

October 6, 2026

Abe Sutton, JD

Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Dear Mr. Sutton:

We, the undersigned organizations, write to request a refinement, beginning with Performance Year (PY) 2027, to how the Long-term Enhanced ACO Design (LEAD) Model sets benchmarks for voluntarily aligned beneficiaries.

We strongly support LEAD's expanded voluntary alignment pathway. The ACO REACH Model demonstrated that signed voluntary alignment (SVA) works: ACOs of many types and sizes used it to enroll patients in accountable care relationships of their own choosing. We appreciate CMS's leadership in carrying that opportunity forward in LEAD, including allowing new beneficiaries to align each month.

Our concern is with how LEAD sets the benchmark for this population once an ACO's SVA population reaches 500 beneficiaries. At that point, CMS applies a separate benchmark based on the historical spending of the beneficiaries who are voluntarily aligned in the performance year. Because every beneficiary in that cohort is alive at the start of the performance year, their historical spending excludes the end-of-life costs that a portion of the same population will incur during the performance year, costs for which the ACO remains fully accountable. This constant-cohort approach tends to understate expected costs.

Wakely Consulting Group and the Complex Care Alliance documented this effect and shared their analysis with CMS in June. For Aged and Disabled beneficiaries, prior-year spending fell 13.1 percent below performance-year spending under the constant-cohort approach, compared with 4.9 percent under standard attribution. The gap widened after risk adjustment. Those results predate the updated LEAD risk models and are being reassessed, but the underlying concern with the constant-cohort approach remains and isn't expected to be fixed with the new risk adjustment models. We also note that the Innovation Center encountered a similar dynamic in the Pioneer ACO Model and ultimately adjusted its approach.

We appreciate the changes the Innovation Center made to the voluntarily aligned benchmark methodology for High Needs-eligible beneficiaries. While the changes meaningfully improve the methodology, they do not, however, fully resolve the concern for those beneficiaries, and the methodology for the Aged and Disabled category was unchanged. As a result, a number of ACOs, including some of the undersigned, are planning to voluntarily align significantly fewer beneficiaries than they otherwise would. We are concerned that use of the voluntary alignment pathway, and overall attribution to LEAD, may fall well short of what CMS intends.

RECOMMENDATION: When an ACO has more than 500 voluntarily aligned members, and the voluntarily aligned benchmark applies, CMS limits it to a range from 10 percent below to 10

percent above that claims-based aligned benchmark. **We request that CMS raise the lower bound to 100 percent of the claims-based aligned benchmark.** Whenever the voluntary-aligned benchmark falls below the claims-based aligned benchmark for the same category, the latter would apply. This would protect against an understated baseline while preserving a higher benchmark for voluntarily aligned populations whose historical spending supports one.

Alternatively, CMS could apply a benchmark adjustment at the eligibility-category level that accounts for the cost of mortality in the performance year that doesn't exist in the base years. This could be applied consistent with how we understand CMS is applying the seasonality adjustment to beneficiaries added mid-year under the hybrid alignment methodology.

We appreciate that the Innovation Center has indicated that in future years they will use the experience with voluntarily aligned members in the early years to support a more accurate benchmark. We recommend CMS apply one of our suggested policies in PY 2027 and for every subsequent year the constant cohort benchmark methodology is used.

Thank you for your leadership and consideration of this request. We welcome the opportunity to discuss implementation. For questions or further discussion, please contact David Pittman at david@pittmanpolicy.com.

Sincerely,

Accountable Care Coalition of Georgia, LLC
Advanced Care Innovations
Advocate Health
American Choice Healthcare LEAD, LLC
America's MDE
APA ACO
Arbital Health
Arvon CIN
Asaar Medical
Astrana Care Partners ACO
Atlas ACO
Belong Health
Bloom Healthcare
Buena Vida y Salud, LLC
CareConnectMD
Complete Care Collaborative of the East, LLC
Complete Care Collaborative of the Midwest, LLC
Complete Care Collaborative of the South, LLC
Complete Care Collaborative of the West, LLC
Curana LEAD ACO
Duly Health and Care
Equality Health ACO

Health Partners for the Elderly, LLC
Honest Health
Hopscotch Primary Care
ilumed
Intention Healthcare ACO
Intermountain Health
Intrinsia Health
Long Term Care ACO, LLC
Mid-Atlantic Collaborative Care, LLC
On Belay Health Solutions
Optimal Care ACO, LLC
Pathways Accountable Care, LLC
Pearl Health, Inc
Primary Care Alliance
Provider Partners Connect Care, LLC
Rancho Health Management ACO
Responsive Care Solutions LEAD
Silver State ACO
Sound Accountable Care
Summit Health
Theoria Medical
Trinity Health

Esse Health ACO
EverWell Health, LLC
Focus MSSP
HarmonyCares

Vitae Health Systems ACO LLC
Vytalize Health
Wellvana
West Florida ACO LLC