CLIENT ALERTS & INSIGHTS

The LEAD Model-Kidney Care's Value-Based Care Journey LEADs Here

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Featured Practices: Healthcare, Dialysis, Nephrology & Vascular Access

Following our original publication on April 23, 2026, we have had numerous conversations with stakeholders, nephrology practices, industry associations and the Center for Medicare and Medicaid Innovation ("Innovation Center"), and reviewed additional guidance and publications set forth by the Innovation Center, including the Innovation Center's May 12, 2026 KCC Newsletter. Based on those conversations, it is clear that the Innovation Center is actively seeking input from nephrology practices, kidney care entities and other stakeholders regarding what elements should be carried forward-or improved upon-in any future kidney care model.

We are publishing this revised version of our article to reflect the insights gained from those discussions and engagements and to ensure that nephrology providers and kidney care organizations have the most current and accurate information available as they evaluate their options under the LEAD Model. We will continue to follow up with additional updates as further information becomes available.

Key Takeaways for Kidney Care Providers:

- LEAD is fundamentally a primary care-centered ACO model. Beneficiary alignment, quality measures and payment structures are built around primary care delivery-not specialty-driven attribution.
- The Comprehensive Kidney Care Contracting ("CKCC") model is scheduled to sunset at the end of 2027. Based on discussions with Innovation Center leadership, CMS is considering the development of a kidney-specific sister model to LEAD that will succeed CKCC and preserve nephrology-led accountability for kidney beneficiaries.
- Looking ahead, nephrology practices have two primary pathways: (i) joining a LEAD ACO as a Preferred Provider beginning in 2027, and (ii) participating in a potential kidney-specific sister model, should one be developed following CKCC's conclusion.
- CMS-Administered Risk Arrangements ("CARA") chronic condition bundles-where the primary kidney care opportunity sits-will be phased in over multiple years, not at model launch.
- Non-Primary Care Capitation ("NPCC") allows LEAD ACOs to pay nephrologists or dialysis providers a fixed monthly amount, but providers electing NPCC cannot simultaneously participate in CARA.

- A nephrology practice may serve as a Preferred Provider in a LEAD ACO and later transition into the kidney-specific sister model, but cannot be a Participant Provider in both models at the same time.
- CMS expects to offer additional LEAD application windows for future performance years; the May 17, 2026 deadline applies only to the initial cohort.

A Continuous Value-Based Kidney Care Journey

For more than a decade, nephrology practices have participated in Innovation Center kidney-focused models-beginning with ESRD Seamless Care Organizations ("ESCOs") under the Comprehensive ESRD Care ("CEC") Model (2015-2021), followed by today's Kidney Care Choices ("KCC") Model (2022-2027). With KCC scheduled to end in December 2027, kidney care providers are approaching a critical transition point. The Long-term Enhanced ACO Design ("LEAD") Model, for which CMS released the Request for Applications ("RFA") on March 31, 2026 (revised April 15, 2026), represents the next phase of CMS's value-based care strategy-but it differs fundamentally from the kidney-specific models that preceded it.

Unlike the CEC and KCC models, LEAD is not designed around kidney care. It is a broad, primary care-centered accountable care organization ("ACO") model that applies to all Medicare fee-for-service beneficiaries. Patients with chronic kidney disease ("CKD") or end-stage renal disease ("ESRD") are included in the general ACO population rather than segmented into a kidney-specific cohort. As a result, the role available to nephrology practices under LEAD-and the strategies required to participate successfully-look very different from what kidney care providers have experienced over the past decade.

Importantly, the Innovation Center has indicated that it is considering the development of a kidney-specific sister model to LEAD to succeed CKCC after 2027. CMS has clarified that it was not contemplating LEAD, in its current form, as a viable pathway for nephrology total cost of care risk. Instead, CMS sees value in continuing to build on the work from KCC, with a focus on nephrology-led care for beneficiaries with kidney disease. Any integration into LEAD would need to be customized in a way to blend many of the advances of LEAD with the design features of KCC. The Innovation Center is actively soliciting input from nephrology practices and kidney care organizations as it designs that successor model. In the interim, nephrology providers may participate in LEAD beginning January 1, 2027, most commonly by joining a LEAD ACO as a Preferred Provider.

A Critical Alignment Reality: LEAD is a Primary Care Model

Before evaluating LEAD as a pathway for kidney care participation, nephrology providers need to understand a core structural constraint: beneficiary alignment under LEAD is fundamentally driven by primary care relationships. The model's attribution rules strongly favor primary care providers ("PCPs"), which materially limits the ability of specialty practices to align patients independently.

LEAD uses a two-stage, claims-based alignment methodology based on Primary Care Qualified Evaluation and Management ("PQEM") services. In Stage 1, if 10% or more of a beneficiary's PQEM-allowable charges are billed by primary care specialties-such as family medicine, internal medicine, geriatrics, general practice or primary care nurse practitioners-the beneficiary is aligned

exclusively based on those primary care providers. Only in Stage 2, where less than 10% of PQEM charges are billed by primary care providers, does CMS consider certain non-primary care specialties for alignment, including nephrology (Specialty Code 39).

Equally important, the PQEM code set used for alignment consists of standard evaluation and management visits, preventive services, chronic care management and related HCPCS/CPT codes listed in Appendix C of the RFA. Monthly Capitation Payment ("MCP") codes for dialysis services are excluded. As a practical matter, this means dialysis patients will only be aligned to a LEAD ACO if they receive qualifying E&M services-such as an Annual Wellness Visit-from a PCP who is a Participant Provider in the ACO. A nephrology practice that primarily bills dialysis services will face significant challenges achieving the PQEM plurality required to align a meaningful patient population.

What does this mean in practice? Under the alignment rules as currently written, it would be extremely difficult-if not impractical-for a nephrology practice to form a standalone LEAD ACO and expect to align a critical mass of CKD or ESRD patients. The model simply does not support specialty-driven attribution in the way prior kidney-specific models did. That limitation, however, does not exclude nephrology practices from LEAD altogether. Instead, it shifts the most viable strategy toward partnership, particularly through serving as a Preferred Provider within an existing, primary care-led ACO where the nephrology practice contributes clinical expertise, care management capabilities and downstream cost-of-care improvement. Separately, a potential kidney-specific sister model under consideration by CMS would be expected to use kidney-appropriate alignment methodologies designed for nephrology-led organizations, restoring a more direct attribution pathway for kidney populations.

Pathways for Nephrology in LEAD

Although LEAD creates meaningful opportunities for specialty engagement, the Innovation Center has been clear that the model is not designed for nephrology practices to operate as stand-alone Participant Providers, given its PCP-driven attribution framework. As a result, the most practical role for most nephrology practices under LEAD is participation as a Preferred Provider. Participant Provider status generally makes sense only where a nephrology group is closely integrated with a robust primary care network capable of meeting PQEM alignment thresholds.

Preferred Provider Participation: Nephrology practices, dialysis facilities and transplant centers may join a LEAD ACO as Preferred Providers. This role does not require whole-TIN participation, is not used for beneficiary alignment and allows significant operational flexibility-including the ability to participate in multiple ACOs or Medicare models at the same time. As a Preferred Provider, a nephrology practice may participate in NPCC payment arrangements, share in ACO savings, access LEAD's fraud-and-abuse waivers, and eventually participate in CARA when applicable episodes become available. This flexibility is especially important for practices currently participating in CKCC. A nephrology practice may remain a CKCC Participant Provider through the model's final year while simultaneously joining a LEAD ACO as a Preferred Provider. The applicable non-duplication rules prohibit holding Participant Provider status in both models at the same time, but they do not prevent a practice from holding Preferred Provider status in LEAD while participating fully in CKCC. Once the kidney-specific sister model launches, a nephrology practice could likewise serve as a Preferred Provider in a general LEAD ACO while participating as a Participant Provider in the kidney-specific model.

Participant Provider Within a Broader ACO: Participation as a LEAD Participant Provider requires whole-TIN inclusion, mandatory capitation and exclusivity from other shared savings programs. Because LEAD's alignment methodology prioritizes primary care, nephrology practices should generally avoid Participant Provider status unless they own, employ or are deeply integrated with a primary care platform that can reliably drive PQEM-based alignment for CKD and ESRD patients.

Non-Duplication Considerations: A nephrology practice cannot be a Participant Provider in both LEAD and the KCC Model at the same time. Accordingly, a CKCC Participant Provider seeking Participant Provider status in a LEAD ACO beginning in PY 2027 would need to disenroll from CKCC in its final year. In contrast, a nephrology practice that wishes to remain in CKCC through December 2027 can still participate in LEAD as a Preferred Provider and then transition to the kidney-specific sister model once it becomes available.

Non-Primary Care Capitation

One of LEAD's most significant-and most relevant-features for nephrology practices is Non-Primary Care Capitation. NPCC is a new payment option under LEAD that was not available in ACO REACH. It permits a LEAD ACO that has elected Primary Care Capitation ("PCC") to extend prospective capitation to specialty services through sub-capitation arrangements with non-primary care providers.

Under NPCC, CMS converts the portion of the ACO's benchmark attributable to services furnished by the specialty provider into a prospective, per-beneficiary per-month payment, which the ACO then pays downstream to the specialty group. In exchange, the specialty provider agrees to be accountable for the cost and quality of that category of care. Importantly, NPCC is true prospective capitation: the payment is not reconciled against actual fee-for-service spending, and the ACO bears the upside and downside risk associated with the capitation amount.

For nephrology practices, NPCC allows a LEAD ACO to pay a fixed monthly amount covering all contracted nephrology or dialysis services for aligned beneficiaries. This structure creates predictable revenue and supports greater flexibility in care delivery-such as integrating telehealth, patient education, care coordination and remote monitoring-without reliance on visit-driven fee-for-service incentives. In this respect, NPCC mirrors sub-capitated arrangements commonly used in Medicare Advantage, bringing similar flexibility into Original Medicare.

The NPCC payment amount is calculated by CMS based on the specialty provider's historical claims, expressed as a percentage of the ACO's total benchmark. The ACO selects a claims reduction percentage, ranging from 1% to 100%, for NPCC-participating services. CMS continues to pay any non-reduced portion of claims under standard fee-for-service rules, while the reduced portion is incorporated into the NPCC payment stream.

Participation rules vary by risk track. Under the Global Risk Option, non-primary care providers in Participant TINs may elect NPCC or the Advanced Payment Option ("APO"), and Preferred Providers may elect PCC, NPCC or both. Under the Professional Risk Option, non-primary care Participant Providers may elect NPCC or APO, and Preferred Providers may elect PCC, NPCC or APO-but may not combine PCC with NPCC or APO.

Critical Limitation:

NPCC and CARA Are mutually xeclusive. Specialty providers that elect NPCC or APO may not participate in CARA, as concurrent participation would interfere with CMS's ability to administer episode-based reconciliation. As a result, nephrology practices must make a strategic choice between the predictable, monthly revenue of NPCC and the episodic upside potential of CARA. The two cannot be used simultaneously.

CMS-Administered Risk Arrangements

CMS-Administered Risk Arrangements are a voluntary, episode-based risk option available within LEAD for ACOs that elect the Global Risk Option. CARA is designed to increase specialty-provider accountability for quality and cost through CMS-administered episode-based risk arrangements ("EBRAs"). Participation is limited to Preferred Providers; Participant TINs are not eligible to participate in CARA.

Within the Innovation Center, CARA operates as a distinct initiative nested inside LEAD. Its structure signals CMS's broader interest in testing whether centrally administered, specialty-focused episodes can scale across multiple value-based models. CARA builds on CMS's existing "shadow bundles" work, which has supplied episode-level analytics-using BPCI Advanced methodology-to ACOs in ACO REACH, the Shared Savings Program and the KCC Model.

Episode Categories and Timing. CARA includes three categories of episodes: (i) acute inpatient medical conditions, (i) procedural episodes and (iii) chronic condition episodes. CMS plans to launch CARA with acute medical and procedural episodes, while chronic condition episodes will be phased in after launch. Episode triggering begins on January 1, 2028.

For kidney care providers, the most relevant CARA episodes fall within the chronic condition and procedural categories, including:

- Chronic kidney disease
- End-stage renal disease
- Kidney transplant management
- Vascular access and renal procedures, such as hemodialysis access creation and acute kidney injury requiring new inpatient dialysis

Because CKD and ESRD episodes are classified as chronic condition episodes, they will not be available when CARA launches in 2028. Based on the RFA language indicating that chronic condition EBCMs will be "phased in early in the initiative," and on discussions with CMS leadership, a realistic timeline for kidney-focused chronic condition bundles is likely three to five years after model launch, placing availability around 2030-2032. Procedural bundles-such as vascular access-may become available earlier.

How CARA Works: CARA functions as a nested episode bundle within a longitudinal total-cost-of-care model. Each episode has a defined trigger, episode window, attributed costs and associated quality measures. CMS prices episodes using established EBCM methodology and provides target price reports to LEAD ACOs. The ACO then uses this information to negotiate episode-based arrangements with Preferred Providers.

Importantly, CMS administers the episode mechanics-including pricing, reconciliation and payment-centrally. The specialist's role is limited to negotiating commercial terms with the ACO. Under the finalized arrangement, if a Preferred Provider's Medicare fee-for-service payments fall below the episode target price, the provider may receive a reconciliation payment; if spending exceeds the target, the provider may owe a repayment. Episode parameters, including quality thresholds and risk corridors, are negotiated between the ACO and the Preferred Provider and submitted to CMS for approval and administration through the CMS platform.

The CEC-KCC-LEAD Evolution

The Comprehensive ESRD Care Model (2015-2021) was CMS's first specialty-focused ACO model. Under CEC, dialysis providers and nephrologists formed ESRD Seamless Care Organizations to manage patients receiving dialysis. While the model achieved measurable clinical improvements-including reduced hospitalizations and better dialysis-related care-it ultimately failed to generate net Medicare savings. Although gross spending declined by nearly 2%, those reductions were more than offset by incentive payments. The key takeaway from CEC was clear: specialty-led ACOs can improve outcomes, but without the right financial architecture, clinical success alone does not translate into program sustainability.

CMS launched the Kidney Care Choices Model in 2022 to address those shortcomings. KCC included two tracks. Kidney Care First paid nephrologists capitated amounts to manage patients with CKD Stages 4 and 5 and ESRD, along with a $15,000 transplant bonus. The Comprehensive Kidney Care Contracting track allowed Kidney Contracting Entities ("KCEs") to assume responsibility for total cost of care under graduated, professional or global risk arrangements. Unlike CEC, CKCC required nephrologist and transplant provider participation, supported broader provider networks and used separate benchmarks for CKD and ESRD populations.

Early results under KCC were mixed but instructive. CMS's initial evaluation found no statistically significant Medicare savings in the first performance year, but several kidney-specific clinical metrics improved meaningfully. Optimal dialysis starts increased by approximately 16%, home dialysis utilization rose by 22-32%, and transplant wait-listing increased by roughly 15%. In response to financial underperformance, CMS reduced CKD capitation payments, eliminated the transplant bonus after 2025, and discontinued the Kidney Care First track due to lower-than-expected participation and losses. CMS extended KCC through December 2027 to allow participants time to transition and to enable development of a successor model.

That transition is now underway. CMS extended KCC in part to finalize LEAD and to explore a kidney-specific sister model that would follow CKCC's conclusion. Innovation Center leadership has consistently emphasized that LEAD is not intended to replace kidney-focused value-based care. As noted above, CMS has been clear that any kidney-specific model would need to be customized to blend the advances of LEAD with the design features of KCC, preserving nephrology-led care for beneficiaries with kidney disease. Until that model takes shape, participation in LEAD as a Preferred Provider serves as a practical bridge for 2027.

Opportunities Within LEAD for Kidney Care Providers

Although LEAD is not a kidney-specific model, it includes several structural features that-if used thoughtfully-can create meaningful opportunities for nephrology practices that participate strategically.

Flexibility for High-Needs and ESRD-Heavy ACOs: LEAD allows ACOs with a high concentration of medically complex patients to operate at smaller minimum sizes. Specifically, an ACO in which more than 40% of aligned beneficiaries qualify as High Needs-including ESRD patients, frail beneficiaries or dual-eligible individuals-may begin participation with as few as 800 aligned beneficiaries in Performance Year 1, increasing to 1,600 by Performance Year 5. While this flexibility does not resolve the primary care-driven alignment limitation for standalone nephrology practices, it does make it more feasible for primary care groups partnering closely with nephrologists to form smaller, kidney-focused ACOs with substantial ESRD populations.

Ten-Year Benchmark Stability: LEAD's ten-year model period (2027-2036), with no rebasing during that timeframe, provides long-term financial visibility that prior kidney models lacked. Under CEC and KCC, year-over-year success often reduced future earning potential through benchmark resets. LEAD eliminates that dynamic. For kidney care providers, this means that investments in upstream CKD management, home dialysis and care coordination can generate value over a full decade rather than being penalized in subsequent years.

Separate ESRD Benchmarks and Risk Adjustment: LEAD establishes separate per-beneficiary benchmarks for Aged & Disabled, ESRD, and High-Needs beneficiaries. ESRD patients are risk adjusted using the 2023 ESRD CMS-HCC risk adjustment model. This structure reduces the risk that ACOs will be financially penalized for caring for high-cost dialysis populations and makes inclusion of ESRD patients more economically viable within a general ACO.

1.5% Administrative Add-On: LEAD provides a non-repayable administrative add-on equal to 1.5% of the ACO's total benchmark for higher-spending ACOs-defined as those whose average beneficiary expenditures exceed regional Medicare fee-for-service spending. This add-on is excluded from performance-year expenditure calculations and is not subject to repayment, functioning instead as an adjustment to support infrastructure and care management investments. ACOs with meaningful ESRD populations are more likely to qualify as higher-spending organizations, making this add-on particularly relevant for kidney-focused partnerships.

Fraud and Abuse Waivers: LEAD includes access to Innovation Center fraud-and-abuse waivers, including protections under the CMS-sponsored model arrangement safe harbor. These waivers can protect appropriately structured financial relationships among ACOs, Participant Providers, Preferred Providers and beneficiaries, and enable the sharing of savings and funding of patient-focused interventions that would otherwise raise compliance concerns under the Anti-Kickback Statute.

Beneficiary Engagement Incentives: LEAD introduces several beneficiary engagement tools that can support kidney care delivery. These include Part B cost-sharing support, which may be used to reduce or eliminate beneficiary cost-sharing for selected services; incentives tied to participation in evidence-based chronic disease prevention programs; and a potential Part D premium buydown beginning in 2029 to support medication adherence. Used thoughtfully, these tools can help address

adherence, access and engagement challenges common among advanced CKD and ESRD populations.

Medicare-Medicaid Integration: Because many ESRD patients are dually eligible, LEAD's Medicare-Medicaid integration pilot is particularly relevant for kidney care providers. The pilot-currently limited to two states-includes a planning phase from March 2026 through December 2027 and is intended to test frameworks for data sharing, care coordination and potential alignment of incentives between Medicare ACOs and state Medicaid agencies or managed care organizations.

Challenges for Nephrology Providers

One of the most immediate challenges nephrology practices will encounter under LEAD is that the model's core quality measures are not kidney-specific. LEAD relies on five claims-based and CAHPS measures carried over from ACO REACH, along with two new electronic clinical quality measures focused on blood pressure control and diabetes glycemic status. These measures address conditions nephrologists manage every day-and hypertension and diabetes remain the leading drivers of CKD-but they do not directly capture the kidney-specific outcomes most meaningful to nephrology practices, such as transplant rates, home dialysis utilization or optimal dialysis starts. As a result, nephrology practices participating in LEAD will need to actively advocate for kidney-focused priorities within the ACO, including through NPCC arrangements, episode-based contracts, or shared savings distribution methodologies, rather than relying on LEAD's core quality framework to do that work automatically.

LEAD also does not include CKD-specific capitation payments or a direct transplant bonus, both of which were central features of KCC. Their absence shifts more responsibility to nephrology practices and ACO partners to structure internal financial incentives that reward desired kidney-care outcomes. While this provides greater flexibility in design, it also means that incentives must be deliberately negotiated-nothing is "built in."

For dialysis providers, particularly those involved in joint-venture clinic structures, LEAD may introduce real financial tension. Many of the care improvements that reduce total cost of care-greater home dialysis adoption, increased transplant access and stronger upstream CKD management-may also reduce in-center dialysis volume. That dynamic makes careful economic alignment essential. Physician groups, dialysis operators and ACO partners will need to ensure that financial arrangements reward improved outcomes rather than reinforcing legacy volume incentives.

Finally, the mutual exclusivity between NPCC and CARA presents a strategic decision point. Nephrology practices cannot participate in both arrangements simultaneously. NPCC offers stability and predictability through prospective capitation, while CARA offers episodic upside tied to performance-but kidney-specific chronic condition episodes are likely several years away. For most practices, NPCC will be the more practical near-term option, with CARA becoming more relevant once CKD and ESRD chronic condition episodes are finalized and available.

The Future of Kidney-Specific Value-Based Care

The next phase of kidney-specific value-based care is beginning to take shape. The Innovation Center has indicated that it is considering the development of a kidney-specific sister model to LEAD to follow CKCC's sunset at the end of 2027 and is actively seeking input from nephrology stakeholders on its design. Several consistent themes have emerged from CMS communications and stakeholder discussions.

- First, LEAD is not intended to function as the primary model for kidney patients. Instead, any kidney-specific model under consideration would operate as a separate, parallel initiative designed specifically for nephrology-led organizations and kidney beneficiaries. While LEAD may serve as a bridge, CMS does not intend to force kidney populations into a primary-care attribution framework long term.
- Second, CMS has indicated that any sister model would likely carry forward selected LEAD features-including benchmark stability, multiyear loss spreading and capitation-while adapting them to the realities of kidney care delivery. Unlike LEAD, a kidney-specific model would be expected to use kidney-appropriate alignment methodologies, kidney-focused quality measures and payment structures that place nephrologists at the center of accountability.
- Third, stakeholders have been clear-and CMS appears receptive-that kidney-specific quality metrics matter. Feedback consistently emphasized that CKCC's kidney-focused measures more accurately reflected clinical performance and outcomes than general ACO quality metrics. Comparable kidney-specific measures are expected to play a central role in the successor model.

Taken together, these signals point to a durable two-track strategy for nephrology practices. In the near term, practices should view LEAD Preferred Provider participation as a transitional opportunity, not a replacement for kidney-specific value-based care. Over the longer term, nephrologists should prepare to participate directly in a kidney-focused successor model-should one be developed-that restores nephrology-led attribution and accountability while incorporating the financial lessons learned from prior Innovation Center models. These observations reflect ongoing discussions with Innovation Center leadership and stakeholders and are provided for planning purposes, not as formal regulatory guidance.

Seizing the Future

As nephrology providers plan their next steps, several strategic priorities stand out:

Assess Your Current Position: With CKCC ending in 2027 and a kidney-specific successor model under consideration, most nephrology practices should pursue a dual strategy: enter LEAD as a Preferred Provider where feasible and prepare for participation in the kidney-specific model at launch. Given LEAD's primary care-driven attribution structure, standalone nephrology ACO participation is not practical under the current RFA. CMS has indicated that additional LEAD application windows are expected beyond the initial May 17, 2026 deadline.

- *Next Steps:* Begin identifying LEAD ACOs forming in your market-particularly those anchored by strong primary care networks-and initiate discussions regarding Preferred Provider participation. Practices currently participating in CKCC may join a LEAD ACO as a Preferred Provider while remaining a CKCC Participant Provider through the model's final year.

Consider Preferred Provider Status as the Default Entry Point: For most nephrology practices, Preferred Provider participation offers the most balanced and flexible way to engage with LEAD. It provides access to NPCC capitation, shared savings, beneficiary engagement tools and-over time-CARA opportunities, without requiring whole-TIN participation or limiting participation in a potential kidney-specific model. Preferred Provider status also preserves optionality: practices can participate, gain experience with LEAD infrastructure and reassess their level of commitment as the model evolves.

- *Next Steps:* Develop a Nephrology-focused term sheet for potential LEAD partners that outlines expected NPCC rates for CKD and ESRD populations, governance and data-sharing rights, care management responsibilities, and a roadmap for transitioning to episode-based CARA arrangements once kidney-specific bundles become available.

Plan for NPCC or CARA-Not Both: Because NPCC and CARA are mutually exclusive, nephrology practices should make a deliberate strategic choice. NPCC provides immediate, predictable revenue and operational flexibility. CARA offers performance-based upside but will not include CKD or ESRD chronic condition episodes for several years and requires Global Risk participation at the ACO level.

- *Next Steps:* For most practices, NPCC will be the more practical option in the near term (PY 2027-2029), with a potential shift to CARA once kidney-specific episodes are finalized. Practices should nonetheless begin tracking episode-level utilization and cost data now to prepare for future CARA negotiations.

Use LEAD's Flexibilities to Sustain Kidney Care Innovation: Participation in prior Innovation Center models drove meaningful advances in home dialysis adoption, care coordination and outpatient management. LEAD's long-time horizon and payment flexibility provide an opportunity to continue-and scale-those investments.

- *Next Steps:* Build on lessons learned under CEC and KCC by strengthening home dialysis programs, structured CKD clinics and remote monitoring infrastructure. NPCC payments can help finance telehealth, education and proactive outreach. Establish internal performance targets-such as sustained home dialysis rates or reductions in unplanned hospitalizations-even where those outcomes are not directly reflected in LEAD's core quality metrics.

Re-Center Transplant Strategy: Although KCC's transplant bonus has ended, LEAD's ten-year duration increases the likelihood that ACOs can realize the long-term cost savings associated with successful transplantation.

- *Next Steps:* Formalize transplant referral protocols, define expected timeframes for evaluation and wait-listing, and consider gainsharing arrangements tied to transplant-related milestones. These incentives can be embedded within shared savings methodologies to ensure transplant-related value is recognized.

Address Social Determinants of Health: LEAD allows ACOs to offer beneficiary engagement incentives including Part B cost sharing support, chronic disease prevention incentives and potentially Part D premium support.

- *Next Steps:* Implement routine screening for social determinants of health and develop targeted interventions-such as transportation assistance, nutrition support or behavioral health integration-aligned with measurable reductions in emergency department use and inpatient admissions.

Monitor ACCESS as a Complementary Tool: LEAD ACOs may participate in the Advancing Chronic Care with Effective Scalable Solutions ("ACCESS") Model, including the cardio-kidney-metabolic track.

- *Next Steps:* Evaluate whether ACCESS participation, alongside LEAD Preferred Provider status, can create a more comprehensive continuum of care-addressing early-stage CKD through ACCESS and advanced CKD and ESRD through LEAD NPCC or future CARA arrangements.

Conclusion and Next Steps for Kidney Care Providers

Bottom line: Nephrology practices face two clear and complementary pathways. First, LEAD offers an immediate opportunity to engage in value-based care beginning in 2027 through Preferred Provider participation, providing access to NPCC, shared savings, beneficiary engagement tools and-over time-CARA. Second, CMS is considering the development of a kidney-specific sister model that would restore nephrology-led accountability through kidney-tailored alignment, quality measures and payment structures following CKCC's sunset.

In practical terms, nephrology practices should be focused on several near-term priorities. These include identifying LEAD ACOs forming in their markets and initiating conversations about Preferred Provider arrangements-whether for the May 17, 2026, initial cohort or subsequent application windows. Practices currently participating in CKCC should consider maintaining Participant Provider status through the model's final year while simultaneously joining a LEAD ACO as a Preferred Provider. Practices should also begin developing NPCC term sheets that clearly define required capitation rates, governance and data access rights, and care management responsibilities. Reviewing internal performance data from CEC and KCC can help identify where prior initiatives drove value and where cost pressures emerged. Finally, nephrology practices should actively engage with CMS and industry associations to inform the design of the kidney-specific successor model-the Innovation Center has made clear that stakeholder input will shape the next phase of kidney value-based care.

LEAD is best understood as a bridge, not an endpoint. Nephrology practices that establish strong Preferred Provider positions now will be better positioned to navigate the transition from CKCC and

to participate meaningfully in the kidney-specific model when it launches. We will continue to monitor developments and provide updates as additional guidance becomes available.

Key CMS Resources-LEAD Model

- 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: CMS Bets on the Long Game with 10-Year LEAD ACO Model

Read Part 2: CMS Puts Specialists in the Game with LEAD

Read Part 3: LEAD vs. ACO REACH-What's Changing and Why the LEAD Model Matters for ACOs and Participating Providers

Read Part 4: The LEAD Model-Kidney Care’s Value-Based Care Journey LEADs Here