Beyond the Model: How Leading Organizations Will Win Under CMS LEAD RFA

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Educational Webinar Series

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Milliman **MedInsight**

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Agenda

- **What's New in LEAD**
  - What's in the RFA and how does it compare to MSSP/REACH?
  - How to decide which model is best for your ACO?

- **Driving Success Through Analytics**
  - Financial Analytics
  - Designing Program Initiatives
  - Operationalizing Initiatives

Poll 1: Which best describes your ACO?

- Integrated Delivery Systems/Hospital-Led
- Physician-Driven/Multispecialty Group
- High Needs, High Complexity Patient-Focused
- FQHC/RHC-Led
- Aggregators/Virtual Physician Organizations

Poll 2: Where is your organization today with CMS ACO models?

- Currently in ACO REACH
- Currently in MSSP
- Previously participated (MSSP / REACH / other CMS ACO model)
- Not currently in a CMS ACO model
- Other

What's New in LEAD

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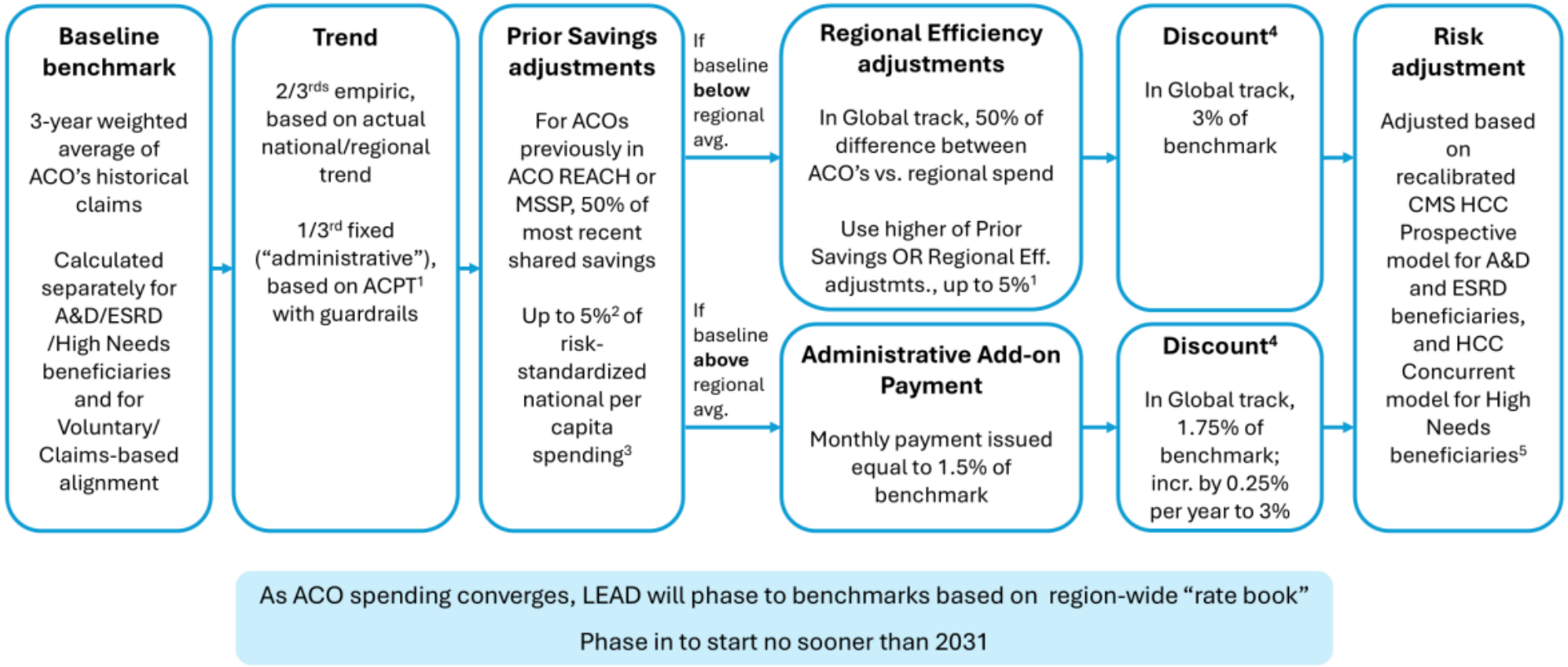
Building the Performance Year Benchmark: CMS's RFA Overview

Figure 2. LEAD Benchmarking Approach



Source: CMS LEAD RFA, Section VIII, Figure 2

ACO Model Comparison: Key Parameters

	MSSP	LEAD	DC/REACH
Duration	5 Year Agreement Periods (rebasing available)	10 Years (no rebasing – transition to Ratebook after 5 years)	6 Years (2021-2026) (no rebasing)
Risk Tracks/ Savings Rates	*BASIC A/B* – 40% Savings, 0% Loss *BASIC C/D/E* – 50% Savings, 30% Loss *ENHANCED* – 75% Savings, 40% Loss	*Professional* – 50% Savings/Loss *Global* – 100% Savings/Loss including Discount on benchmark (1.75% - 3% depending on regional efficiency and performance year)	*Professional* – 50% Savings/Loss *Global* – 100% Savings/Loss including Discount on benchmark (2% - 4% over time)
Provider Level	TIN level	TIN level	TIN-NPI level
Attribution	1yr Prospective Claims-Based (1yr) or 1yr Retrospective Claims-Based	1yr Prospective Claims-Based Only or 1yr Prospective Claims-Based + Voluntary (Hybrid) *Hybrid alignment will offer the ability to add TINs mid-year*	2yr Prospective Claims-Based + Voluntary
Benchmark Cohorts	ESRD Disabled Aged Dual Aged Non-Dual	ESRD High Needs Aged & Disabled	ESRD Aged & Disabled

How Much Is No Rebasing Actually Worth?

No rebasing means your population health investments and care coordination programs don't penalize your future benchmark.

MSSP ACOs

Unless you are rebasing in 2027, staying in MSSP means you will rebase twice over the 10-year LEAD period.

Each rebase resets your benchmark to actual costs (with ~50% mitigation via prior savings or regional adjustment), meaning any efficiency you've achieved becomes the go-forward expectation.

LEAD eliminates that second rebase entirely.

REACH ACOs

LEAD offers a continuation path.

Prior Savings Adjustment:

LEAD credits your prior 3 years of per-capita savings into your new benchmark if higher than regional efficiency adjustment. This could be particularly meaningful for high-spending REACH ACOs.

Leaving for MSSP in 2028 or beyond means:

- You forfeit the Prior Savings Adjustment
- Additional benchmark rebase over the 10-year LEAD period

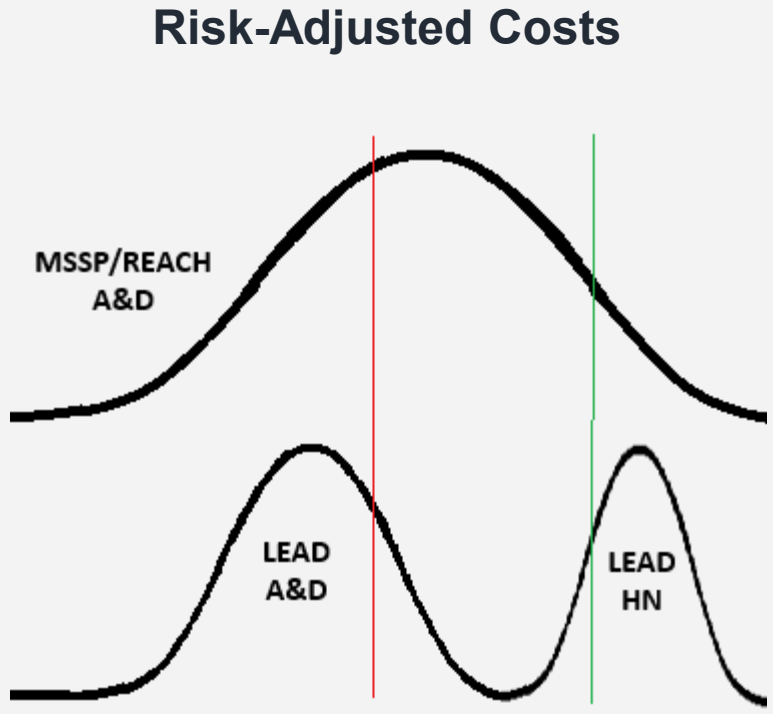
But is it really no rebasing?

Or is it no ACO-specific rebasing for 5+ years - with a regional convergence mechanism waiting at the end? We'll come back to that.

Source: CMS LEAD RFA, Section VIII.A–B

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

- A&D risk pool gets healthier: average risk score drops, spending variance compresses
- Your ACO's A&D regional efficiency could change completely
  - Not necessarily aligned with historical MSSP/REACH
- Specialists who looked inefficient against a mixed A&D pool may actually be regionally efficient when split across A&D/High Needs
  - The historical understanding that high-cost specialists underperform is potentially out the window
- PCPs who looked efficiency historically may now be inefficient



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

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

Lower-Spending ACOs (Global Risk Only):

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

CMS is saying:

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

Higher-Spending ACOs:

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

CMS is saying:

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

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

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

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

Source: CMS LEAD RFA, Section VIII.B

The ACPT Guardrails Tell You What CMS Expects

The guardrails compare the three-way blend to the two-way blend trend methods.

The ACPT is the “third leg” designed to ease the ratchet effect: when ACOs collectively slow spending below projections, benchmarks rise above actual spending, creating savings for everyone. It doesn’t eliminate the ratchet, but it adds a counterweight.

But CMS capped it with guardrails. Look at the asymmetry:

Performance Year	PY 1 (2027)	PY 2 (2028)	PY 3 (2029)	PY 4 (2030)	PY 5 (2031)
Upper Bound	+0.3%	+0.6%	+0.9%	+1.2%	+1.5%
Lower Bound	−0.2%	−0.4%	−0.6%	−0.8%	−1.0%

The upside widens faster (+0.3%/yr) than the downside (−0.2%/yr). Over time, the expected value tilts toward ACOs. This is intentional - CMS needs participation.

Something we will be watching:

45% of Original Medicare beneficiaries are already aligned to an ACO. LEAD's goal is to grow that number - making regional and national trends more competitive over time. Overall market dynamics may matter more than the ACPT itself.

Source: CMS LEAD RFA, Section VIII.C - 45% alignment stat from RFA p. 11

What the Rate Book Means for Your ACO

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

Lower-Spending ACOs:

Convergence works in your favor.

Today you get 50% of the gap via the Regional Efficiency Adjustment. The rate book closes the remaining distance - your benchmark moves up toward the regional sta

The better you are relative to the region today, the more the rate book rewards you long-term.

Higher-Spending ACOs:

Convergence is the end of the runway.

Your benchmark moves down toward the regional standard. The value of LEAD was the time: ramped discount, 1.5% add-on, no rebasing. The rate book is what that time was for.

The question isn't whether convergence happens - it's whether you used the runway to transform your cost structure.

Three areas where implementation details will shape the outcome:

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

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

Source: CMS LEAD RFA, Section VIII.G

Major Decision Points When Weighing MSSP vs. LEAD

1. How does your organization value the stability of MSSP/CMS vs. the potential volatility of CMMI/LEAD?

2. Does the shift in the approach to the High Needs population change the projected performance of your ACO?

3. How valuable are the capitation mechanisms and additional cash flow offered in LEAD?

4. Is your projected performance high enough to outweigh the discount in the global track vs. Enhanced MSSP model?

Key Financial Analytics

Forecast estimated LEAD and MSSP performance

Provider assessment (TINs)

Utilization analytics to identify opportunities

Specialty assessment by clinical area (CARA)

Driving Success Through Analytics

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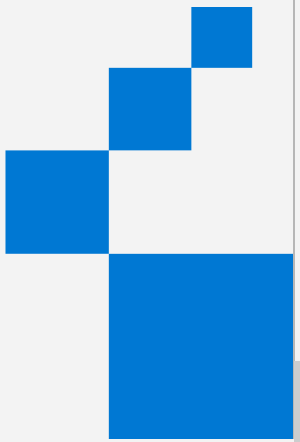
Data-driven decision-making is essential for VBC/ACO success

Key capabilities for value based care organizations



Financial Analysis

- Analyze risk contract terms
- Understand areas of reduced revenue due to converting services from FFS to risk financials
- Set budgets & targets for savings
- Monitor progress

Right-Size Utilization

- Convert financial budgets & savings targets to utilization rates & unit cost requirements
- Identify areas of excess utilization & cost
- Develop targeted interventions to drive savings

Manage Patients

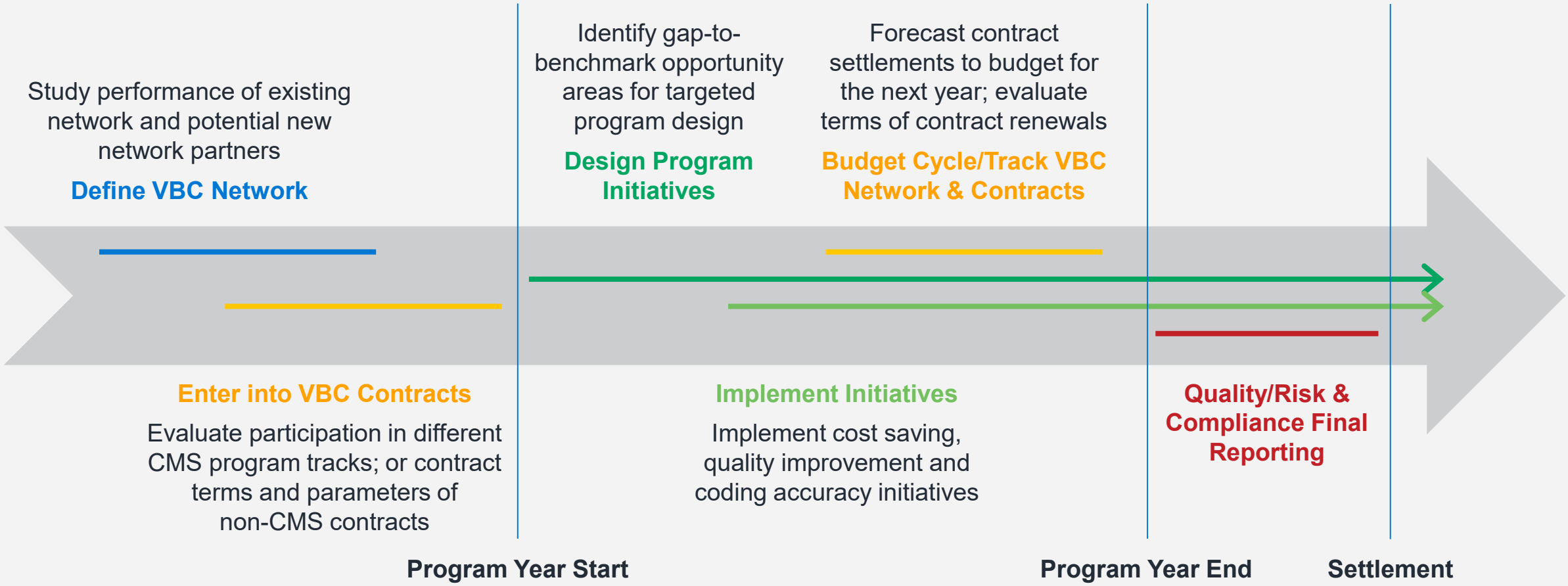
- Stratify & risk patients for targeted outreach by care coordinators
- Identify and close quality and risk coding gaps
- Addressing health equity through SDOH analysis and programs

Physician Engagement

- Measure and report physician partner performance
- Evaluate the broader network of physician partners and non-partners

AD HOC ANALYTICS

Annual cycle of activity for a VBC contract



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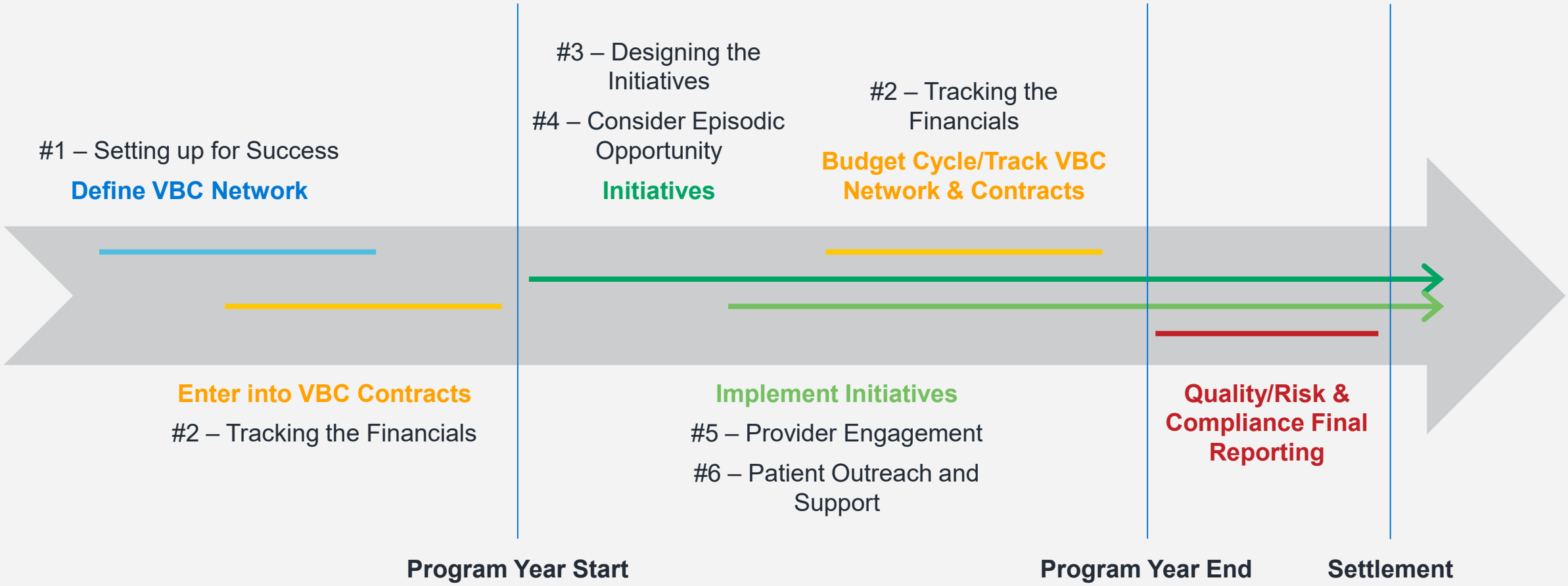
Annual cycle of activity for a VBC contract



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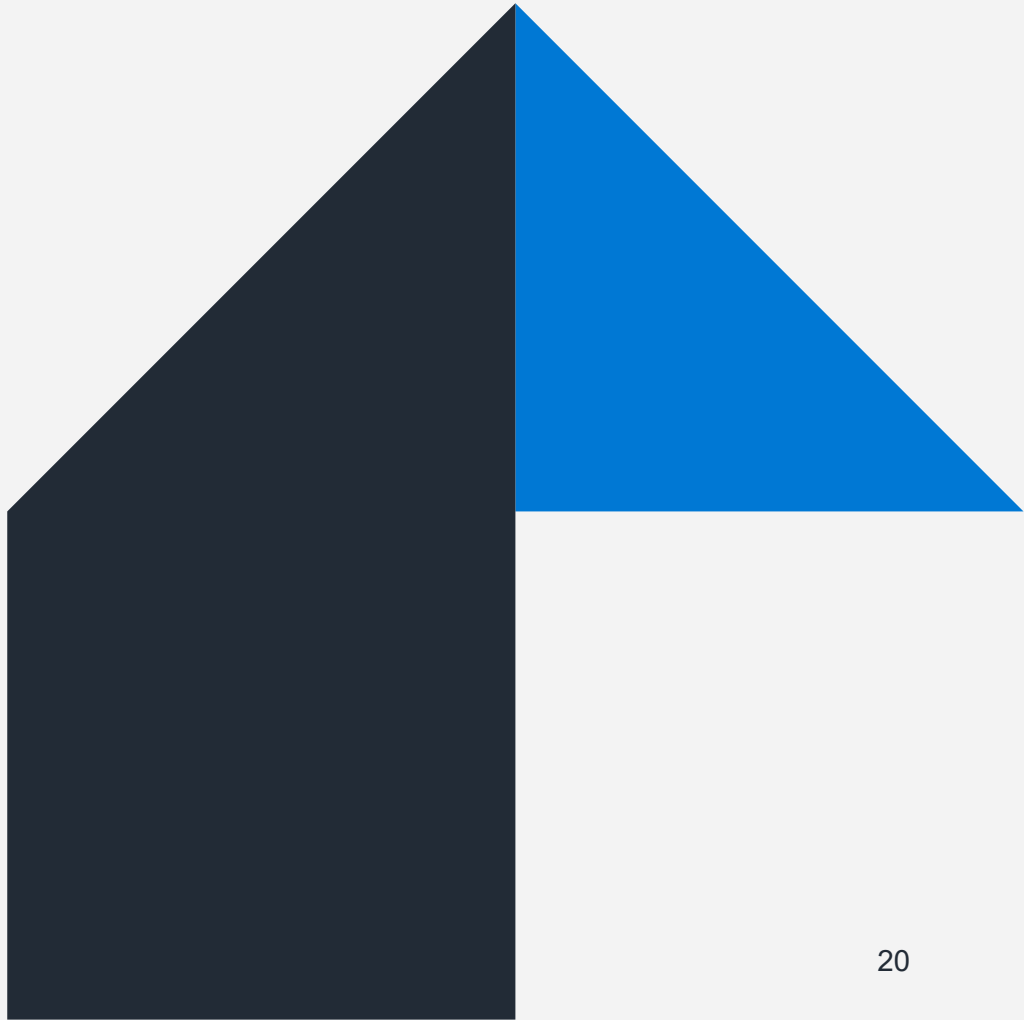
Financial Analytics

1. **Setting up for success** – defining your network and contract terms
2. **Tracking the financials** – contract forecasting and modeling



Which Program Gives You the Best Opportunity to Win?

Before entering into a contract, ensure terms are favorable and fair

①

Which Program?

MSSP · REACH / LEAD

Each program has distinct risk structures, benchmark methodologies, and shared savings rates. Model your expected performance under each to identify your optimal entry point.

②

Which Risk Track?

FULL RISK · LOWER RISK

Higher risk tracks offer greater upside but require stronger performance. Quantify the tradeoff based on your specific attributed population and historical spend patterns.

③

Which Assignment?

PROSPECTIVE · RETROSPECTIVE

Assignment methodology determines which patients count and when. The right choice depends on your patient panel stability, care patterns, and contract year timing.

Similar considerations apply for non-CMS contracts

Who Should Be In Your Network?

Not every provider group improves your ACO's financial position. Analyze each participating provider, identifying who creates value and who creates drag before you commit to the performance year.

WITHOUT UNDERWRITING

Losses are invisible until it's too late

- × Provider groups are admitted based on size or relationships not financial fit
- × Low-benchmark populations suppress ACO-level performance metrics
- × Overspending providers drain shared savings from the entire ACO
- × Issues only surface during reconciliation, when it's too late to act

WITH FORECAST CAPABILITIES

Know before you commit

- ✓ Model each provider's expected PBPM performance against their benchmark
- ✓ Identify low-benchmark groups whose inclusion suppresses ACO-level metrics
- ✓ Quantify the annual dollar impact of including or excluding each provider
- ✓ Make network composition decisions with a full financial picture in hand

The following slides show a simplified example — 5 providers, before and after forecast underwriting.

All Five Providers In the ACO

#1 Setting up for Success

ANNUAL GROSS SAVINGS

$3.5M

2.8% savings rate

Two providers are spending above their benchmarks, creating a combined $3.3M drag on ACO performance. Identify these performance patterns before including providers in your clinically integrated network.

Provider	Benchmark PBPM	Spend PBPM	Savings %	Annual Gross Savings	Shared Savings
Provider 1	$1,384	$1,212	12.4%	$3.6M	$3.2M
Provider 2	$1,477	$1,575	**-6.6%**	**($1.9M)**	**($1.9M)**
Provider 3	$1,352	$1,234	8.7%	$2.1M	$2.1M
Provider 4	$1,505	$1,501	0.3%	$0.1M	$0.1M
Provider 5	$1,093	$1,179	**-7.9%**	**($1.4M)**	**($1.4M)**
ACO Total	**$1,379**	**$1,340**	**2.8%**	**$3.5M**	**$3.4M**

Common Challenges with Effectively Managing Value-Based Care Contracts

Value-based care contracts are becoming a greater portion of overall provider revenue. These contracts can be complex and vary greatly by payer and line of business. MedInsight has expertise in helping providers navigate the intricacies of these programs to provide opportunities for greater savings.

Standardization

- For providers in multiple contracts, they are likely receiving data from multiple sources.
- Reporting comes in different forms, requiring a large lift from data teams before becoming usable

Detail

- Reporting may only provide a view at the highest level (e.g. the ACO level).
- The default reporting may not provide any actionable items or ways to improve performance throughout the year

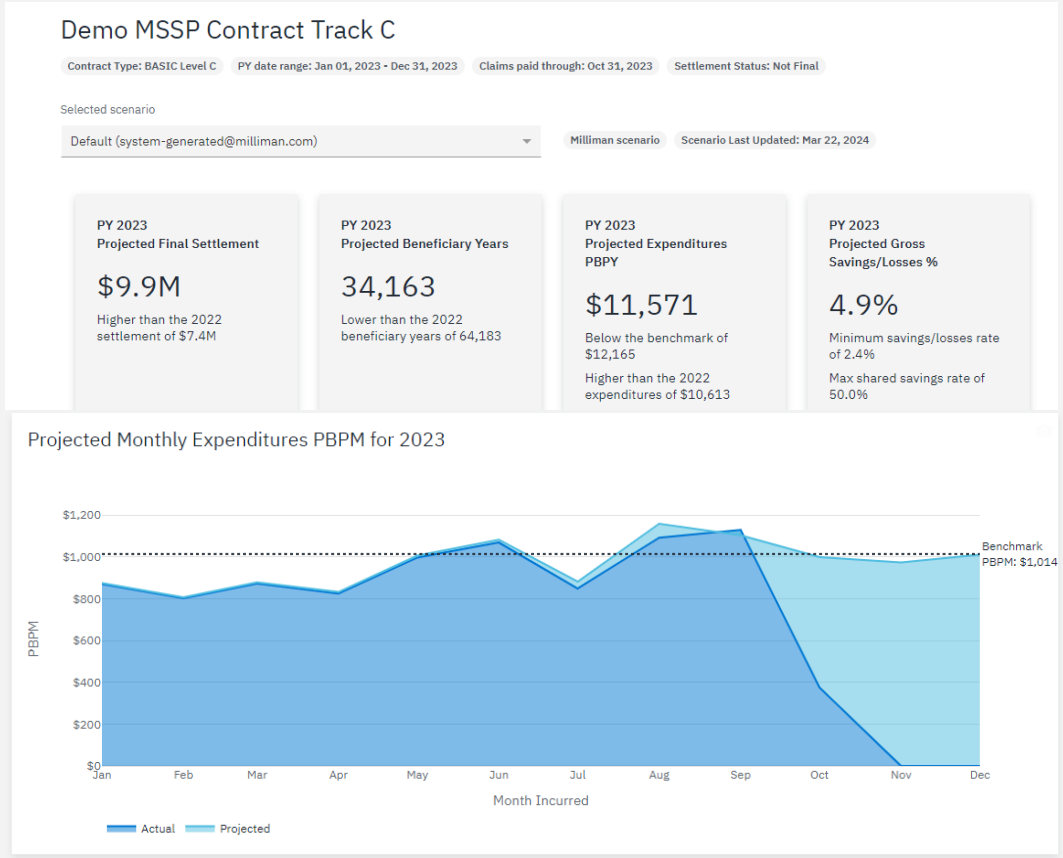
Timeliness

- Reporting can be inconsistent in delivery
- Providers need the ability to forecast potential cash inflows and outflows and are unable to without additional information from payers

Audit

- Final settlement calculations that come from partners need to be validated and confirmed
- Modeling the exact contract parameters can be difficult due to the uniqueness of each contract

Proactive Contract Forecasting and Modeling



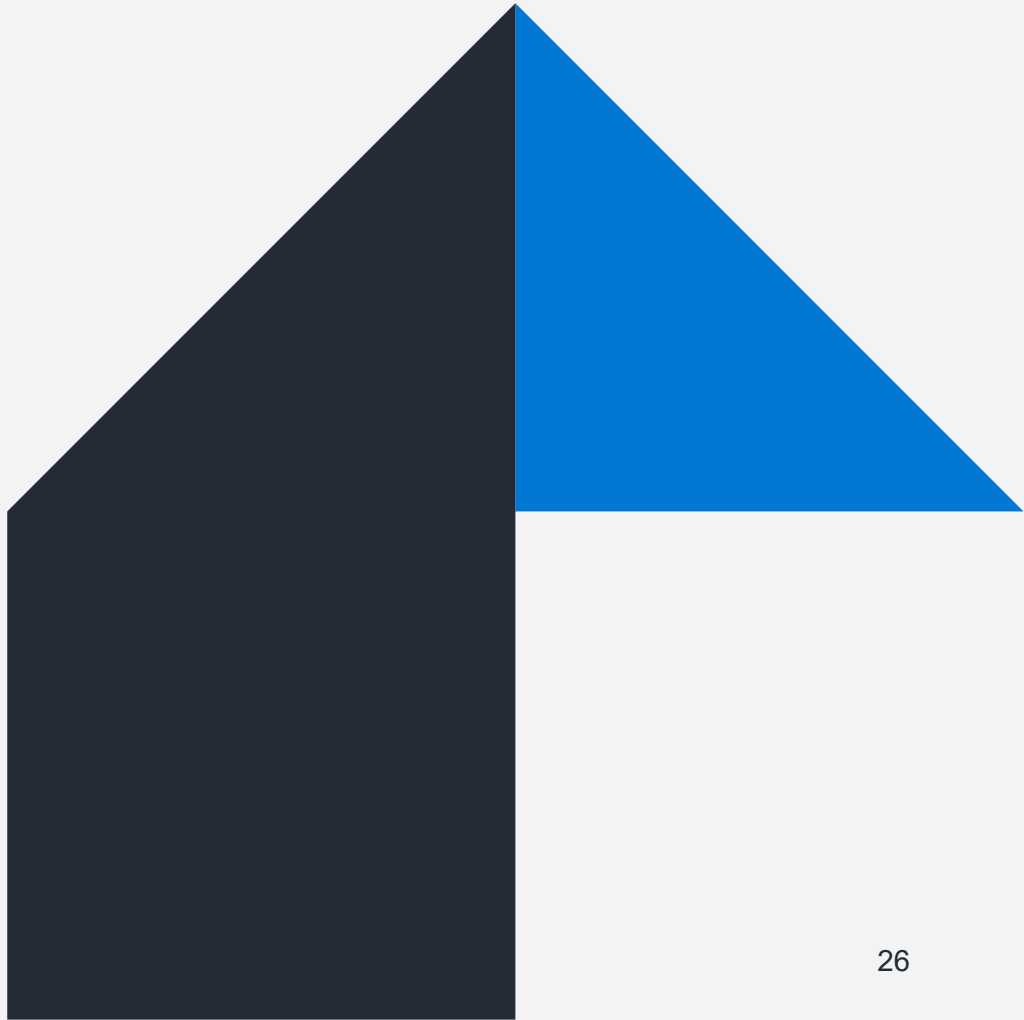
Essential Contract Modeling Capabilities:

- Customized Medicare FFS, Commercial, Medicare Advantage, and Medicaid contracts
- Forecast end of year settlement throughout the performance year to allow budgeting and planning
- Validate payer settlement estimates
- Settlement detail - Transparent build up of all assumptions and projections
- Risk unit level detail- See performance by provider subgroup (e.g. TIN) to facilitate gainshare payouts
- Scenario modeling – create a range of estimates based on different modeling scenarios
- Contract building – create new contracts or edit terms of existing contracts to forecast future success

Designing Program Initiatives

#3 – Initiative design – identify areas of opportunity across cost and utilization, quality and risk scoring

#4 – Consider episodic opportunity – measure and track specialist performance to succeed in episodic payment models



Identifying Opportunity for Initiative Success

Maximizing investment in value-based care initiatives through data analytics

Cost and Utilization

Achieving total cost of care savings

- Identifying areas of potential service overutilization through a gap to benchmark analysis helps identify that are key for total cost of care reduction initiatives
- Analysis must support overall initiative identification and drill down to support initiative design. Including provider, attributed PCP and patient-level detail

Risk Code Capture

Properly documenting patient risk

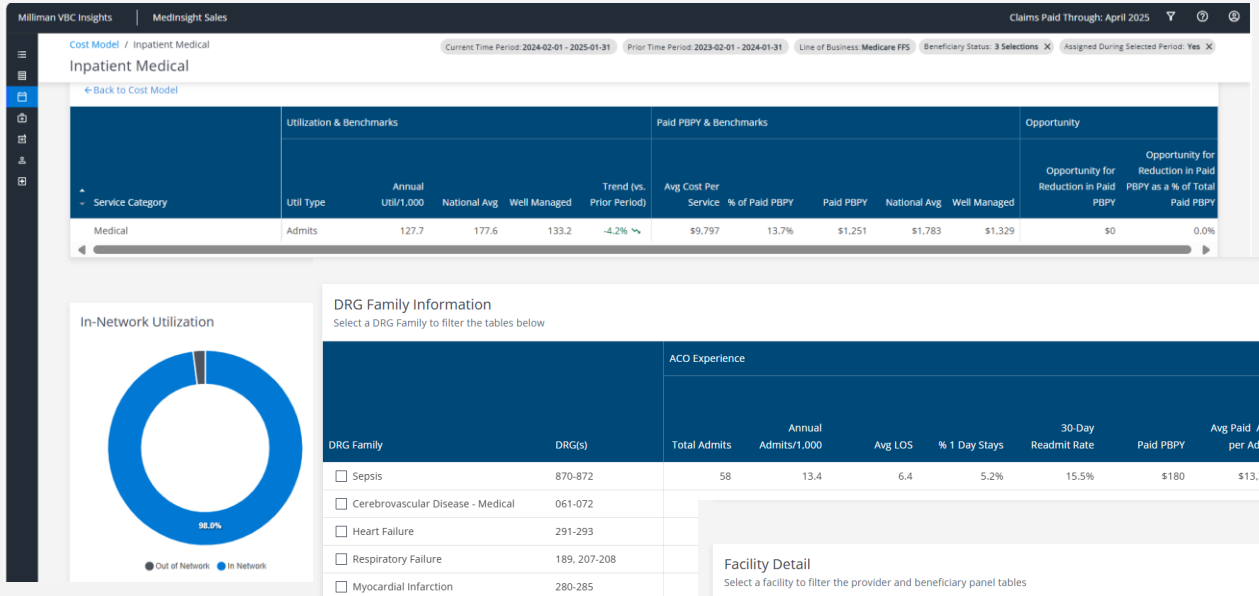
- Capturing existing patient risk factors is essential for success in value-based contracts with a risk adjustment component
- Analytics should track conditions coded in previous years that have not been coded in the current year
- Information should be made available to attributed provider offices to schedule annual well visits and individual diagnosis information should be available at the point of care

Quality Measures

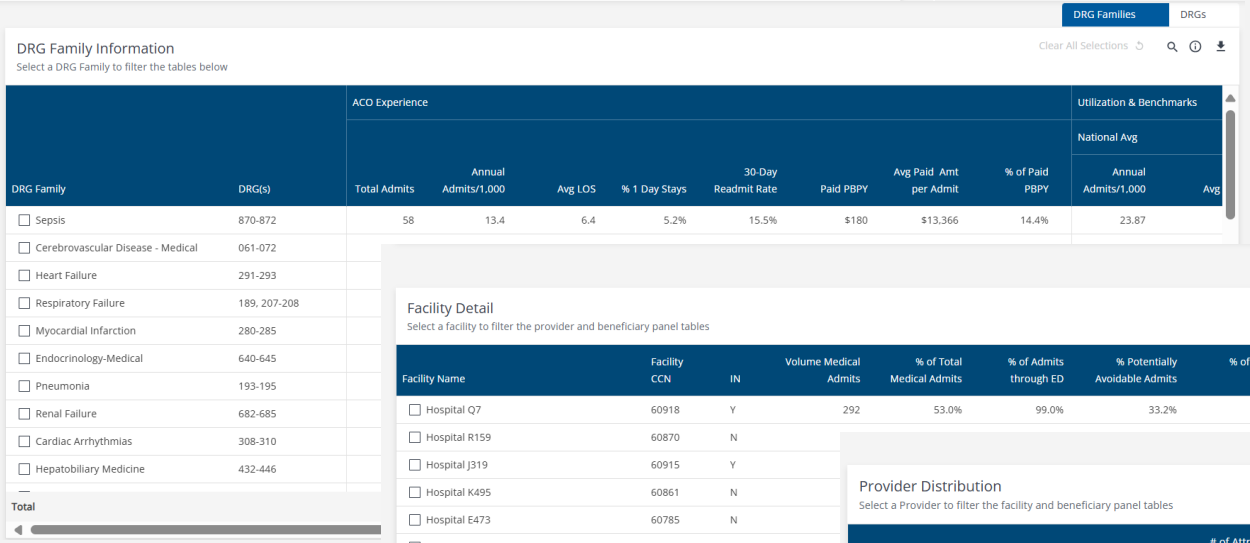
Improving compliance with quality measures

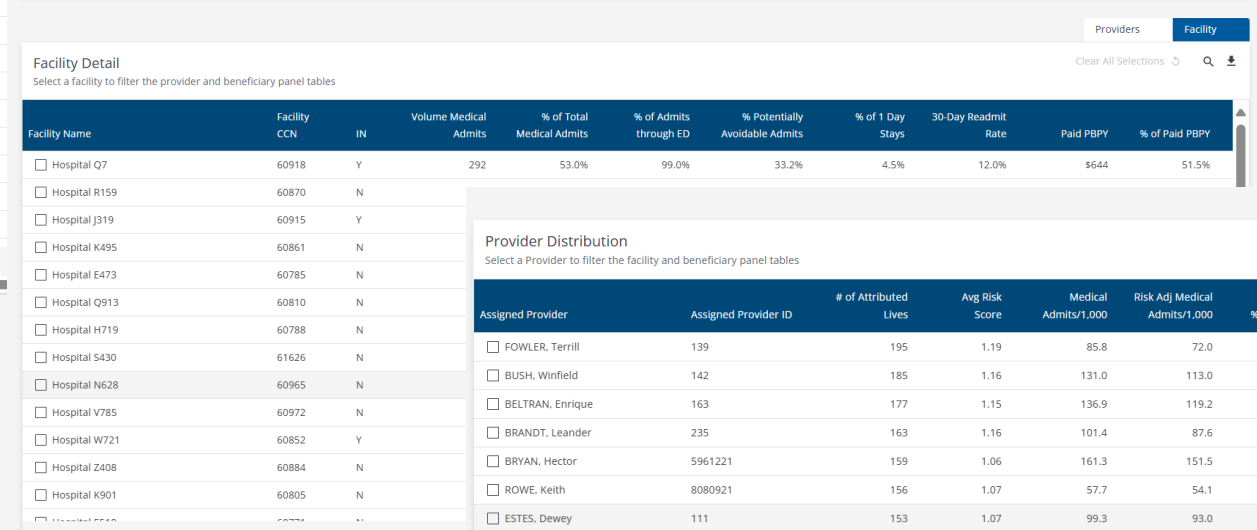
- Achieving quality targets is essential for contract success. Analytics must track quality measure compliance rates, progress across the year, and individual patients with services due
- Detailed information on patients with quality gaps should be provided to attributed physicians regularly, ideally with point of care prompting

Initiative Identification with Drill Down to Actionable Detail

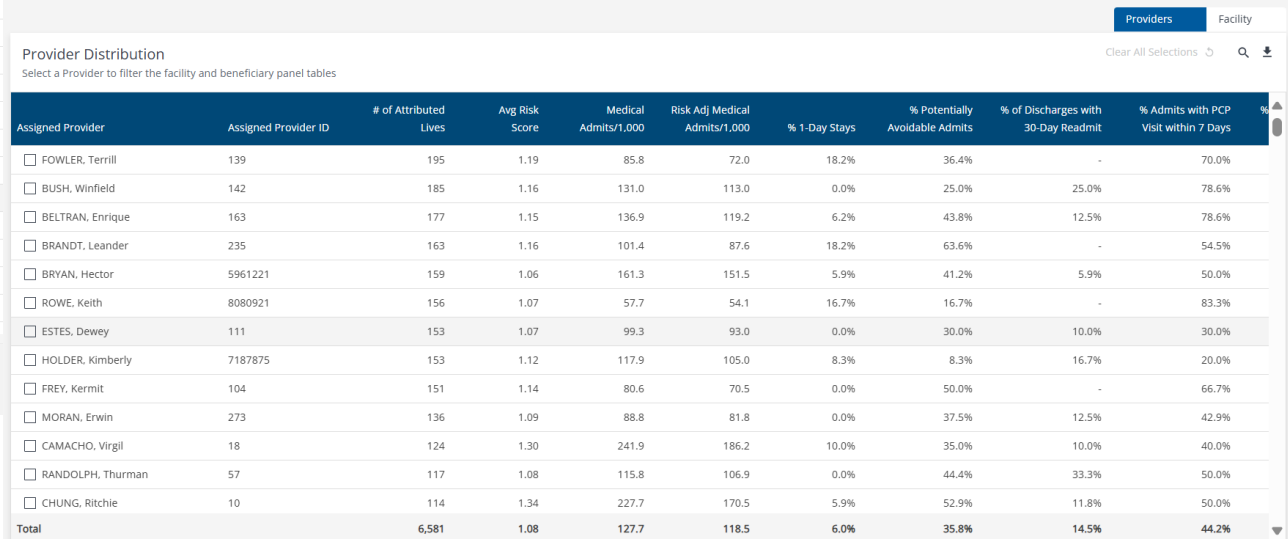


- Analytics should support overall identification of high utilization through gap-to-benchmark analysis
- Drill down analysis to scope initiative identification is essential





- Detailed information at the patient level allows for initial action and intervention



Growing Focus on Specialty Care from CMS

Problem

- ACOs are at risk for the total cost of care through primarily primary care physicians
- However, specialists (who may receive little to no direct attribution in these programs) are involved in a significant portion of the total cost of care
- ACOs need to develop strategies to engage non-attributing specialists to manage high-cost conditions and events

Industry Trends

- CMS continues to strive to incorporate specialists in value-based payment
  - *Ambulatory Specialty Model (ASM)*: small now but could grow rapidly (in both scope and breadth) over time
  - *CMS Administered Risk Arrangements (CARA):* within LEAD, will enable episode-based risk arrangements between ACOs and their specialists and provider organizations
- CMS goal of having 100% of Traditional Medicare beneficiaries in accountable care relationships by 2030
- As selection and risk adjustment become less profitable, engaging in specialty care risk management strategies likely to become the next area of revenue generation within VBC

Key Capabilities for Measuring Specialty Performance

Three primary use cases

1

Specialist comparison

- **Provider profiling**: Assess provider performance and efficiency on a risk-adjusted basis.
- **Network management**: Define provider networks and tier providers based on performance metrics.
- **Primary care engagement**: Share benchmarking insights with PCPs to support value-based care models (e.g., ACOs).
- **Specialist engagement**: Enable targeted performance improvement for specialists in value-based contracts.

2

Drivers of spend

- **Medical economics**: Break down medical spend by episode to identify cost drivers and care patterns.
- **Trend modeling**: Identify key drivers of healthcare cost trends to inform cost containment strategies.

3

Value-based payment

- **Episode-based payment**: Support the transition to value-based care with an episode-based payment program.

Sample analytics to understand the variation in cost and practice patterns for care managed by specialists

Significant variation in total episode cost, service categories spend, and quality measures

- Some of this variation is within the control of the specialist, highlighting potential opportunity for cost savings and improved quality
- Risk-adjusted benchmarks allow for identification of these opportunities

Organizations that appropriately identify specialist-driven variation can achieve improvements through:

- Changes in specialist practice patterns
- Steering beneficiaries to top performing specialists
- Partnering with top performing specialty providers

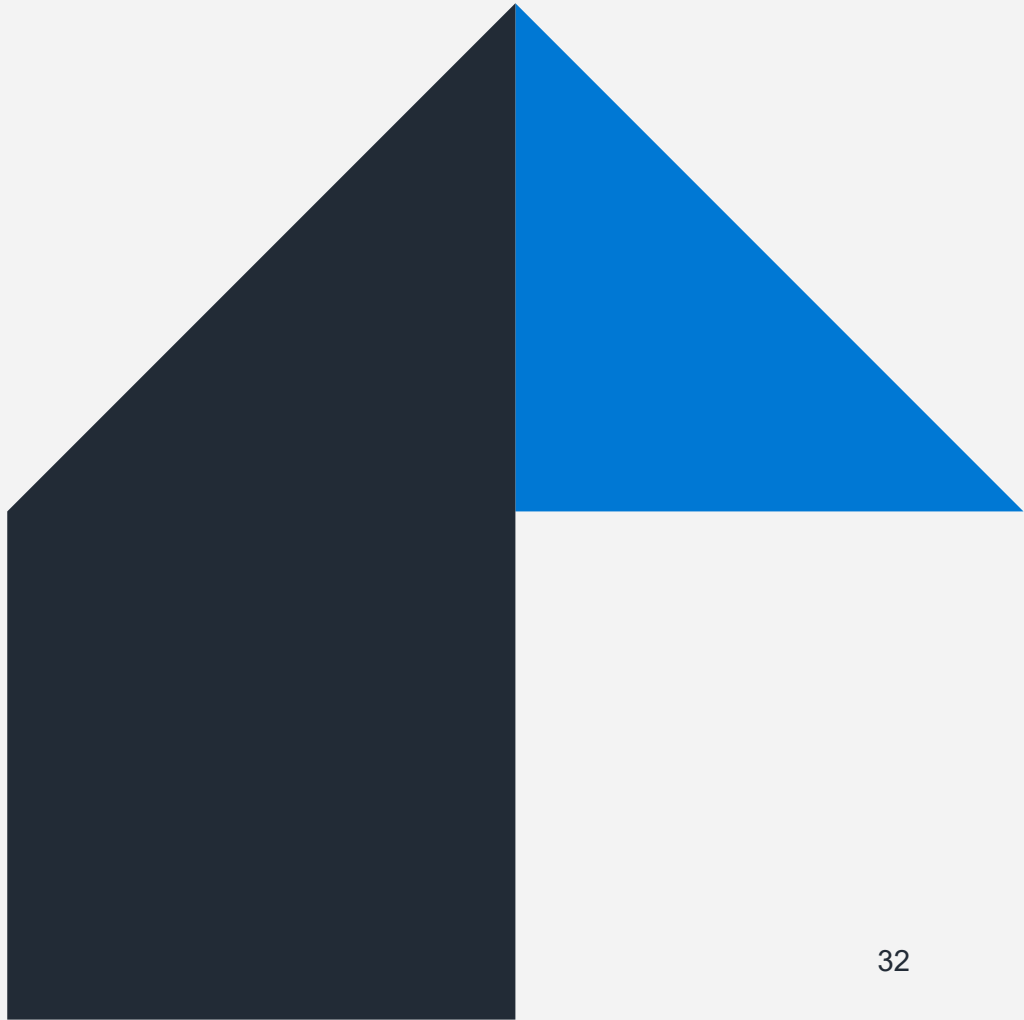
ILLUSTRATIVE EXAMPLE:
Orthopedic Surgery Practices: Knee Arthroplasty Episodes
Medicare FFS

Percentile	10th	25th	50th	75th	90th	National Average
Episode Cost (Standardized)						
	$20,860	$17,878	$15,800	$14,178	$12,787	$16,332
Post Acute						
SNF	$801	$157	$0	$0	$0	$231
Home Health	$2,448	$1,980	$976	$295	$99	$1,150
IRF	$1,638	$596	$0	$0	$0	$461
Total	$4,068	$2,729	$1,687	$595	$167	$1,842
Site of Care						
IP %	38%	11%	2%	0%	0%	12%
OP %	62%	89%	98%	100%	100%	88%
Quality						
ED Visits per 1,000	96.77	65.57	33.33	0.00	0.00	42.11
Readmissions per 1,000	83.33	41.67	0.00	0.00	0.00	32.03
% Avoidable ED Visits	25.17	0.00	0.00	0.00	0.00	15.14

Operationalize Initiatives

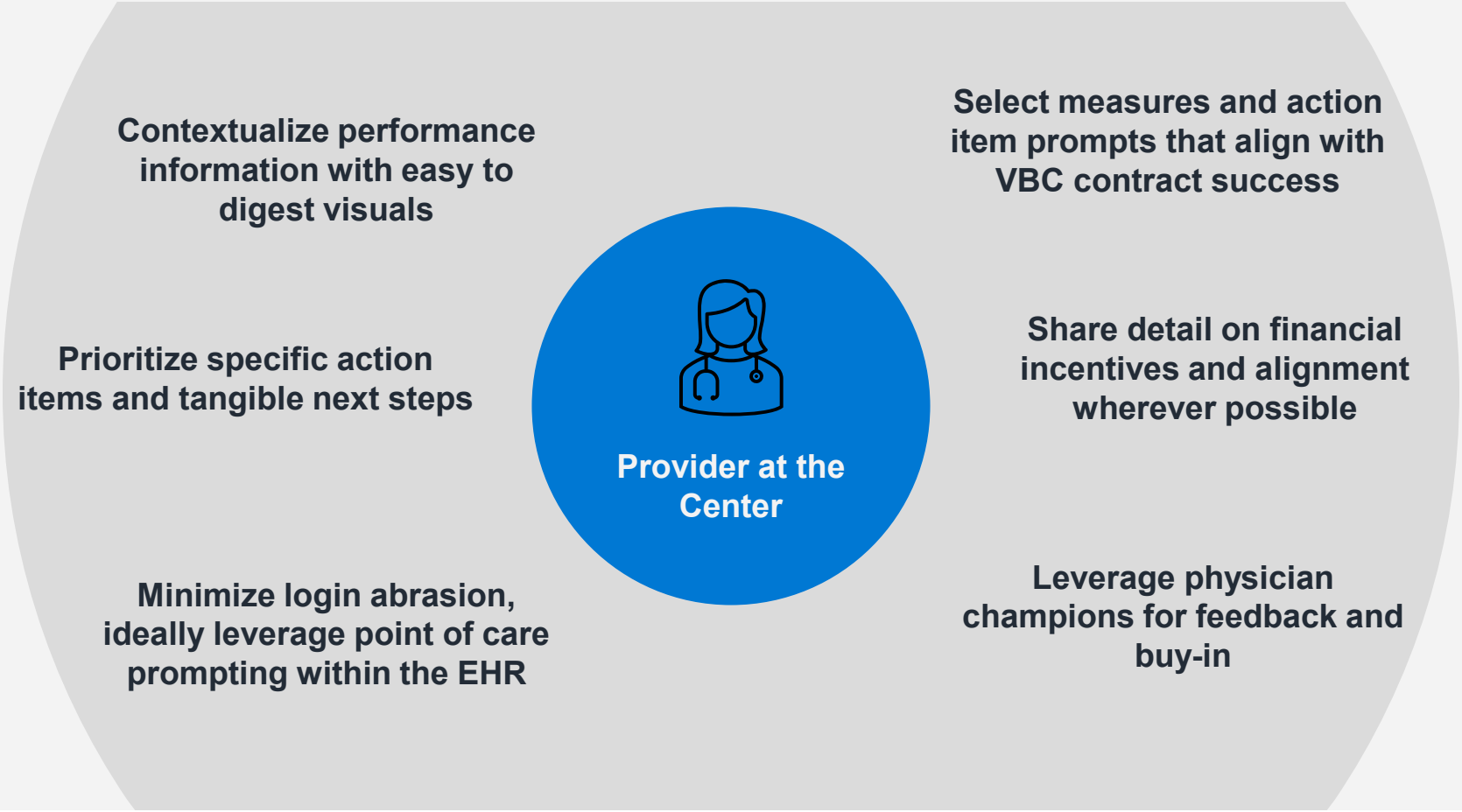
#5 - Provider Enablement – sharing data with providers to facilitate specific, actionable participation

#6 - Patient Outreach and Support – identifying patients with additional clinical needs to provide additional support



Engaging Primary Care in Value Based Care

Primary care providers are a key piece of VBC strategy, but engagement can be a challenge

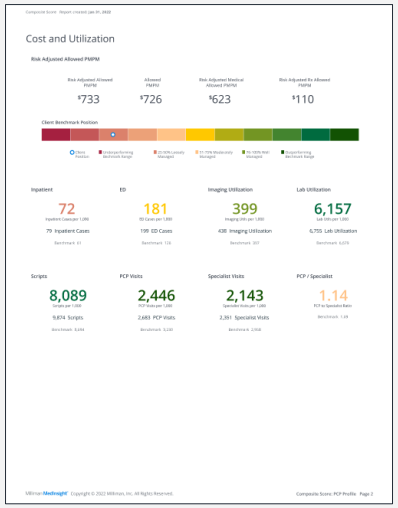


Key Facets of Provider Enablement

Targeted features and content to support Provider Reporting needs

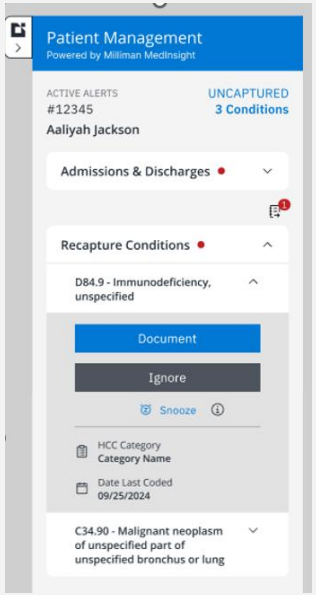
Provider Scoring and Scorecarding

- PCP and practice level measurement of cost and utilization, quality, and appropriateness KPIs
- Metrics are compiled into an easy to digest scorecard for access or distribution to providers and/or practices



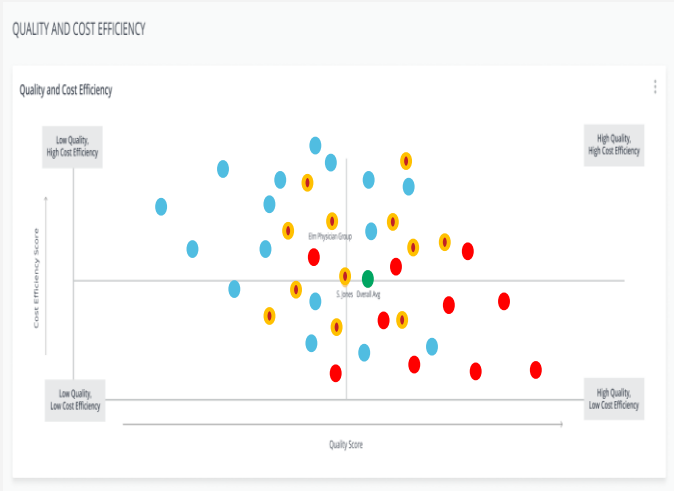
Actionable Insights Pushed to Providers

- Actionable lists of PCP-driven activities compiled across quality, risk coding and utilization
- PCPs can access lists through SSO-enabled portal or optional EHR-integrated POC prompts



Network Level Performance Reporting

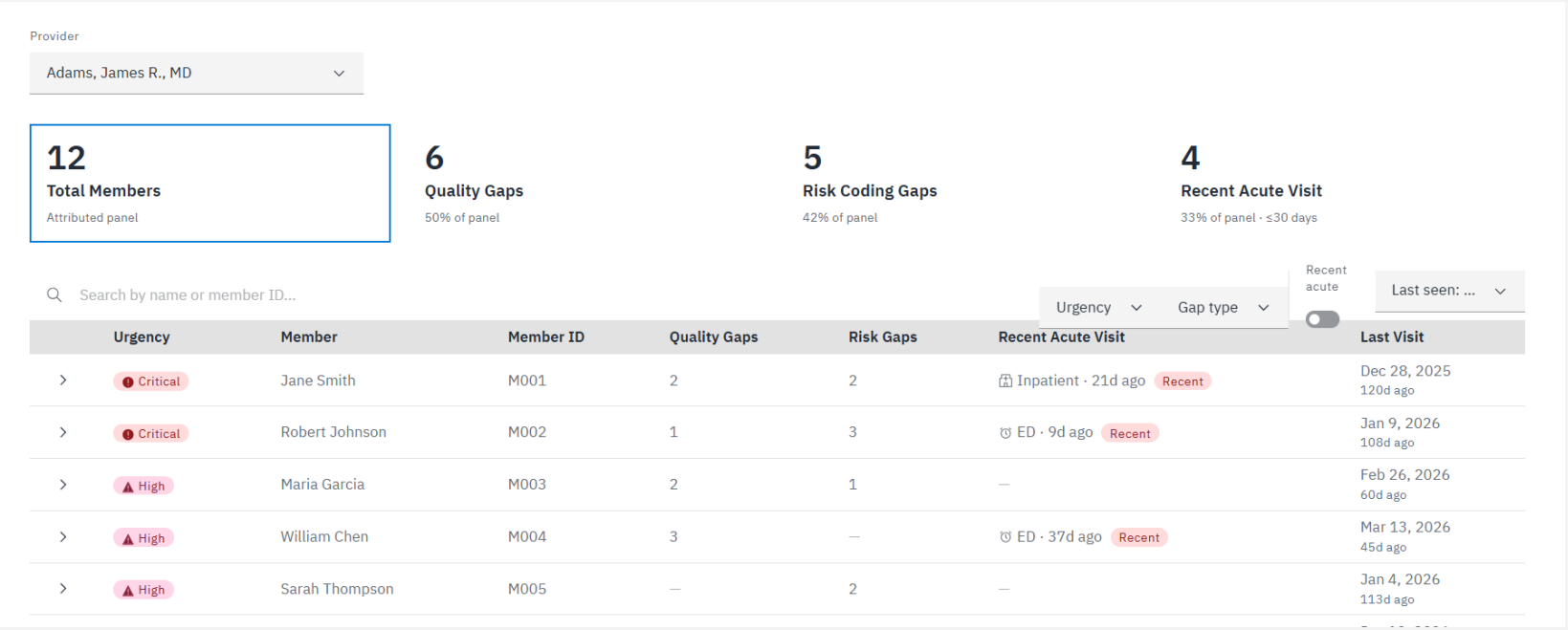
- Reports showing PCP and practice level performance across cost and utilization, quality and appropriateness
- Additional reporting includes: out of network reporting, attribution reconciliation and affinity reporting, referral patterns, and more

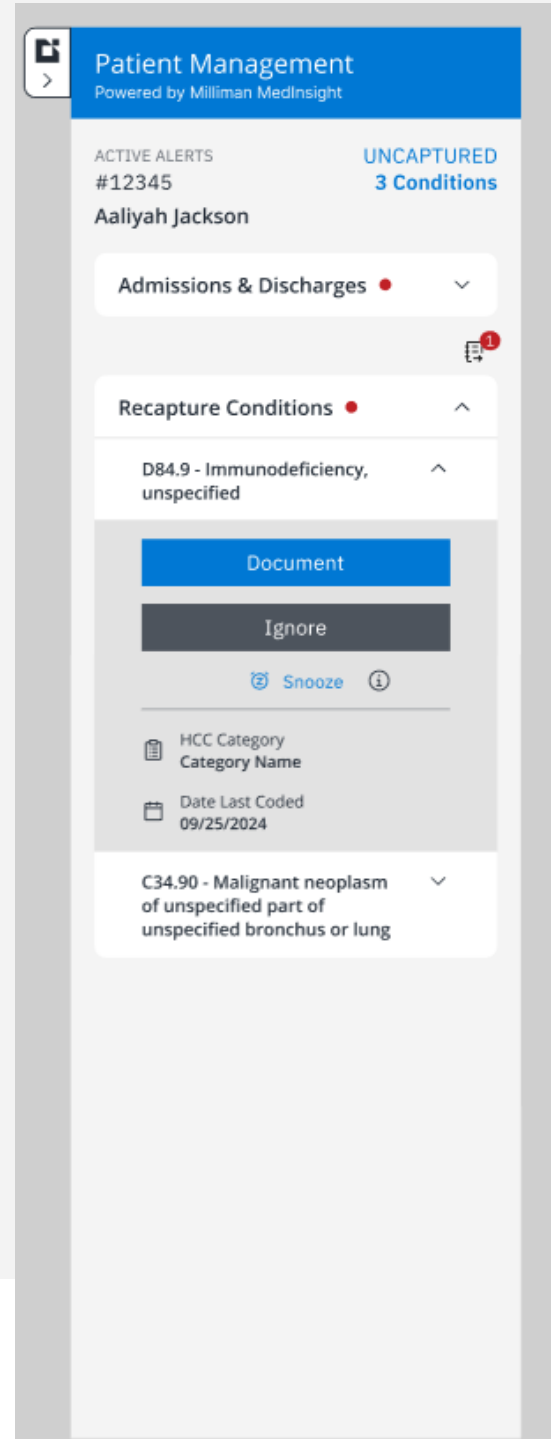


#5 PROVIDER ENABLEMENT

Sample Prioritized Actionable Lists

Primary care providers are a key piece of VBC strategy, but engagement can be a challenge

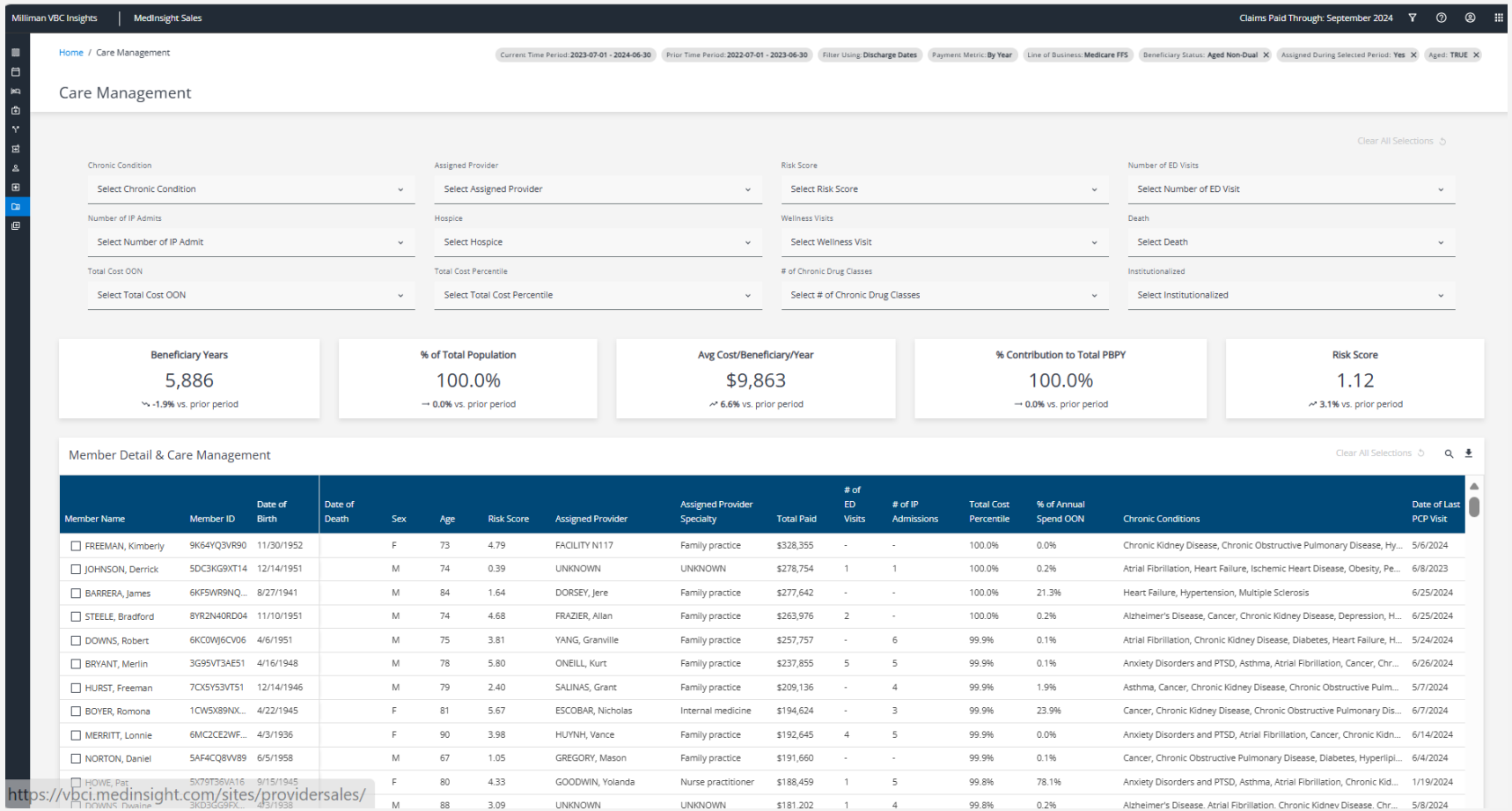




- Goal to provide targeted detail to facilitate provider intervention
- Actionable lists of patients with specific provider action items generated for key initiatives (e.g. open care gaps, uncoded risk scores)
- Providers can view detail by initiative (e.g. closing annual wellness visit care gap) or by patient (e.g. all open action items for a single patient)
- Providers can engage through SSO enabled log in to a portal view, or can participate in EHR integration for point of care prompting

Identifying Patients with Additional Needs

Pinpointing patients for case management, condition management, or other outreach and support



- Generate lists of patients meeting specific criteria including presence of a chronic condition, high risk score, utilization of ED or Inpatient services, etc.
- Ability to exclude patients meeting criteria including hospice utilization or other elements
- Patient-level detail allows for clinician evaluation including claim level detail on inpatient and outpatient care, and pharmacy use

A comprehensive approach

The MedInsight Value-Based Care Platform

Organizations often take their first steps with bundled payment programs, using data and benchmarks to manage inpatient care—no dedicated VBC team required.

Starting the VBC journey

Bundles

As organizations progress, ACO Builder equips them with the modeling tools needed to evaluate opportunities, design contracts, and manage risk for ACO participation.

Advancing decision-making

ACO Builder

As VBC programs mature, MedInsight's advanced analytics enable tailored analyses, better risk management, and robust business intelligence.

Evolving with advanced analytics

VBC Analytics

At the leading edge, the Innovation Portal empowers data scientists with access to comprehensive data and advanced tools, driving innovation and continuous improvement.

Reaching advanced capabilities

Innovation Portal

1 — 2 — 3 — 4 — 5 — 6 — 7 →

Epic

Leveraging existing tools

Early VBC efforts are tracked and managed through existing EMR systems like Epic, providing an accessible foundation for VBC management.

VBC Insight

Scaling with targeted analytics

Deeper VBC engagement brings the need for specialized analytics. VBC Insights supports strategic planning and daily operations for ACOs.

VBC Contracts

Managing growing complexity

With multiple VBC contracts, MedInsight simplifies performance tracking and outcome optimization, making complex management easier.

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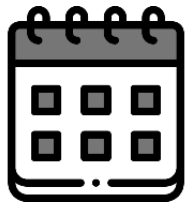
LEAD: Are You Prepared?



Schedule a LEAD readiness assessment with Milliman MedInsight experts.

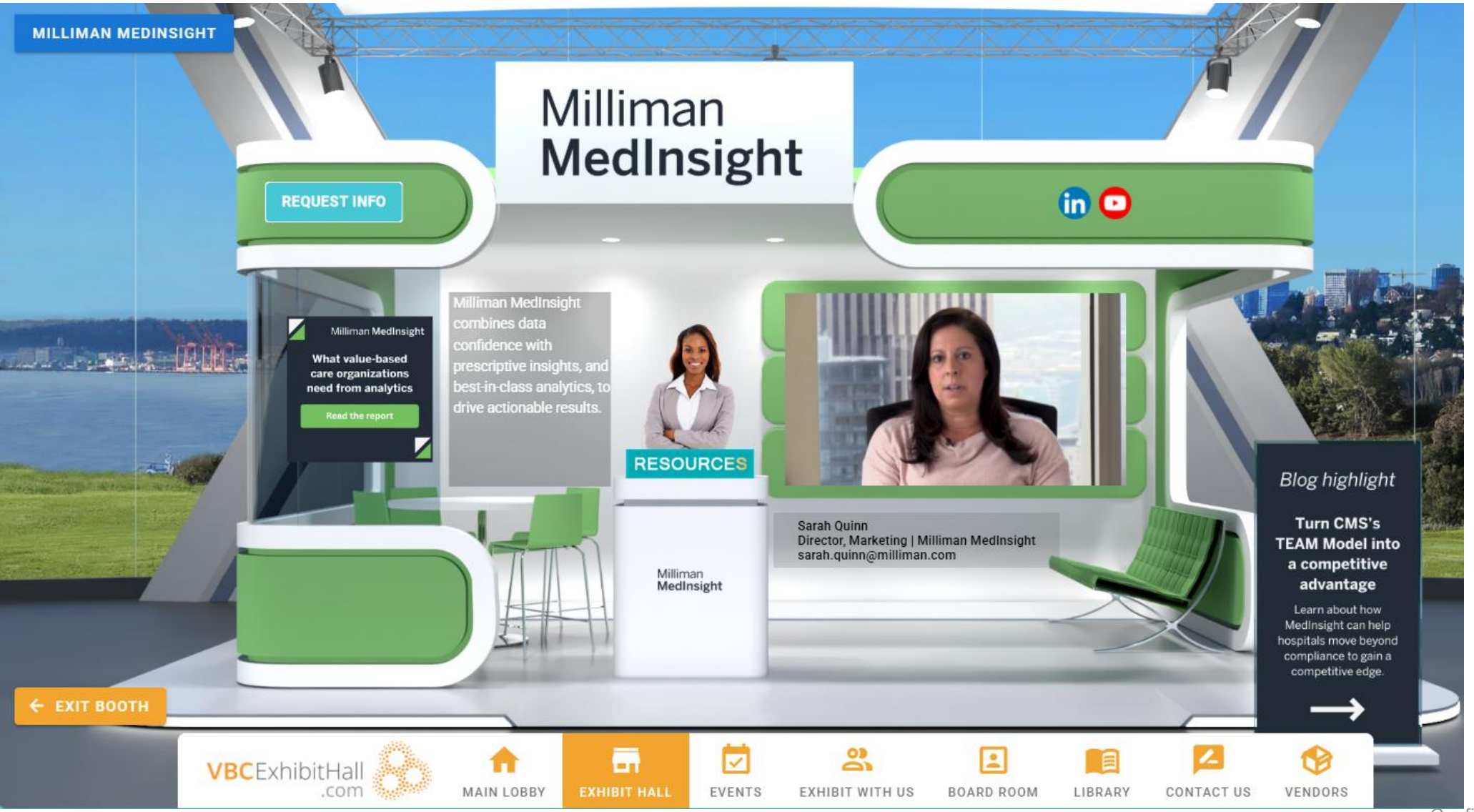
Book a call or demo to **learn how Milliman MedInsight tools can help your organization win under LEAD**.

Q&A

If you have a question, please add it to the chat or submit via Q&A.

Visit our VBCExhibitHall.com Virtual Booth

VBCExhibitHall.com



ENTER BOOTH

Thank you

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