The LEAD Model and the Coming Rebuild of Value-Based Care Plumbin

JAN 04, 2026 • PAID

3

Share

Abstract

CMS has announced a new Innovation Center accountable care model called the Long-term Enhanced ACO Design Model, known as LEAD, that is explicitly positioned to follow the conclusion of ACO REACH at the end of 2026.

LEAD is described by CMS as a ten year voluntary model running from January 2027 through December 31, 2036, with a Request for Applications beginning in March 2026.

CMS frames LEAD as a response to financial and administrative barriers that ha kept many providers, especially smaller, independent, rural, and community hea center settings, from participating in ACOs or staying in them.

CMS also introduces a new modular component called CMS Administered Risk Arrangements, or CARA, described as a digital data-sharing and payment systen intended to make it easier for ACOs to build episode-based risk arrangements w preferred downstream providers without pushing consolidation.

Key implications for investors and builders include:

- LEAD’s ten year performance period with a stated predictable window without rebasing changes the payback math for infrastructure, clinical operations, and analytics investment

- The model offers two risk sharing options, Global Risk and Professional Risk, creates distinct customer segments for enablement vendors

- Prospective, capitated population-based payments and other flexible cash flow mechanisms are explicitly called out as a design feature, pulling demand forward workflow, care model, and financial operations tooling

- Benefit enhancements and beneficiary engagement incentives, including Part B sharing support and a Part D premium buy down by 2029, create product surfaces that are not just clinical, but behavioral, economic, and actuarial

- CMS describes an explicit Medicare-Medicaid integration planning phase from March 2026 through December 2027 with two states, implying a new class of integration operators, compliance tooling, and data operations that sit inside Or Medicare accountable care

- Rural provider support through non-reconciled add-on payments and lower alignment minimums creates a subsidized channel for enablement infrastructure

- CARA episode rails and preferred provider relationship tooling create new non ownership coordination primitives

Table of Contents

Prospective payments and the comeback of boring finance software

Benefit enhancements and engagement incentives as product wedges

Rural ACO infrastructure enablement and the subsidy channel

Medicare-Medicaid integration, two states, and a giant new services layer

A practical investor map of company archetypes that fit LEAD

What to ignore, where people will waste money anyway

Which REACH-era business models are structurally dead

Exit paths and who actually buys these companies

Where smart people will screw this up

Closing thoughts, how to ride the tailwind without getting clipped

Understanding what CMS actually said about LEAD

LEAD is not being pitched by CMS as a minor tweak to the alphabet soup. CMS describes it as the Innovation Center's newest ACO focused model, set to launch following the conclusion of ACO REACH at the end of 2026, and CMS makes a p of calling out improved benchmarking intended to appeal to a broader mix of providers, including smaller, independent, or rural-based practices, plus provide new to ACOs and those serving specialized patient populations. CMS also says, plainly, that LEAD offers a ten year performance period, described as the longes CMS has ever tested, and that it offers a predictable window without rebasing ar pathway toward sustainable long term benchmarks and savings. Those phrases a marketing fluff. They are a map of where CMS believes the prior market failed a where it wants private actors to rebuild capabilities.

That framing matters because it narrows the target. CMS is not saying it wants t cleverest spreadsheet. It is saying it wants durability, inclusiveness, and tools tha providers spend time meeting patient needs while being accountable for cost an quality. CMS also ties LEAD to coordinated care for high-needs patients, includ dual eligible beneficiaries and people who are homebound or home limited, whi polite way of saying the model is being designed around populations that break care management stacks.

It is also worth grounding the timeline in CMS's own prior documentation for A REACH, because the end date is not rumor. CMS's ACO REACH fact sheet says model timeline ends on December 31, 2026, and the general FAQs repeat that th redesign starts January 1, 2023 and spans performance years ending December 3 2026. So the bridge is explicit: REACH ends, LEAD begins.

The Innovation Center strategy refresh adds crucial context that LEAD is not standalone policy. CMS set a goal of having every Medicare fee for service benefi in an accountable care relationship by 2030, with interim targets. That positions LEAD as a central pillar in a much broader accountable care expansion agenda, one-off demonstration. For investors, this changes market sizing from counting participants to thinking about accountable care penetration across Traditional Medicare. It also suggests that tools helping marginal providers enter accountab care relationships, especially safety net and underserved populations, fit the stat direction of travel and may benefit from regulatory and programmatic tailwinds beyond LEAD alone.

Why the ten year window changes venture math and operator incentives

The shortest way to say this is that a ten year model is not a pilot, it is a market. Under short programs, rational participants behave like tourists. They rent wha can, do the highlights, and keep one eye on the exit. A long horizon flips the beh operators buy the house, redo the plumbing, and stop pretending a couple care managers and a dashboard will fix admissions. CMS leans into this directly by

describing LEAD as a predictable window without rebasing, a phrase that signal things at once. First, it is a deliberate attempt to reduce the perpetual benchmar anxiety that drives short-term gaming. Second, it creates the precondition for lo lived vendor relationships, because customers can justify implementation effort the contract does not feel like it might vanish mid-rollout.

For investors, the key is not whether this is morally good. The key is that custom lifetime value can actually exist. ACO enablement has been plagued by two ugly realities: switching costs are high, and program stability has historically been lo than the switching costs. That combination kills adoption of deep tools and mak shallow tools look artificially attractive. A ten year model reduces the stability mismatch and makes deep tooling investable, even if the sales cycle stays slow ar implementation remains painful. The punchline is that the slow stuff starts to w which is annoying for everyone who likes a quick multiple, but great for anyone likes actual moats.

CMS is also explicit that many providers have not historically participated in or dropped out of ACOs because of financial and administrative obstacles, and that LEAD is designed to address such barriers through enhanced, flexible cash flow payments and greater freedom and tools to meet patient needs. That is basically saying: this program is going to create demand for enablement layers that turn c flow into clinical behavior change, and that reduce the admin tax that made participation unattractive.

The venture math shift is simple. A product that costs five hundred thousand to implement makes no sense if the customer relationship lasts three years but mak perfect sense if it lasts ten years. Customer lifetime value triples. Allowable cust acquisition cost triples. Payback period tolerance extends. Companies can invest years in implementation knowing they have eight more years to harvest returns. opens up opportunities for high-touch, high-implementation-cost products that create durable value and customer lock-in. It also means the companies that win look boring: they will still be slightly annoying in year eight because they are embedded in the work. That is the good kind of annoying.

The LEAD revenue engine and where n take rates show up

LEAD's basic economic skeleton is visible even before an RFA is published. CM states there are two voluntary risk-sharing options. Global Risk can receive up t hundred percent of savings and is liable for up to one hundred percent of losses relative to benchmark. Professional Risk can receive up to fifty percent of saving is liable for up to fifty percent of losses relative to benchmark. Those are not jus policy details, they define two buyer archetypes. Global Risk buyers will pay for anything that reduces catastrophic downside and improves early detection of hig cost trajectories. Professional Risk buyers will pay for tools that maximize upsid capture and operationalize selective interventions with favorable marginal retur because their downside is partially bounded but their upside is also capped.

In practice, that means the vendor landscape is going to bifurcate. One class of companies will sell "do not blow up" infrastructure: utilization forecasting, post control, network steering where allowed, and the unglamorous operational rails risk adjustment integrity, claims runout management, and reconciliation readine Another class will sell "turn care into savings" infrastructure: care gap closure t actually sticks, longitudinal chronic disease pathways, and team-based care worl that make preventive care more than a checkbox. CMS describes flexible, capitat population-based payments that support team-based care and downstream value based care arrangements, which signals that the program is engineered to fund t staffing and workflow changes that most operators want but cannot finance und pure fee for service dynamics. When CMS says "capitated population-based payments," it is also implying a larger surface area for leakage, because cash flow flexibility can be spent on nonsense. That creates an opportunity for software an services that act like spend governors, tying prospective payments to measured clinical throughput and outcomes, not vibes.

CARA and the rise of episode rails insi total cost of care

CARA is where LEAD gets interesting for new business formation, because it is naming the missing middleware. CMS describes CARA as providing robust CMS support to enable episode-based risk arrangements between ACOs and specialis provider organizations, facilitating preferred provider relationships. CMS then g further and calls CARA a digital data-sharing and payment system designed as a voluntary modular component of total cost of care models, with flexible design t could scale, and it lists specific mechanics: sharing episode data, providing comr contracting frameworks by enabling export into contracting templates, allowing configurable episode design, and making payment to ACOs and preferred provic based on their episode-based risk arrangements. That is a lot of specificity for a page, and it is basically a roadmap for where infrastructure entrepreneurs can bu around, on top of, and adjacent to CMS rails.

The entrepreneurial angle is that episode contracting has always been a pain bec it is not one problem, it is seven problems stacked on top of each other. Defining episode is an informatics problem and a clinical governance problem. Pricing it actuarial problem. Reconciling it is a claims operations problem. Paying out is a payments problem. Auditing it is a compliance problem. Keeping everybody hon a behavioral economics problem. CMS is hinting it wants to absorb part of that p through CARA's templates, data sharing, and payment rails, but that still leaves huge private market for tools that make the episode definitions clinically sane, t contracts operationally workable, and the performance management continuous instead of annual. If CARA really does make exportable contracting templates ar configurable episodes available, the barrier to running dozens of micro-episodes drops, and suddenly the specialist enablement market expands beyond big syster

CARA is not reinsurance. It does not take tail risk off ACO balance sheets. Wha does is reduce transaction costs and operational friction for episode-based risk arrangements and preferred provider relationships. That can indirectly change t economics of specialty engagement by making it cheaper and faster to operation preferred networks, but it is not a capital solution. Any investor thesis that depe on CARA lowering capital needs via reinsurance should be revised. The real opportunity is episode ops as a product category: episode definition governance,

specialty pathway design, pricing support, contract lifecycle management, dispu resolution workflows, and ongoing performance management that ties to the CA data and payment flow.

Preferred provider relationships witho consolidation, the real opportunity

CMS says out loud that CARA is meant to support customized risk-sharing arrangements with preferred providers without driving consolidation. That is a goal with a business model hiding inside it. The current market path of least resistance has been consolidation because it simplifies contracting, data access, governance. If CMS wants to avoid that, then the market needs a new kind of glu infrastructure that makes non-ownership relationships behave like ownership, a operationally. That is where the best startups will live.

One obvious wedge is preferred provider performance management. The ACO n to see episode-level outcomes, cost, and variation. The specialist group needs to the same, plus how the ACO's primary care behavior affects specialist performar Everyone needs to see attribution logic and leakage. Then someone needs to run monthly huddles and tie remediation plans to contract terms without turning it compliance circus. This is not "analytics." This is a product that blends data ops contracting ops, and clinical ops into one routine. In a ten year model, this routi becomes a durable operational cadence, which is exactly what supports a durabl revenue stream.

Another wedge is the contracting lifecycle. If CMS provides templates, the differentiator becomes how fast a network can stand up thirty preferred provide arrangements that are actually adopted by clinicians. That adoption depends on workflow nudges, referral pathway tooling, scheduling access, and closed-loop feedback. In other words, the winner is not the company that can generate a PDI contract, it is the company that can turn the contract into changed referral beha without a fistfight. CARA is CMS admitting that the contract mechanics are a ba

but it also invites the private sector to build the rest of the stack that makes "preferred provider" real in daily practice.

High needs populations, risk adjustme and products that finally have time

CMS centers high-needs populations repeatedly. LEAD is described as focusing better serving coordinated care for high-needs patients, including dual eligible a homebound or home limited beneficiaries, and CMS describes integrating high- support across all ACOs through more accurate risk adjustment and benchmark That signals two things. First, CMS expects more high-needs lives to be inside accountable care, not segregated into special programs. Second, CMS is signalin wants the market to stop treating high-needs populations as a margin-killer and treating them as a capability to be built.

From an investor standpoint, high-needs enablement is where defensibility lives because it is hard, messy, and requires integration of clinical and operational mu Homebound care coordination is a logistics problem. Dual eligible care is a bene navigation and care coordination problem across funding streams. Complex chr care is a medication management and longitudinal monitoring problem. Most pc solutions that look sexy on a demo fail in these contexts because the real constra not knowledge, it is execution capacity and caregiver bandwidth.

The ten year period matters because high-needs programs often have front-loade costs. Building an in-home pathway, staffing teams, integrating community-base services, setting up after-hours coverage, and aligning primary care and specialty takes time. Under short models, operators underinvest, then complain that high populations are "too hard." Under LEAD, the model duration makes it rational t invest in high-needs infrastructure that pays back over several years. CMS explic frames LEAD as offering flexibility to check in with patients regularly, reach out before problems escalate, and coordinate care between visits, which is basically a description of the operational cadence required to manage high-needs lives.

Prospective payments and the comeba of boring finance software

The most underappreciated opportunity in value based care is that most organiz are not financially instrumented for it. They can run fee for service billing. They cannot run capitation-like cash flow, allocate it to teams, track it against outcom and prove the spend made sense. CMS says LEAD is designed to provide enhanc flexible cash flow payments and flexible, capitated population-based payments to support team-based care. That translates to a surge in demand for finance, contr and reconciliation tooling that is not optional if an organization wants to survive under two-sided risk.

There is a business category here that sounds boring but is probably going to be "value based care general ledger plus." Think of it as a layer that sits between cla and clinical operations and answers basic questions that most ACOs still cannot answer cleanly. Which patient segments consumed the prospective payment doll Which interventions drove measurable utilization change. Which vendors delive promised services. Which teams are under- or over-resourced. Which preferred provider arrangements are net positive after admin overhead. These are finance questions, but they need clinical dimensionality, and they need to tie to benchma performance. In REACH-era markets, many organizations tried to approximate t with spreadsheets and a prayer. In a ten year model, the spreadsheet approach becomes an existential risk because small errors compound and governance mem fades. Long duration is what makes real financial systems pay back, because the of building them is amortized over years instead of quarters.

Benefit enhancements and engagemen incentives as product wedges

CMS describes "healthy living flexibilities" that include benefit enhancements a beneficiary engagement incentives, including Part B cost sharing support and, b 2029, a Part D premium buy down, and CMS says ACOs can choose whether to implement these and must submit an implementation plan if they do. CMS also

examples like expanding Medical Nutrition Therapy conditions for full risk AC describes engagement incentives oriented around chronic disease prevention rev tied to healthy activities. Whether one likes the policy choices is not the point h The point is that CMS is giving ACOs new levers that are part insurance design, behavioral economics, and part program operations. That is a new product surfa

This creates three immediate business model lanes. One lane is benefit design operations for ACOs: productizing the workflow of choosing which enhancemen offer, building the implementation plan CMS expects, operationalizing eligibilit tracking cost and impact. Another lane is compliance and program integrity: bec incentives involving food products, premium offsets, and other value transfer mechanisms become magnets for waste and reputational risk, CMS explicitly no will apply strict safeguards for at least one incentive category. That creates dema for audit trails, controls, and monitoring that looks more like fintech complianc typical care management tooling. The third lane is MNT network enablement: if coverage expands for full-risk ACOs, the constraint becomes supply, scheduling, the operational integration of dietitians into primary care workflows, which is a classic "services plus software" wedge that can scale if it becomes a standard LE playbook.

CMS also describes a Substance Access beneficiary engagement incentive that w enable ACOs and providers to consult with aligned patients about possible bene hemp products, funded entirely at the participant's expense, only available in sta where such products are legal, with strict program integrity safeguards. Whatev opinion is on this policy, it is now a real operational surface area. The business opportunity is not to become a hemp company. The opportunity is to build the compliance, eligibility, documentation, and guardrail tooling that ACOs would n to even consider offering it without setting their own reputations on fire. The fa CMS also notes this incentive is being made available to ACO REACH participa performance year 2026 means the market for operationalization starts before LE begins. In other words, vendors can pilot with REACH participants in 2026 and learnings into LEAD 2027.

Rural ACO infrastructure enablement a the subsidy channel

The LEAD FAQ section includes a detail that changes the go-to-market for rura enablement. CMS states LEAD will support rural providers by offering an add-o payment that would not be reconciled to help create necessary infrastructure to an ACO, and by allowing lower beneficiary alignment minimums for ACOs with providers new to ACOs, including rural providers. That is not vague policy inter a specific design feature. The business implication is that "rural ACO enableme no longer just a services-heavy dream that requires outside capital. CMS is expli carving out non-reconciled money to fund infrastructure and lowering alignmen hurdles that historically blocked small entrants. That creates a clean wedge for companies that package an infrastructure starter kit targeted at rural health clir FQHC-adjacent rural networks, and independent groups: implementation servic plus lightweight tooling that gets them operational fast, with the add-on payme used as the funding source rather than venture dollars. The investor-grade insig that this is a subsidized customer acquisition channel created by CMS design, n philanthropic bet.

Medicare-Medicaid integration, two states, and a giant new services layer

CMS describes Medicaid integration as a component of LEAD, with an initial planning phase from March 2026 through December 2027 during which CMS w identify two states interested in partnering to develop a framework for ACO-Me partnership arrangements, including data sharing and care coordination to impr outcomes for dual eligible beneficiaries, and it notes the opportunity for ACOs i selected states to enter partnership arrangements with Medicaid organizations i planning period succeeds. This is remarkably concrete for an announcement pag it creates a tight entrepreneurial target: build the integration services and toolin makes these partnerships operational, auditable, and scalable.

A lot of people hear “integration” and immediately think big enterprise software That is a trap. The immediate need will be operations. Who is responsible for wh care coordination function. How to avoid duplicative case management. How to incentives across funding streams. How to share data without turning into a year long integration project. How to document workflows in a way that satisfies CM state Medicaid partners. Companies that behave like “integration operators” and a packaged operating model, with lightweight tech that makes it measurable, wi likely have the fastest path to revenue. Then the platform layer can follow.

The time boxed, small cohort, high intensity implementation environment with t states implies unusually high willingness to pay for operators who can reduce ris speed up execution. The business model here looks like an integration operator t sells a repeatable package: governance templates, consent and data sharing work care coordination operating model, and measurement framework aligned to wha states and CMS will accept. This is not about building a universal platform on d one. It is about winning the first two states, learning the real failure modes, then scaling as CMS expands. The investor insight is that a constrained pilot window named timelines can create a strong beachhead market if a team is ready early.

There is also a quiet analytics opportunity here. Dual eligible populations have heterogeneous risk, high social complexity, and high sensitivity to care transition LEAD succeeds in bringing these lives into coordinated accountable care under Original Medicare arrangements, investors should expect demand for risk mode care stratification approaches that go beyond standard patterns. Not because the is exotic, but because the operational decision points are different. The “right” intervention might be benefits navigation or housing stabilization rather than an clinic visit. Tools that can recommend operational actions, not just predict risk, have an edge.

A practical investor map of company archetypes that fit LEAD

The first archetype is the ACO operating core, a combined financial and clinical operations layer designed for ten year endurance. It should include cash flow management for prospective payments, episode and preferred provider arrangen tracking aligned to CARA concepts, reconciliation readiness, and a clinical actic layer that turns risk stratification into team tasks. The moat comes from being painfully integrated into daily workflows, not from fancy models.

The second archetype is the preferred provider enablement stack. Think "episoc program in a box" for specialist groups and post acute providers who need to participate in episode-based arrangements without merging into a giant system. CARA suggests CMS is creating rails for data and payments, but there is still a l market for contract ops, clinical pathway governance, referral workflow shaping performance feedback loops.

The third archetype is high-needs care operations. This is not a telehealth wrapp This is logistics, in-home workflow, caregiver support, medication management, closed-loop coordination that works for homebound and dual eligible populatio LEAD explicitly signals these populations, which implies that vendors able to su them will be pulled by demand rather than pushed by sales.

The fourth archetype is benefit and incentive program operations. As LEAD add benefit enhancements and engagement incentives, ACOs will need help designin implementing, documenting, and measuring these programs. Companies that ca incentives like a controlled clinical program, with clear eligibility logic, distribu controls, audit trails, and outcome measurement, will have a differentiated posit

The fifth archetype is the Medicare-Medicaid partnership operator. In the two-s planning and early implementation window, speed and correctness will matter n than elegance. The winners will likely be teams that can stand up operational partnerships quickly, with enough tech to make data sharing, task ownership, ar accountability visible, and enough governance support to keep stakeholders alig across organizations that historically do not trust each other.

The sixth archetype is rural ACO infrastructure packages. Non-reconciled add-c payments and lower alignment minimums create a subsidy channel for infrastru targeted at rural providers new to ACOs. The product is implementation service lightweight tooling funded by the CMS add-on, not venture capital.

The seventh archetype is value-based care financial operations. Most organizatic cannot run capitation-like cash flow, allocate it to teams, track it against outcom and prove the spend made sense. The boring "VBC general ledger plus" layer th between claims and clinical operations becomes essential infrastructure in a ten model where small errors compound.

What to ignore, where people will wast money anyway

The easiest way to lose money in value based care is to overestimate the willingn providers to change their day. Ten years does not magically make clinicians enjo workflows. It just makes it possible to invest in change management that has tim work. Any pitch that assumes adoption is instant should be treated like a kitche renovation show where everything is done in one weekend. Sure, it looks great o camera, but it is not how real houses work.

Another place money will be wasted is purely generic analytics. LEAD will creat demand for analytics, but analytics without an action loop is just a nicer way to f bad. The value is in products that can take model features, like the split risk tra and the CARA episode constructs, and turn them into operational routines. CM essentially describing a set of levers, not a single lever, and the companies that w will be the ones that can operationalize combinations of levers without melting c the organization.

A final caution is to avoid treating "improved benchmarking" as an excuse to bu another benchmarking consultancy in software clothing. CMS does say improvec benchmarking is part of LEAD. But CMS is also saying the goal is broader participation and fewer barriers. The enduring opportunity is not to explain the

benchmark, it is to build the muscles that let an organization perform against it decade.

Which REACH-era business models are structurally dead

Several REACH-era company categories simply do not survive the transition to I Benchmark arbitrage aggregators that built businesses around timing cohort en and exit to capture favorable benchmark windows lose their edge when benchma stabilize for ten years. Thin enablement layers that depended on frequent partic churn and could sell shallowly because customers might leave anyway cannot co when customers expect decade-long relationships and will pay for depth.

Risk wrappers whose primary value proposition was absorbing tail risk for a fee margin compression if CARA or other CMS mechanisms reduce the capital inte of participation. Their business model depended on information asymmetry and capital scarcity. LEAD appears designed to reduce both.

Geographic arbitrage platforms that selected markets based on regional benchm quirks lose their model if LEAD moves toward more stable, less regionally sensi benchmarks. The companies that thrived by being in the right place at the right will struggle when location matters less and operations matter more.

Compliance-light operators that treated ACO participation as a financial trade r than a clinical operating model will exit. Ten years is too long to fake operationa capability. The scrutiny increases, the benchmark advantages erode, and the fina engineering gets exposed as underinvestment in care delivery.

Exit paths and who actually buys these companies

The buyers for LEAD-era companies will differ from REACH-era buyers. Health systems become more credible acquirers because ten year contracts align with th

capital planning cycles and strategic horizons. They can justify acquiring enable infrastructure knowing it will be used for a decade rather than three years.

Payers will acquire selectively, focusing on companies that help them compete ir Medicare Advantage or support their own provider network strategies. But paye less interested in pure ACO plays than they were during REACH because LEAD inside Original Medicare and does not directly feed MA enrollment.

Private equity-backed platform companies will be active buyers if they can const rollup theses around operational infrastructure that scales across multiple ACO key is whether they can underwrite to stable cash flow over ten years rather than quick flips. The PE shops that win will be those comfortable with longer hold pe and operational value creation.

Public market comps remain thin but could improve if a few companies reach sc and demonstrate durable unit economics under LEAD. The challenge is that pul markets want predictable growth and clear margin expansion. LEAD creates the conditions for that but does not guarantee it.

Strategic buyers from adjacent markets, like pharmacy benefit managers, post-ac networks, and specialty care platforms, will acquire where LEAD companies giv them access to primary care relationships or total cost of care contracting capab they lack organically.

Where smart people will screw this up

LEAD will absolutely create new failure modes. Overbuilding infrastructure bef customer demand materializes is the classic mistake. CMS creates the regulatory conditions for a market, but that does not mean demand appears instantly. Com that raise too much, build too broadly, and burn cash waiting for LEAD particip to arrive will run out of runway.

Betting on CARA details that end up being narrower than expected is another tr CARA could be transformative or it could be a marginal improvement dependin

how CMS prices, scopes, and operationalizes it. Building an entire company thes around CARA being generous is risky until the RFA provides specifics.

Misreading CMS's tolerance for aggressive monetization inside benefit enhancer is a reputational hazard. CMS explicitly calls out program integrity concerns for incentive categories. Companies that treat these as revenue opportunities withou building serious compliance infrastructure will get burned, and they will take th customers down with them.

Underestimating implementation friction is perennial. Ten years gives time for adoption, but it does not eliminate the fact that care delivery organizations are r change-resistant, and resource-constrained. Products that look clean in demos b require heroic implementation effort will struggle regardless of time horizon.

Ignoring the fact that CMS can and does change models mid-flight would be nai Ten years is a commitment, but CMS retains authority to modify, suspend, or terminate if circumstances change. Any investor thesis should stress test what happens if LEAD gets restructured in year five.

Closing thoughts, how to ride the tailwind without getting clipped

LEAD is a policy move that signals a shift from experimentation to institution-building. CMS is explicitly setting a ten year window, stating a predictable perio without rebasing, introducing new rails via CARA for episode-based arrangemer with preferred providers, and calling out prospective, capitated population-base payments and other flexible cash flow tools, with additional beneficiary incentiv rural support mechanisms, and a concrete Medicare-Medicaid integration plann timeline. These are not subtle cues. They are CMS pointing at the exact stress po that have blocked durable accountable care and inviting the market to build the missing infrastructure.

For investors and entrepreneurs, the cleanest strategy is to focus on what becom more valuable the longer the model lasts. Operational systems. Financial control

tie money to actions. Preferred provider relationship tooling that prevents consolidation by making relationships behave like integration. High-needs care operations that can survive real-world constraints. Program operations for benef and incentives with measurement and auditability. Integration operator layers fo Medicare-Medicaid partnership pathway. Rural enablement infrastructure funde CMS add-ons. Episode ops platforms that plug into CARA rails. The common th is not that these are glamorous. The common theme is that these are the things organizations will still be using in year eight, because they are the things that ke them solvent and credible.

If a market is being created for ten years, the best businesses will look like they built to still be slightly annoying in ten years, because they are embedded in the That is the good kind of annoying.

3 Likes

← Previous

Nex

Discussion about this post

Comments Restacks

Write a comment...

© 2026 Thoughts on Healthcare · Privacy • Terms • Collection notice
Substack is the home for great culture