&D, ESRD, and High Needs)
  - Alignment type (voluntarily aligned and claims aligned)

Historical Benchmark

- Risk-standardized, trended, and weighted-average blend of Historical Baseline Expenditures across three base years.

Adjusted Historical Benchmark

- Historical Benchmark after applying ACO-specific adjustments (Regional Efficiency Adjustment or Prior Savings Adjustment).

Performance Year Benchmark

- Historical benchmark after applying PY risk adjustment, three-way blended trend factor, Hybrid Alignment Benchmark Adjustment (if applicable), and combining beneficiary categories, before applying any discount, Quality Withold, or Quality Earn Back.
  - Used to determine the ACO’s shared savings or shared losses for the Performance Year

The Four-Step Benchmarking Process

Step 1: Calculate Historical Baseline Expenditures

- CMS identifies beneficiaries and calculates Medicare Parts A & B expenditures for the ACO's three base years (BY1-BY3), separately by beneficiary category and alignment type.

Step 2: Risk Standardize, Trend, and Weight Historical Expenditures

- CMS standardizes expenditures across base years by dividing by risk scores, applying trend factors, and weighting base years to produce a single Historical Benchmark. Note: weighting differs for Newly Entering and Renewing ACOs.

Step 3: Apply ACO-Specific Benchmark Adjustments

- CMS determines whether the ACO is higher or lower spending relative to regional FFS expenditures and applies the higher of the Regional Efficiency Adjustment or Prior Savings Adjustment.

Step 4: Update Adjusted Historical Benchmark to the Performance Year

- CMS applies a three-way blended trend factor, performance year risk adjustment, and, if applicable, Hybrid Alignment Benchmark Adjustment, and combines the resulting beneficiary category–level benchmarks to produce the final PY Benchmark.

** If receiving the PSA, Higher-spending ACOs may also receive a separate 1.5 percent Administrative Add-On capitation payment, which is not included in the Performance Year Benchmark.*

Step 1: Calculate Historical Baseline Expenditures

Identifying Beneficiaries and Expenditures for Three Base Years

Step 1: Base Year Structure and Included Costs

Three-Year Historical Baseline Period (PY 2027)

- BY1 = CY 2024 | BY2 = CY 2025 | BY3 = CY 2026
- Baseline period is fixed for the duration of participation
- Recalculated each PY using that PY's Participant TIN List

Costs Included

- All Medicare Parts A & B payments: Inpatient, SNF, Home Health, Hospice, Physician/Supplier, Outpatient, DME
- 3-month claims run-out period for complete data
- IME payments

Exclusions

- DSH payments and denied claims excluded
- SAHS billing codes: 100% excluded
- Skin substitute expenditures: 65% excluded for CY2024 and CY2025

Step 1: BY3 Phased Approach

BY3 (CY 2026) requires special handling due to data availability timing.

Preliminary Report (December 2026)

- Adjustment 1: Uses Q1-Q3 data with a completion factor applied:
  - Applied to Q1-Q3 2026 claims to account for claims not yet fully adjudicated (based on avg completion rate in 2024-2025 reference population)
- Adjustment 2: Q4 estimated using seasonality adjustment based on historical patterns:
  - Ratio of Q1-Q4 PBPM to Q1-Q3 PBPM in 2024-2025 reference population; multiplied by Q1-Q3 PBPM to estimate full-year BY 3
- Adjustment 3: Alignment completion factor, estimates full-year aligned beneficiary months from Q1-Q3 experience

Updated Reports (Through May 2027)

- Progressive updates as additional claims data becomes available
- Full run-out incorporated for more accurate expenditure calculations
- Final BY3 data used for definitive benchmark calculations

Key Consideration

- Completion factors and seasonality adjustments ensure BY3 data is comparable to BY1 and BY2, which have full-year claims with complete run-out

For PY 2027 only: If an ACO's higher/lower spending designation changes between calculations, the ACO may choose which designation to use for PY 2027

Beginning 2028, complete run-out is available; preliminary reports will not need these adjustments.

Step 1: Beneficiary Categories and Alignment Types

Three Beneficiary Categories

- Aged and Disabled (A&D): Standard Medicare beneficiaries
- ESRD: Beneficiaries with End-Stage Renal Disease
- High Needs: Beneficiaries meeting high-needs criteria as defined in the PY 2027 Alignment and Financial Methodology Paper

Two Alignment Types

- Claims-Aligned: Attributed based on primary care utilization patterns
- Voluntarily Aligned: Beneficiaries who designate the ACO as their provider

Result: Six Historical Baseline Expenditure Amounts

- 3 beneficiary categories x 2 alignment types = 6 separate calculations per base year
- Each combination tracked independently through all four benchmark steps

Step 1: Whole TIN Alignment

- CMS performs claims-based alignment using the Participant TIN list submitted for each PY
- Alignment-eligible beneficiaries must have at least one PQEM service paid by Medicare FFS during the 12-month alignment period (ends 3 months before PY/BY start)
- Alignment compares total PQEM allowable charges from Participant TINs vs. all non-Participant billing TINs; plurality of charges determines alignment
- **Two-track algorithm:**
  - if >=10% of PQEM charges from Primary Care Specialists, alignment is based on those services;
  - if <10%, based on Selected Non-Primary Care Specialists
- **Tie-breaker:** beneficiary aligns to the ACO if a Participant TIN billed the most recent PQEM service
- Allowable charges must be incurred in alignment period and paid within 3 months after period ends

Exclusions:

- **Specialty-care NPPs, FQHCs, and RHCs:** ACOs may identify NPP NPIs and safety net CCNs that primarily furnish specialty care and request exclusion from alignment and Primary Care Capitation
- **Primary care during short SNF stays:** Part B services excluded if billed under CPT 99304-99318 AND a SNF facility claim overlaps the service dates
- **PQEM services billed under non-Participant TINs:** Services by an ACO Participant Provider but billed under a non-Participant TIN are excluded from that TIN's charges (via rendering NPI)
- **TIN matching:** Part B claims use Rendering TIN; FQHC/CAH2/RHC Part A claims require CCN-to-PECOS TIN match against Participant TIN list
- **Physician specialty:** determined by CMS Specialty Code on claim; for CAH2, by PECOS-recorded specialty

Voluntary Alignment Benchmarks for High Needs Beneficiaries

- No historical base-year voluntary alignment exists, so VA benchmark uses base-year spending for beneficiaries voluntarily aligned in the CURRENT PY
- VA Historical Benchmark compared to claims-aligned Historical Benchmark; two-sided 10% guardrail constrains the VA benchmark
- **Modified High Needs methodology (PY 2027):** VA Historical Baseline Expenditures for High Needs use ONLY BY 3 data
- Beneficiary contributes to VA High Needs benchmark only if the beneficiary met High Needs criteria during BY 3
- VA High Needs beneficiaries not High Needs in BY 3 also excluded from BY 3 average risk score (for growth cap reference)
- **Minimum alignment threshold:** if ACO has <500 VA beneficiaries contributing BY 3 expenditures, CMS applies claims-aligned benchmarks to VA beneficiaries instead

Step 2: Risk Standardize, Trend, and Weight

Creating a Single Comparable Historical Benchmark

Step 2: Risk Standardization and Trending

Risk Standardization

- Divide, for each beneficiary category, the ACO's Historical Baseline Expenditures for each BY by the ACO's average risk score for aligned beneficiaries in that beneficiary category for that BY
- Removes the effect of differences in patient health status across years
- Enables fair comparison across base years with different population mixes

Trending (Bringing BY1 and BY2 Forward to BY3 Dollars)

- Apply national-regional blended trend factors to BY1 and BY2 expenditures
- Accounts for healthcare cost growth between base years
- Ensures all three base years are expressed in equivalent BY3 dollar values
- Trend factors reflect both national spending patterns and regional cost differences

Step 2: Base Year Weighting

ACO Type	BY1 Weight	BY2 Weight	BY3 Weight	Rationale
New ACOs	10%	30%	60%	Emphasizes most recent data; newer ACOs lack extensive history
Renewing ACOs	33%	33%	33%	Equal weighting; stable performance history across all years
Insufficient Data (2 BYs)	Varies	Varies	Varies	Alternative weights if fewer than 2 BYs have sufficient aligned beneficiaries

Weighting Rationale

- New ACOs: More weight on recent data (60% BY3) because provider composition may have changed; recent data is more representative of current practice patterns.
- Renewing ACOs: Equal weight (1/3 each) because stable provider compositions and longer track records; equal weighting smooths year-to-year volatility.

Insufficient Claims History Rules

- If only 2 BYs have sufficient claims: Renewing ACOs use 50%/50%; New ACOs weight 2/3 on the more recent year, 1/3 on the less recent.
- If only 1 BY has sufficient claims: That year is weighted at 100%.
- Alignment minimums: Standard ACOs = 5,000 beneficiaries; Newly Entering = lower minimums growing over time; High Needs/ESRD = 800 to 1,600.
- ACOs must meet the alignment minimum in at least one BY to be eligible for LEAD participation

Risk Score Growth Cap: Models by Category

Category	Growth Cap	Risk Adjustment Model
A&D	3% (symmetric)	2024 CMMI HCC Prospective V1 (recalibrated on non-High Needs A&D)
ESRD	3% (symmetric)	2023 ESRD CMS-HCC Prospective (no LEAD-specific modifications)
High Needs	4% (symmetric)	CMMI HCC Concurrent V2 (V28 architecture, recalibrated on High Needs)

High Needs Risk Score Growth Cap

- **A&D and ESRD:** symmetric 3% risk score growth cap
- **High Needs:** symmetric 4% risk score growth cap (announced for PY 2027 and PY 2028)
- **Reference year:** BY 3 is static reference for measuring risk score growth (at least PY 2027-2028)
- Single cap per beneficiary category combining claims-aligned and voluntarily aligned beneficiaries
- BY 3 reference risk score for High Needs uses ONLY beneficiaries classified as High Needs in BY 3; VA beneficiaries not High Needs in BY 3 are excluded from the reference
- CMS intends to phase in AI-inferred risk adjustment model for payment beginning PY 2029 and may adjust or remove the cap

Step 3: ACO-Specific Benchmark Adjustments

Adjusting for Spending Efficiency and Prior Performance

Step 3: Higher/Lower-Spending ACO Designation

Determination Process

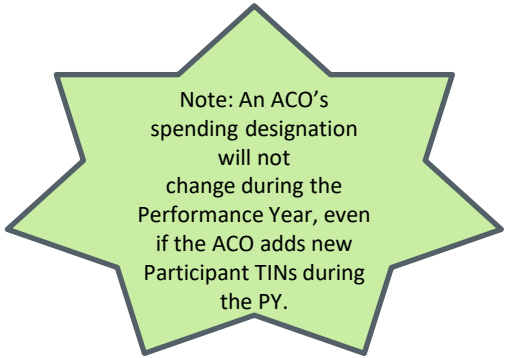
- Compare ACO's Historical Benchmark to regional FFS expenditures in BY3
- Regional expenditures = county-weighted average based on ACO's aligned beneficiary months
- CMS compares ACO Historical Benchmark to BY 3 FFS expenditures in its service area
- Comparison done per beneficiary category; combined into single ACO-level difference using BY 3 beneficiary category weights
- Base years remain fixed, but designation recalculated each PY using that PY's Participant TIN List
- Designation does NOT change mid-PY (even with hybrid alignment TIN additions)
- **PY 2027 only:** preliminary designation in December 2026 (Preliminary Benchmark Report); final in May 2027 (Q1 Report); ACO may retain either if it changes
- **PY 2028+:** final designation in Q4 of the year before the PY

Higher-Spending ACO: Historical Benchmark > Regional FFS Expenditures

- Eligible for Administrative Add-On (1.5% of total benchmark)
- Add-On paid as capitation, NOT subject to benchmark cap
- NOT included in the Performance Year Benchmark calculation

Lower-Spending ACO: Historical Benchmark < Regional FFS Expenditures

- Eligible for Regional Efficiency Adjustment (Global Risk ACOs)
- Subject to either 5% or 3% benchmark adjustment cap



Step 3: Regional Efficiency Adjustment and Prior Savings Adjustment

Regional Efficiency Adjustment (REA)

- For lower-spending ACOs in Global Risk arrangement
- Calculation: 50% x (Regional FFS Expenditures - Historical Benchmark)
- Exclusion: Higher-spending TINs not in SSP/REACH in prior 2 years excluded from REA calculation

Prior Savings Adjustment (PSA)

- For Renewing ACOs based on predecessor ACO savings (both Global and Professional)
- Calculation: 50% of average savings across 3 BYs, with proration factor
  - Proration: average predecessor beneficiary months / current PY months, capped at 100%
  - (PY Benchmark - PY Expenditures) / aligned beneficiary months; GROSS Medicare savings (before discount/share)
- Predecessor ACO thresholds: 40% TIN overlap for BY3; 30% for BY1/BY2
  - Continuity test: predecessor REACH or SSP ACO qualifies if >=40% of TINs participated; multiple predecessors use beneficiary-weighted average
  - Qualifying predecessor: identified from BY 3; BY 1/BY 2 savings count only if >=30% TIN overlap

If Eligible for Both REA and PSA: ACO receives the higher of the two adjustments (not both)

Step 3: Benchmark Adjustment Caps and Administrative Add-On

Standard Cap: 5%

- Applies to most ACOs receiving benchmark adjustments
- Limits total upward adjustment to 5% of benchmark

Reduced Cap: 3%

- Applies to lower-spending ACOs with recent SSP participation
- Threshold: 40% or more of TINs participated in SSP in prior 2 years

Administrative Add-On (Higher-Spending ACOs)

- Eligible if receiving the Prior Savings Adjustment
- 1.5% of the total benchmark amount
- Paid as capitation (separate from shared savings calculations)
- NOT subject to the benchmark adjustment cap
- NOT included in the Performance Year Benchmark

Step 4: Update to the Performance Year

Trending and Risk-Adjusting the Final Benchmark

Step 4: Three-Way Blended Trend Factor and Risk Adjustment

Three-Way Blended Trend Factor

- Accounts for annual Medicare cost growth
- Components: (Blended national trend & regional trend) & ACPT
- ACPT based on modified USPCC growth projections
- ACPT Guardrail: Limits the three-way blend to within +0.3 / -0.2 percentage points of the two-way national/regional blend

Performance Year Risk Adjustment

- Apply PY risk scores to adjust benchmark for actual patient acuity
- Risk Score Growth Caps (symmetric, reference year = BY3):
- A&D: 3% cap | ESRD: 3% cap | High Needs: 4% cap

Risk Adjustment Models

- A&D: 2024 CMMI HCC Prospective V1
- ESRD: 2023 ESRD CMS-HCC Prospective
- High Needs: CMMI HCC Concurrent V2

Step 4: Three-Way Blended Trend Factor: Calculation

Three-Way Blend = (2/3) × Two-Way Blend (National + Regional) + (1/3) × ACPT

Subject to ACPT guardrail constraints (see below)

Component 1: National FFS Growth (within Two-Way Blend)

- Actual per capita expenditure growth observed in the LEAD National Reference Population
- Calculated as the ratio of mean expenditures in the update year to the prior year across the national FFS population (excluding ACO-aligned beneficiaries)

Component 2: Regional FFS Growth (within Two-Way Blend)

- Actual per capita expenditure growth in the ACO's service area (county-level)
- Reflects local market conditions and spending patterns specific to the ACO's geography

Component 3: ACPT (Prospective Growth Rate)

- Forward-looking projected FFS spending growth from the CMS Office of the Actuary (OACT)
- Based on USPCC projections, modified to exclude DSH payments and include hospice
- Published prospectively before each Performance Year begins

ESRD vs. Non-ESRD

- All three components are calculated separately for ESRD and non-ESRD populations
- Each enrollment type receives its own blended trend factor reflecting distinct cost trajectories

ACPT Guardrail Constraint

- The three-way blend is constrained so that it does not diverge from the two-way blend by more than the guardrail bounds
- Guardrails widen over time as the program matures (PY1: +0.3/-0.2 pp; PY5+: +1.5/-1.0 pp)
- Applied to the cumulative trend from BY3 to the current PY at reconciliation
- Adjustments do not carry forward to future PYs

Effective Calculation

Final Trend = max(Two-Way − Lower Bound, min(Two-Way + Upper Bound, Three-Way Blend))

Key Principle

- Blending retrospective (national + regional) with prospective (ACPT) growth creates predictability while anchoring in actual spending experience
- Guardrails prevent the ACPT from causing excessive divergence from observed trends during early model years

Accountable Care Prospective Trend (ACPT)

What Is the ACPT?

- Prospectively determined external growth factor used to update the benchmark from BY3 to the Performance Year
- Based on projected FFS Medicare per capita cost (USPCC) growth as estimated by the CMS Office of the Actuary, modified to exclude DSH payments and include hospice claims
- Separate projections for ESRD and non-ESRD populations; updated annually prior to each PY

Role in the Three-Way Blended Trend Factor

- 2/3 weight: Two-way blend of actual national and regional FFS growth (observed in LEAD National Reference Population)
- 1/3 weight: ACPT (prospectively set growth rate from OACT projections)

ACPT Guardrail Policy

- Limits three-way blend to within a set range of the two-way national/regional blend
- PY 2027 guardrail: +0.3 / -0.2 percentage points; widens over time
- Applies to cumulative trend from BY3 to the current PY at reconciliation; adjustments do not carry forward

Design Principle

- Goal: Trend benchmarks HIGHER than actual realized Medicare spending, but BELOW what spending would be absent ACOs
- Creates a predictable, forward-looking target that rewards spending-growth reduction

Performance Year	Upper Bound	Lower Bound
PY 1	+0.3%	-0.2%
PY 2	+0.6%	-0.4%
PY 3	+0.9%	-0.6%
PY 4	+1.2%	-0.8%
PY 5–10	+1.5%	-1.0%

Cumulative ACPT Guardrail Bounds (pp from two-way blend)

Step 4: Hybrid Alignment Adjustment and Final Benchmark

Hybrid Alignment Benchmark Adjustment

- Applies to beneficiaries added mid-year through voluntary alignment
- Adjustment Factor = Average PBPM during partial-year period / Average full-year PBPM
- Accounts for higher per-member costs during shorter coverage periods

Combining Benchmark Components

- Within each beneficiary category: Claims-aligned + Voluntarily aligned benchmarks combined by beneficiary month-weighted average
- Across categories: A&D + ESRD + High Needs benchmarks summed for total PY Benchmark

Final Performance Year Benchmark

- Adjusted Historical Benchmark x PY Trend Factor x PY Risk Score Ratio = Category-Level PY Benchmark
- Sum across all beneficiary categories and alignment types = Total ACO Performance Year Benchmark

Mid-Year Alignment: Hybrid Alignment Process

- Initial prospective alignment before PY, plus one mid-year Participant TIN Add Window
- **PY 2027 TIN Add Window:** December 14, 2026 - January 14, 2027; new TIN beneficiaries effective April 1
- **Voluntary alignment:** may be added monthly; SVA due at least 45 days before effective month
- **Benchmark seasonality adjustment:** benchmarks for hybrid-aligned beneficiaries are multiplied by a factor = partial-year avg PBPM / full-year avg PBPM (from CY 2024-2025 reference population)
- Claims-based hybrid (eff. April 1): factor = Q2-Q4 PBPM / full-year PBPM
- PY 2027 factors are national (not varied by beneficiary category); may be refined in future years

Mid-Year Alignment: Voluntary Alignment Adjustment Factors

SVA Effective Date	Benchmark Adjustment Factor
January 1 - March 31	1.000 (no adjustment)
April 1 - June 30	Q2-Q4 PBPM / Full-Year PBPM
July 1 - September 30	Q3-Q4 PBPM / Full-Year PBPM
October 1 - December 31	Q4 PBPM / Full-Year PBPM

Mid-Year High Needs Status Changes

- CMS checks High Needs eligibility quarterly (up to 4 chances per PY)
- If newly qualifying at a quarterly check, beneficiary is RETROACTIVELY assigned High Needs effective the beginning of the PY
- For hybrid-alignment ACOs, High Needs evaluated at time of alignment; qualifying beneficiaries are High Needs from alignment date forward
- Once determined High Needs, status is retained for duration of LEAD alignment even if criteria no longer met (supports continuity of care)
- **Category precedence:** High Needs > A&D; ESRD > High Needs
- Beneficiary is treated as High Needs for full aligned period (benchmark, expenditures, financial settlement)

PY 2027 Benchmark Release Schedule

Report	Release	Claims Period	Adjustments Applied
Preliminary Report	Dec 2026	Jan-Sep 2026 (paid thru Oct 2026)	Q1-Q3 completion factor + Q4 seasonality
Preliminary Update	Feb 2027	Jan-Dec 2026 (no run-out)	Q1-Q4 completion factor
Q1 Report	May 2027	Jan-Dec 2026 (run-out thru Mar 2027)	None
Q2 Report	Aug 2027	Jan-Dec 2026 (run-out thru Mar 2027)	None
Q3 Report	Nov 2027	Jan-Dec 2026 (run-out thru Mar 2027)	None
Q4 Report	Feb 2028	Jan-Dec 2026 (run-out thru Mar 2027)	None

Financial Guarantee Policy: Required Percentages

Risk Option	Shared Losses + Base PCC	Enhanced PCC Only	Combined (SL + PCC + EPCC)	SL + TCC
Professional	2.0%	1.5%	3.5%	N/A
Global	2.5%	1.5%	4.0%	4.0%

Actuary Perspectives

Speakers: Actuary Perspectives

Brad Heywood
Wakely

Andrew Webster
Oliver Wyman

Jonah Broulette
Milliman

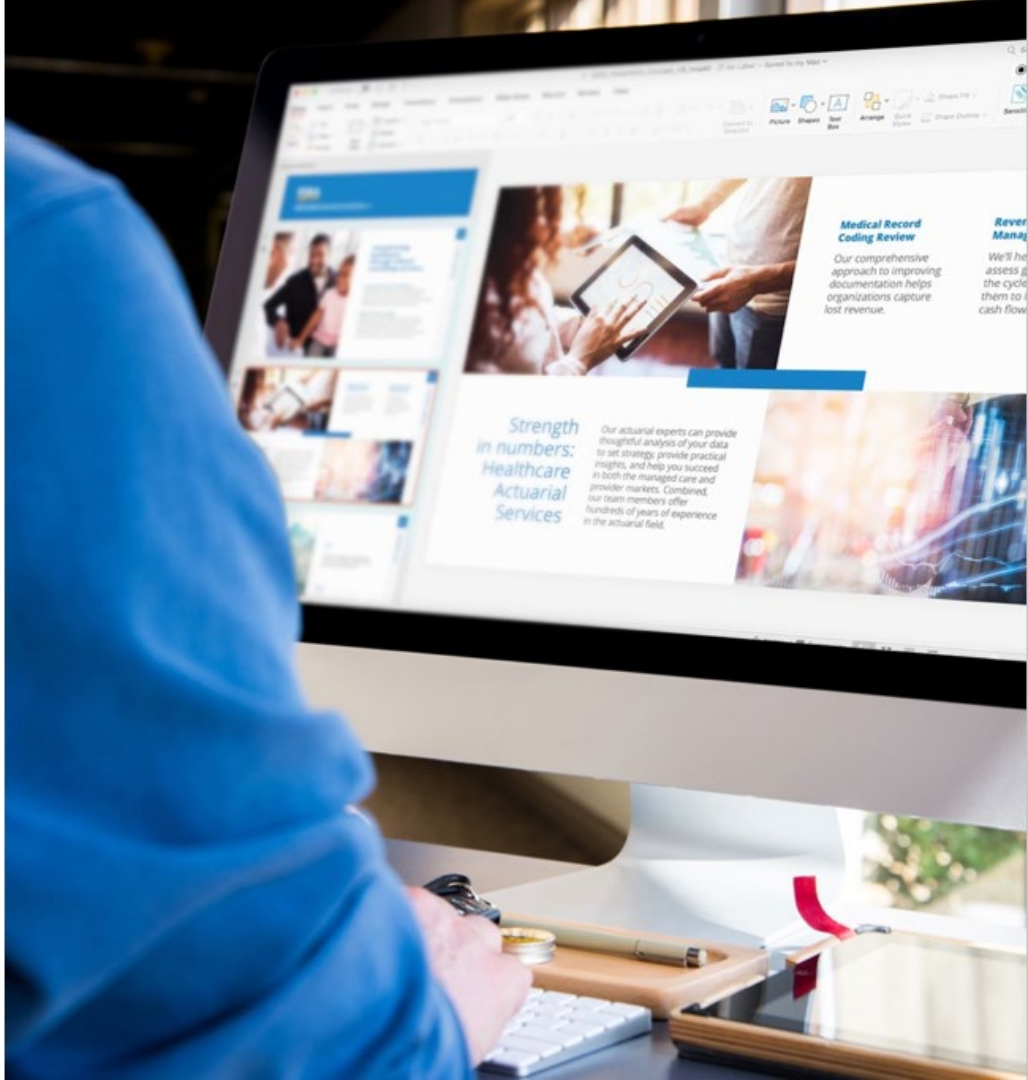
Actuary Perspective:
ACOs with High Needs Populations

Wakely
An HMA Company

High Needs in the LEAD Model

NAACOS Webinar: LEAD Financial Methodology

What the PY 2027 financial methodology means for organizations serving seriously ill and long-stay populations



Presented by:

Brad Heywood, ASA, MAAA

Senior Consulting Actuary • Wakely, An HMA Company • August 2026

High Needs Is Now a Beneficiary Category

STRUCTURAL SHIFT FROM ACO REACH

ACO REACH

The High Needs Population ACO was a separate ACO type, with its own participation standards, alignment minimum, and benchmark construction. The organization was the unit of accountability.

LEAD

There is one ACO construct. High Needs is one of three beneficiary categories that runs through alignment, benchmarking, risk adjustment, and settlement. The category is the unit of accountability.

ACOs can be designated as High Needs for minimum membership alignment purposes

SIX HISTORICAL BASELINE EXPENDITURE AMOUNTS PER ACO

A&D	**A&D**	**ESRD**	**ESRD**	**High Needs**	**High Needs**
Claims aligned	Voluntarily aligned	Claims aligned	Voluntarily aligned	Claims aligned	Voluntarily aligned

What survives of the old designation is narrow, and it is not financial

› ACOs with at least 40 percent of aligned beneficiaries in the High Needs or ESRD categories qualify for lower alignment minimums, provided they demonstrated three care delivery capabilities in the application: 24/7 provider access with EMR, advance care planning training, and the ability to deliver care in the home.
› That designation allows a minimum of 800 aligned beneficiaries in PY 1, growing to 1,600 by PY 5, against 5,000 for a standard Renewing ACO. The High Needs ACO designation does not change benchmarks, expenditures, or shared savings calculations.
› A two-time buffer permits the threshold to fall to 30 percent, and it cannot be used in consecutive Performance Years.

Source: LEAD Alignment and Financial Methodology Paper (July 14, 2026), Sections 1.2, 2.6, and 3.2, and Table 2.6.1.

The High Needs Cohort Is Not Fixed on January 1

ELIGIBILITY AND COHORT MIGRATION

CMS RECHECKS ELIGIBILITY FOUR TIMES A YEAR

JANUARY 1

Initial classification for the Performance Year, using the rolling 12-month claims lookback, with a 60-month lookback for frailty by equipment

APRIL 1

First reassessment. Hybrid alignment additions are also evaluated at their alignment date.

JULY 1

A beneficiary qualifying quarterly is treated as High Needs retroactive to January 1 (or their original alignment date for Hybrid).

OCTOBER 1

Final check of the year.

SEVEN QUALIFYING CRITERIA · ANY ONE IS SUFFICIENT

Mobility impairment
Qualifying ICD-10 conditions

Frailty by equipment
Hospital bed or transfer DME

Frailty by index
Kim claims-based frailty index

High acuity
A&D risk score 3.0 or greater (either prospective or concurrent risk scores)

ESRD acuity
ESRD risk score 0.35 or greater

Acuity and utilization
A&D risk score 2.0 - 3.0 with 2+ unplanned admits

Institutional stay
45+ covered SNF days in 12 months

Once in, always in
Classification holds for the duration of the model, including future Performance Years

ESRD takes precedence over High Needs to avoid eliminating the ESRD cohort– a correction made after the initial RFA was released

Source: LEAD Alignment and Financial Methodology Paper (July 14, 2026), Section 2.5, Tables 2.5.1 and 2.5.2, and Appendix B.

Four Places the Math Works Differently / is Important for High Needs

Each applies to the High Needs beneficiary category specifically, not to the ACO as a whole.

Risk score growth cap

4 percent for High Needs

› Symmetric, against 3 percent for A&D and ESRD

› Base Year 3 is the static reference for PY 2027 and PY 2028 *(similar to AD and ESRD)*

› CMMI concurrent model V2, recalibrated on High Needs only

› AI-inferred model phased in from PY 2029 *(similar to AD and ESRD)*

Regional Comparison

County level, by category

› Regional FFS computed separately for each beneficiary category *(i.e. High Needs benes compared to regional High Needs population)*

› Weighted based upon where aligned beneficiaries reside

› May lead to prior High Needs ACOs showing as more regionally efficient than originally expected for the High Needs cohort, but not the AD cohort

› Cap on Regional Blend *(and prior savings)* now has a risk-adjusted cap potentially resulting in a much higher benchmark adjustment for High Needs

Voluntary alignment

High Needs VA historical benchmarks: BY 3 only for PY 2027

› Only beneficiaries High Needs in BY 3 contribute expenditures

› That same population sets the BY 3 symmetric risk score cap reference

› Below 500 voluntarily aligned, claims benchmarks apply *(similar to AD and ESRD – potentially more impactful for High Needs)*

› CMS may revise the method after PY 2027

SNF alignment exclusion

CPT 99304 to 99318

› Excluded when a SNF facility claim overlaps the service date

› Stated intent is care during a short SNF stay

› Change from ACO REACH – Important to know how it impacts your ACO

Source: LEAD Alignment and Financial Methodology Paper (July 14, 2026), Sections 2.3, 3.2, 3.4.1 to 3.4.3, and 3.5.2, and Table 3.4.3.3. Dollar values are CMS illustrative examples.

Finalizing Participation Decisions

SUMMARY

THE PRACTICAL VIEW

For a High Needs heavy organization, the economics turn less on the headline risk sharing percentages and more on four inputs that are measurable today.

Each can be estimated from claims and alignment data an organization already holds. None requires waiting for further CMS guidance. The items below the line do.

OPEN, PENDING CMS GUIDANCE

› Operational terms for carrying REACH voluntary alignment into LEAD
› Whether the voluntary alignment benchmark method is revised after PY 2027
› The AI-inferred risk model from PY 2029, and the future of the growth cap

01 Test minimum membership durability, not just the current mix

Model whether the panel holds at 40 percent High Needs or ESRD across ten years. The buffer permits 30 percent twice, and not in consecutive years. Below 30 percent, the 5,000 minimum applies.

02 Measure efficiency against the right comparison group

Compare the High Needs panel to county-level High Needs fee-for-service, weighted by beneficiary residence. Total-population efficiency is not a proxy for it and can point the wrong direction.

03 Estimate headroom under the 4 percent risk score cap

Project measured acuity growth against a static Base Year 3 reference for PY 2027 and PY 2028. Where projected growth exceeds the cap, the excess is benchmark that is foregone.

04 Price the two risk options against your own volatility

Professional pays 60 percent of savings at 50 percent of losses. Global pays 100 percent of both, adds Regional Efficiency Adjustment and Total Care Capitation eligibility, and carries a 3 percent discount for lower-spending ACOs.

Source: LEAD Alignment and Financial Methodology Paper (July 14, 2026), Sections 1.3, 2.4, 2.6, 3.2, 3.4, 3.5.2, 5.2.1, and 5.3.3.

Actuary Perspective:
ACOs with Spending < Region

OLIVER WYMAN
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PY 2027 LEAD Financial Methodology and Actuary Perspectives: Lower Spending ACOs

NAACOS Webinar

8/6/2026, Andrew Webster

Lower-spending ACOs: LEAD Professional vs. Shared Savings Program BASIC Level E

LEAD Pro risk option pays 60% on first-dollar savings vs. 50% in BASIC E (60% proposed). LEAD Professional does not allow a **Regional Efficiency Adjustment**. If CMS finalizes the proposed 60% BASIC LEVEL E rate, the sharing-rate advantage disappears and lower-spending ACOs are left comparing capitation and cash flow against a regional benchmark lift under BASIC Level E.

	LEAD Professional Risk Option	MSSP BASIC track, Level E
Shared savings rate	60% of gross savings in Corridor 1 (savings up to 10% of benchmark); 35% / 15% / 5% in Corridors 2–4	50% of savings, first dollar. Proposed 60% for agreement periods starting Jan 1st 2027 (CY2027 PFS proposed rule)
Shared loss rate	50% in Corridor 1, then 35% / 15% / 5% the only corridor where savings and loss rates differ	Fixed 30%, first dollar
Payout and loss limits	Governed by the corridor schedule; optional Stop-Loss Reinsurance (residual-based, elected annually)	Savings capped at 10% of updated benchmark; losses capped at 8% of participants' Parts A/B FFS revenue, not to exceed 4% of benchmark
Regional / efficiency benchmark adjustment	None. **The Regional Efficiency Adjustment is reserved for Global Risk**	Positive regional adjustment: 35% of the ACO-to-region gap in the first agreement period, 50% thereafter, capped at 5% of national per capita FFS
Prior savings adjustment	Renewing ACOs in both tracks. Requires ≥40% of Participant TINs from a predecessor **REACH** or MSSP ACO; higher of this or the REA, subject to the cap	50% scaling factor today; proposed increase to 75% for agreement periods starting Jan 1st 2027 (CY2027 PFS proposed rule)
Benchmark discount	None in Professional	None
Quality	3% withhold on the benchmark, earned back on 7 measures plus a Prevention and Quality Plan	APP Plus over 40%-ile MIPS
Prospective payment	Primary Care Capitation required, plus optional NPCC or APO for non-primary-care providers. Total Care Capitation is not available.	None. Prepaid shared savings is proposed for removal
MSR / MLR	None, settlement is first-dollar through the corridor schedule	Elected at entry: 0%, symmetrical 0.5 to 2.0%, or size-varying
Benchmark trend	Three-way blend: two-thirds observed national/regional growth, one-third ACPT	Three-way blend with ACPT; proposed guardrail of –1.0 / +1.5 points vs. national growth
Term and exit	2027 to 2036 model term; minimum four PYs in Professional before moving to Global; 2% benchmark reduction if the ACO exits after PY1	5-year agreement period; Level E is the top of the BASIC glide path

The Regional Efficiency Adjustment (REA) pays lower-spending ACOs half the gap to their region but only in Global Risk, and only category by category

The REA is computed and capped separately for each beneficiary category and alignment type, so a category where the ACO sits **above** region contributes zero rather than offsetting the categories where it sits below.

Mechanics (§ 3.4.3)

Uncapped REA = 50% × (BY3 regional FFS – ACO Historical Benchmark), where positive

Global Risk only. Professional Risk ACOs receive no REA at any spending level.

Capped at 5% of modified USPCC × the ACO's **PY** average risk score dropping to **3%** for lower-spending ACOs with more than 40% of Participant TINs in a Shared Savings Program ACO in the prior two years.

Higher of the REA or the Prior Savings Adjustment — never both, and both sit under the same cap.

CMS worked example — Tables 3.4.3.1 and 3.4.3.3

Category	Difference	Uncapped REA	Cap	Applied REA
A&D	$50	$25	$51	$25
ESRD	($500)	$0	$396	$0
High Needs	$500	$250	$180.25	$180.25

All PBPM. Caps are 5% × USPCC base × PY risk score (e.g. High Needs: $3,500 × 1.030 × 5% = $180.25), so the High Needs adjustment is cut by $69.75 while ESRD contributes nothing.

Special treatment for lower-spending ACOs

Exclusive access to the REA. Only lower-spending ACOs in Global Risk can receive it; it is the single largest benchmark lever available to an efficient ACO.

New, higher-spending TINs are carved out. A TIN that is both new to Medicare ACO models (no MSSP or REACH in the prior two years) and higher-spending is excluded from the REA calculation, so recruiting does not dilute the adjustment. In the CMS example this lifts the uncapped High Needs REA from $250 to $350 PBPM.

But the carve-out cuts both ways. Beneficiaries aligned through excluded TINs do not receive the REA, and the cap itself is computed only on the beneficiaries of contributing TINs.

A tighter cap for MSSP graduates. Lower-spending ACOs with more than 40% of TINs from a recent Shared Savings Program ACO face a 3% rather than 5% benchmark adjustment cap.

A worse discount deal. Lower-spending Global ACOs pay a flat 3% discount from PY2027 onward, while higher-spending ACOs start at 1.75% and only reach 3% in PY2032.

The higher-spending counterpart. Higher-spending ACOs instead receive a 1.5% Administrative Add-On paid as monthly capitation which is outside the benchmark, outside PY expenditures and outside the adjustment cap.

Lower-spending ACOs: LEAD Global vs. Shared Savings Program ENHANCED

Global buys 100% first-dollar savings and the Regional Efficiency Adjustment for a flat 3% discount ENHANCED never charges. LEAD Global preference depends on if the REA plus the extra 25 points of sharing outweigh the discount and CMS has proposed cutting the ENHANCED regional adjustment weight from 50% to 35% for AP27 ACOs, which widens LEAD's edge.

	LEAD — Global Risk Option	MSSP — ENHANCED track
Shared savings rate	100% of gross savings in Corridor 1 (savings up to 15% of benchmark); 50% / 25% / 10% in Corridors 2–4	75% × quality score, first dollar; capped at 20% of updated benchmark
Shared loss rate	Symmetrical: 100% in Corridor 1, then 50% / 25% / 10%	1 minus (75% × quality score), floored at 40% and capped at 75%; losses capped at 15% of updated benchmark
Benchmark discount	3% flat for every year a lower-spending ACO is in Global. Higher-spending ACOs start at 1.75% and reach 3% only in PY2032	None
Regional / efficiency benchmark adjustment	REA = 50% of the positive gap to BY3 regional FFS, by beneficiary category and alignment type; capped at 5% of modified USPCC risk-adjusted (3% if >40% of TINs came from a recent MSSP ACO in the last 2 years)	Positive regional adjustment: 35% of the gap in the first agreement period, 50% thereafter, capped at 5% of national per capita FFS. Proposed reduction of the ENHANCED maximum weight to 35%
Prior savings adjustment	Renewing ACOs; higher of the REA or the PSA, both under the same cap	Renewing ACOs; highest of the regional, prior savings or population adjustment. Proposed scaling increase from 50% to 75%
Quality linkage	3% withhold, earned back against 7 measures plus a Prevention and Quality Plan	APP Plus set scales the loss rate
Prospective payment	Total Care Capitation (100% fee reduction for Participant TINs) or Primary Care Capitation with NPCC / APO; one-time add-on of 20% of the first monthly payment	None. Prepaid shared savings is proposed for removal
Risk mitigation	Optional Stop-Loss Reinsurance on a residual-expenditure basis, elected annually; financial guarantee and extended repayment option	Expenditures truncated at the 99th percentile; repayment mechanism required
MSR / MLR	None, first-dollar settlement through the corridor schedule	Elected at entry: 0%, symmetrical 0.5–2.0%, or size-varying
Benchmark trend	Three-way blend: two-thirds observed national/regional growth, one-third ACPT	Three-way blend with ACPT; proposed guardrail of –1.0 / +1.5 points vs. national growth
Term and entry	2027–2036; ACOs may enter Global directly. Newly entering ACOs may drop to Professional after year one; renewing ACOs may not	5-year agreement period; open to ACOs experienced with performance-based risk

Actuary Perspective: ACOs with Spending > Region and Eligible for Add-on Payment

LEAD Model for higher-spending ACOs

NAACOS Webinar: LEAD Financial Methodology

What the PY 2027 financial methodology means for organizations higher-spending than the regional benchmark

Presented by:

Jonah Broulette, ASA, MAAA

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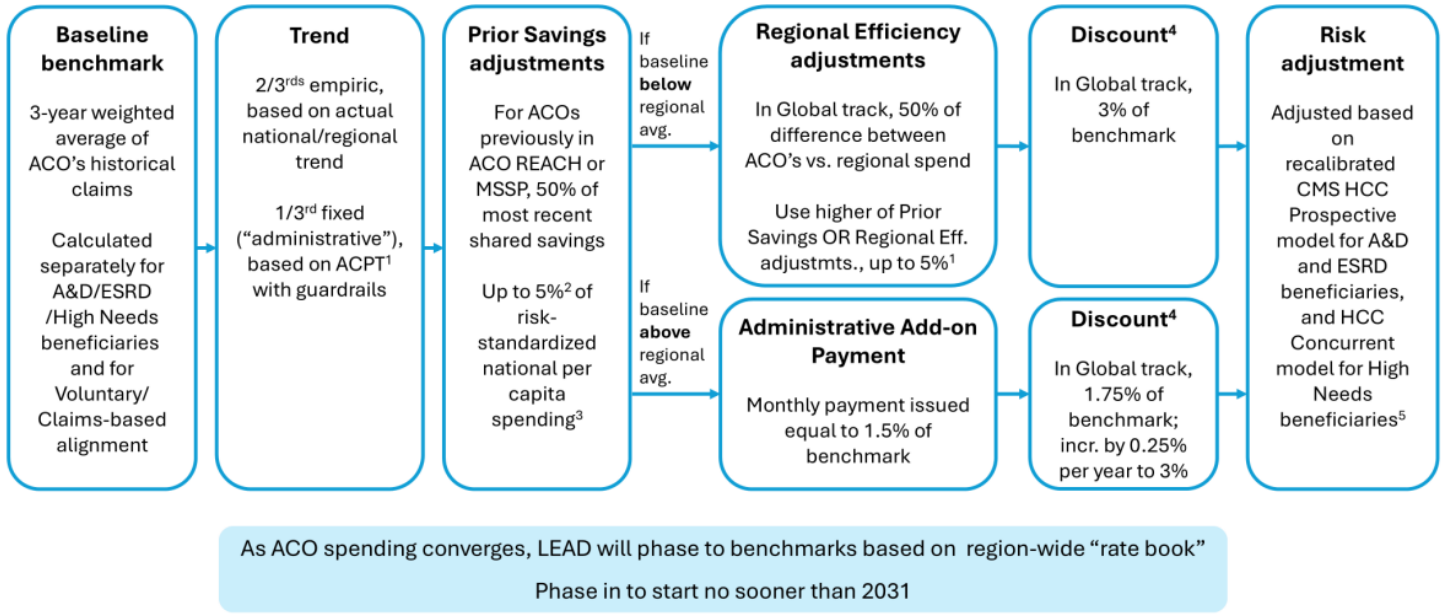
LEAD's Performance Year Benchmark

Figure 2. LEAD Benchmarking Approach



Source: CMS LEAD RFA, Section VIII.B

ACO-Specific Benchmark Adjustments

Lower-Spending ACOs (Global Risk Only)

Regional Efficiency Adjustment

50% of gap between ACO and regional spending

Only applies to ACOs below regional average

One-directional: no penalty for being above

Higher-Spending ACOs

1.5% Administrative Add-On Capitation

Capitated payment = 1.5% of total benchmark

Supports infrastructure investment

Not reconciled - ACOs keep this regardless

Combined cap: 3% of risk-standardized USPCC (lower-spending ACOs from MSSP) | 5% (all others)

Renewing ACOs also eligible for a Prior Savings Adjustment (50% of prorated avg per-capita savings from prior 3 years)

ACO receives the higher of Regional Efficiency Adjustment or Prior Savings Adjustment - not both

Source: CMS LEAD RFA, Section VIII.B

Every ACO Has a Path - But Check Which One You're On

CMS designed two on-ramps to make LEAD viable for different ACO profiles

Lower-Spending ACOs (Global Risk Only):

Regional Efficiency Adjustment - 50% of the gap below the regional average.

CMS is saying:

"We need you in the model. Here's your reward for being efficient."

Higher-Spending ACOs:

1.5% Admin Add-On - unconditional operating capital. No reconciliation.

CMS is saying:

"We know you need infrastructure to transform. Here's a runway."

Going deeper: Are you sure you're still higher-spending?

In MSSP and ACO REACH, High Needs beneficiaries were pooled into A&D or ESRD. LEAD carves them into a separate benchmark category. What remains in your A&D population is structurally different - likely higher-cost relative to the regional average.

An ACO that was historically classified as "higher-spending" may now fall below the regional threshold. That would shift the ACO from the 1.5% Add-On track to the Regional Efficiency Adjustment track - a fundamentally different value proposition. Re-examine your cost position before you model.

Source: CMS LEAD RFA, Section VIII.B

The Long Game: Regional Rate Book Transition

After approximately 5 years, CMS will gradually phase in a regional rate book - an administratively set benchmark based on regional spending patterns

Transition timing:

- No sooner than PY 6 (2032) in any region
- Assessed at the regional level, not model-wide
- Criteria-based, not tied to a specific calendar date

Three criteria that drive timing:

1. ACO Participation Rate - share of beneficiaries in accountable care
2. Savings Generated - cumulative savings already achieved in the region
3. Higher-Spending ACO Share - proportion of participating ACOs that are higher-spending

Phase-in is gradual: rate book weight increases as conditions are met; historical expenditure weight decreases correspondingly

The endgame: administratively set benchmarks replace historical-expenditure-based ones by the end of the 10-year model period

Source: CMS LEAD RFA, Section VIII.G

What the Rate Book Means for Your ACO

The rate book is the endgame - administratively set benchmarks replacing historical ones. It won't arrive until at least PY 6, but the directional signal matters now because it looks very different depending on where you sit.

Lower-Spending ACOs:

Harder initially. Potentially better in long run.

3% Discount. You get 50% of the gap via the Regional Efficiency Adjustment (similar to MSSP).

Then rate book closes the remaining distance - your benchmark moves up toward the regional standard.

Higher-Spending ACOs:

Easier initially. Potentially harder in long run.

1.75% discount (year 1, rising 0.25% per year up to 3%). 1.5% Admin Add-On - unconditional operating capital. Unclear if/when this will expire.

Only a net 0.25% discount (rising 0.25% per year up to 1.5%) as long as add-on is active.

Then rate book closes the remaining distance - your benchmark moves down toward the regional standard.

Three areas where implementation details will shape the outcome:

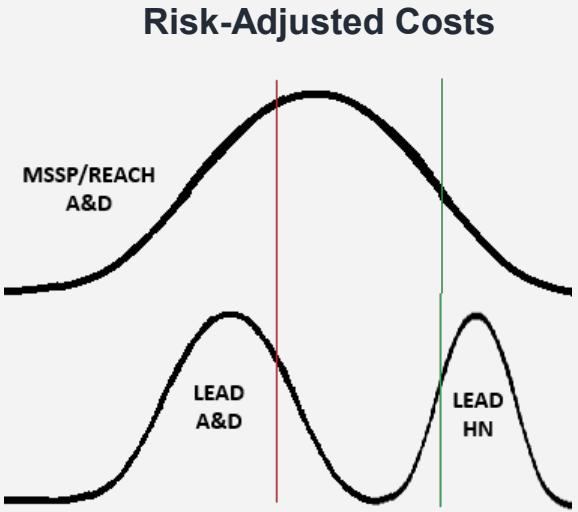
1. The methods use to establish rate book cost base – base periods, updates, adjustment factors?
2. How CMS defines "regional" for rate book purposes - same as trending regions, or different?
3. The pace of phase-in - criteria-based, assessed regionally, gradual weight increase?

We don't have enough detail to model this yet. But the direction is clear, and it should inform your 10-year planning today.

Source: CMS LEAD RFA, Section VIII.G

What Happens When You Pull High Needs Out of A&D (and ESRD)

- ***Who is considered High Needs? People meeting at least one of the CMMI-defined requirements which include characteristics such as impaired mobility, frailty, severe chronic conditions, high risk score, and/or extensive SNF care*** (CMS LEAD RFA, Section VII.A)
- Aged and Disabled (A&D) risk pool gets healthier: average risk score drops, spending variance compresses
- Your ACO's A&D regional efficiency could change completely
  - Not necessarily aligned with historical MSSP/REACH
- Specialists who looked inefficient against a mixed pool may actually be regionally efficient when split across A&D/High Needs
  - The historical understanding that high-cost specialists underperform is potentially out the window
- PCPs who looked efficiency historically may now be inefficient



Questions?

Key Dates

- **Aug 5, 2026:** Participant TIN List due to CMS
- **Aug 2026:** Financial guarantee template available to accepted ACOs
- **Sep 11, 2026:** Final risk sharing option due to CMS
- **Sep 15 - Dec 31, 2026:** Pre-implementation SVA period (SVA due Oct 23 for Jan 1 effectiveness)
- **Dec 14, 2026 - Jan 14, 2027:** Mid-year TIN Add Window
- **Dec 31, 2026:** Financial guarantee documentation due; Preliminary Benchmark Report and spending designation released
- **May 2027:** Final spending designation (Q1 Benchmark Report)

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