

# Aligning Medicare and Medicaid Incentives Through Accountable Care: What States Need to Know About CMS' LEAD Model

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The Centers for Medicare & Medicaid Services (CMS) Innovation Center's new [Long-term Enhanced ACO Design \(LEAD\)](#) model includes an opportunity for two state Medicaid agencies to work with CMS to better coordinate care for people who are dually eligible for Medicare and Medicaid and who receive their Medicare benefits through Original Medicare. Under the LEAD model's Medicare-Medicaid integration component, CMS plans to create partnerships between Medicare [accountable care organizations \(ACOs\)](#) and the selected states to better align Medicare and Medicaid service delivery for this population. The approach would make the LEAD model the only currently available option to further Medicare-Medicaid integration for people in Original Medicare. The model also aims to better align financial incentives across the two programs and reduce cost-shifting.

This Center for Health Care Strategies (CHCS) *Policy Cheat Sheet* highlights key features of the LEAD model and outlines initial considerations for state policymakers as they explore whether this opportunity could support their goals for Medicare-Medicaid integration.

## Why does this opportunity matter for states?

For states, the LEAD model's Medicare-Medicaid integration component offers a rare opportunity to improve care coordination for the [37 percent](#) of dually eligible individuals who are in Original Medicare. If successful, LEAD could allow states to benefit from Medicare savings generated by Medicaid-supported care coordination and investments in home- and community-based services (HCBS).

## How will CMS select states and structure LEAD's planning phase?

Building on [CMS' earlier efforts to promote accountable care](#), the LEAD model is designed to expand participation in Medicare ACOs beyond large provider groups and health systems to include smaller, independent, or rural practices and provider groups that are new to Medicare ACOs. The model will test a 10-year financing or benchmarking approach from January 2027 through December 2036, giving participating providers a longer, more stable path toward value-based care, including time to invest in care redesign, adapt to the model, and potentially see longer-term savings. It also prioritizes providers serving high-need patients and those dually eligible for Medicare and Medicaid.

CMS will select states for the LEAD model's Medicare-Medicaid integration partnership component based on several criteria, such as:

- A large, high-cost dually eligible population, particularly with high use of Medicaid-funded long-term services and supports (LTSS);
- Strong potential for savings based on high Medicare costs or high rates of cost growth;
- Meaningful Medicare ACO penetration, particularly among full-benefit dually eligible individuals;
- Past state efforts to integrate care for dually eligible individuals, including through contracts with [dual eligible special needs plans \(D-SNPs\)](#) or participation in the federal [Financial Alignment Initiative](#); and
- Completeness of the state's [Transformed Medicaid Statistical Information System \(T-MSIS\)](#) analytic files data on enrollment, service utilization, and costs.

CMS will select two states to enter an initial planning phase, running through December 2027, during which a framework for ACO-Medicaid partnership agreements will be developed. Planning activities may include:

- Identifying existing data sources and data exchange processes;
- Developing care coordination activities for dually eligible individuals;
- Determining how Medicaid managed care requirements apply to these partnerships; and
- Establishing financing parameters to support shared savings among participating states.

Following completion of the planning phase, LEAD ACOs in participating states could begin establishing partnerships with the Medicaid agencies and/or their Medicaid managed care organizations (MCOs) in 2028.

## What should states consider before applying?

Participation in the LEAD model's Medicare-Medicaid integration component will require states to take on meaningful planning and oversight responsibilities. As a result, the opportunity is likely to be most attractive to states that see strategic value in extending Medicare-Medicaid integration beyond existing managed care approaches. As state policymakers weigh this opportunity, key considerations include:

### 1. Extent of Medicare ACO Penetration Among Dually Eligible Individuals in Original Medicare

As of January 2026, an [estimated 14.3 million Medicare beneficiaries](#) nationally are attributed to a Medicare ACO, including a substantial number of dually eligible individuals. [Among dually eligible individuals in Original Medicare](#), ACO attribution has grown substantially, from just 2.2 percent in 2012 to approximately 35 percent, or 1.4 million people, in 2024. Yet despite this growth, Medicaid agencies remain generally unfamiliar with Medicare accountable care models, even though these arrangements now account for a large share of dually eligible individuals in Original Medicare.

States with a significant concentration of [full-benefit dually eligible individuals](#) in Original Medicare and meaningful Medicare ACO penetration, especially among the full-benefit population, will be best positioned for this opportunity. The extent of Medicare ACO penetration among dually eligible populations varies considerably across and even within states. For example, in 2025, penetration rates varied from a high of [32 percent in New Hampshire to a low of four percent in Arizona](#). As interested states work to expand internal and external ACO knowledge, a California Department of Health Care Services [fact sheet on Medicare ACOs](#), MedPAC [resource on ACO payment basics](#), and ATI Advisory [data tool](#), may be helpful.

## 2. Capabilities of Existing Data-Sharing Pathways to Support Timely Coordination

States whose dually eligible populations access Medicaid benefits — including HCBS or behavioral health services — through fee-for-service will need to determine if involved Medicaid or partner agencies and designated waiver case management entities have sufficient data-sharing capacity to support timely service coordination. Because timely coordination will be a key aspect of an ACO-Medicaid partnership, Medicaid and partner agencies may need to implement system enhancements and new processes to support effective coordination. For states with Medicaid managed LTSS contractors, specific data-sharing pathways, elements, and capacities will need to be assessed at the Medicaid MCO level.

Additionally, LEAD ACOs will need to develop timely and accurate data feeds that combine Medicare and Medicaid data sources to create a complete profile of their patient population. Medicaid agencies with established data-sharing pathways with external partners, such as integrated D-SNPs or managed LTSS entities, may be primed to meet this requirement since they are likely to have existing data sources and exchange mechanisms that can be adopted and modified. Other mechanisms for data sharing, such as regional or statewide health information exchange organizations, may also be of value. States interested in this opportunity may want to consider whether existing capacity can support data integration and sharing for dually eligible populations or if capacity would need to be built out during the planning phase.

## 3. Potential State Savings Opportunity and Risk of Cost Shifting

CMS and states will determine how LEAD ACOs and Medicaid partners will calculate and share in Medicare savings, such as potential savings from reduced hospitalizations or avoided skilled nursing facility (SNF) stays. As with other integration platforms, there is also some potential for cost shifting from Medicare to Medicaid as LEAD ACOs seek to reduce Medicare service use. To limit this potential, partnership arrangements will include bilateral risk-sharing arrangements that encourage greater accountability for health care costs across Medicare and Medicaid for dually eligible individuals. States will need to be able to track and calculate changes in Medicaid service use and spending for eligible members to ensure that any increased costs can be recouped from the Medicare savings generated by the LEAD ACOs. States also will need to monitor use of Medicaid services that also are covered by Medicare, such as durable medical equipment and home health, to ensure that Medicaid remains the payer of last resort. For a state with an ACO-Medicaid MCO partnership arrangement, the state, CMS, and Medicaid MCO will need to consider how the expected impact of reducing Medicare spending and separate Medicare and Medicaid payment structures would impact MCO rates.

## 4. Opportunities and Levers for Care Coordination

Medicare ACOs and interested Medicaid programs will need to align their goals to improve transitions of care, manage chronic conditions, and reduce avoidable hospitalizations for dually eligible populations. The degree of coordination that will be required or expected between providers and care coordinators participating in LEAD ACOs and Medicaid fee-for-service or managed care arrangements is yet to be determined. However, the model provides incentives for Medicaid MCOs, Medicaid health home lead entities, and/or Medicaid-funded HCBS and SNF providers to engage in care coordination with ACO providers. These incentives did not exist previously. This coordination could be especially important for dually eligible individuals with LTSS or significant behavioral health needs.

Additionally, to support dually eligible individuals effectively, any integrated LEAD framework will need to address the overlap between Medicare and Medicaid care coordination activities. To accomplish this, policymakers could draw from state and health plan experience “coordinating the care coordinators” within integrated D-SNP programs. For example, Medicare ACOs are not required to establish a comprehensive, plan-led [model of care \(MOC\)](#) unlike D-SNPs. Given the high-need target populations to be served under LEAD and the model’s goal to better coordinate across Medicare and Medicaid, states may want to consider developing an integrated MOC. Similarly, selected states could establish shared risk stratification approaches between Medicare ACOs and Medicaid MCOs to identify high-risk patients that require additional support, set processes to identify and communicate changes in an individual’s condition, and exchange clinical information, with the goal of improving health outcomes and reducing costs.

## 5. Alignment with Established Integration and Contracting Strategies

States have made considerable investments to both develop [highly or fully integrated D-SNP](#) programs and implement sophisticated procurement strategies for their Medicaid managed care programs. To the extent that states are operating fully or highly integrated D-SNP programs in areas of the state where they are also exploring a potential LEAD ACO-Medicaid framework, it will be important to review integration goals and consider whether the objectives of both the LEAD model and other established programs can be met. States may benefit from consulting with health plan partners, health care providers, and other key stakeholders as they consider this opportunity.

Additionally, states pursuing this opportunity will need to consider how the 2028 launch of the integrated LEAD component aligns with their existing Medicaid MCO procurement timelines. If states will re-procure Medicaid MCO contracts during the 10-year demonstration period, it will be helpful to anticipate how potential disruptions to LEAD ACO and Medicaid MCO partnerships would be managed.

## What’s next?

The LEAD model’s Medicare-Medicaid integration component gives states an opportunity to shape how Medicare and Medicaid work together for dually eligible individuals in Original Medicare and share in potential Medicare savings. The opportunity is likely to be most attractive for states that already have a strong foundation in Medicare-Medicaid integration, meaningful Medicare ACO penetration among their dually eligible populations, and the operational capacity to support planning, oversight, and data sharing. In the near term, interested states will need to decide whether this model complements or complicates their existing integration and contracting strategies.



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