CLIENT ALERTS & INSIGHTS

CMS Puts Specialists in the Game with LEAD

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Featured Practices: Healthcare

Key Takeaways for Specialists

- Specialist physicians now have a practical pathway to participate in ACO programs, not just support them. LEAD is built to integrate specialty care into ACO performance and rewards.
- Two Participation Paths: Participant Provider (whole-practice accountability with potential shared savings/losses) or Preferred Provider (narrower, contract-based collaboration model). The choice is not permanent and can change as the relationship evolves.
- Advanced Payment Option (APO) and Non-Primary Care Capitation (NPCC) payment structures shift the focus from volume to value and provide predictable revenue.
- CMS-Administered Risk Arrangements (CARA) lets specialists take on defined, episode-based accountability - while CMS handles the back-end episode accounting and reconciliation.

For years, many specialist physicians have watched Medicare's ACO programs from the sidelines, uncertain how to participate in models historically centered on primary care providers. The Long-term Enhanced ACO Design (LEAD) Model marks a fundamental shift in this dynamic. As noted in our kick-off article in this series, *CMS Bets on the Long Game with 10-Year LEAD ACO Model,* as the 10-year successor to ACO REACH, LEAD is explicitly designed to integrate more specialists - including nephrology, cardiology, oncology, orthopedics, behavioral health, and other disciplines - into the fold of accountable care. By introducing flexible payment options and risk-sharing tools tailored to specialty practices, LEAD enables specialist providers to engage in ACOs beyond being "guest stars" under fee-for-service, but as true partners in population health management.

Why Now?

Historically, specialists had limited direct incentives in ACOs. A cardiologist or oncologist might join an ACO's physician network, but their income still came largely from fee-for-service billing, and they often had no formal share in the ACO's savings (or losses). Moreover, only primary care encounters drove patient attribution, so specialists couldn't directly bring their patient panels into an ACO. As a result, many specialist groups had little motivation to participate beyond goodwill or informal referrals. LEAD addresses these issues head-on. The model provides new roles and payment pathways for specialists, targeting their engagement as a vital goal. Specialist practices now have multiple entry points into accountable care - they may join an existing ACO on favorable terms, forge risk-sharing contracts with ACO partners, or even lead niche ACOs focused on complex patient populations.

In this article, we review how specialists can participate in LEAD, the key mechanisms that make it attractive (and different from business as usual), and opportunities and challenges for specialty providers to consider.

Two Paths to Joining an ACO: Participant Provider vs. Preferred Provider

The first consideration for a specialist practice is how to join an ACO under LEAD. The model defines two types of provider participation with distinct implications:

- **Participant Provider:**
  - A full ACO member that brings an entire practice (all clinicians billing under a common Tax Identification Number or TIN) into the ACO.
  - The core of the ACO; their patients are *aligned* to the ACO for cost and quality accountability.

Traditionally, Participant Providers have been primary care practices, since alignment in Medicare ACO models primarily depends on where beneficiaries receive their primary care services. However, LEAD does not require Participant Providers to be primary care physicians - multi-specialty groups or specialist practices can also be Participant Providers. The key requirement is "whole TIN" participation: if a cardiology or orthopedic practice becomes a Participant Provider, *all* the Medicare clinicians under that TIN must participate in the ACO. Unlike ACO REACH, which allowed cherry-picking individual providers, "whole TIN" participation ensures that an ACO's core participants are fully committed. Participant Providers are directly accountable for the ACO's financial and quality performance, have representation in the ACO's governance, and can receive shared savings (or owe shared losses) in proportion to their patient population and financial results.

- **Preferred Provider:**
  - A more limited affiliation than Participant Providers; can be contracted at the individual NPI level (allowing flexibility to include, for example, one specialist in a practice but not their whole group).
  - Patients are *not* brought into the ACO's aligned population, and the provider is not directly responsible for overall ACO performance.

Preferred Providers do not trigger beneficiary alignment - i.e., their patients typically wouldn't be counted in the ACO's benchmark or attributed lives - and they are not required to meet the full spectrum of ACO participation requirements. However, they can share in risk or receive incentive payments through the ACO via special contracts. In essence, a Preferred Provider arrangement allows a specialist to collaborate with an ACO on specific initiatives (like a care coordination program or an episode bundle) without fully integrating their practice into the ACO.

Which Model to Choose?

For many specialist groups, the Preferred Provider route will be the initial step. This may be true for specialties that rarely provide primary care or preventive services (e.g., radiology; surgical subspecialties; behavioral health providers). By becoming Preferred Providers, these specialists can engage in an ACO's value-based initiatives such as accepting referrals from ACO physicians, participating in care management programs, or entering a financial gainsharing agreement without managing an attributed patient population year-round.

On the other hand, larger specialty groups that provide a significant portion of patients' care (e.g., multi-specialty clinics; endocrinologists or nephrologists who serve as principal care providers for chronic disease patients) may consider full Participant Provider status to start. As Participant Providers, such specialists could directly bring their patient panel into the ACO, potentially qualifying for shared savings on patients' total cost of care - not just their specialty services.

Notably, the choice between Participant vs. Preferred is not a permanent dichotomy. An ACO and Preferred Provider could start a relationship with the specialist as a Preferred Provider - for example, a behavioral health group might contract to provide embedded therapists for the ACO's primary care clinics and be paid under a performance bonus arrangement. If the partnership proves successful and the specialist practice is ready for deeper integration, the group could become a Participant Provider in a future year (noting that such transition means moving to whole-TIN participation). LEAD's designers have emphasized flexibility, seeking to make it easier for ACOs and specialists to work together in stages that work for both.

Flexible Payments: From Volume to Value for Specialists

For most specialists, a key question is how participating in an ACO will impact their payment structure and long-term financial stability. LEAD's answer - offer *voluntary* alternatives to pure fee-for-service that can provide more predictable revenue and reward value-driven care. Two of the most significant options are Non-Primary Care Capitation (NPCC) and the Advanced Payment Option (APO):

- **Non-Primary Care Capitation (NPCC):** This new LEAD feature paves the way for ACOs to pay specialist providers on a *capitated* basis. An ACO that chooses to implement NPCC will pay a specialist or specialty group a fixed per-member per-month amount to cover all care in that specialty for the ACO's patients. For example, a LEAD ACO might pay a dermatology group $X per month for each aligned patient under the group's care, instead of the dermatologists billing Medicare for each visit and biopsy. Crucially, NPCC differs from existing capitation in one key respect: the payments to the specialist or specialty group are not "settled up" against actual fee-for-service claims. That is, the specialist does not have to return money if they provided fewer services than expected, nor can they bill extra if they provided more - the fixed payment is their total reimbursement for that patient's care (aside from any separate quality bonuses). The specialist is effectively a sub-capitated partner, bearing full risk (and benefits) for managing the cost of their services to the patient. If they keep costs below the capitation amount (for instance, by practicing efficient, proactive care), the specialist keeps the surplus as additional profit; if the patient's care exceeds the budget (e.g. more high-intensity services or complications), the specialist absorbs the excess cost as a loss.

How this differs from standard practice: In traditional Medicare, specialists are paid per service - which can encourage higher volumes of visits or procedures without directly rewarding quality or coordination. The incentive flips under NPCC: the specialist is rewarded for keeping patients healthy and using resources efficiently . For instance, a cardiology group under NPCC might invest in remote monitoring and care coordination for heart failure patients to prevent hospital admissions. The fixed capitation gives them flexibility to deploy nurses or telehealth even if those services aren't separately billable since preventing an ICU stay keeps them within budget. It's a significant shift: specialists must be confident in their cost-management capabilities, but it opens the door to *innovation in care delivery*. NPCC arrangements will be negotiated between the ACO and the specialist group - so practices should be prepared to analyze their own cost data and propose capitation rates that are financially viable for both sides. As a safeguard, ACOs implementing NPCC or other novel payments can use fraud and abuse waivers provided by CMMI to structure these payments without violating Stark Law or Anti-Kickback statutes (as long as they remain within model parameters).

- **Advanced Payment Option (APO):** While this mechanism primarily flows to the ACO as a whole, it can indirectly benefit specialists. APO provides an upfront monthly payment to the ACO, based on expected fee-for-service billings, which is later reconciled against actual claims. In essence, CMS advances a portion of the ACO's future revenue to bolster immediate cash flow. A specialist-led ACO or an ACO with significant specialist participation could use APO funds to, for instance, *hire care managers for a pulmonology practice's chronic disease patients or invest in data analytics for an oncology group's population health tracking*. Because APO payments are recouped from subsequent claims, they don't represent new revenue per se, but they *smooth out cash flow* and provide liquidity right when an ACO (and its providers) might need it for startup costs or care improvements. For specialists joining an existing ACO, APO means the ACO is better positioned to support infrastructure that you might rely on - for example, funding a pharmacist-led medication management program that helps both primary care and specialists manage complex patients.

In addition to NPCC and APO, LEAD continues the Primary Care Capitation (PCC) and Total Care Capitation (TCC) options from ACO REACH (the latter only for Global track ACOs). Those primarily impact how primary care is paid, but they have implications for specialists as well. For instance, if an ACO implements TCC (full capitation of all services) in the Global track, the ACO might choose to pay its specialist Participant Providers on a sub-capitated basis internally. Under PCC or TCC, specialists will notice that some of their services are "paid" by the ACO rather than through the usual Medicare Part B claims - meaning the ACO will forward payments to the practice out of its capitation fund. Specialists should clarify during contracting *how and when they'll receive payment* under any capitation arrangement, and how those payments relate to their own service costs and patient load.

Overall, the variety of payment models in LEAD gives specialists and ACOs many options to craft arrangements that align with their goals, whether that means stable monthly revenue, performance bonuses, or simply maintaining fee-for-service, but with the potential for a shared savings payment at year-end.

Engaging in Episode-Based Risk (CARA) - When It Makes Sense for Specialists

Perhaps the most groundbreaking opportunity for specialists in LEAD is the CMS-Administered Risk Arrangements (CARA) program. CARA enables an ACO to establish Episode-Based Risk Arrangements (EBRAs) with specialists or provider entities (including hospitals or post-acute providers) and have CMS directly facilitate the arrangements. In traditional ACOs, if a provider and an ACO wanted to share risk on, for example, orthopedic surgery costs, they would have to negotiate a complex private arrangement and manually track performance. CARA removes these obstacles by offering a menu of predefined episodes and a standardized reconciliation process managed by CMS.

Here's how an EBRA might work in practice for a specialist:

- **Defining the Episode:** CMS will provide a set of episode definitions, likely based on established clinical groupings (for instance, episodes for joint replacement surgery, cardiac stent procedures, chemotherapy for breast cancer, or management of a condition like chronic kidney disease). A specialist group and the ACO agree to participate in one or more relevant episodes. They define the parameters: specifying which services and time period are included in the episode, and what the target price (budget) for that episode will be.
- **Risk Agreement:** The ACO and specialist negotiate how they will share any variance from the episode budget. For example, a nephrology practice might agree to split any dialysis-related episode savings 50/50 with the ACO, or a surgical hospital might agree to bear 75% of any losses above the joint replacement episode target. The exact division is up to the participants, but the key is that the specialist now has "skin in the game" - a direct financial reward for efficiency and a commensurate accountability for overages.
- **CMS Reconciliation:** After the performance period (and using what could be very timely data throughout), CMS calculates the actual cost for each episode and compares it to the target. CMS then pays out savings or collects losses according to the pre-arranged split, directly to/from the ACO and the specialist. This is done as part of the model's financial reconciliation, meaning specialists do not have to build new infrastructure for tracking episodes. Both parties also get detailed *episode-level data* from CMS to know where costs came from, enabling insights into care patterns and improvement opportunities.

For specialists, CARA's EBRA approach is a game-changer. It allows them to focus on discrete areas of care where they can impact costs and quality - essentially mini "bundled payment" programs - within the larger ACO. A few examples illustrate the possibilities:

- **Orthopedic Surgery:** An orthopedic group could join an ACO as a Preferred Provider and enter a CARA episode arrangement for total hip and knee replacements. The episode might cover the surgery and all related care for 90 days after discharge. If the surgeons implement care pathways that reduce complications, length of stay, or expensive post-acute care, the total episode cost might come in under the benchmark, yielding shared savings. If, conversely, patients have avoidable readmissions or receive excessive post-op therapy driving costs up, the surgeons would share in the loss. Either way, the surgeons are financially tied to the outcomes of the episode, not just the volume of surgeries which align their incentives with the ACO's population health goals.
- **Oncology:** An oncology practice could enter a CARA episode arrangement with an ACO for chemotherapy administration and associated hospitalizations for breast cancer patients. By carefully managing side effects, coordinating with primary care and palliative care, and avoiding redundant imaging or inappropriate hospital days, the oncology group can help bring episode spending below target and earn a portion of the savings. While this model parallels features of the Oncology Care Model (OCM) and its successor, CARA allows it to occur under the ACO umbrella, potentially combining with other ACO supports (like waivers to reduce patient drug co-pays or to provide home health services that prevent ER visits).

- **Behavioral Health:** Mental health and substance use are major drivers of hospitalizations and costs for many ACO patients, yet behavioral health providers have often been outside formal ACO contracts. Under LEAD, an ACO might designate a community behavioral health center as a Preferred Provider and set up a CARA episode or payment arrangement for crisis stabilization services. The behavioral health provider could agree to manage patients' psychiatric care during acute episodes (e.g., severe depression or substance relapse), with an incentive to avoid expensive inpatient psychiatric admissions. CARA could track the per-episode costs of behavioral health crises and enable the provider to share in savings if they succeed in stabilizing patients in outpatient settings. Meanwhile, the ACO could support this effort by using telehealth waivers or expanding access to community-based services (like home visits or telepsychiatry) for these patients, recognizing that better mental health control can reduce total medical spending.

From a broader perspective, CARA offers a "structured yet flexible framework" for specialist integration. It moves specialty engagement from ad hoc arrangements to a scalable model supported by CMS. As one industry analysis noted, this approach can be a *"catalyst for incorporating specialists and other preferred providers in [an ACO's] care management framework in a way that moves the needle for managing total cost of care."*

Weighing the Opportunities and Risks for Specialists

The LEAD Model's overture to specialists comes with clear opportunities:

- **New Revenue Streams:** Specialists can earn money in ways previously unavailable in Medicare fee-for-service. For instance, if a specialist's efficient care delivery results in savings on an episode budget, they receive a direct share of those savings through CARA - analogous to a bonus for cost-effective practice. Under NPCC, specialists receive a *predictable monthly payment irrespective* of visit volume, converting their deep clinical expertise into a steady revenue source. For many specialist practices, especially in fields like oncology or nephrology where high-cost treatments are common, this predictability can be a welcome relief from volume-driven volatility.

- **Greater Clinical Autonomy and Innovation:** LEAD's payment flexibilities free specialists from the strictures of only billing for discrete services and allow clinicians to practice in more patient-centered ways. A capitated specialist has greater leeway to invest time in care coordination, telehealth check-ins, or preventive interventions that aren't reimbursed under standard fee schedules. Similarly, episode arrangements encourage specialists to redesign care pathways - for example, an orthopedic surgeon might implement a "prehab" program to optimize patients' health before surgery, reducing complications and costs. In short, LEAD can empower specialists to focus on outcomes over volume, with a financial upside for success.

- **Deeper Integration with Primary Care:** In an ACO, specialists can collaborate more closely with primary care physicians (PCPs) and share tools and data (often funded by the ACO). A cardiologist as part of an ACO, for example, might get access to the ACO's care management platform or data analytics identifying high-risk patients in need of cardiology consults. This team-based approach can enhance referrals for the specialist *and* improve patient care (e.g., ensuring a patient's cardiologist and PCP are on the same page about medication management). For specialties like behavioral health, which historically operate in silos, ACO participation can facilitate warm hand-offs from primary care and support integrated treatment plans, ultimately leading to better patient engagement and reduced downstream costs.

On the other hand, specialists should consider the challenges and obligations that come with LEAD's opportunities:

- **Financial Risk and Accountability:** Taking on risk - whether through NPCC or an episode arrangement - means a possibility of lower earnings or even losses if actual costs run high. Specialists must have the infrastructure (or support from the ACO) to manage this risk. This includes robust data analytics to track performance, care management programs to control costs, and possibly stop-loss protections or reinsurance for rare catastrophic cases. Practices should carefully model potential scenarios before committing to capitation levels or risk-sharing percentages. The RFA will likely require demonstrating the ability to handle financial risk (e.g., through reserves or insurance), even for those joining as Preferred Providers.

- **Data-Sharing and Reporting Requirements:** All ACO participants need to use certified EHR technology and share data to enable care coordination and quality reporting. Specialists in LEAD will be expected to promptly communicate clinical data (e.g., test results, consult notes) to the ACO and other providers. They may also need to help the ACO report electronic clinical quality measures (eCQMs) that involve specialist-driven outcomes, such as cancer screening rates or HbA1c control for diabetes. For some specialty practices, particularly smaller or independent ones, this could necessitate EHR upgrades or new data interfaces. Recognizing this, the model includes a "Tech Enabler" initiative to support smaller ACOs and partners in adopting high-value technology tools.
- **Care Coordination & Compliance:** Joining an ACO means integrating into a broader care network. Specialists should expect greater involvement in care coordination activities - for example, participating in ACO care team meetings or adhering to evidence-based care pathways that the ACO adopts. They may also be called upon to extend office hours or offer telehealth access as part of the ACO's strategy to reduce ER visits (supported by the model's waivers and payment flexibilities). From a compliance perspective, specialists in an ACO must follow program rules around beneficiary protections, documentation, and marketing (for instance, how patients are informed of cost-sharing support or care management programs). The fraud and abuse waivers provided under LEAD will protect legitimate incentive payments and care redesign efforts, as long as arrangements are set up in compliance with the model's terms - so legal and compliance review of any specialist-ACO contracts is essential.

Action Steps Before May 17, 2026

With the first LEAD Model application deadline on May 17, 2026 swiftly approaching, specialist practices that see the potential in this model should start engaging with ACO partners immediately. Steps to consider:

- **Educate and Strategize:** Learn the key details of the LEAD Model and identify how your specialty could fit in. What patient population do you serve, and what aspect of their care could you manage more effectively under an ACO construct? For instance, if you are a nephrology practice, note that LEAD will fully integrate care for end-stage renal disease and late-stage CKD patients into ACOs, and even offers *lower participation thresholds* for high-needs focused organizations. This means a nephrology-led ACO (or an ACO that you co-lead with primary care partners) might only need *a few thousand or even a thousand* aligned patients to be viable, instead of 5,000 in a standard ACO. A cardiovascular group might look at how many of its heart failure patients could be aligned through voluntary alignment or in partnership with a primary care ACO. The goal is to define your value proposition: e.g., "With capitated payments, our cardiology clinic can reduce hospitalizations for ACO patients with heart failure by 15%, saving $X per patient."
- **Reach Out to ACOs and Potential Partners:** If you're not already affiliated with an ACO, initiate conversations with ACOs in your region. Many established ACOs (including Medicare Shared Savings Program participants) are evaluating LEAD and seeking specialty partners to bolster care for high-cost conditions. Bring concrete ideas to the table - for example, a proposal to manage orthopedic surgery episodes via CARA, or to pilot a capitated model for oncology services. Be prepared with data on your past performance if available (e.g., readmission rates, cost per episode, quality metrics) to build trust that your practice can contribute to shared savings. If you are part of an existing REACH ACO, find out if they plan to apply to LEAD and advocate for inclusion of your specialty in their application. CMMI is encouraging early applications (future application rounds aren't guaranteed and may have stricter rules), so the sooner you align with an ACO's strategy, the better.
- **Assess Readiness for Risk and Investment:** Evaluate your practice's ability to succeed under these new payment models. Do you have the care management capabilities to thrive under NPCC or episode bundles? What gaps would need to be filled - for example, hiring a nurse navigator, enhancing your EMR for better data exchange, or contracting with a care management service? Identify if you'll need support from the ACO (financial or technical) to make these changes and negotiate for those resources as part of your participation. The LEAD Model's flexibility means there is room to customize agreements - for instance, you might negotiate a "performance pool" bonus from the ACO if you meet certain targets, or request an upfront investment (possibly funded by the ACO's Advanced Payment Option) to help you implement a new remote monitoring program.

Looking Ahead:

The LEAD Model represents a watershed moment for specialty providers in Medicare value-based care. It acknowledges that lasting cost and quality improvements require engaging *all* parts of the care continuum - not just primary care - and it offers financial models that can make this engagement feasible for specialists.

By thoughtfully choosing how to participate (full Participant Provider vs. Preferred Provider) and leveraging tools like NPCC and CARA, specialist practices can transform the payment paradigm for their services: moving from volume-driven reimbursement to value-driven partnerships. For many, this will involve a cultural shift toward greater collaboration and accountability, but the potential rewards - stable revenues, shared savings, and meaningful voice in shaping patient care - make it an opportunity well worth serious consideration.

Key CMS Resources - LEAD Model

For clients who want to go directly to CMS sources, the most useful publicly available documents are:

- LEAD Model Request for Applications (RFA) (PDF)
- LEAD Application Submission Portal
- LEAD Model Application Checklist (PDF)
- LEAD Model Payment Factsheet (PDF)
- LEAD Model Overview Factsheet (PDF)
- LEAD Model Value Factsheet (PDF)
- LEAD Model Overview Webinar Slides (PDF)
- LEAD Model Overview Webinar Transcript
- CMS-Administered Risk Arrangements (CARA) Factsheet (PDF)

This client alert is the second installment in our four-part series on the CMMI LEAD Model.

Next up: *A detailed comparison of ACO REACH and LEAD - what's changing, what's staying the same, and how organizations can navigate the transition. Future articles will also explore nephrology-specific considerations, including how LEAD differs from the CKCC kidney care model and the new CMS "ACCESS" initiative for chronic disease.*

The Benesch Healthcare team monitors developments related to the LEAD Model and other CMMI initiatives and may provide additional updates as they become available. Please contact the authors of this article for additional information or if you have any questions.

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