

Policy Updates: Spring 2026

WHAT WE KNOW, WHAT WE DON'T, AND HOW WE'RE EVALUATING WHAT'S AHEAD



The policy environment is moving fast and not always with clarity. Since its founding in 2010, CMMI has launched over 50 models. Only four have ever been certified for expansion into permanent Medicare. Most were redesigned, consolidated, or sunset before running their full course. This does not mean they failed — it's because testing is the Innovation Center's purpose.

That context matters now, particularly as several models move from announcement into active implementation simultaneously. The LEAD Model RFA was released on March 31, adding a concrete application timeline to a landscape that also includes ACCESS going live in July, TEAM's first performance year underway, and state Rural Health Transformation programs moving into procurement.

As the leading value-based care enabler for rural healthcare organizations, we want to cut through the noise with what we actually know, what remains uncertain, and how we're approaching evaluation alongside you.

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LEAD Model

THE DEVIL'S IN THE DISCOUNT

LEAD — a voluntary, 10-year, full-risk capitated model — launches January 2027 as the successor to ACO REACH. The Request for Applications was released March 31, 2026.

Applications are due May 17, 2026 with Participant TIN lists due August 5, 2026.

With the RFA now public, here is what's confirmed:

- Benchmarks based solely on historical costs, with no rebasing over the model's 10-year life
- Two risk tracks: Global (100% shared savings, 100% downside risk) and Professional (50% upside, 50% downside risk)
- Higher-spending ACOs receive an administrative add-on payment not subject to repayment and excluded from total cost of care at settlement
- Quality withhold reduced to 3% (vs. 5% in REACH)
- Rural add-on capitation payment confirmed (dollar amount, eligibility, and duration being evaluated at the TIN level)
- TIN-level enrollment consistent with MSSP, simplifying administration
- ACPT guardrails that limit early volatility: $\pm 0.3\%/0.2\%$ vs. national/regional blend in PY1, widening gradually to $\pm 1.5\%/1.0\%$ by PY5
- AI-inferred risk scores phased into risk adjustment beginning PY2029 at one-third weight, reaching 100% by PY2031 — a fundamental methodological shift with meaningful modeling implications

Our read: LEAD is not a universal upgrade over MSSP.

Whether it's the right move for your organization depends almost entirely on where your practices sit relative to regional fee-for-service spending.

For higher-spending, more regionally inefficient practices: LEAD looks interesting. Our initial modeling suggests a higher-spending practice that can achieve mid-single-digit gross savings rates may perform better in LEAD than in MSSP Enhanced. That's because CMS included two features in LEAD specifically to attract higher-spending providers: the administrative add-on payment (not subject to repayment, not included in TCOC at settlement) and a lower discount rate to CMS than that paid by more regionally efficient practices.

For lower-spending, more efficient practices: The picture is different. Based on our preliminary modeling, the breakeven against MSSP Enhanced moves to a double-digit gross savings rate — a very high bar. Outside of some upfront cash flow benefit, it's hard to make a compelling case for LEAD over MSSP for this group.

Implications for organizations interested in joining a Wellvana ACO: We will evaluate all tracks and start years in both MSSP and LEAD for every TIN in your organization under our Accurate Practice Placement (APP) process and come to you with a recommendation on what we believe will be the most optimal for your specific organization. In both LEAD and MSSP, Wellvana takes on the upfront risk.

Important note: Wellvana covers an industry-leading 90% of all available MSSP benchmark year, track, and attribution combinations, helping your organization find the most advantageous path possible on your value-based care journey.

ACCESS Model

VENDOR-LED, OUTCOMES REQUIRED

ACCESS is a 10-year vendor-led model that begins its first performance period July 5, 2026. The model funds technology-enabled management across four clinical tracks, paying organizations only when patients hit measurable clinical targets:

- **Early Cardio-Kidney-Metabolic (eCKM):** hypertension, dyslipidemia, obesity or overweight with marker of central obesity, and prediabetes
- **Cardio-Kidney-Metabolic (CKM):** diabetes, chronic kidney disease, and atherosclerotic cardiovascular disease
- **Musculoskeletal (MSK):** chronic musculoskeletal pain
- **Behavioral Health (BH):** depression and anxiety

Outcome targets include metrics like blood pressure control, A1c management, and patient-reported pain and mental health improvements. Payments are tied to clinical improvement relative to each patient's starting point.

The structural challenge: ACCESS participants and their affiliated entities cannot submit Part B fee-for-service claims for aligned beneficiaries during active enrollment. This effectively excludes health systems and multi-specialty groups from being participants themselves. This is a vendor-led model by design.

The Wellvana approach: We're evaluating a short list of preferred ACCESS vendor partners and will prioritize those with a documented history of superior clinical outcomes. We'll use the scale of our network to negotiate favorable rates. Because we aggregate our partners' claims and quality data, we can monitor whether an ACCESS participant is truly driving ACO savings. If it's not working, we'll see it and adjust.

Financial note: Outcome Aligned Payments won't impact MSSP benchmarks or expenditures in 2026 or 2027, but the PCP co-management payments (~\$30 per service, up to ~\$100 per beneficiary per year) will hit expenditures from day one.

Bottom line: The exclusion of health systems as participants tempers our enthusiasm. We'll only engage with vendors who can deliver differentiated clinical outcomes, demonstrable returns, and alignment with how our network delivers care.

Rural Health Transformation

**\$50 BILLION, 50 STATES,
50 STRATEGIES**

This is the largest program in the current policy landscape: \$50 billion over five years across all 50 states, authorized by the One Big Beautiful Bill Act. States have moved from application into active implementation.

Where things stand: All 50 state awards have been announced. First-year distributions average \$200 million per state, ranging from \$147 million to \$281 million. Texas leads at \$281 million (“Rural Texas Strong”), Alaska follows at \$272 million; New Jersey and Connecticut sit at the lower end of the range.

Half the fund is distributed equally — \$100 million per state regardless of size or need. The other half is weighted by rurality, current or proposed state policy actions, and the application’s potential for impact. CMS has established a dedicated office to manage the program and will convene states annually at a Rural Health Summit (during the CMS Quality Conference) to accelerate cross-state learning.

States are required to show measurable outcomes or face funding clawbacks. That accountability structure matters — it means partners who can demonstrate results have a structural advantage in state procurement processes.

What’s encouraging: Most states are channeling RHT toward value-based care infrastructure. [A USofCare analysis](#) found that the majority of state plans explicitly invest in ACO models as the sustainable path forward — with MSSP and LEAD cited as the complementary federal programs these investments are designed to connect to. CMS has reinforced this framing, positioning RHT alongside ACCESS and LEAD as a cohesive strategy for moving rural and safety-net providers toward outcomes-based payment.

The long game: States are already thinking about what happens when the five-year money runs out. ACO-style models resonate as the sustainable path, and RHT is the on-ramp that lets rural providers make investments they couldn’t otherwise afford — in technology, care model redesign, and data integration tightly embedded in local communities.

Wellvana’s role: We intend to participate in state-level RFPs in Year 1 in select markets where we have the deepest rural presence, focusing on the key foundations of value-based care (e.g., quality strategy, VBC infrastructure design, AI advancement, data interoperability, and ACO performance management). If you’d like support with your RHT strategy, email us at policy@wellvana.com.

TEAM Model

MANDATORY EPISODES, NOW LIVE

The TEAM model launched January 1, 2026, with approximately 740 mandatory participating hospitals in selected Core-Based Statistical Areas (CBSAs). Selected acute care hospitals coordinate care from surgery through 30 days post-hospitalization for patients with Original Medicare undergoing one of five procedures:

- Lower extremity joint replacement
- Surgical hip fracture treatment
- Spinal fusion
- Coronary artery bypass graft (CABG)
- Major bowel procedures

Performance Year Structure: Performance Year 1 (2026) is upside-only for most hospitals — shared savings up to 10% of episode spend with no downside risk. 2027 moves to two-sided risk, with exposure of up to $\pm 20\%$ for standard hospitals.

For rural hospitals and safety-net hospitals specifically: Track 2 provides reduced two-sided risk and reward for performance years 2 through 5 — not just the first year of risk. Rural hospitals are required to participate (TEAM is mandatory in selected CBSAs regardless of hospital designation), but this extended protection materially reduces their downside exposure as the model matures through 2030.

TEAM and MSSP can run simultaneously: CMS explicitly permits overlap between TEAM and MSSP. If a beneficiary attributed to an MSSP ACO triggers a TEAM episode at a selected hospital, savings are calculated independently under both programs. This is intentional — CMS is testing how episode-based and total cost of care arrangements interact. For Wellvana partners operating in selected CBSAs, this means TEAM is not an either/or decision relative to MSSP participation.

Where surplus opportunity exists: SNF utilization and length of stay, readmission reduction, and post-acute spend management remain the primary levers for generating savings under TEAM.

Wellvana support available: If your organization was selected for TEAM, Wellvana's Site of Care post-acute team is available for support. Email policy@wellvana.com for more details.

The Wellvana Approach

Informed, Engaged, Customized for Partners

Policy volatility is the norm right now. Models get redesigned, variables change, and what looks attractive at announcement can look very different at implementation. But the landscape is also becoming more concrete. The LEAD RFA is public with an application deadline. State RHT awards have been distributed and implementation is underway. ACCESS is live. TEAM's first performance year is in progress. The window for observation is narrowing — the time to evaluate and act is now.

As the largest value-based care enabler for rural healthcare organizations, Wellvana can help you maximize your financial opportunity and drive improved patient outcomes. As we enter PY27 ACO placement season, we're ready to crunch the numbers to help you have a nuanced perspective on which programs and contracts make the most sense for your providers.

Reach out to growth@wellvana.com to schedule a consultation.

About Wellvana

Wellvana is a national leader in value-based care enablement, serving more than 850,000 patients across 40 states.

With an expansive rural network of hospitals, health systems, and independent primary care practices, Wellvana helps future-forward organizations take the right risks, unlock new revenue, and deliver better patient outcomes.

In 2024, Wellvana's ACO participants generated over \$337 million in savings to Medicare, with the company's flagship ACO achieving more savings than any other MSSP ACO in the nation.

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