ICRC | Integrated Care Resource Center

Using the Long-term Enhanced ACO Design (LEAD) Model to Better Coordinate Care for Dually Eligible Beneficiaries in Original Medicare

March 25, 2026

Logistics

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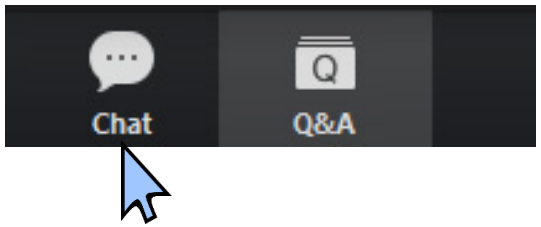

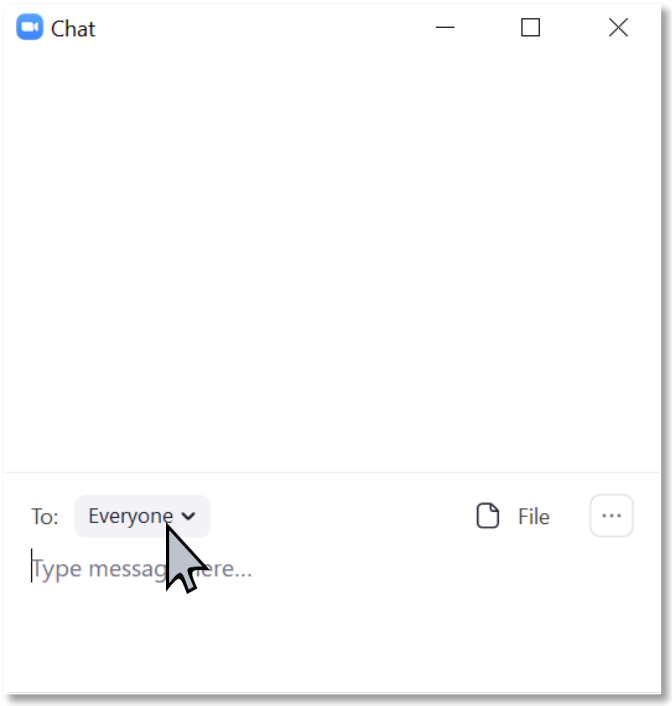

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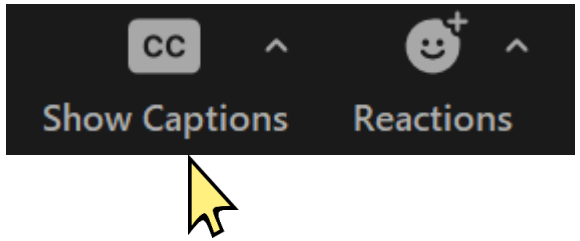

Agenda

- Welcome and introductions
- LEAD model overview
- Dual integration component of LEAD
- Questions and discussion
- Next steps

LEAD Model Overview

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LEAD Model Overview

- LEAD is a **10-year Medicare Accountable Care Organization (ACO) model** offered by the CMS Innovation Center, beginning January 1, 2027.
- It builds on prior Innovation Center ACO models, with policies designed to broaden ACO participation.
- LEAD is intended to work better for **rural, safety net, and independent providers,** particularly providers serving patients with **historically high Medicare costs**.
- It also includes a new **Medicare–Medicaid integration opportunity** designed to improve care coordination and quality of care for dually eligible beneficiaries in Original Medicare. This policy aims to align financial incentives across Medicare and Medicaid providers to coordinate care across the continuum.

Providers in LEAD

- An ACO is a group of Medicare-enrolled providers that takes responsibility for the **quality of care** and **total Medicare costs** for a population of Medicare beneficiaries.
- **LEAD is designed for a wide spectrum of health care providers**.
- LEAD includes two participant types:
  - **Participant Providers:** Physicians and health care organizations that take direct accountability for cost and quality and drive beneficiary alignment under the model. Participant Providers are typically primary care providers, though not required to be.
  - **Preferred Providers:** Physicians and health care organizations that can take indirect financial accountability and do not drive beneficiary alignment or quality performance. Preferred Providers are typically specialists and institutional providers (e.g., post-acute care) but not required to be.

Beneficiary Eligibility and Alignment in LEAD

- LEAD applies to **Original Medicare beneficiaries with Parts A and B**.
- Beneficiaries are **aligned** to ACOs for purposes of accountability; they do not directly enroll in the model.
- LEAD includes three alignment pathways:
  - **Claims-based alignment:** CMS will align beneficiaries to ACOs based on their claims history and primary care utilization patterns.
  - **Voluntary alignment:** Beneficiaries voluntarily align to an ACO by choosing a provider affiliated with that ACO as their primary provider.
  - **Medicaid-based alignment:** CMS will align dually eligible beneficiaries to ACOs if they receive Medicaid benefits through one of the ACO's Medicaid partners (state Medicaid agency or Medicaid managed care organization) and are not already aligned to another ACO.

ACO Benchmarking and Shared Savings

- LEAD is a **Medicare total cost of care model**.
- Each ACO receives a **benchmark**, or Medicare total cost of care spending target, for its aligned beneficiaries.
- CMS compares actual Medicare spending for the ACO's aligned beneficiaries to that benchmark at the end of the performance year.
- If spending is below benchmark and quality requirements are met, the ACO may earn **shared savings**. If spending is above benchmark, the ACO may owe **shared losses**, depending on the risk option selected.
- LEAD offers two risk-sharing options:
  - **Professional Risk:** 50 percent of savings and 50 percent of losses
  - **Global Risk:** 100 percent of savings and 100 percent of losses

Additional Payment Incentives and Flexibilities in LEAD

- One challenge in ACO models is that shared savings are typically calculated **after** the performance year ends.
- LEAD addresses that by offering **upfront, prospective payments** that can give ACOs more stable cash flow to support care delivery improvements during the year.
- LEAD includes two main capitation options; ACOs must choose one:
  - **Primary Care Capitation (PCC):** a capitated payment for primary care services, plus an enhanced primary care payment above historical primary care spending, to support greater investment in primary care.
  - **Total Care Capitation (TCC):** a broader capitated payment for Medicare Part A and B services delivered by participating primary care and specialty providers
- LEAD also includes a new **administrative add-on payment** intended to support participation by ACOs with historically higher spending.

Quality and Beneficiary Engagement Tools and Flexibilities

- An ACO's shared savings amount will be tied to a **targeted set of quality measures** and implementation of a prevention and quality plan. LEAD ACOs will be measured on 7 quality measures:
  - Risk-Standardized All-Condition Readmission
  - All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
  - Days at Home for Patients with Complex, Chronic Conditions
  - Timely Follow-Up After Acute Exacerbations of Chronic Conditions
  - CAHPS Patient Experience Survey
  - Controlling High Blood Pressure
  - Diabetes: Glycemic Status Assessment Greater Than 9%
- The model also includes **benefit enhancements (BEs)** and **beneficiary engagement incentives (BEIs)** intended to support prevention, healthier behaviors, and better care navigation. Example BEs and BEIs in LEAD include:
  - Expanded eligibility for Medical Nutrition Therapy
  - Part B Cost Sharing Support
  - Chronic Disease Prevention Incentive

What's New in LEAD

- **Longer performance period:** LEAD runs for 10 years, which gives organizations more time to invest in care transformation and see results.
- **New benchmarking approach:** The LEAD benchmarking methodology is designed to work for a wider range of participants, including both new and experienced ACOs.
- **Stronger focus on complex populations:** LEAD includes policies aimed at better serving High Needs beneficiaries and dually eligible beneficiaries.
- **New tools for specialist engagement:** LEAD includes more levers for ACOs to engage specialist and other non-primary-care providers.

Dual Integration Component

Lead Integration Partnerships

- In participating states, LEAD ACOs will have the option to enter into formal partnership agreements with the **state Medicaid agency (SMA)** and/or **Medicaid managed care organizations (MCO)**, depending on the state's delivery system *(LEAD is intended to work in both Medicaid fee-for-service and Medicaid managed care states)*
- These agreements would describe how the parties will work together to better coordinate care for dually eligible beneficiaries. Partnership activities could include:
  - Designated care coordination points of contact
  - Protocols for identifying and communicating changes in beneficiary condition
  - Shared risk stratification approaches
  - Structured information-sharing from home- and community-based providers
  - Exchange of clinical information, such as medications, assessments, and falls risk
- These would be **two-way agreements** between the ACO and the Medicaid partner (SMA or MCO); CMS would not be a party to the agreement.

Benefits of LEAD Medicare-Medicaid Integration

- Extends integration efforts to dually eligible beneficiaries in Original Medicare, not just those in managed care arrangements.
- Creates an opportunity for states to benefit from Medicare savings generated by Medicaid-supported care coordination and HCBS investments.
- Incentivizes and rewards value-based approach to care provided in the home, which can improve patient outcomes and reduce costs.
- Over the longer term, may also lead to Medicaid savings by helping beneficiaries remain in or return to the community and reduce or delay the need for HCBS services. The driver of this dynamic is better care coordination and integration of clinical support in the home.

Medicaid-Based Alignment

- LEAD would include **Medicaid-based alignment** for certain dually eligible beneficiaries.
- Under this approach, CMS would align a beneficiary to a LEAD ACO if the beneficiary:
  - receives Medicare benefits through fee-for-service Medicare
  - receives Medicaid benefits from an SMA or MCO that is partnered with that ACO
  - is not already aligned to another ACO
  - and resides in the ACO's service area
- This pathway is intended to bring more dually eligible beneficiaries into an accountable care arrangement, especially those who may not already have a strong primary care alignment pattern.

Shared Savings

- Partnership agreements would specify how LEAD ACOs and Medicaid partners share savings.
- A core principle is that states should be able to benefit when better coordination reduces Medicare spending — but with **guardrails against cost shifting** from Medicare to Medicaid.
- Process for calculating shared savings:
  - Changes in Medicaid spending would be calculated for eligible beneficiaries
  - If Medicaid costs increase, the ACO would first reimburse the Medicaid partner for those increases from its Medicare shared savings
  - Any remaining Medicare savings could then be shared between the ACO and the Medicaid partner based on the terms of the agreement

Example of how an ACO-Medicaid Partnership Could Function

- The ACO's RN care coordinators work directly with the MCO's LTSS case managers.
- The MCO and the ACO develop a risk stratification protocol to identify high risk patients. The RN care coordinators and the LTSS case managers review each high-risk beneficiary at a regular cadence to determine whether additional supports are needed.
- Personal care aides delivering HCBS services are required to notify the LTSS case manager if they observe significant changes in a beneficiary's condition, such as worsening mobility or confusion. The LTSS case manager shares this information with the ACO RN care coordinator who can quickly arrange clinical follow-up.
- Beneficiaries who do not have a primary care provider (PCP) are aligned to the ACO. The RN care coordinator will help these beneficiaries schedule a visit with an ACO PCP and establish a longitudinal care relationship.

Together, these activities reduce hospitalizations for dually eligible beneficiaries aligned to the ACO by 25% and total Medicare costs by 15%. The ACO shares these savings with the MCO according to the terms of their partnership arrangement.

Planning Phase and Timeline

- The Medicaid integration component of LEAD would be subject to a **two-year planning phase** that begins spring 2026.
- During that period, CMS would work with the selected states to establish the framework for how this component would operate in that state.
- Planning activities may include:
  - Identifying available data sources and data exchange mechanisms
  - Establishing methodologies for calculating Medicaid spending changes and Medicare savings
  - Developing recommended or required care coordination activities
  - Determining how requirements would apply in managed care environments
- **Pending successful completion of the planning phase**, state Medicaid agencies and/or MCOs could enter partnership agreements with LEAD ACOs effective in 2028.

State Selection Criteria

CMS will initially select two states to participate in the Medicare-Medicaid Integration component of LEAD.

CMS will base its selection of states on several criteria, including:

- Presence of a substantial population of full-benefit dually eligible beneficiaries with Original Medicare, especially those with significant LTSS needs
- Meaningful opportunity for Medicare savings, including high-cost or high-growth markets
- A meaningful ACO presence
- Prior state experience or interest in integrated care for dually eligible beneficiaries, or demonstrated capacity to support new integration efforts
- Strong Medicaid data quality to support alignment, monitoring, and evaluation

Participation Expectations for States

States interested in this opportunity should expect to engage in both **policy and operational planning**.

Likely responsibilities would include:

- Designating policy and finance staff to work with CMS during the planning phase
- Identifying how data would be shared to support Medicaid-based alignment, monitoring, and evaluation
- Supporting the development of partnership and care coordination expectations
- In managed care states: determine whether/how to establish qualifications or advise on an MCO's participation

Questions and Discussion

Discussion questions

- What questions do you have about this opportunity?
- Do you think current ACOs/potential ACOs in your state might be interested in this opportunity? Why or why not?
- What barriers or challenges do you anticipate?
- What additional information or resources would be helpful?

Next steps

Next steps: Contact CMS

- Reach out to CMS with questions or to express interest in participating

Thank you!

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