CMS INNOVATION CENTER · JANUARY 1, 2027 TO DECEMBER 31, 2036

LEAD

What the new Medicare ACO model means for a nursing facility.

Who the ACO is. Why a resident acknowledges rather than enrolls. How the payout runs. Why your Medicare claims keep paying. Then seven questions a facility will ask.

A ten-year agreement with CMS.

On January 1, 2027, CMS starts the Long-term Enhanced ACO Design Model, called LEAD, and it runs through December 31, 2036. It replaces ACO REACH, which ends December 31, 2026. An ACO in LEAD agrees to be measured on total Part A and Part B spending, and on quality, for a defined group of Original Medicare beneficiaries.

One benchmark. No rebasing.

CMS builds a benchmark from three base years, which for a 2027 start are 2024, 2025, and 2026, trends it forward, adjusts it for how sick the population is, and applies no traditional rebasing at any point in the ten years. Spend under the benchmark and the ACO shares the savings. Spend over it and the ACO shares the loss.

Two ways to hold the risk.

100%
GLOBAL

50%
PROFESSIONAL

There are two risk options. Global carries up to 100 percent of savings and losses, after CMS takes a discount of 1.75 to 3 percent off the benchmark. Professional carries up to 50 percent of each, with no discount.

The facility is usually not the ACO.

Most nursing facilities will not be the ACO. The ACO is the entity that holds the agreement with CMS, posts the financial guarantee, and alone owes CMS for any losses. When a facility joins through a company that runs the clinical and operational side, the facility's relationship is a contract with that company.

Participant TIN or Preferred Provider.

CMS recognizes two kinds of provider inside an ACO. A Participant TIN drives which beneficiaries are aligned, reports quality, must accept capitation, and joins as a whole TIN. A Preferred Provider does none of that, may take capitation or decline it, and is still eligible for shared savings. CMS names post-acute facilities as the typical Preferred Provider.

How a resident gets counted.

Alignment runs on primary care visits billed under a Participant TIN, and nurse practitioners and physician assistants count as primary care for that purpose. One rule is specific to us. CMS drops nursing facility visit codes 99304 through 99318 from the alignment count whenever the visit overlaps a SNF facility claim. A resident on a Part A skilled stay does not align through those visits. A long-stay resident can.

No resident enrolls in anything.

LEAD is not a health plan and it has no network. The resident's Medicare benefits stay exactly as they are, including the right to see any provider who accepts Medicare. Alignment happens one of two ways. CMS can align a resident from claims history, with no signature at all. Or the resident can choose a clinician affiliated with the ACO as their primary source of care, which is done on a signed voluntary alignment form.

The signature acknowledges a relationship that already exists.

CMS allows it in a care setting, or at home where the relationship with the clinician predates the ask. Beneficiary notification letters carry over from ACO REACH, and outreach may explain alignment but may not steer a resident's choice of Medicare coverage or insurance product.

The forms are being collected now.

ACOs accepted for 2027 are collecting these forms now, in the optional implementation period that opened September 15 and closes December 31, 2026. Under hybrid alignment, new voluntary alignments are picked up monthly during the year.

Money moves at final settlement.

Money moves after the performance year closes, at what CMS calls final settlement. CMS compares actual Part A and B spending on the aligned residents to the benchmark. Three percent of the benchmark sits at risk for quality and is earned back on performance, though nothing is withheld from payments during the year.

CMS's own worked example.

$102M
BENCHMARK

4.5%
SAVED

$2M
TO THE ACO

An ACO with a $102 million benchmark saves 4.5 percent, earns back 80 percent of the quality withhold, sits in Professional at 50 percent, and receives about $2 million. The same year under Global, after a 1.75 percent discount, pays about $2.2 million.

CMS pays the ACO. The ACO pays you.

The ACO then pays its providers under their contracts, so a facility's share is a contract term and not a CMS rule. Losses run the same direction. But the ACO alone owes CMS, and CMS requires it to pass at least 1 percent of total downside, on average, to its Participant TINs. Whether any of that reaches a facility is again the contract.

None of this touches the claim.

Participant and Preferred Providers keep billing Medicare as usual. If the ACO elects capitation, CMS reduces the fee-for-service payment on affected claims by a percentage the ACO selects, anywhere from 1 to 100 percent, and pays the ACO a monthly amount in its place. Some reduction is mandatory for Participant Providers. It is optional for Preferred Providers.

No fee reduction, no change.

A facility that does not agree to a fee reduction is paid by Medicare on every Part A and Part B claim the same as today, and shared savings arrive later as a separate payment. In CMS's example of a health system ACO, the preferred post-acute providers took a 60 percent fee reduction. Read your agreement for that clause before any other.

FAQ

Seven questions a facility will ask before it signs.

FAQ · ONE

Can a resident say no?

Yes. Voluntary alignment is a choice, and alignment of either kind never limits where the resident gets care. Where an ACO REACH form carries into LEAD, the ACO must send notice with instructions for opting out.

FAQ · TWO

Does the resident pay more, and what do they get?

Nothing more. One LEAD ACO lists the three-day SNF stay waiver, the home health homebound waiver, concurrent hospice care, expanded telehealth, and care management among its resident features. CMS adds expanded Medical Nutrition Therapy for full-risk ACOs and a Part D premium buydown by 2029, and each ACO chooses which enhancements to run.

FAQ · THREE

Can we be in LEAD and the Shared Savings Program together?

Not as a Participant TIN. CMS bars a Participant TIN from sitting in LEAD and in the Shared Savings Program, ACO PC Flex, or Kidney Care Choices at once. Overlap with GUIDE and TEAM is allowed.

FAQ · FOUR

How large must the ACO be?

Five thousand aligned beneficiaries in year one. A newly entering ACO needs 1,000. An ACO whose population is more than 40 percent High Needs needs 800, which is the door most facility-based ACOs will walk through. High Needs beneficiaries are risk adjusted on diagnoses from the current year instead of the prior one.

FAQ · FIVE

What is measured?

Unplanned admissions for adults with multiple chronic conditions, days at home, timely follow-up after acute events, and a CAHPS survey. Two electronic measures, diabetes and blood pressure control, are optional to report in 2027 and 2028.

FAQ · SIX

What if it goes badly?

The ACO may leave at any time. Leaving after one year costs it a 2 percent benchmark reduction at that year's settlement, and for 2027 it can withdraw without liability by notifying CMS on or before February 28, 2027. A facility's own exit terms are in its contract.

FAQ · SEVEN

We missed May 17. Are we out?

CMS expects future application cycles and has given no dates. A facility does not apply, though. The ACO does. Participant TIN lists for 2027 closed on September 8, 2026, and ACOs using hybrid alignment get one chance to add TINs during the year, with those beneficiaries effective April 1.

The facility's own Part A claims for aligned residents sit inside the spending total the ACO is paid to bring down. A facility that signs is betting that fewer hospital transfers, the ability to skill in place, and a share of the savings are worth more than the skilled days it may give up.

Put a number on that bet before anyone signs.

SOURCES

Where every figure in this deck comes from.

CMS, LEAD Model Frequently Asked Questions
cms.gov/priorities/innovation/lead-model-frequently-asked-questions

CMS, LEAD Model Technical FAQs, August 17, 2026
cms.gov/priorities/innovation/files/lead-tech-faqs.pdf

CMS, LEAD Model Payment Factsheet
cms.gov/priorities/innovation/files/lead-payment-fs.pdf

America's LEAD, Frequently Asked Questions
americaslead.com/faq

Mabel, The CMS LEAD Model: What ACOs Need to Know
getmabel.com/blog/cms-lead-model

MedVision, The CMS ACO LEAD Model: 8 Readiness Questions
medvision-solutions.com/blog/key-questions-for-acos-preparing-for-cms-lead-model

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