

# Understanding Medicare-Medicaid Integration for Dually Eligible Individuals

More than 13 million people in the U.S. are [eligible for both Medicare and Medicaid](#). Despite having access to two insurance programs, this population — often called dually eligible individuals — frequently encounters fragmented, poorly coordinated care. It is critical for states to integrate care to improve outcomes and manage costs for this growing population.

**What’s the issue?** Dually eligible individuals make up a relatively small share of enrollment — 20% in Medicare and 13% in Medicaid — but [account for over one-third of spending for Medicare and nearly one-third for Medicaid](#). Despite this spending, care for this population is often fragmented across the two systems. Aligning financing and service delivery is challenging because Medicare and Medicaid operate separately and follow different rules.

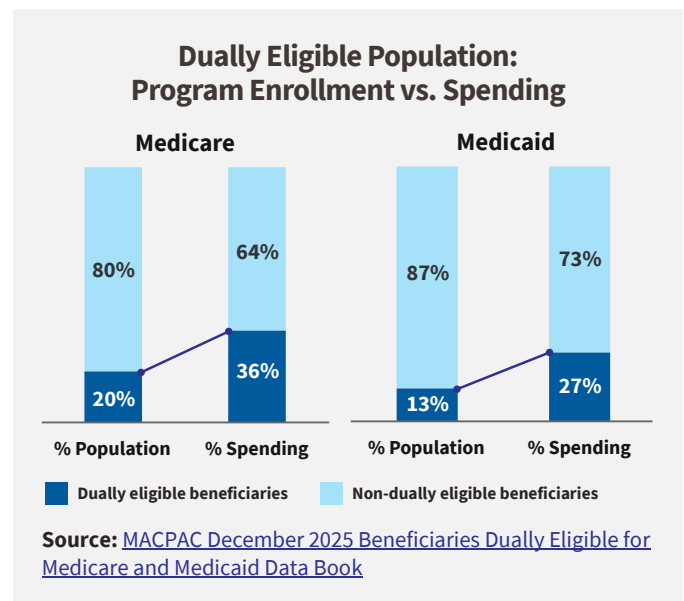
**Why it matters.** Improved coordination between Medicare and Medicaid could ensure more efficient use of federal and state resources, strengthen health outcomes, improve the care experience for enrollees, and reduce administrative burden for providers.

**Who are dually eligible individuals?** People who are dually eligible qualify for Medicare based on age (65+) **or** disability, **and** for Medicaid based on income and other factors.

- They have complex health needs — [85% have two or more chronic conditions](#), and many have behavioral health needs, disabilities, and/or need long-term care in their homes, communities, or nursing facilities.
- About half of the population experiences [at least one limitation in daily activities](#) — such as bathing, grooming, dressing, or using the bathroom — and roughly one in four face three to six limitations.

**What does it mean to be dually eligible?** Dually eligible individuals receive care financed by both programs, with coverage varying based on their Medicaid eligibility status.

- **Full-benefit dually eligible individuals** (74% of this population) receive full benefits from both programs. Medicare usually pays for most care and services, while Medicaid covers services that Medicare does not.
- **Partial-benefit dually eligible individuals** receive full Medicare coverage, while Medicaid helps only with premiums and cost-sharing.

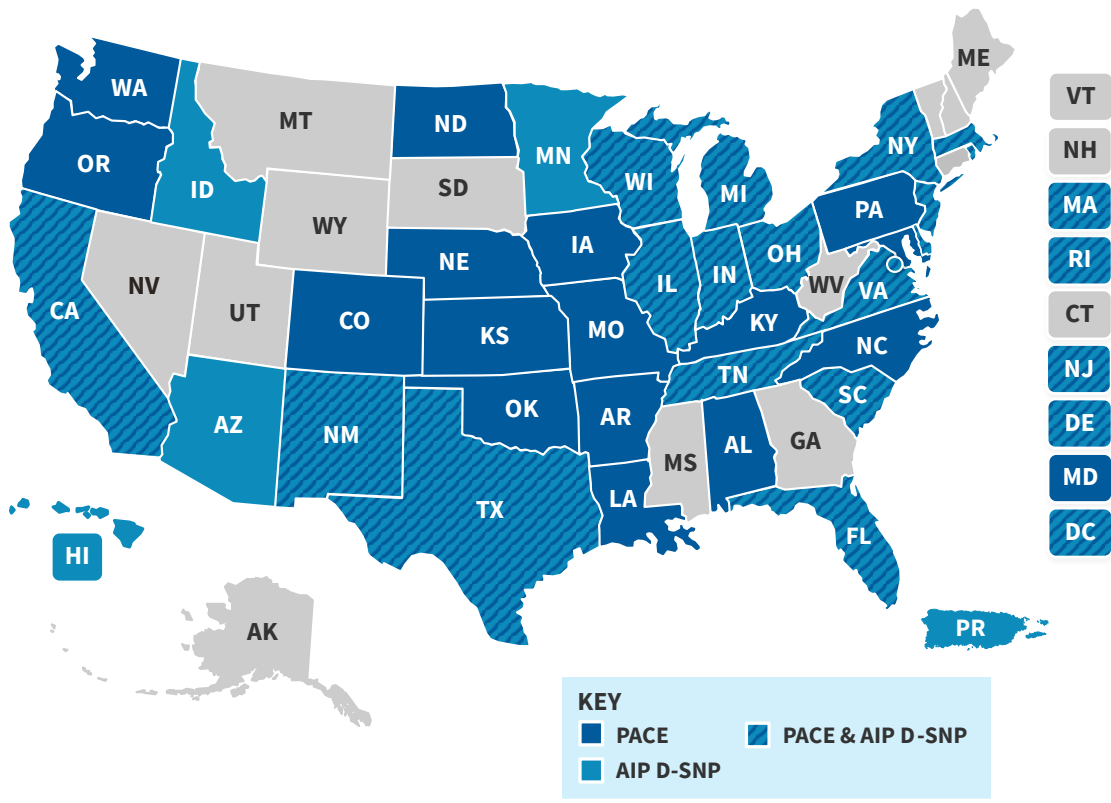


**The challenge.** Medicare and Medicaid were not designed to work together — the programs have different rules and processes and lack coordination in many areas. Efforts to better integrate the two programs have been underway for years, and while there have been successes, effective integration remains a challenge. As of 2024, only [23% of full-benefit dually eligible individuals](#) were enrolled in an integrated care program across 38 states, the District of Columbia, and Puerto Rico.

**Medicare-Medicaid integration current landscape.** The federal government and states, along with health plan and provider partners, have primarily sought to integrate Medicare and Medicaid using three models ([see next page](#) for more details):

- **Dual Eligible Special Needs Plans (D-SNPs)** are a type of Medicare Advantage plan that is designed to coordinate Medicare and Medicaid benefits for dually eligible individuals. It is the most widely available model. As of December 2025, [D-SNP enrollment](#) was over six million nationwide, roughly 45% of dually eligible enrollees. While not all D-SNPs integrate Medicaid services, [Applicable Integrated Plans \(AIPs\)](#) are D-SNPs [that meet certain federal requirements](#) to operate at a higher integration level.
- The **Program for All-Inclusive Care for the Elderly (PACE)** is a provider-led model that originated in the 1970s and is the most integrated approach. As of December 2025, PACE organizations operated in 34 states and the District of Columbia [enrolled about 75,000 dually eligible individuals](#).
- **Financial Alignment Initiative (FAI)** demonstrations tested capitated and managed fee-for-service models for over 10 years, and concluded in December 2025. At their peak, participating states enrolled approximately 450,000 full-benefit members. At their conclusion, states transitioned to D-SNP models.

**National Picture of Medicare-Medicaid Integration, March 2026**



Sources: Centers for Medicare & Medicaid Services. “[CY 2026 Integrated D-SNPs List \(XLSX\)](#)” and “[Monthly Enrollment by Contract.](#)”

**What’s next?** States continue to implement programs that better align Medicare and Medicaid. To further progress, states and their federal partners will need to use available integration options and explore new pathways that consider state-specific delivery systems. As the policy landscape continues to evolve, opportunities to advance integration have the potential to lead to more efficient care delivery and contribute to improved care experiences and health outcomes for dually eligible individuals.

**medicaidfyi.** is a series of explainers from the Center for Health Care Strategies (CHCS) offering clear insights to help states, health plans, providers, and policymakers improve the quality and efficiency of Medicaid.

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## A Closer Look at Medicare-Medicaid Integration Models

**Dual Eligible Special Needs Plans (D-SNPs)** are a Medicare Advantage health plan that enrolls only dually eligible individuals. In addition to a contract with the Center for Medicare & Medicaid services (CMS) to provide Medicare benefits, D-SNPs must contract with the Medicaid agency in the state in which they operate. All D-SNPs must *coordinate* the delivery of Medicare and Medicaid services for enrollees, and they may *integrate* coverage as well. There are [three levels of D-SNP integration status](#), and states can use their contracting authority to increase the level of integration provided by D-SNPs. The three levels are:

- **Coordination-Only D-SNPs (CO D-SNPs)** meet minimum D-SNP contract requirements, but do not cover Medicaid behavioral health services or long-term services and supports (LTSS). CO D-SNPs must share information about enrollees’ hospital and skilled nursing facility admissions with the state or the state’s designee to support care coordination.
- **Highly Integrated D-SNPs (HIDE SNPs)** cover Medicaid behavioral health services, LTSS, or both under a capitated contract. The contract for Medicaid benefits must cover the D-SNP’s entire service area.
- **Fully Integrated D-SNPs (FIDE SNPs)** cover the full range of Medicaid benefits, as well as share costs with Medicare. Benefits are provided by one entity having both a contract with CMS and a capitated Medicaid managed care contract with the state. As with HIDE SNPs, the managed care contract must cover the entire service area. FIDE SNPs must use [exclusively aligned enrollment](#).

**Applicable Integrated Plans (AIPs)** are FIDE SNPs or HIDE SNPs using exclusively aligned enrollment, or CO D-SNPs using exclusively aligned enrollment and also cover at least some Medicaid benefits through the D-SNP or an affiliated Medicaid managed care organization (MCO). AIPs must use an integrated appeal and grievance process and adhere to Medicaid managed care rules.

[Beginning in 2027](#), D-SNPs with affiliated MCOs must limit their plan offerings to one D-SNP per MCO service area and ensure that new full-benefit dual eligible members are also enrolled in the D-SNP’s affiliated MCO. [By 2030](#), both new and continuing full-benefit members must also be enrolled in the affiliated MCO.

**PACE** organizations provide comprehensive medical and social services to dually eligible individuals age 55 and older who meet their state’s [nursing home level of need criteria](#) and continue to live at home. [PACE organizations](#) are Medicare providers. States can provide PACE services as a state plan option.