CLIENT ALERTS & INSIGHTS

LEAD vs. ACO REACH-What's Changing and Why the LEAD Model Matters for ACOs and Participating Providers

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Featured Practices: Healthcare

Key Takeaways for ACOs:

- **10-Year Commitment Replaces Short-Term REACH Model:** Starting January 1, 2027, LEAD offers a 10-year model (spanning the years 2027-2036) to effectively replace the ACO REACH model when it sunsets on December 31, 2026. Unlike REACH's 4-year run with periodic benchmark rebasing, LEAD locks in each ACO's spending baseline for the full decade-no mid-model resets. This unprecedented stability is designed to foster long-term increased participation and investment in care transformation. LEAD reduces the administrative burden in the short term from the model perspective.

- **Broader Provider Participation & High-Needs Focus:** LEAD opens the door to small, rural and independent practices to join the model and integrates high-needs patients into every ACO's population (no separate High-Needs ACO track). ACOs with over 40% high-needs patients receive lower enrollment minimums. LEAD also requires full TIN participation (entire practice groups join), ending the NPI-level pick-and-choose flexibility of REACH but broadening provider participation.
- **New Payment Tools & Specialists**: LEAD builds on REACH's payment options: Primary Care Capitation (PCC), Total Care Capitation (TCC) and Advanced Payment Option (APO), adding Non-Primary Care Capitation (NPCC) for sub-capitating specialists and a 1.5% "administrative" bonus for ACOs with high baseline spending. LEAD's optional CMS-Administered Risk Arrangements (CARA) enables specialists to share risk in defined care episodes. CMS handles reconciliation, significantly lowering hurdles to meaningful specialist engagement and advancing increased provider reach of the LEAD model compared to REACH.

- **LEAD Medicaid Integration, Safeguards & Application Deadline:** LEAD will launch a Medicare/Medicaid integration pilot with two states and expand beneficiary incentives (Part B cost-sharing support with potential Part D premium relief by 2029). Participation comes with HHS fraud and abuse waivers covering both Stark Law and the Anti-Kickback Statute (AKS), and a safe harbor for CMS-sponsored models. CMS released the RFA on March 31, 2026. ACOs must apply by May 17, 2026 for the first performance year starting January 1, 2027.

REACH vs. LEAD: Side-by-Side

The Long-term Enhanced ACO Design ("LEAD") model is Centers for Medicare & Medicaid Services Innovation Center's (Innovation Center) newly announced successor to the ACO Realizing Equity, Access, and Community Health (REACH) model. While LEAD retains the core framework of two-sided risk and population-based payments, it introduces critical changes aimed at making the program more sustainable, inclusive and effective to foster longer term administration for providers. Below is a high-level comparison of REACH and LEAD across key dimensions:

Dimension	REACH (2023-2026)	LEAD (2027-2036)
Model Duration & Benchmark	4-year demo (2023-26) with a historical benchmark rebased over time, culminating in a full transition to a regional "rate book" by final year[1] [2]. Short timeframe required quick return on investments, and the benchmarks reset to lower levels as ACOs saved money.	The 10-year model (2027-36)- the longest CMS ACO test to date-has a fixed baseline for the entire decade (no rebasing). **Impact:** ACOs keep early savings by not losing them to benchmark cuts fostering long-term care transformation. The second half of the decade may transition to rate book only after years of stability.
Risk-Sharing Options	**Two risk-sharing options:** Global (100% risk) with ~3% benchmark discount (CMS's standard savings share)[3] with ACOs taking on the maximum risk/reward. Professional (50% risk) with no discount. Lower risk path (no discount) similar to MSSP's highest track.	**Two risk-sharing options:** Global (100% risk) with ~1.75-3% sliding benchmark discount (smaller for historically high-cost ACOs). Professional (50% risk) with no discount (same as REACH). **New:** ACOs choosing Professional must remain there for 4 years before switching to Global (promotes stability but decreases flexibility). Both tracks still offer full upside savings, with quality-adjusted earnbacks (see below).

Benchmarking & Savings	Baseline spending set using 2017-2019 historical data updated annually with a blend of national/regional growth. Planned move to regional rate-based benchmarks by 2026, effectively "resetting" targets. High-performing ACOs risked shrinking benchmarks (referred to as the "ratcheting effect"). Limited prior savings credit. Regional adjustment penalizes historically efficient ACOs.	No benchmark resets for 10 years, so baseline spending is locked in for the model's duration. Annual trend updates use a mix of national/regional growth with guardrails. **Prior savings adjustment:** LEAD aims to reward experienced ACOs by adjusting benchmarks upward if they've already achieved low spending. No downside of rebasing means sustained incentives for continuous improvement over a decade.
Beneficiary Alignment	Prospective attribution alignment: ACOs had an aligned beneficiary list at start of year with ongoing voluntary alignment for patients choosing a provider. Flexibility to add newly joining providers' patients during the year was limited. High-risk patients could be in a separate High-Needs ACO model.	**Two alignment options:** Prospective: Fixed annual list. Hybrid: Prospective base list + continuous monthly additions via voluntary alignment + one-time mid-year alignment for patients of newly added providers. **Unified model:** High-needs patients are included in all LEAD ACOs (no separate track like in REACH). ACOs with >40% high-needs patients get a significantly lower minimum (<<5,000) to participate. This encourages enrollment of frail, chronically ill and dual-eligible beneficiaries by leveling the field for ACOs that serve them.

Payment Options (Capitation & Advanced Payments)	Primary Care Capitation (PCC) and Total Care Capitation (TCC) available. Advanced Payment Option (APO) for cash flow (monthly upfront payment recouped against claims). **No specialty capitation:** REACH lacked an equivalent to NPCC introduced in LEAD, making it harder for specialists to participate in the risk arrangements. **New entrant & small ACO benefit:** Some ACOs received fixed upfront investment payments (the AIP program) to support early infrastructure-which had to be repaid through earned savings.	PCC and TCC continue with similar mechanics and APO continues with advance payments reconciled later. **New:** Non-Primary Care Capitation (NPCC) allows true sub-capitation for specialists (fixed monthly payments *not* reconciled against FFS), enabling direct specialist accountability for cost and quality. **Also new:** 1.5% of benchmark Administrative Payment to higher-cost ACOs, *not* recouped later, giving providers (often in rural or high-disparity areas) upfront dollars to invest in care improvements. These enhancements address previous barriers by supplying capital and incentivizing engagement of smaller, independent and rural providers in ACOs.
Specialist Integration	**Limited specialist participation:** REACH permitted "Preferred Provider" agreements, but any shared-savings or payment bundles that had to be privately arranged with core ACO alignment were still driven by primary care. No CMS-operated structure for specialist episodes. Specialists were seldom deeply involved[4]. **TIN participation:** REACH allows NPI-by-NPI participation providing flexibility.	**Built-in specialist risk-sharing:** LEAD's Global track ACOs can use CARA (CMS-Administered Risk Arrangements) to partner with specialists on standardized episode bundles or custom arrangements with CMS handling reconciliation. NPCC (above) lets ACOs pay specialists prospectively, giving them a stake in cost control. Together, these features make specialist collaboration far more feasible. **Whole-TIN participation:** LEAD's whole-TIN participation requirement for Participant Providers means if, for example, an orthopedic group joins a LEAD ACO, all its doctors are in-creating a stronger, broader specialist commitment to the ACO's success.

Quality Measures & Withhold	Quality score and a 5% withholding of an ACO's benchmark tied to performance (in REACH's later years). Quality measured by a small set of claims-based metrics and patient experience (CAHPS); no eCQM reporting required under REACH. High Performers Pool provided bonus payments for top scores, and an optional pay-for-improvement factor was included, like MSSP.	Quality score and a 3% withhold of benchmark, with potential to earn back all, or part, of the withholdings based on performance. LEAD carries over 4 claims-based measures and CAHPS from REACH and adds two electronic clinical quality measures (eCQMs) in phases over the first 4 years. This gradual eCQM adoption acknowledges data-sharing challenges and pushes ACOs toward more robust health IT use. The High Performers Pool and improvement bonus continue. All ACOs must implement a Preventive & Quality Strategy to address population health and disparities.
Medicaid & Whole-Person Care	**No direct Medicaid integration.**REACH focused on Medicare fee-for-service (FFS) only (though dually eligible patients could be aligned, there was no formal link to state Medicaid programs). Beneficiary incentives were limited (e.g., a modest gift-card reward for getting primary care) due to regulatory constraints.	**Medicare-Medicaid Alignment Pilot:** LEAD will work with two states (one with FFS Medicaid, one with managed care) to develop partnerships between ACOs and state Medicaid agencies/MCOs. Goal is to align care management and possibly share savings for dual-eligible patients, bridging the long-standing gap between Medicare and Medicaid services. Expanded beneficiary benefits: LEAD ACOs can offer *Part B cost-sharing relief* (waiving copays) and other in-kind benefits (e.g. healthy food, chronic disease program rewards) to encourage preventive care. By 2029, ACOs may even subsidize Part D premiums for aligned patients. These shifts reflect a holistic approach to patient engagement and are enabled by the fraud & abuse waivers and a new CMS-sponsored model safe harbor protecting such arrangements.

Fraud & Abuse Waivers	***Yes -*** As an Innovation Center model, REACH participants operated under HHS-issued waivers of Stark Law and AKSand certain beneficiary inducement rules subject to specific conditions (as previously established for Next Gen and other models). These waivers allowed ACOs to distribute shared savings to physicians, integrate clinical care across entities, and provide approved patient incentives without violating federal fraud and abuse laws.	***Yes -*** LEAD continues the use of Section 1115A waiver authority to permit innovative financial arrangements and patient incentives. CMS indicated it will apply the AKS safe harbor for CMS-sponsored models to protect remuneration under LEAD, including payments between ACOs and providers and the expanded Beneficiary Engagement Incentives (e.g., co-pay waivers) described above. In practice, LEAD ACOs will have at least the same fraud-and-abuse waivers that REACH did (for shared savings distribution, beneficiary incentives, etc.), with modifications as needed to cover LEAD's new features. All waivers require strict compliance with model rules and good-faith participation (violations can lead to removal from the model). These safeguards give ACOs flexibility to innovate while protecting against program integrity risks.

Table: *Key differences between REACH and the new LEAD Model across major design elements. Sources: CMS LEAD RFA, CMS LEAD Payment Factsheet, CMS CARA Factsheet, CMS LEAD Model page.*

From REACH to LEAD: Building on Success & Addressing Pitfalls

The LEAD Model is not just a routine extension of REACH; it is a reengineering of the ACO model to incorporate lessons learned from REACH and its predecessor programs. While REACH made strides in advancing health equity and provider-led innovation in 2023-2026, its short time frame and methodology posed challenges:

- **Benchmark Ratcheting Effect:** Under REACH, ACOs that achieved savings saw their future benchmarks diminished due to periodic rebasing and a shift to regional spending targets (the ratcheting effect). This discouraged long-term investments and made short-term administration tedious. LEAD directly fixes the ratcheting effect by removing rebasing for the entire 10 years, allowing compounding improvements without penalty.

- **Specialist Participation Barriers:** In REACH, despite the ability to designate Preferred Providers, getting specialists meaningfully engaged was difficult because there was no turnkey method to share risk or reward for specialist-driven episodes. LEAD addresses specialist participation barriers with CARA and NPCC, making it far easier for specialists to join and benefit, supporting improvements in care integration for complex cases (e.g., oncologists or orthopedic surgeons actively collaborating with ACOs on cost control).
- **High-Needs Patient Care & Health Equity:** REACH's separate High Needs ACO option was a valuable experiment but effectively segregated high-cost patients. LEAD mainstreams high-needs patients, giving every ACO the tools to serve high-needs populations, like adjusted risk scores, tailored benchmarks and reduced patient minimums. This change was directly advocated by stakeholders (NAACOS called it a "win" for ACOs) and is expected to remove disincentives to enrolling sicker patients.
- **Financial Barriers for New Entrants:** Many small or rural providers passed on REACH due to lack of capital and fear of immediate losses. LEAD's new 1.5% upfront payment and phased risk requirements tackle financial barriers to participation-meaning new ACOs can get an infusion of funds without repayment obligations, and Professional-track ACOs have four years to acclimate before considering full risk. This allows for potential broader adoption of the LEAD model compared to REACH.
- **Transition Continuity:** CMS has smoothed the path from REACH to LEAD. Current REACH participants can transition into LEAD via an abbreviated application process-indicating CMS's intent to retain successful ACOs. However, past performance matters: organizations with compliance issues or poor outcomes in REACH will face extra scrutiny or may be turned away. The clear message is that LEAD is meant to build on REACH's successes while correcting its shortcomings.

What's Unchanged?

Despite the numerous upgrades, LEAD preserves many fundamental aspects of REACH:

- **Voluntary Participation & Two-Sided Risk:** Participation in both models is voluntary and limited to those confident in managing clinical and financial risk. The choice of 100% full risk vs. 50% partial risk remains, with identical sharing rates, though LEAD may adjust some details like the Global discount and commitment period.
- **Core Payment Philosophy:** Both models move away from FFS by introducing population-based payments (capitations) and opportunities to earn savings on total cost of care. Primary Care Capitation, Total Care Capitation and advanced payments in REACH continue in LEAD with similar structures. The underlying goal is unchanged: give providers budget flexibility to deliver care in innovative ways (e.g., telehealth, care management) without being penalized for reducing volume.

- **Quality Incentives:** Both REACH and LEAD tie financial rewards to quality performance through a withhold-and-earn-back mechanism and offer additional bonuses for top-tier performers. The overall approach of balancing cost and quality accountability is consistent.
- **Regulatory Waivers:** As noted, LEAD will use HHS's waiver authority in much the same way as REACH did-protecting arrangements that meet model rules. For example, both models allow ACOs to provide approved in-kind beneficiary benefits like preventive care rewards and permit financial relationships, like shared savings distributions and provider performance bonuses, that would normally implicate the Stark Law or AKS. Participants in both models must still maintain robust compliance. Misuse of waivers or any program integrity lapses can lead to corrective action or termination from the model.

Preparing for the Transition

For ACOs and providers, the advent of LEAD is both an opportunity and a call to action:

- **Planning the Transition:** Current REACH participants should prepare their transition to LEAD now. CMS has made it relatively easy to carry over into the new model, whose abbreviated application is open through May 17, 2026, but there are still choices to make and applications to complete. For instance, consider whether to stick with the same risk track or move to Global (keeping in mind the 4-year lock-in if you start in the Professional track). Analyze how the removal of rebasing might affect your long-term financial projections-many REACH ACOs will find their benchmarks in LEAD are higher than they would have been in MSSP or a continued REACH scenario due to the no-rebasing policy and prior savings credit.
- **New to ACOs:** Provider organizations new to ACOs-especially physician groups, rural hospitals, FQHCs and specialty clinics-should take a fresh look at LEAD. The model directly addresses many past barriers such as lack of upfront capital and concern about high-cost patients, offering tools and protections to succeed. For example, a small rural ACO could receive the 1.5% benchmark add-on, face gentler trends if serving high-needs patients, and start in the Professional track to limit risk while still accessing capitation payments. These changes may make the difference between an untenable financial gamble and a feasible new revenue model focused on population health. These groups also offer a new demographic for ACOs to approach and work into the population health fold.

- **Specialists and Specialty-Focused Organizations (e.g., cardiology, oncology, nephrology groups):** As detailed in our second article in this series, LEAD creates tangible avenues for specialist providers to participate in value-based care without forming their own ACO from scratch. Specialists should reach out to ACOs in their region to discuss CARA episode arrangements or NPCC deals. For specialists who felt left out of REACH, LEAD might change that calculus by enabling them to contract with ACOs on more equal footing. This is particularly timely for specialists serving complex patients that ACOs will now be keen to enroll, like oncology practices managing high-cost therapies or nephrology groups caring for CKD/ESRD patients-if these areas are of relevance, see our upcoming fourth article.
- **Preparing for the May 17 Deadline:** All ACOs-whether coming from REACH, MSSP or newly formed-should review the RFA and prepare to apply by the May 17, 2026 deadline. Key steps include securing executive buy-in for a 10-year commitment, arranging the required 2-4% financial guarantee (which may be higher than what you had in REACH), and solidifying your provider network at the TIN level. If you intend to use new features like NPCC or Beneficiary Incentives, start drafting your strategy now since the application asks about the planned use of these options (though they are not binding). CMS will also evaluate each organization's compliance record and any past issues in programs like MSSP or REACH-a reminder to ensure your house is in order.
- **Letters of Interest:** If you are not ready for 2027 but are considering a later start, submit a non-binding LOI by April 20, 2026 to stay informed of future rounds. However, be aware that CMS may modify requirements for later cohorts, so delaying might mean a higher bar to clear. The safest bet for eligible organizations is to apply now for the first cohort to lock in the model's initial parameters.

LEAD is Innovation Center's ambitious effort to take the ACO movement to the next level. It seeks to provide long-term stability, equitable benchmarking and flexible payment tools that ACOs have been asking for, while doubling down on health equity and multi-payer integration to achieve broader system transformation. For health care providers, the transition from REACH to LEAD is more evolution than revolution-many principles remain the same, but the improvements address pain points that may have hindered progress. With the application period now open, ACOs should swiftly evaluate their readiness for LEAD, educate their teams on the new model options and decide how to position themselves for success in this new era of accountable care.

Related Development: CMS ACCESS Model Launches, First Applicants Accepted

In a related Innovation Center development, CMS announced that more than 150 leading health care organizations have been accepted to participate in the launch of the ACCESS (Advancing Chronic Care with Effective Scalable Solutions) Model. Most of these organizations have not previously served Medicare beneficiaries and will bring additional technology-supported care options to help people manage chronic conditions such as high blood pressure, diabetes, chronic pain and depression.

CMS is extending the initial ACCESS application deadline to May 15, 2026, so that more organizations can participate when it launches on July 5, 2026. Medicare enrollment is required for

participation but not for the initial ACCESS application. The voluntary ACCESS Model focuses on conditions affecting more than two-thirds of people with Medicare. All participating organizations must adhere to strict guardrails, including enrollment in Medicare Part B as providers or suppliers, compliance with licensure, data privacy and security standards, outcome-reporting, and other quality standards.

Notably, private payers representing 165 million members across Medicare Advantage, Medicaid and commercial coverage committed to align with the ACCESS Model's payment approach, with many beginning this year. The ACCESS Model is relevant context for ACOs evaluating the LEAD Model, particularly nephrology and chronic care-focused organizations, as both initiatives reflect CMS's broader push toward scalable, technology-enabled value-based care.

For more information, visit the CMS ACCESS Model webpage or email ACCESSModelTeam@cms.hhs.gov.

This client alert is the third in a four-part series on the Innovation Center LEAD Model. We will next dive deeper into nephrology-specific perspectives on LEAD (implications for CKD/ESRD care and how LEAD differs from kidney models like CKCC and the new ACCESS initiative).

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)

The Benesch Healthcare team monitors developments related to the LEAD Model and other Innovation Center 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.

read part 1
read part 2
read part 4

[1]Long-term Enhanced Accountable Care Organization Design (LEAD) Model Request for Applications, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 31, 2026), https://www.cms.gov/priorities/innovation/files/lead-rfa.pdf.

[2]Innovation Insight: CMS Invites ACOs to Apply to the New LEAD Model, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 31, 2026), https://www.cms.gov/priorities/innovation/innovation-insight-cms-invites-acos-apply-new-lead-model.

[3]Payment Factsheet for the Long-term Enhanced Accountable Care Organization Design (LEAD) Model, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/priorities/innovation/files/lead-payment-fs.pdf.

[4]CMS-Administered Risk Arrangements (CARA) Factsheet, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/priorities/innovation/files/lead-cara-fs.pdf.