national council on aging

Integrated Care 101

Supporting Dual Eligible Beneficiaries

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Agenda

1. Introducing Dual Eligibles and Integrated Care
2. Overview of Integrated Care: Challenges of Coordination and Models of Integrated Care
3. Program of All-Inclusive Care for the Elderly (PACE)
4. Dual Eligible Special Needs Plans (D-SNPs)
5. Financial Alignment Plans/ MMPs
6. Accountable Care Organizations (ACOs)
7. Next Steps

Introducing Dual Eligibles and Integrated Care

Definitions and Key Statistics

Definition of Dual Eligibles and Integrated Care

Dual Eligibles are individuals who receive both Medicare and Medicaid benefits. They are a high-need, high-cost group of older adults and people with disabilities, with varied health needs, who typically have lower incomes and assets, making them eligible for Medicaid assistance to “wrap around” their Medicare coverage.

Integrated Care involves models of care that align or attempt to align financing, administration and delivery of services from two different health-care systems, Medicare and Medicaid, through a single entity to reduce fragmentation, improve outcomes and lower costs.

Statistics About Dual Eligibles

- There were 11.9 million dual eligibles in 2025:
  - more than 90% of whom have one or more chronic conditions
  - over 85% have two or more chronic conditions.

- Duals over age 65 account for 60-65% (approx. 7.7 million) of the total

- Dual individuals with disabilities under age 65 account for 35-40% (approx. 4.2 million) of the total who qualified based on intellectual, developmental, behavioral or physical disabilities.

Full Duals vs Partial Duals

- **Full Benefit Dually Eligible Individuals**
  74% of duals receive full benefits from both programs

- **Partial Benefit Dually Eligible Individuals**
  26% receive full Medicare coverage while Medicaid helps only with premiums and cost-sharing

- **Whether someone is a full or a partial dual eligible varies based on their Medicaid eligibility status**

Overview of Integrated Care

Challenges of Coordination

Introduction to Integrated Care Models

Traditional Medicare

What does Medicare cover?

Part A (Hospital Insurance): Part A covers hospital stays, skilled nursing care, and some home health services.

Part B (Medical Insurance): Part B covers doctor visits, outpatient care, preventive services, lab tests, and more.

Part D (Prescription Drug Coverage): Part D is optional drug coverage (you must choose and enroll in a separate plan). Unless you have other creditable drug coverage, failure to enroll in Part D when you're eligible will result in a penalty that will last as long as you have Medicare coverage.

PLEASE NOTE: Medicare does not cover Long-Term Services and Supports (LTSS) or Non-Emergency Medical Transportation. These benefits are, however, covered under Medicaid.

Medicare Advantage (Part C)

What is Medicare Advantage?

Part C Medicare Advantage:
Medicare Advantage plans are private insurance plans that must cover all the same services original Medicare does, including hospital stays, short term nursing home stays, doctor visits and diagnostic and lab tests.

Medicare Advantage plans may include some restrictions on provider networks (Health Maintenance Organizations or Preferred Provider Organizations) or may include Special Needs Plans that serve targeted populations, such as dual eligibles.

Supplemental Benefits: Medicare Advantage may offer supplemental benefits traditional Medicare does not, including vision, hearing, dental, health club memberships and medical related transportation. Some may even help with additional payments like utilities.

Medicaid

What does Medicaid cover?

For low-income dual eligibles, Medicaid closes the gap between individuals' budgets and Medicare's costs and benefits.

It helps pay Medicare premiums and it covers services such as LTSS and Non-Emergency Medical Transportation that Medicare does not. In some cases, it may also pay more for or provide better access to durable medical equipment.

The Challenge of Coordination

Why is Integrated Care so complicated?

Medicare and Medicaid were not designed to work together. They have different rules and processes and, in many ways, lack coordination. Medicare is the first payer for items it covers but it lacks key benefits such as long-term services and supports.

➢**KEY DISTINCTION:** While Medicare is administered by CMS, Medicaid is administered jointly by CMS and the States

Efforts at improved integration have made strides but significant challenges remain.

Definition of Integrated Care

OVERVIEW OF INTEGRATED CARE MODELS

Prominent models of integrated care include:

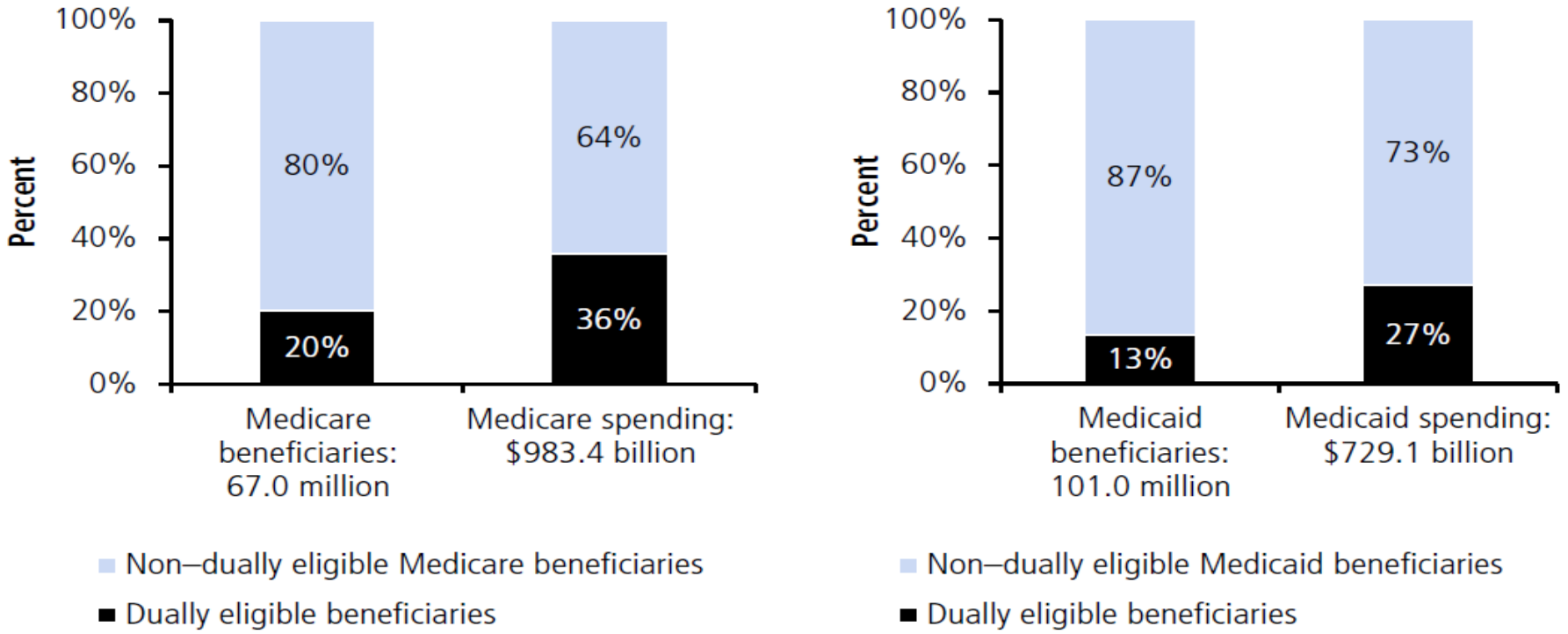
- Programs of All-Inclusive Care for the Elderly (PACE)
- Dual Eligible Special Needs Plans (also known as D-SNPs)
- Financial Alignment Initiative Demonstrations or *Medicare-Medicaid Plans*
  Phased out in late 2025. Replaced by Fully Integrated & Highly Integrated D-SNPs
- Accountable Care Organizations (ACOs)
- Models that are fee-for-service on one side and managed on the other;
- Models that are fee-for-service both in Medicare and Medicaid

Integrated Care by the Numbers

Dually Eligible Population: Program Enrollment vs Spending

Exhibit

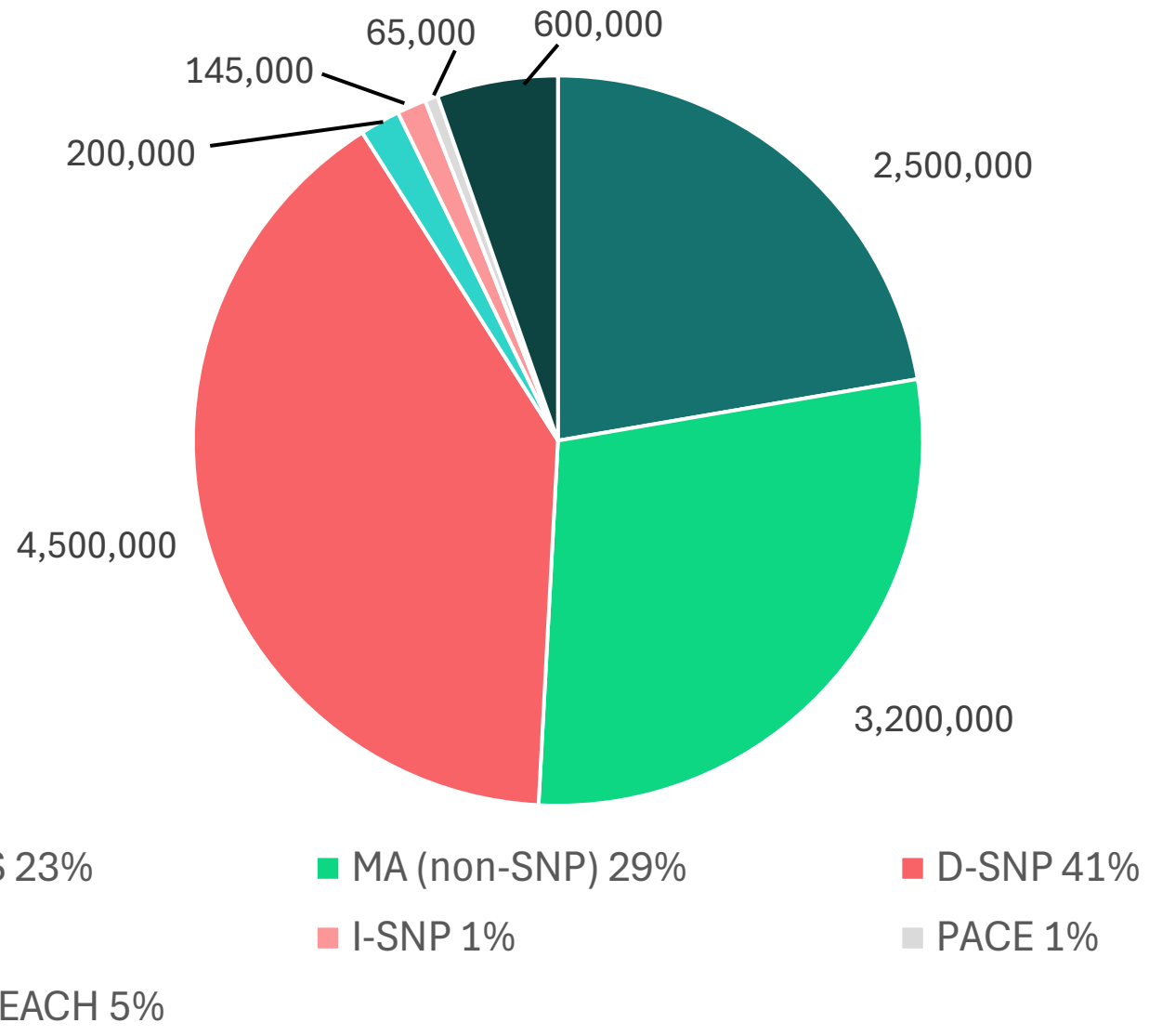
Dually eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2022



Source: MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and spending data. In MedPAC and MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. December 1, 2025.

Integrated Care by the Numbers

Snapshot of Distribution of over 11 million Dual Eligible Enrollees in 2024-2025



Sources: ATI Advisory 2024-2025 MA Enrollment Trends, KFF Medicaid Managed Care Tracker 2024, MedPAC/MACPAC Duals Data Book 2024.

Program of All-Inclusive Care for the Elderly (PACE)

- ✪ What is PACE?
- ✪ Growth of PACE
- ✪ Future Trajectory

Program of All-Inclusive Care for the Elderly (PACE)

What is PACE?

PACE is a comprehensive health care model designed for adults age 55 or over who require nursing home level care but wish to remain living in their communities – and can do so safely with support.

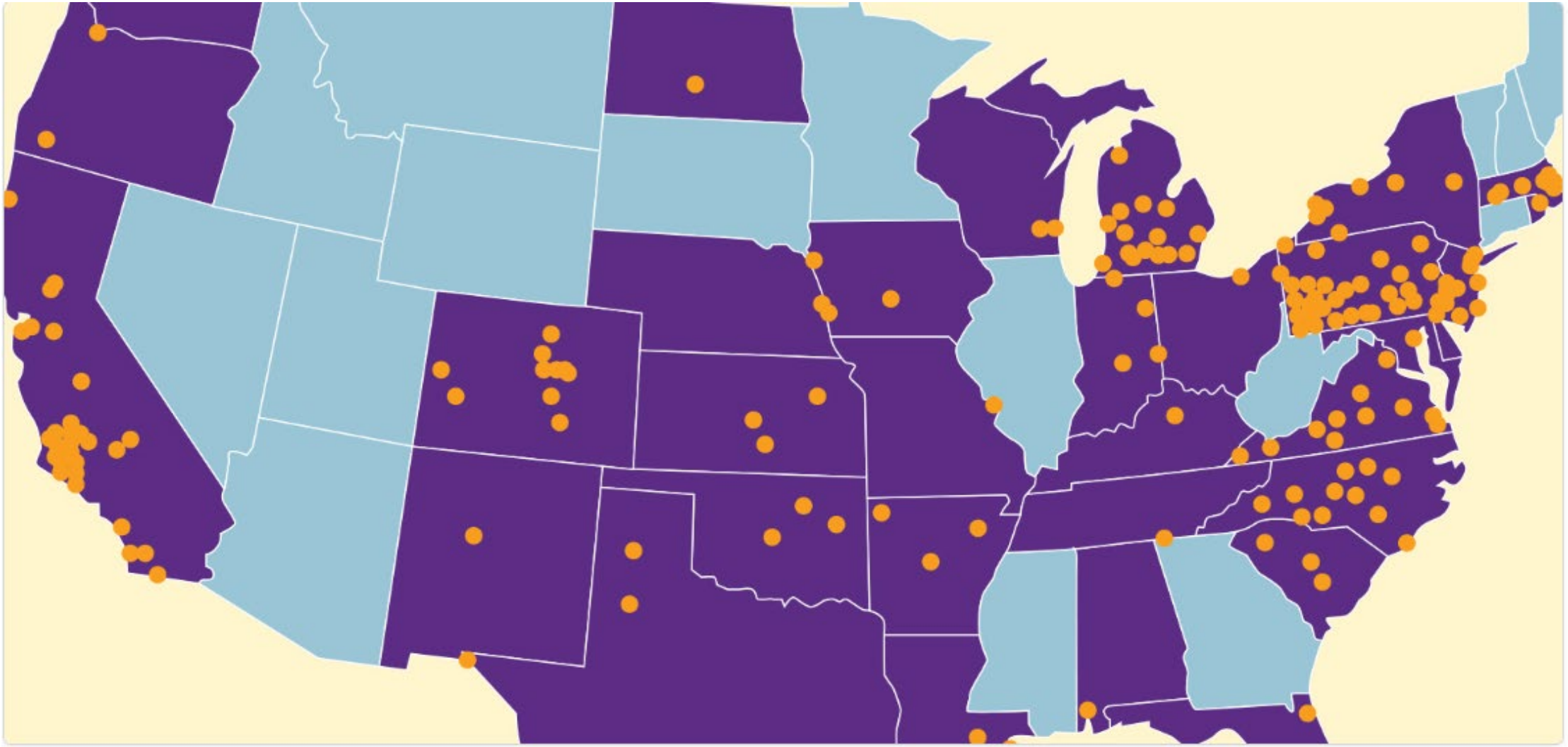
PACE provides integrated medical, social and long-term care services, usually financed by a combination of Medicare and Medicaid, to individuals. PACE pools Medicare and Medicaid funds into a single capitated payment allowing flexible service delivery.

PACE is implemented by an interdisciplinary team (IDT), a team of health professionals, including nurses, doctors, social workers and therapists who together develop a customized care plan for each enrollee.

The PACE Center is the hub for services, offering primary care, dentistry, day center, rehabilitation and social activities.

Mapping the Growth of PACE

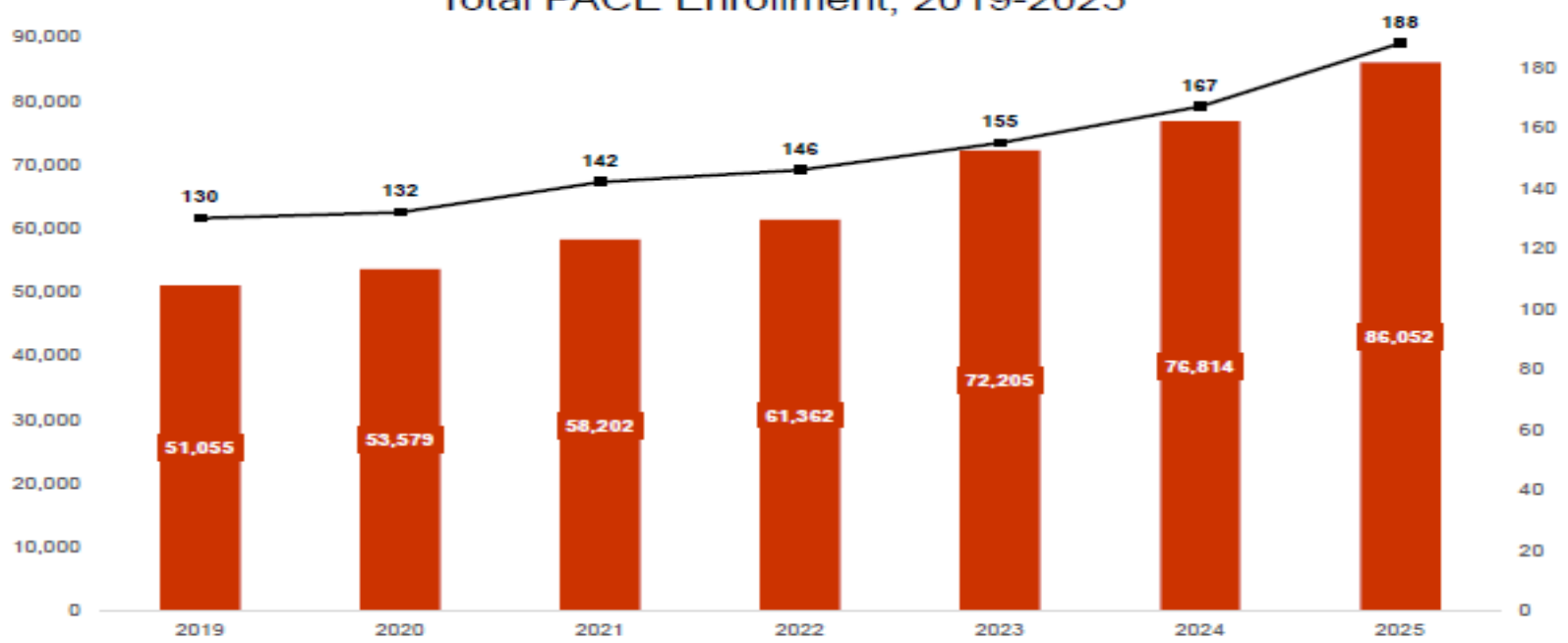
There are 202 PACE Sites in 33 States and the District of Columbia



Integrated Care by the Numbers – Growth of PACE

PACE enrollment grew steadily from 51,000 in 2019 to 94,500 this year

NUMBER OF PACE ORGANIZATIONS AND TOTAL PACE ENROLLMENT HAS INCREASED OVER THE LAST 6 YEARS



PACE organization and enrollment growth has increased over the last 6 years, now totaling over 86,000 participants.

- Since 2019, the number of PACE Organizations has increased by **45 percent** and total PACE enrollment has increased by **69 percent**.
- Additional substantial growth anticipated in upcoming years reflecting new states and programs coming online.

ATI Advisory

Source: National PACE Association data from September 2019, April 2020, December 2021, July 2022, December 2023, October 2024, July 2025

Program of All-Inclusive Care for the Elderly

Recent Growth of PACE

CMS Policy change in 2019 authorizes private ownership of PACE programs

- Private equity & venture capital entities now control 15% of active PACE programs.
- For-profits are better able to fund the intensive upfront capital outlays PACE requires.
- For-profit entities growing faster than non-profits and driving expansion of PACE programs.

PACE has grown to 202 centers in 33 states serving 94,500 older adults

Program of All-Inclusive Care for the Elderly

Future Plans for PACE

Deregulation to Facilitate Investment and Scaling

Administration and National PACE Association are advocating deregulation to facilitate scaling of the PACE model. This includes:

- Loosening Staffing Requirements for prior training
- Allowing Nurse Practitioners & Physician Assistants to serve as primary care providers and personnel to serve in multiple capacities on IDTs
- Curbing burdensome paperwork deadlines & streamlining center approval

SCALE to 200,000 enrollees by 2028

Mandate PACE in every state and open enrollment to younger duals with physical disabilities, chronic conditions, etc.

D-SNPs

What are D-SNPs?
Growth of D-SNP model
What's next for D-SNPs

What is a Dual Eligible Special Needs Plan (D-SNP)?

D-SNP Overview

As previously mentioned, D-SNPs are Medicare Advantage Plans. They must contract with states, but states are not required to contract with D-SNPs.

Key requirements for the contract are included in MIPPA legislation but states can add more requirements to further integrate care.

Key coverage Areas:

- Cover all standard Medicare services (Medicare A, B, D)
- Medicaid Benefits (coordination with state Medicaid programs which may include dental, vision, hearing, transportation, behavioral health and LTSS)
- Additional Services (Care Coordination, over the counter allowance, and supplemental benefits for chronically ill)

What is a Dual Special Needs Plan (D-SNP)?

Levels of Integration for D-SNPs

Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs):

FIDE SNPs are Medicare Advantage Plans that fully integrate care for dually eligible beneficiaries under a single managed care organization.

- Created under the ACA. FIDE SNPs include primary, acute and LTSS coverage.
- FIDE SNPs must also cover behavioral health unless behavioral health is carved out of state capitation.
- Some FIDE SNPs are eligible for payment adjustments due to the high concentration of frail individuals they serve.
- Implemented by contracts with State Medicaid Agencies, FIDE SNPs must cover the 8 minimum MIPPA requirements.

What is a Duals Special Needs Plan (D-SNP)?

Levels of Integration for D-SNPs

Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs)

- HIDE SNPs have a higher level of integration than typical D-SNPs, but a lower level than FIDE SNPs. They became available in 2021.
- HIDE SNPs require a contract with the state Medicaid agency that complies with the 8 MIPPA requirements.
- HIDE SNPs also include coverage of LTSS benefits or behavioral health or both.

What is a Duals Special Needs Plan (D-SNP)?

Levels of Integration for D-SNPs

Coordination-Only D-SNPs:

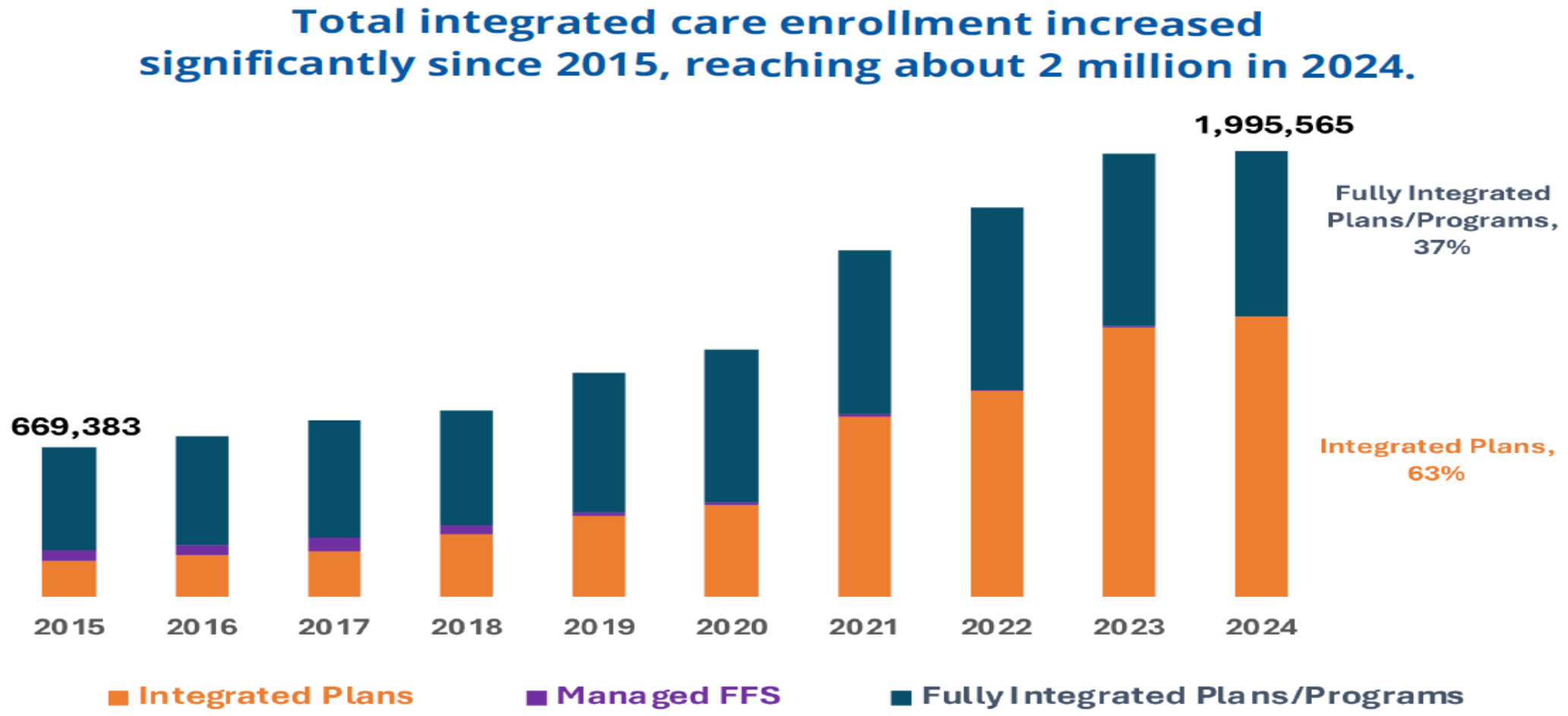
- Coordination-Only D-SNPs require a lower level of integration than HIDE or FIDE SNPs.

- While coordination-only plans are required to have a contract with the state Medicaid agency to coordinate care, communication and data, they are not required to manage Medicaid behavioral health or long-term services and supports (LTSS).

- As of early 2023, 57% of D-SNP enrollees were in coordination-only plans.

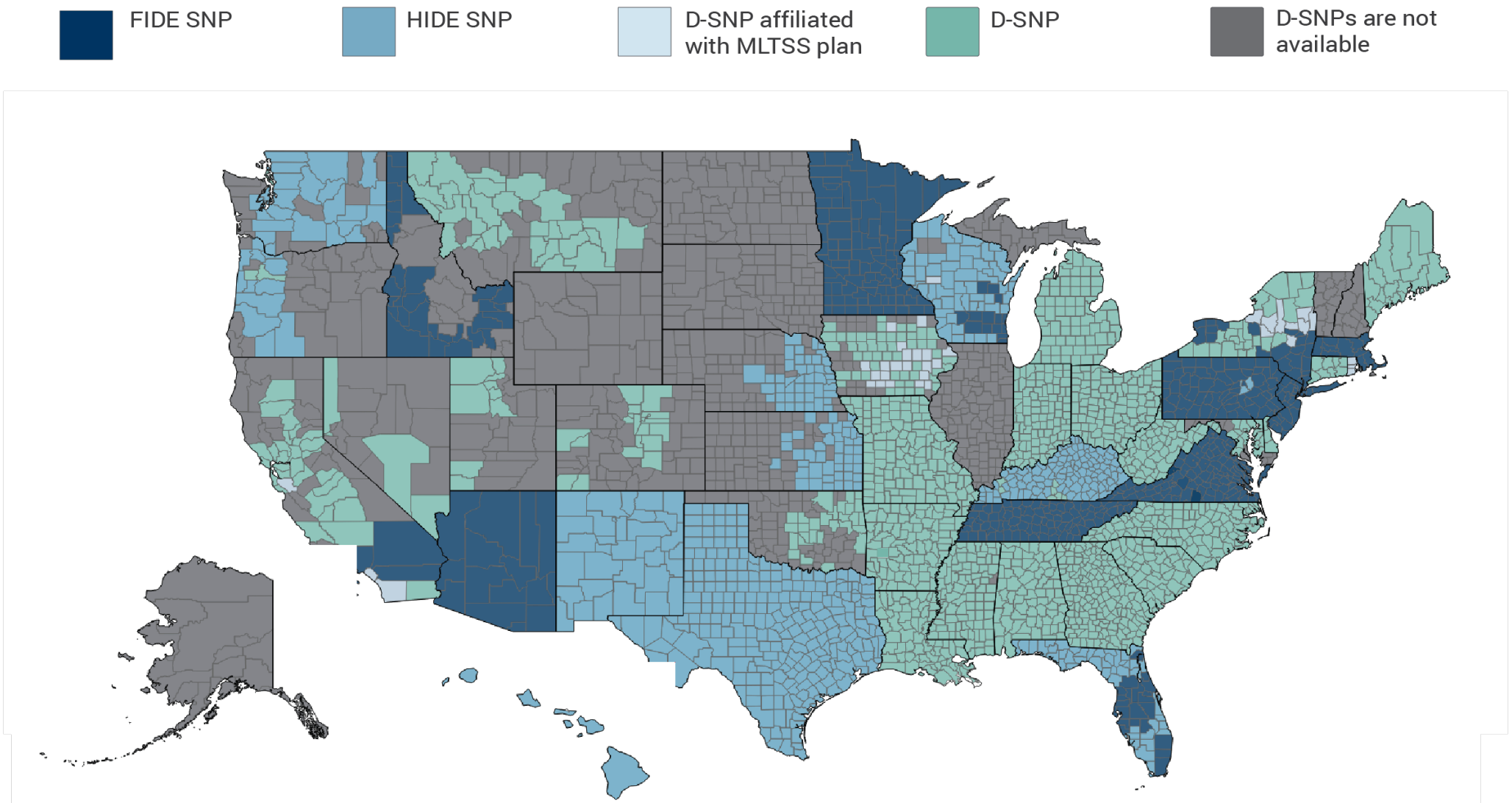
Integrated Care by the Numbers

Total Integrated Care Enrollment nearly tripled from 2015 to 2024 *Source: CMS MMCO, 2024 Report*



Mapping Integrated Care

Map of D-SNP Coverage 2021 (Source: MACPAC, 2024)



Lookalike D-SNPs

What are lookalike D-SNP plans?

- Lookalike D-SNPs are MA Plans marketed heavily to dual eligible populations that lack a state contract to provide integrated care. Lookalike plans put responsibility on the consumer to navigate two separate delivery systems.

- According to MedPAC, in 2019, 220,000 enrollees in 35 states signed up for D-SNP lookalike plans. Since then, enforcement markedly reduced that number.

- By policy, CMS will not renew non-SNP plans with over 60% of their enrollees being duals in January of the prior year.

- C-SNPs are MA plans that implement CMS approved Models of Care & must provide case managers and condition–specific provider networks. They can be good options for non-duals, but consumer advocates warn they lack state contracts and coordination that many duals need.

Financial Alignment Initiative & MMPs

Overview of the Financial Alignment Initiative
Evolution into more highly integrated D-SNPs

Duals Demonstration: Financial Alignment Initiative and Medicare-Medicaid Plans (MMPs)

About the Duals Demonstrations:

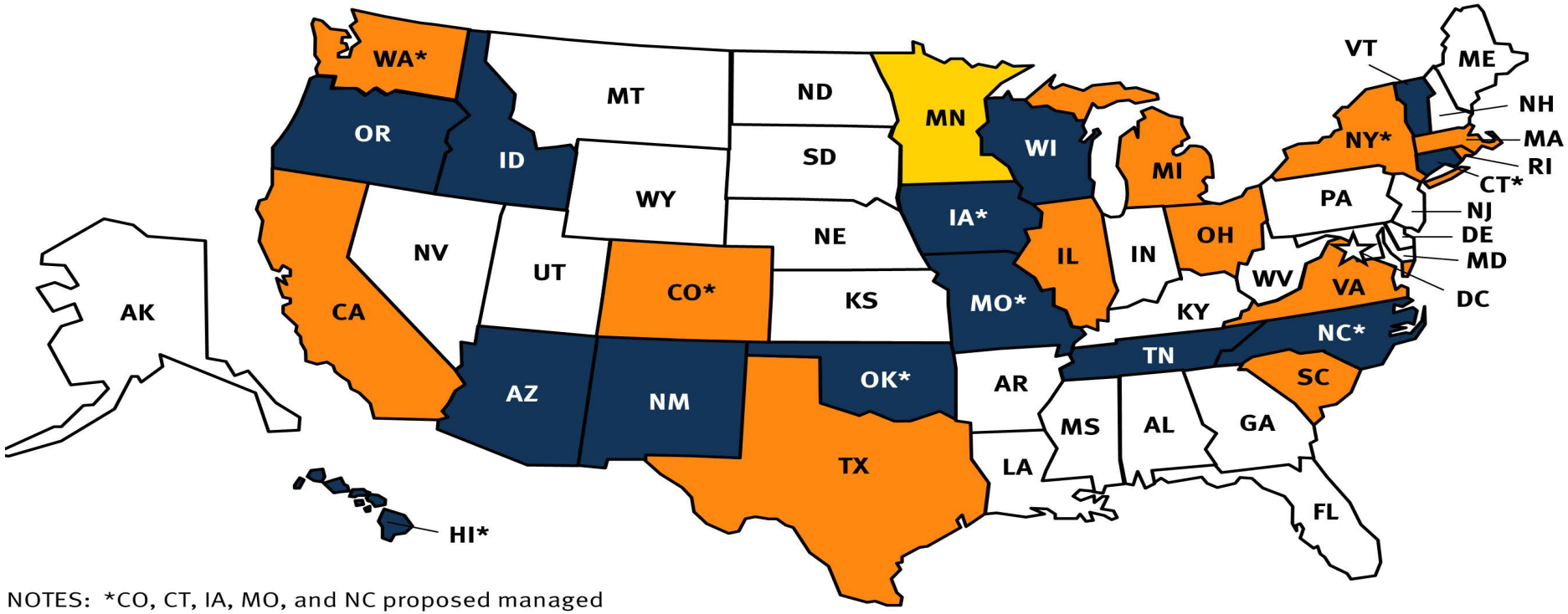
The Financial Alignment Initiative (FAI) launched in 2010 to test ways to improve care for dually eligible beneficiaries and reduce program costs by aligning financing and coordinating care across Medicare and Medicaid. It Integrated primary, acute, behavioral health, and long-term services and supports for dual-eligible beneficiaries.

Unlike D-SNPs, MMPs offered fully-aligned products under three-way contracts between CMS, the state Medicaid agency, and the health plan.

MMPs operated in 13 states, mostly as capitated plans with two operating as managed fee-for-service. In 2020, there were 435,000 enrollees in these plans.

Duals Demonstration Map

State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, November 2015



NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; WA received approval for both demonstrations, but subsequently withdrew its capitated model; NY withdrew its managed FFS demonstration and received approval for 2 capitated demonstrations. All other states proposed capitated models.
SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals and state websites.

- MOU signed with CMS to implement financial alignment demonstration (12 states)
- MOU signed with CMS to implement administrative alignment demonstration (1 state)
- Proposal withdrawn (13 states plus NY managed FFS and WA capitated)
- Not participating in demonstration (24 states and DC)

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Duals Demonstration: Financial Alignment Initiative and Medicare-Medicaid Plans

Transition to D-SNPs, Findings and Next Steps

- CMS ended the FAI and transitioned Medicare-Medicaid Plans into D-SNPs by December 2025. Some MMP states used passive enrollment to enroll beneficiaries into D-SNPs run by the same insurance company as the duals plan.

- Evaluations conducted by RTI had mixed, but largely positive findings. Key benefits include improved care coordination, reduced avoidable hospitalizations/ readmissions and well-received supplemental benefits. However, D-SNPs were deemed the more sustainable model.

- **Positive Features of MMPs are being incorporated into D-SNPs**. These include
  - *Between 2027 and 2030 D-SNPs will be required to ensure Medicare D-SNPs and affiliated Medicaid plans in overlapping service areas are run by the same company to enhance coordination.*
  - *Standardized beneficiary protection best practices, including unified appeal processes, enrollee advisory committees and considering social determinants of health in health-risk assessments are now codified as D-SNP requirements.*

Accountable Care Organizations

Past: REACH Demonstration

Future: LEAD Demonstration



Accountable Care Organizations

REACH ACO MODEL – Past and Present (in final fiscal year)

Accountable Care Organizations (ACOs): ACOs are voluntary networks of primary and specialty care doctors, hospitals and other health care providers that come together to break down silos, and deliver high-quality, coordinated care to patients, improve health outcomes and manage costs.

REACH ACO Model had two voluntary risk-sharing options
Two voluntary risk-sharing options. In each, participating providers accept Medicare claims reductions and agree to receive at least some compensation from their ACO.

Inclusion of a dedicated high-needs population track resulted in ***19.3% of beneficiaries in ACO Reach being dual eligibles***.

Findings: Very effective at achieving healthcare savings and enhancing quality of care, even for high-needs populations. Faced challenges enrolling at-risk individuals.

Accountable Care Organizations

Long-Term Enhanced ACO Design (LEAD) MODEL: THE FUTURE

LEAD is the successor to the REACH model, designed to build on its success and fix financial and administrative weaknesses.

LEAD launches in January 2027 with a 10-year performance period. It locks in the spending baseline for a full decade and provides financial predictability.

Instead of having a standalone high-needs track, LEAD will integrate high-need and dual eligible patients into every ACO's population. Enhanced risk adjustment and tailored benchmarking should ensure caring for sicker, complex patients does not create financial disadvantages for providers.

Includes policies designed to help smaller and rural entities participate, and capitated payments for specialist care that REACH lacked.

Next Steps: Emerging Trends

Fiscal Pressures Could Prompt Move Away From Managed Care/ Medicare Advantage

Fiscal pressures from HR 1 and narrower margins may lead some states to consider curbing managed care, and some health insurers to offer fewer Medicare Advantage options. This could mean a return to increased reliance on fee-for-service delivery systems.

Advantages include avoiding:

a) Prior authorization barriers that may limit access to critical procedures, medications or facility stays;

b) Narrow provider networks that make it hard to find doctors consumers like or that create disruptions of care continuity; and,

c) Adverse selection for more vulnerable duals

Disadvantages include:

a) Loss of administrative simplification and care coordination

b) Administrative wrangling and inefficient cost-shifting between Medicare and Medicaid; and,

c) Loss of potentially desirable supplemental benefits

NCOA Resources

Learn More

Learn More: NCOA Resources on Integrated Care

What Does It Mean to Be Dual-Eligible for Medicare and Medicaid?

Integrated Care for People with Medicare and Medicaid (2025)

Dually Eligible for Medicare and Medicaid: What Are My Coverage Options? (2025)

Helping Dual Eligibles: How State Medicaid Agencies and State Health Insurance Programs Collaborate (2026)

Collaboration Between State Medicaid Agencies and State Health Insurance Assistance Programs [In Partnership with Advancing States and SHIP TA Center]

How Do I Know if I Qualify for Medicaid? A Guide for Older Adults (2026)

Questions and Comments

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