March 13, 2026

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U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: LEAD Model and Opportunities to Promote Integration for Dually Eligible Individuals

The Medicare-Medicaid Integration Alliance (MMIA) is a coalition of organizations committed to improving health care and services for people who are dually eligible for Medicare and Medicaid. We are writing to share suggestions and raise considerations related to the forthcoming Medicare ACO LEAD Model and its potential implications for dually eligible individuals.

We applaud the Centers for Medicare & Medicaid Innovation (CMMI) for its goals to expand accountable care approaches within Medicare fee-for-service (FFS) and to develop new potential for these approaches to better serve the dually eligible population. Because people who are dually eligible rely on both programs for their care—including long-term services and supports (LTSS), home- and community-based services (HCBS), and community-based behavioral health services—it is critical that new Medicare payment and delivery models recognize the existing coverage landscape and build on best practices from other models. This letter outlines key considerations for the LEAD Model, particularly given its focus on the inclusion of dually eligible individuals and the development of a new integrated model.

These considerations reflect broad stakeholder consensus and are intended to promote greater alignment between Medicare and Medicaid in meeting the needs of dually eligible individuals. Together, they illustrate a vision for an accessible, meaningfully integrated, high-value system of care that is person-centered and responsive to the full range of individuals' needs. While these considerations are drafted to apply specifically to the integrated model track, several should also be considered within the broader LEAD Model, which we highlight separately.

- ***Medicare and Medicaid benefits must be coordinated***. *All* benefits and services within integrated models—including LTSS, behavioral health, and acute care—should be fully coordinated. Financing and incentives should be aligned across Medicare and Medicaid and structured to reduce fragmentation, support beneficiaries in achieving their care goals and remaining in the community, and eliminate waste or redundancies in the current system (e.g., care coordination that is separately funded by Medicare and Medicaid).
- ***The two insurance programs should feel like one under integrated models*** for those who enroll and the providers that serve them. The administrative distinctions between the two programs should be invisible to dually eligible individuals within an integrated coverage option, meaning one insurance card, one explanation of benefits, one prior authorization process, etc. This requires CMS and states to review and align existing administrative requirements. While this alignment may be challenging at the outset, it will substantially reduce red tape and minimize provider and beneficiary confusion. Beneficiaries and providers should also be actively engaged in identifying barriers and crafting materials that are clear, accessible, and easy to use. Integrated models should also preserve and incorporate all existing Medicare and Medicaid beneficiary protections and

requirements, and defer to the most protective standards if and where discrepancies exist between state and federal standards.

- ***A coordinated care experience is essential.*** Evidence and discussions with beneficiaries indicate that every dually eligible individual should have access to care navigation support. Each person should have a care plan that they – or (with the individual's agreement) their caregiver – help develop and formally approve. The care plan should be reviewed at least annually and during care transitions (e.g., post hospitalization). Additionally, individuals should have access to an interdisciplinary care team with expertise tailored to their specific needs.
- ***Access to benefits must be maintained.*** People who are dually eligible should maintain timely access to the full range of Medicare and Medicaid benefits for which they are eligible, regardless of the model in which they are enrolled. Entities that assume responsibility for these individuals should be required to provide meaningful care navigation support and to prevent, identify, and promptly correct improper billing, including inappropriate cost-sharing or balance billing. The model should include clear safeguards to ensure accurate coordination with Medicaid and to protect beneficiaries from financial harm. They should also have access to independent support separate from any at-risk entity if they encounter challenges with billing or navigating their coverage, such as through an ombudsman program or SHIP.
- ***Continuity of care should be prioritized.*** Dually eligible individuals often have more significant and complex care needs than those enrolled in Medicare or Medicaid alone, and their networks of providers and supports are carefully established to meet those needs. ACO models typically use enrollment mechanisms, such as attribution, passive enrollment, etc. Similar to requirements in the ACO REACH model, it will be important to ensure that individuals are supported in understanding the coverage landscape. When these approaches are used, LEAD ACOs or other entities should be required to clearly communicate that individuals will maintain freedom to choose their providers consistent with Medicare FFS rules. Beneficiaries should also receive clear communication from providers about all beneficiary rights and protections, including freedom of choice.
- ***Support understanding of integrated models and the choice landscape.*** Navigating coverage options as a dually eligible individual is difficult. Individuals may be eligible for multiple types of Medicare Advantage plans, must consider their Medicaid coverage, and in some areas may also have access to integrated models. Yet, there is limited support available to help people make these important coverage decisions, and brokers often aggressively target this population. Without additional support, clear communication, and more thoughtful design of the coverage landscape, integrated models may struggle to achieve the enrollment numbers needed to sustain meaningful care coordination. Solutions should include virtual, telephonic, and in-person support. People should have access to unbiased, adequately funded, and well-trained sources of support (e.g., building on the SHIP model), and policymakers should take steps to reduce incentives for brokers to steer individuals toward non-integrated coverage options, among other protections.
- ***Strong state partnership is essential for ensuring program integrity and providing people with the best possible experience and advancing person-centered integration.*** Given the central role states play in Medicaid policy and delivery systems, they must be meaningfully involved in decisions affecting their dually eligible populations and in the design and implementation of integrated models. States invest significant resources and expertise—alongside the federal government—in serving this population, and close partnership is necessary to

ensure those investments are aligned, coordinated, and responsive to individuals' needs. CMS should consider providing grant funding to support states with engagement in these efforts.

Additional Considerations for LEAD

While the principles above are most directly relevant to LEAD's integrated model track, there are several considerations above that we would strongly encourage CMMI to consider applying more broadly as it releases additional details about the model:

- ***Allow states to exclude dually eligible individuals from the LEAD Model***. CMMI should ensure that participation in LEAD complements, rather than competes with, states' existing Medicare-Medicaid integration efforts. The most effective way to achieve this is to allow states to determine whether the LEAD Model should be permitted to target their dually eligible population.
- ***Extend care coordination requirements to the LEAD Model more broadly***. Because CMMI is targeting the dually eligible population and permitting attribution, it should require a defined level of care coordination across the LEAD model. All LEAD organizations that assume risk for dually eligible individuals should be required to meet the care coordination standards outlined above and to coordinate Medicaid benefits as part of their responsibilities.
- ***Consider Medicaid costs and experience when assessing outcomes.*** Medicaid spending should be measured for all LEAD ACOs with attributed dually eligible individuals, and ACOs should be held accountable if Medicaid costs increase inappropriately or if there is evidence of cost-shifting. Research indicates that without an integrated arrangement, cost-shifting from Medicare Advantage plans to Medicaid can occur. These dynamics should be considered when CMMI evaluates shared savings and assesses the total cost and performance of the model.
- ***Prioritize education and monitoring***. Given the complexity of coverage options for dually eligible individuals, clear communication should be provided to any individual attributed to the LEAD Model. Enhanced monitoring should also focus on these beneficiaries to ensure they can access their full range of benefits without delay, receive the care coordination described above, and maintain access to their established network of care and support.

MMIA appreciates CMMI's efforts to advance accountable care and to improve outcomes for individuals with complex needs. As the LEAD Model is refined and implemented, MMIA encourages CMMI to apply integration-focused principles and safeguards to ensure that dually eligible individuals experience coordinated, transparent, and person-centered care—and are not subject to unintended fragmentation or disruption.

Thank you for considering these suggestions. For any questions or additional discussion, please contact Amy Abdnor at aabdnor@arnoldventures.org or Michelle Herman Soper at michelle@atiadvisory.com.