Summary of NASDOH/CMMI Meeting with Community-Based Organizations

Meeting: "Engaging Community-Based Organizations in CMMI Models" | July 22, 2026

Context: Lutheran Services in America was invited by the National Alliance to Impact the Social Determinants of Health (NASDOH) to attend this initial meeting with CMS (Centers for Medicare and Medicaid Services) and CMMI (Center for Medicare and Medicaid Innovation) staff. The discussion focused on two new CMS Medicaid-related models they are developing to ensure improved outcomes while containing costs: LEAD and ASPIRE. Lutheran Services in America, along with other community-based organizations (CBOs,) was invited to provide feedback given our essential role in ensuring models like ASPIRE and LEAD can be successful.

As these models progress, we will continue to seek opportunities to shape and engage with innovative policy, payment, and care delivery approaches through CMMI and other agencies.

The summary combines the meeting notes with information from CMS model pages.

Key takeaway: CMS is signaling a stronger push toward prevention, coordination, and whole-person care, and as such, participants emphasized that CBOs cannot be treated as unfunded implementation partners. Across both models, the main ask was for stronger, more formal payment and partnership structures, so community providers can be compensated for the value they provide. Accordingly, SSO and CBO participation will depend on funding that adequately covers costs, with clear metrics, and more formal accountability for how CBOs are compensated based on actual costs.

LEAD (Long-term Enhanced ACO Design)

What is it? LEAD is CMS's newest ACO-focused model and successor to ACO REACH. It is a 10-year voluntary model scheduled to run from January 1, 2027 through December 31, 2036, and is designed to create a more stable, long-term pathway for accountable care participation.

Core purpose: LEAD aims to reduce financial and administrative barriers to ACO participation, attract a broader mix of providers, and improve coordinated care for high-need populations with a focus on dually eligible older adults and/or homebound populations while supporting prevention and patient choice.

Key features discussed:

- Greater flexibility and easier entry for new ACOs, including smaller, independent, and rural providers.
- Expanded attention to dual eligibles and homebound or home-limited populations.
- New beneficiary alignment options, including claims-based and voluntary with lower alignment minimums for ACOs serving a higher share of high-needs beneficiaries.
- A stronger focus on prevention, care coordination, healthy living strategies, and patient engagement.
- Testing of new payment structures with specialists through CMS-administered risk arrangements (CARA).
- A longer performance period and more predictable benchmarking to support sustainability.

Summary of Stakeholder Feedback:

- CMS staff emphasized that LEAD is intended to create a more accessible on-ramp for providers that have historically struggled to enter ACOs, including rural practices.
- Participants welcomed the model's stability and the potential for rural engagement and stressed that CBOs need more than referral relationships; they need formal financing arrangements that include data sharing/transparency.
- Stakeholders argued that providers often rely on CBOs to close social care gaps without paying them adequately, and that this weakens both sustainability and quality of evaluations.
- CMS said it is interested in stronger formal relationships between health care organizations and CBOs, but also noted that broader payment changes may require statutory authority and congressional action.

ASPIRE (Accelerating State Pediatric Innovation Readiness and Effectiveness)

What it is: ASPIRE is a state-based Medicaid and CHIP model for children and youth up to age 21 who have, or are at risk of developing, complex medical or behavioral health needs. Up to five states will participate in the 10-year model.

Core purpose: ASPIRE is designed to improve whole-person care for children and families by strengthening accountability for quality and cost, improving early intervention, and helping youth thrive in the least restrictive setting possible.

Key features discussed:

- States will be the primary applicants, with state Medicaid agencies working with accountable entities such as ACOs.
- The model places heavy emphasis on cross-sector case management, care coordination, caregiver support, transitional care, and comprehensive care plans.
- CMS will provide cooperative agreement funding to participating states to help build/further develop infrastructure, and some of that may support ACO implementation.
- ACOs will be required to stand up partnership councils with the aim of streamlining efforts through more efficient cross-sector coordination.
- CMS expects states to leverage existing Medicaid and waiver authorities where family caregiving and related supports are already reimbursable.
- The model includes attention to justice-involved youth and other populations that can be identified through state data systems.
- CMS also described the model as incorporating quality measures and systems intended to support better outcomes for children and families.

Meeting clarifications and stakeholder feedback:

- CMS said it hopes states will use regional structures to support comparison groups and stronger evaluation.
- Participants asked whether state funds could support CBOs directly; CMS said states cannot use model dollars for services that Medicaid already covers, and it was not yet prepared to say how states might pass through funds to CBOs.

- Stakeholders urged CMS to require or strongly incentivize CBO involvement because CBOs are often the entities helping close social care gaps without receiving direct or adequate reimbursement.
- CMS acknowledged that it would be helpful for states to identify questions about how ASPIRE funds could build on existing social care infrastructure, including models already operating under Medicaid waivers.

Further Insights on Both Models:

Cross-cutting themes from the discussion

- Prevention, care coordination, and whole-person care were framed as central to both models.
- CMMI staff said they want to see more formal arrangements between health care entities and community-based organizations.
- Participants stressed that "what gets measured gets funded," and that CBOs need access to data, metrics, and payment structures that reflect their contribution to outcomes.
- Several participants noted that traditional total-cost-of-care calculations often do not capture the value of preventive and social care services.
- Stakeholders repeatedly asked for stronger incentives, or explicit requirements, for applicants to work with CBOs on both the front end (design and implementation) and the back end (measurement, coding, and payment).
- CMS staff acknowledged these concerns and said they heard the request for structured funding and stronger partnership expectations for CBOs.

Implications for Lutheran Services in America and Strong Connections to Partnering for Impact

- LEAD's rural provider emphasis and longer-term stability may create opportunities for rural LSA network members to participate in accountable care arrangements.
- Both LEAD and ASPIRE create openings for stronger partnerships between health care organizations and CBOs, especially where social care is essential to achieving outcomes.
- The meeting reinforced the need for continued advocacy around direct and adequate reimbursement for CBO services, stronger data access, and formal inclusion of CBOs in value-based payment models.
- CMS appeared receptive to continued stakeholder engagement and specifically acknowledged the longstanding concern that community providers are often expected to produce outcomes without adequate funding.