National MLTSS Health Plan Association

Integrated Care Options for Dually Eligible Individuals

Executive Summary

Over 12 million Americans are dually eligible for both Medicare and Medicaid. Dually eligible individuals have complex health and social needs, including a high burden of chronic disease — over 25% of dually eligible individuals have five or more chronic conditions, and over 40% are in fair or poor health. Dually eligible individuals, while accounting for only 17% of Medicare enrollees and 14% of Medicaid enrollees, account for 1/3 of each programs spending— underscoring the importance of integrated care, which aims to minimize administrative burden and costs to states and the Federal government while providing high-quality care for this population.

While integrated care is delivered primarily through Dual Eligible Specials Needs Plans (D-SNPs) - Medicare Advantage (MA) plans specifically designed to meet the needs of dually eligible individuals – there are many other coverage options for this population. In this brief, we explore the differences between several of the most relevant models, including other types of Special Needs Plans (SNPs), Medicare-Medicaid Plans (MMPs), the Program for All-Inclusive Care for the Elderly (PACE) and the Accountable Care Organization Realizing Equity, Access, and Community Health Model (ACO REACH).

The integrated care landscape is as varied as the dually eligible population, and multiple coverage options ensure robust opportunities for member choice and competition. Ultimately, we believe that D-SNPs are the only truly *integrated* and *scalable* model available for dually eligible individuals. The D-SNP platform is robust and is supported by managed care networks that span the entire nation. We believe that the expertise, experience, and expansive reach of the D-SNP model can support its continued growth and evolution as the primary pathway for integrated care for dually eligible individuals.

Key Strengths of the D-SNP Model:

Eligibility: D-SNPs are integrated care options specifically designed for dually eligible individuals. FIDE and HIDE SNPs generally enroll full-benefit dually eligible individuals, while CO D-SNPs can enroll both full and partial-benefit duals, providing integrated options for the full spectrum of dually eligible individuals.

Current Enrollment: D-SNPs are the largest integrated care option for dually eligible individuals, with over 6 million enrollees nationwide. D-SNP enrollment is split relatively evenly between CO D-SNPs and more integrated options. There are a significant number of dually eligible individuals not enrolled in any type of integrated plan. As the largest integrated care model, D-SNPs are best-positioned to serve these individuals as they transition to integrated options.

Enrollment Processes: Integrated D-SNPs provide frequent opportunities for enrollment, including a monthly Integrated Care Special Enrollment Period (SEP). Many states also have default enrollment processes through which newly-Medicare eligible individuals are enrolled into their Medicaid MCO's companion HIDE or FIDE SNP, simplifying what can be a complex and confusing process for people aging into Medicare. Frequent opportunities for enrollment into integrated D-SNPs facilitates member choice and allows individuals the opportunity to choose an integrated plan at the time that works best for their individual circumstances.

Scalability: D-SNPs are well-positioned to scale and grow their reach, especially in states with established Medicaid managed care infrastructure. Recent CMS regulations governing integrated D-SNPs facilitate the growth of D-SNPs alongside companion Medicaid MCOs. CO D-SNPs may serve as a first step towards more integrated models in states in which D-SNPs do not currently operate. The tiered D-SNP system – with integration increasing from CO D-SNPs to HIDE SNPs to FIDE SNPs – allows states to choose the integration level that works for them today with the ability to move across the integration continuum in the future. Other models face significant barriers to their scalability.

Provider Network Requirements: Integrated D-SNPs offer robust provider networks that enable enrollees to access both their Medicare and Medicaid benefits. D-SNPs are required to maintain provider networks that support the integration of Medicare and Medicaid benefits. These broad provider networks, supported by the existing managed care infrastructure in many states, enable individuals to seamlessly access providers across both their Medicare and Medicaid coverage.

Financing: D-SNPs were specifically designed to be financed via monthly prospective capitation payments from CMS for Medicare-covered services and from states for Medicaid-covered services. This integrated financing structure allows D-SNPs to take on risk to provide both Medicaid and Medicare services to members.

State Role: One of the strengths of the D-SNP model is the partnership between Medicare Advantage Organizations and the state(s) in which they operate. D-SNPs are the only model that requires a State Medicaid Agency Contract (SMAC), ensuring states retain authority over and oversight of benefit design, care coordination, data sharing, provider networks, and Medicare-Medicaid integration. This collaborative relationship allows states to leverage their D-SNP contracts to advance their integrated care goals at their own pace.

Risk Adjustment: Integrated D-SNPs use the CMS-Hierarchical Condition Categories (CMS-HCC) model to risk-adjust payments for Medicare-covered services. For Medicaid-covered services, they rely on state-specific risk adjustment methodologies, which vary by state and program design. This system enables D-SNPs to be responsive to the differences in populations between the states in which they operate. FIDE SNPs may also receive an

additional frailty payment if their plan has high average enrollee frailty, allowing these plans to serve individuals with higher needs.

Wraparound Benefits: Integrated D-SNPs, and especially FIDE SNPs, offer comprehensive wraparound benefits, which are Medicaid services that "wraparound" and supplement Medicare-covered services for dually eligible individuals. FIDE SNPs are required to provide integrated Medicaid and Medicare benefits for all enrollees, and wraparound benefits for eligible individuals may include LTSS, behavioral health, dental, and/or vision. Integrating these services into one plan provides members with a more seamless experience when accessing necessary benefits.

Detailed Analyses of Integrated Care Options

Eligibility

D-SNPs are integrated care options specifically designed for dually eligible individuals. FIDE and HIDE SNPs generally enroll full-benefit dually eligible individuals, while CO D-SNPs can enroll both full and partial-benefit duals, providing integrated options for the full spectrum of dually eligible individuals.

Other options, such as PACE, C-SNPs, and I-SNPs, do not require enrollees to be dually eligible, though a significant portion of their membership are duals. These programs have other eligibility requirements that can be rigid and restrictive.

Model	Eligibility
FIDE SNPs	Enrollees must be full-benefit dually eligible individuals and live within the FIDE SNP's service area. FIDE SNPs operate with Exclusively Aligned Enrollment (EAE), which requires that individuals be enrolled in an MAOs companion Medicaid MCO to enroll in their FIDE SNP.
HIDE SNPs	Enrollees must be full-benefit dually eligible individuals and live within the HIDE SNP's service area.
CO D-SNPs	Enrollees may be full or partial-benefit dually eligible individuals; states may choose to limit enrollment to full-benefit dually eligible individuals or certain groups of partial-benefit dually eligible individuals. Enrollees must live with the CO D-SNP's service area.
I-SNPs	Enrollees must be enrolled in Medicare Parts A and B, have either resided in a participating long-term care facility for at least 90 days or require an institutional level of care for at least 90 days, and live within the I-SNP service area.
C-SNPs	Enrollees must be enrolled in Medicare Parts A and B, have documented confirmation of a C-SNP eligible chronic condition as confirmed by a healthcare provider.

PACE	Enrollees must be age 55+, reside in a PACE service area, meet nursing home level-of-care criteria, and be able to live in their community with PACE support.
PACE Without Walls	PACE Without Walls is a model proposal and is not currently in operation. Eligibility would follow traditional PACE eligibility.
ACO REACH	To be eligible for alignment to an ACO REACH entity, enrollees must be enrolled in Medicare Parts A and B, must not be enrolled in any Medicare plan, not be enrolled in PACE, hospice, or certain other CMS models, reside in a county within the ACO's service area, and have a primary care provider who is a qualifying Participant Provider in a REACH ACO.
MMPs	Enrollees must be full-benefit dually eligible individuals, reside in the service area of the MMP, and complete an enrollment request (the state or CMS on behalf of the individual can also complete this request).

Current Enrollment

D-SNPs are the largest integrated care option for dually eligible individuals, with over 6 million enrollees nationwide. D-SNP enrollment is split relatively evenly between CO D-SNPs and more integrated options. At their peak, MMPs served over 400,000 individuals, but enrollment has dropped as the model approaches its end. Many MMP enrollees have been or will be transitioned into D-SNPs.

Other models enroll smaller numbers of dually eligible individuals. For example, about 15% of enrollees in C-SNPs are duals, accounting for just under 100,000 individuals. There are also about 100,000 dually eligible individuals enrolled in I-SNPs. PACE currently serves the fewest number of dually eligible individuals and has the most significant constraints on its scalability of all integrated care options.

Despite these integrated care options, there are still a significant number of dually eligible individuals not enrolled in any type of integrated plan. As the largest integrated care model, D-SNPs are best-positioned to serve these individuals as they transition to integrated options.

Model	Current Enrollment
FIDE SNPs	As of June 2025, 369,669 dually eligible individuals nationwide were enrolled in FIDE SNPs – approximately 6% of individuals enrolled in D-SNPs overall.
HIDE SNPs	As of June 2025, 2,273,389 dually eligible individuals were enrolled in HIDE SNPs.
CO D-SNPs	As of July 2025, 3,513,053 dually eligible individuals were enrolled in CO D-SNPs.
I-SNPs	In 2024, approximately 115,000 individuals were enrolled in I-SNPs nationwide, and 96,506 of these enrollees were dually eligible individuals.

C-SNPs	Approximately 675,000 individuals were enrolled in C-SNPs in 2024, and 126,827 of these enrollees were dually eligible individuals. Between 2023 and 2024, enrollment in C-SNPs increased by about 210,000 enrollees. 97% of C-SNP enrollees are in plans for people with diabetes or cardiovascular conditions.
PACE	In 2024, approximately 62,047 dually eligible individuals were enrolled in PACE across 33 states and Washington, DC. PACE covers only 0.4% of dually eligible individuals nationwide.
PACE Without Walls	PACE Without Walls is a proposed model and is not currently operational.
ACO REACH	As of PY 2025, the ACO REACH model includes 103 ACOs, comprising 161,765 health care providers and organizations, and serves approximately 2.5 million people with Traditional Medicare. In 2024, approximately 302,544 dually eligible individuals were attributed to ACO REACH.
MMPs	In 2022, there were 9 states participating in capitated models under the Financial Alignment Initiative with over 420,000 enrollees. Enrollment has since declined, as the model is sunsetting at the end of 2025.

Enrollment Process

Integrated D-SNPs – HIDE and FIDE SNPs – provide frequent opportunities for enrollment, including the Medicare Annual Enrollment Period, the MA Open Enrollment Period (if already enrolled in an MA plan), as well as during a monthly Integrated Care Special Enrollment Period (SEP). Individuals can also enroll in integrated D-SNPs if a SEP is triggered by a qualifying event.

Many states also have default enrollment processes through which newly-Medicare eligible individuals are enrolled into their Medicaid MCO's companion HIDE or FIDE SNP, simplifying what can be a complex and confusing process for people aging into Medicare. Frequent opportunities for enrollment into integrated D-SNPs facilitates member choice and allows individuals the opportunity to choose an integrated plan at the time that works best for their individual circumstances.

Model	Enrollment Process
FIDE SNPs	FIDE SNPs operate with exclusively aligned enrollment – enrollees must be enrolled in the FIDE SNP's parent organization's Medicaid MCO. Enrollment can occur during the Medicare Annual Enrollment Period, the MA Open Enrollment Period (if already enrolled in an MA plan), as well as during a monthly Integrated Care SEP, or if a SEP is triggered by another event, including changes in Medicaid status, change in residence, plan termination, or if their current plan receives a contract violation or CMS sanction. Some

	states have default enrollment, in which newly Medicare-eligible individuals are enrolled into their Medicaid MCO's affiliated FIDE SNP.
HIDE SNPs	HIDE SNPs do not currently operate with exclusively aligned enrollment. Enrollment can occur during the Medicare Annual Enrollment Period, the MA Open Enrollment Period (if already enrolled in an MA plan), as well as during a monthly Integrated Care SEP or if a SEP is triggered by another event, including changes in Medicaid status, change in residence, plan termination, or if their current plan receives a contract violation or CMS sanction. Some states have default enrollment, in which newly Medicare-eligible individuals are enrolled into their Medicaid MCO's affiliated HIDE SNP.
CO D-SNPs	Individuals can enroll in CO D-SNPs when they first become Medicare-eligible, during the Annual Enrollment Period (AEP) or during the Medicare Advantage Open Enrollment Period (MA OEP).
I-SNPs	Eligible individuals can enroll in an I-SNP at any time. Coverage begins the first day of the month after enrollment. CMS does not allow passive or default enrollment into I-SNPs.
C-SNPs	C-SNP enrollment occurs during the Medicare Annual Enrollment Period, or during the MA Open Enrollment Period (if already enrolled in an MA plan). Individuals can also enroll during a Special Enrollment Period, which is triggered by a qualifying life event, which include turning 65, the diagnosis of specific chronic conditions, moving into a medical health institution, or moving outside of the enrollee's current plan's service area.
PACE and PACE Without Walls	PACE enrollment is voluntary. There are no provisions for passive or automatic enrollment. Participants may choose to disenroll at any time, with the disenrollment becoming effective on the first day of the month following the notice. Re-enrollment is possible but subject to the PACE organization's approval.
ACO REACH	Individuals do not enroll in ACO REACH; instead, they are aligned to an ACO either via claims-based alignment or voluntary alignment.
MMPs	States typically administer the enrollment process for MMPs. MMP enrollment may be voluntary or passive.

Scalability

D-SNPs are well-positioned to scale and grow their reach, especially in states with established Medicaid managed care infrastructure. Recent CMS regulations governing integrated D-SNPs facilitate the growth of D-SNPs alongside companion Medicaid MCOs. CO D-SNPs may serve as a first step towards more integrated models in states in which D-SNPs do not currently operate. The tiered D-SNP system – with integration increasing from CO D-SNPs to HIDE SNPs to FIDE SNPs – allows states to choose the integration level that works for them today with the ability to move across the integration continuum in the future.

Other models face significant barriers to their scalability. For example, PACE plans are required to have a physical PACE center and scaling I-SNPs would require coordination with long-term care facilities. While ACO REACH is a scalable model within traditional Medicare, it is limited by provider willingness and prohibitions on overlap with other Medicare programs.

Model	Scalability
FIDE SNPs	Establishing a new FIDE SNP must be done in coordination with a state Medicaid agency. State program design choices impact the ability for MAOs to offer integrated D-SNPs, as both behavioral health and LTSS must be carved into Medicaid managed care. Beginning in 2027, MAOs will only be able to offer one D-SNP serving full benefit duals per service area in which they offer a companion Medicaid MCO.
HIDE SNPs	Establishing a new HIDE SNP must be done in coordination with a state Medicaid agency. State program design choices impact the ability for MAOs to offer integrated D-SNPs, as behavioral health and/or LTSS must be carved into Medicaid managed care. Beginning in 2027, MAOs will only be able to offer one D-SNP serving full benefit duals per service area in which they offer a companion Medicaid MCO.
CO D-SNPs	Establishing a new CO D-SNP must be done in coordination with a state Medicaid agency.
I-SNPs	The scalability of I-SNPs is limited by the size of the institutional population and the need for coordination with nursing facilities. To expand geographically, an I-SNP must contract with long-term care facilities in the target area and plans typically focus on states/markets with higher concentrations of nursing homes or assisted living facilities.
C-SNPs	C-SNPs have the option to target a single condition or a group of conditions. MAOs could expand their C-SNP offerings based on how they choose to structure their plan; there are also opportunities for geographic expansion as insurance companies expand the states, counties, and regions in which they offer C-SNPs. C-SNPs have no specified limitations on enrollment or enrollment capacity.
PACE	PACE organizations must operate at least one physical PACE center within or contiguous to their designated service area. These centers must have sufficient capacity for routine attendance by participants and provide comprehensive services. PACE experiences practical capacity limits, often only serving a few hundred participants per center. Establishing additional PACE sites requires approvals from the State Administering Agency and CMS.
PACE Without Walls	PACE Without Walls is a proposed model that allows for the delivery of care in a home setting. Under this model, PACE organizations would not need to operate a physical PACE center and therefore would not experience the same practical capacity limits as traditional PACE.

ACO REACH	ACO REACH has no explicit cap on the number of individuals attributed. The model's growth is primarily limited by the number of providers willing to participate and accept financial risk and overlap restrictions with Medicare Advantage, the Medicare Shared Savings Program (MSSP), and other CMS Innovation Center models.
MMPs	N/A – MMPs are sunsetting in 2025 and transitioning their enrollees to integrated D-SNPs.

Provider Network Requirements

Integrated D-SNPs offer robust provider networks that enable enrollees to access both their Medicare and Medicaid benefits. D-SNPs are required to maintain provider networks that support the integration of Medicare and Medicaid benefits. These broad provider networks, supported by the existing managed care infrastructure in many states, enable individuals to seamlessly access providers across both their Medicare and Medicaid coverage.

Both the PACE and ACO REACH models are structured around limited provider networks, ultimately restricting beneficiary choice.

Model	Provider Network Requirements
FIDE SNPs	All D-SNPs must meet certain Medicare Advantage provider network requirements, including maintaining an adequate provider network for all Medicare-covered benefits, meeting CMS time-and-distance standards for provider access, and including essential community providers, where applicable. FIDE SNPs must also maintain provider networks that support the full integration of Medicare and Medicaid services. States may impose additional requirements through their State Medicaid Agency Contracts (SMACs).
HIDE SNPs	All D-SNPs must meet certain Medicare Advantage provider network requirements, including maintaining an adequate provider network for all Medicare-covered benefits, meeting CMS time-and-distance standards for provider access, and including essential community providers, where applicable. HIDE SNPs must also maintain provider networks adequate for the coverage of LTSS or behavioral health services. States may impose additional requirements through their State Medicaid Agency Contracts (SMACs).
CO D-SNPs	All D-SNPs must meet certain Medicare Advantage provider network requirements, including maintaining an adequate provider network for all Medicare-covered benefits, meeting CMS time-and-distance standards for provider access, and including essential community providers, where applicable. States may impose additional requirements through their State Medicaid Agency Contracts (SMACs).

I-SNPs	CMS does not mandate the specific composition of an I-SNP's provider network beyond general MA requirements. CMS may allow an I-SNP that operates either single or multiple facilities to establish a county-based service area as long as it has at least one long-term care facility that can accept enrollment and is accessible to the county residents.
C-SNPs	C-SNPs are required to provide access to specialized provider networks specific to the designated chronic conditions.
PACE and PACE Without Walls	PACE functions as both provider and payer, with a tightly integrated provider network centered on the PACE interdisciplinary team (IDT) and day center. Each PACE organization directly employs or contracts with healthcare professionals who comprise the interdisciplinary team. All care is authorized through the PACE organization, and participants agree to use PACE-contracted providers exclusively (except in emergencies). PACE organizations are considered providers under Medicare and Medicaid regulations, allowing them to deliver services and contract with other providers without being subject to the same network adequacy requirements that apply to MA or Medicaid MCOs.
ACO REACH	Each ACO REACH organization is built around a core group of Participant Providers, including primary care physicians, FQHCs, RHCs, and sometimes specialists or hospitals. These providers are responsible for delivering care, driving beneficiary alignment, and sharing in the ACO's financial performance. Providers must be Medicare-enrolled and have signed participation agreements with the ACO entity. Beneficiaries aligned to an ACO REACH retain freedom to see any Medicare-enrolled provider, including those outside the ACO network. However, ACOs are incentivized to keep care in-network.
MMPs	CMS reviews the adequacy of MMP provider networks to ensure that beneficiaries have access to comprehensive and coordinated care. CMS requires MMPs to demonstrate an adequate provider network sufficient to provide access to covered services in each demonstration. CMS criteria typically differ based on the location.

Financing

D-SNPs were specifically designed to be financed via monthly prospective capitation payments from CMS for Medicare-covered services and from states for Medicaid-covered services. This integrated financing structure allows D-SNPs to take on risk to provide both Medicaid and Medicare services to members.

MMPs are financed through a unique three-way contract between CMS, the state, and the health plan. MMPs follow a capitated model where each of these entities agree to a blended capitated payment rate that incorporates risk adjustment and savings percentages. As MMPs wind down, lessons learned from this financing structure may be incorporated into integrated D-SNPs.

Model	Financing
FIDE SNPs	FIDE SNPs receive monthly capitated payments from CMS for Medicare-covered services, and monthly capitated payments from states for Medicaid services. FIDE SNPs are also eligible for an additional frailty payment, if the FIDE SNP has "a similar level of average frailty… as the PACE program" as determined by scores on the HOS/HOS-M survey. D-SNPs can charge monthly premiums, but most do not. For the D-SNPs that do charge a monthly premium, they are often structured in a way that the premium is covered for individuals who have full Medicaid benefits, Medicare Savings Programs, and Extra Help (LIS).
HIDE SNPs	HIDE SNPs receive monthly capitated payments from CMS for Medicare-covered services and monthly capitated payments from states for the Medicaid services provided by the D-SNP. D-SNPs can charge monthly premiums, but most do not. For the D-SNPs that do charge a monthly premium, they are often structured in a way that the premium is covered for individuals who have full Medicaid benefits, Medicare Savings Programs, and Extra Help (LIS).
CO D-SNPs	CO D-SNPs receive monthly capitated payments from CMS for Medicare-covered services. CO D-SNPs do not receive capitation payments from state Medicaid agencies. D-SNPs can charge monthly premiums, but most do not. For the D-SNPs that do charge a monthly premium, they are often structured in a way that the premium is covered for individuals who have full Medicaid benefits, Medicare Savings Programs, and Extra Help (LIS).
I-SNPs	I-SNPs receive monthly capitation payments from CMS for Medicare-covered services. For a dually eligible individual in an I-SNP who resides in a nursing facility, Medicaid pays for the daily room and board and personal care costs, while the I-SNP is responsible for the medical care costs. I-SNPs can charge monthly premiums, but many do not. Most I-SNPs offer premiums at or below the low-income premium subsidy amount (LIPSA).
C-SNPs	C-SNPs receive monthly capitated payments from CMS for Medicare-covered services. About three-quarters of C-SNPs charge zero-dollar premiums. In 2024, There were only six C-SNPs offering premiums above the low-income premium subsidy amount (LIPSA).
PACE and PACE Without Walls	PACE is financed through monthly capitated payments from Medicare and Medicaid (for dually eligible enrollees). The Medicaid capitation amount must be less than what would have otherwise been paid under the State plan if the individual were not enrolled in PACE. PACE organizations operate under a full-risk model and do not employ risk corridors or shared savings.
ACO REACH	ACO REACH pairs prospective, population-based payments with two-sided financial risk. ACO REACH establishes a benchmark for each participating ACO, estimating expected Medicare expenditures for aligned individuals in the

	absence of the ACO. At the end of the performance year, CMS compares actual expenditures to the benchmark to calculate shared savings or losses. Participating ACOs select from two risk arrangements: the Professional option, which shares 50% of savings and losses with CMS, or the Global option, which assumes 100% of risk. There are two forms of capitation in the ACO REACH model: Primary Care Capitation (PCC) involves CMS making per-member-per-month (PMPM) payments to the ACO for primary care services. Providers receive FFS payments for non-primary care services. Total Care Capitation (TCC) **i**s available only to Global ACOs and covers all Medicare Part A and B services, making the ACO fully responsible for provider reimbursement. Providers receive FFS payments for claims outside of the scope of the TCC.
MMPs	MMPs are financed through a three-way contract between CMS, the state, and the health plan. MMPs follow a capitated model where each of these three entities agree to a blended capitated payment rate for participating plans for all Medicaid and Medicare benefits for dually eligible beneficiaries. Payment rates are established by: 1. Projecting baseline spending - each state develops a projection of baseline Medicaid spending in the absence of the demonstration, which must be approved by CMS. 2. Applying savings percentages 3. Applying risk adjustments 4. Applying additional risk mitigation techniques 5. Applying withhold percentages. Over time, CMS and states changed these elements to keep the program financially sustainable.

State Role

One of the strengths of the D-SNP model is the partnership between Medicare Advantage Organizations and the state(s) in which they operate. D-SNPs are the only model that requires a State Medicaid Agency Contract (SMAC), ensuring states retain authority over and oversight of benefit design, care coordination, data sharing, provider networks, and Medicare-Medicaid integration. This collaborative relationship allows states to leverage their D-SNP contracts to advance their integrated care goals at their own pace.

Model	State Role
FIDE and HIDE SNPs	To operate, FIDE SNPs must establish a State Medicaid Agency Contract (SMAC) that outlines the Medicaid benefits the plan will cover, the eligible population, the plan's responsibilities regarding Medicare cost-sharing, and the service area, among other specifications. States are not obligated to contract with any specific D-SNPs but can leverage these contracts to advance their integration goals. States also set Medicaid capitation rates and

	monitor FIDE SNPs' performance concerning Medicaid services. State Medicaid program design choices impact the availability of integrated D-SNPs in the state. State decisions around benefits carved into managed care as well as Medicaid managed care procurements impact which MAOs can operate an integrated D-SNP in the state, as well as the level of integration.
CO D-SNPs	To operate, CO D-SNPs must have a contract with the State Medicaid agency. States are not obligated to contract with any specific D-SNPs, including CO D-SNPs. States may view CO D-SNPs as an initial step towards more integrated D-SNPs in the future.
I-SNPs	I-SNPs are subject to state insurance licensing requirements but are not required to contract with State Medicaid Agencies, unless they seek to enroll "institutional-equivalent" members, in which case a contract is required to validate member eligibility.
C-SNPs	C-SNPs are not required to have contracts with the state. Insurance companies decide where C-SNPs will be offered. CMS serves as the primary regulatory body for C-SNPs, however, states may have specific state requirements (ex. licensing/care-coordination requirements) for specialists within the C-SNP provider network.
PACE and PACE Without Walls	States must elect to offer PACE as an optional Medicaid benefit by submitting a State Plan Amendment (SPA) for CMS approval. Once a PACE is established, the state's role includes determining the Medicaid capitation rate, reviewing PACE performance data and participating in audits jointly with CMS, and certifying that each PACE enrollee meets nursing facility level-of-care at enrollment and at least annually thereafter. States are permitted to implement additional or more stringent requirements on PACE organizations.
ACO REACH	Participation in the ACO REACH Model does not require formal approval or agreement from state governments. ACOs must comply with all applicable state licensure requirements regarding risk-bearing entities.
MMPs	MMPs must have a three-way contract between CMS, the state Medicaid agency, and the health plan. This contract outlines requirements for benefit integration, care coordination, quality measurement, and financing. Both CMS and the state Medicaid agency provide oversight of MMPs.

Risk Adjustment

Integrated D-SNPs use the CMS-Hierarchical Condition Categories (CMS-HCC) model to risk-adjust payments for Medicare-covered services. For Medicaid-covered services, they rely on state-specific risk adjustment methodologies, which vary by state and program design. This system enables D-SNPs to be responsive to the differences in populations between the states in which they operate. FIDE SNPs may also receive an additional frailty payment if their plan has high average enrollee frailty, allowing these plans to serve individuals with higher needs.

Under MMPs, CMS and the states jointly develop capitation rates for both Medicare and Medicaid services as part of their contract negotiations. As MMPs wind down, lessons learned from this strategy may be used to inform changes to the D-SNP model.

Model	Risk Adjustment
FIDE SNPs	On the Medicare side, FIDE SNPs receive risk-adjusted payments under the CMS-Hierarchical Condition Categories (CMS-HCC) model. CMS may apply a frailty adjustment to the Medicare risk-adjusted capitation payment if the plan's enrollees demonstrate an average level of functional impairment (measured through the standardized Health Outcomes Survey) that is comparable to beneficiaries in the PACE program. For Medicaid services, risk adjustment methodologies vary by state.
HIDE SNPs	On the Medicare side, HIDE SNPs receive risk-adjusted payments under the CMS-Hierarchical Condition Categories (CMS-HCC) model. For Medicaid services, risk adjustment methodologies vary by state.
CO D-SNPs	CO D-SNPs receive risk-adjusted payments under the CMS-Hierarchical Condition Categories (CMS-HCC) model for Medicare services.
I-SNPs	I-SNPs receive risk-adjusted payments under the CMS-Hierarchical Condition Categories (CMS-HCC) model. The CMS-HCC assigns higher risk weight to individuals who reside in long-term care facilities for longer than 90 days to reflect greater healthcare needs and expected costs.
C-SNPs	CMS capitation payments to C-SNPs are risk-adjusted using the Hierarchical Condition Categories (HCC) Risk Adjustment model (HCC). The HCC model includes many of the same chronic conditions that C-SNPs are designed to manage; therefore, HCC risk adjustment is especially important in C-SNP funding.
PACE and PACE Without Walls	CMS capitation payments to PACE plans are risk-adjusted using the Hierarchical Condition Categories (HCC) Risk Adjustment model (with a PACE-specific approach). The PACE risk adjustment also includes a frailty factor that increases payments for enrollees with functional impairments not captured by diagnoses alone. For Medicaid services, risk adjustment methodologies vary by state.
ACO REACH	CMS capitation payments to ACO REACH organizations are risk-adjusted using the Hierarchical Condition Categories (HCC) Risk Adjustment model (HCC). To mitigate incentives for excessive coding, CMS applies a symmetric cap on risk score growth. For Standard and New Entrant ACOs, this cap is set at ±3% relative to a static reference year, adjusted for demographic changes. For High Needs Population ACOs, a ±10% cap is applied. A retrospective Coding Intensity Factor (CIF) is also applied to ensure that the average risk score growth across all ACOs remains neutral.
MMPs	CMS and the states jointly develop capitation rates for both Medicare and Medicaid services as part of their contract negotiations. Participating plans

	receive prospective capitated payments that consist of three amounts: one from CMS for Medicare Parts A and B, another from CMS for Medicare Part D, and a third from the state for Medicaid. States and CMS establish savings percentages that are deducted upfront from Medicaid and Medicare payments to plans. Risk adjustments are applied separately to Medicare Parts A, B, and D and the Medicaid components of capitated payments. On the Medicare side, FIDE SNPs receive risk-adjusted payments under the CMS-Hierarchical Condition Categories (CMS-HCC) model. On the Medicaid side, states can use different adjustment models so long as they provide incentives for community alternatives to institutional placement; have clear operational rules; have a process to assign beneficiaries to a rate category that is compatible with the beneficiary's risk level and profile; and are budget neutral to Medicaid after application of savings percentages.

Wraparound Benefits

Integrated D-SNPs, and especially FIDE SNPs, offer comprehensive wraparound benefits, which are Medicaid services that "wraparound" and supplement Medicare-covered services for dually eligible individuals. FIDE SNPs are required to provide integrated Medicaid and Medicare benefits for all enrollees, and wraparound benefits for eligible individuals may include LTSS, behavioral health, dental, and/or vision. Integrating these services into one plan provides members with a more seamless experience when accessing necessary benefits.

Model	Wraparound Benefits
FIDE SNPs	FIDE SNP enrollees receive a comprehensive, integrated set of services, including full Medicare and Medicaid benefits. FIDE SNP wraparound benefits vary by state and plan, but may include dental, vision, hearing, non-emergency medical transportation (NEMT), personal care/attendant services, and assistance with Part D expenses, even if not covered by Medicaid.
HIDE SNPs	HIDE SNPs provide some wraparound benefits, but they are typically not as exhaustive as those covered under FIDE SNPs. Wraparound benefits vary by state and plan.
CO D-SNPs	CO DSNPs are not required to provide any Medicaid benefits, only to coordinate them. As a result, they do not offer wraparound benefits, but individuals who are eligible for full Medicaid benefits receive those services through their Medicaid plan.
I-SNPs	I-SNPs, except for rare exceptions, do not offer wraparound benefits. Dually eligible individuals who are enrolled in I-SNPs receive Medicaid benefits through their Medicaid plan.

C-SNPs	C-SNPs do not offer wraparound benefits. Dually eligible individuals who are enrolled in C-SNPs receive Medicaid benefits through their Medicaid plan
PACE and PACE Without Walls	PACE organizations are required to provide at minimum all Medicare- and Medicaid-covered services, resulting in relatively comprehensive, wraparound benefits. Participants receive primary and specialist care (through referrals), hospital and emergency care, prescription drugs, rehabilitation services, long-term services and supports (LTSS) such as personal care attendants in the home, adult day health services at the PACE center, home-delivered meals if needed, homemaker/chore services, transportation to the PACE center and external medical appointments, and end-of-life care. PACE can additionally cover vision and dental services even if a state's Medicaid program does not elect to cover those services.
ACO REACH	Dually eligible individuals attributed to an ACO have access to Medicaid benefits, but the ACO does not pay for these services. However, ACOs are encouraged to coordinate with Medicaid providers. CMS grants waivers that allow REACH ACOs to provide some services not normally reimbursed by FFS Medicare (e.g., telehealth, home visits for high-risk patients).
MMPs	MMPs are required to cover all services included in the Medicaid state plan and all medically necessary Medicare Part A and B services resulting in relatively comprehensive, wraparound benefits. They must also meet all Medicare Part D requirements, including benefits and network adequacy. However, the benefits offered and delivered in MMPs vary across states.

Appendix

Definitions

Medicaid: Medicaid is a public health insurance program for some people or families with limited incomes and resources, including children, pregnant women, older adults, and people with disabilities. Medicaid is a joint Federal and state program.

Medicare: Medicare is a health insurance program offered by the Federal government for people age 65 and older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (ESRD).

Medicare Advantage (MA): Medicare Advantage plans are also known as Medicare Part C; these plans are offered by private companies as an alternative to traditional fee-for-service Medicare.

Dual Eligible Special Needs Plan (D-SNP): D-SNPs are Medicare Advantage plans designed for individuals who are eligible for both Medicare and Medicaid (known as "dual

eligibles"). These plans coordinate Medicare and Medicaid benefits to improve care and reduce duplication, often covering extra services like care coordination and long-term services and supports.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP): FIDE SNPs are a type of D-SNP that offers complete integration of Medicare and Medicaid benefits, including long-term services and supports (LTSS) and behavioral health. They receive capitated payments from both Medicare and Medicaid and provide a single, streamlined plan with enhanced coordination and accountability.

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP): HIDE SNPs are a type of D-SNP that offer integration of most Medicare and Medicaid benefits, including either LTSS or behavioral health (or both). HIDE SNPs hold a capitated contract with the state Medicaid agency in the state in which they operate.

Coordination Only D-SNP (CO D-SNP): CO D-SNPs are a type of D-SNP that are required to coordinate, but not manage, Medicaid benefits.

Chronic Condition Special Needs Plan (C-SNP): A C-SNP is a Medicare Advantage plan for beneficiaries with specific chronic conditions, such as diabetes, chronic heart failure, or HIV/AIDS. These plans tailor their benefits, provider networks, and drug formularies to meet the unique needs of enrollees with these chronic illnesses.

Institutional Special Needs Plan (I-SNP): An I-SNP is for people who live in institutional settings, like nursing homes, or who require a similar level of care at home. These plans are designed to manage care for frail individuals, offering coordinated services that reduce hospitalizations and improve quality of life.

Program of All-Inclusive Care for the Elderly (PACE): PACE is a comprehensive, capitated managed care program for older adults who are eligible for nursing home level care but prefer to remain in their homes or communities. It provides integrated medical and social services, including primary care, long-term care, and transportation, often delivered through a PACE center.

PACE Without Walls: This is a modified PACE model that aims to remove the requirement for participants to receive services at a physical PACE center. It supports home- and community-based care, expanding access to PACE for individuals who cannot or prefer not to attend a center regularly, often through telehealth and mobile care teams.

Accountable Care Organization Realizing Equity, Access, and Community Health Model (ACO REACH): ACO REACH is a value-based care model under Medicare designed to promote health equity, increase provider accountability, and improve care coordination.

It replaces the older Direct Contracting model and encourages innovative, community-focused care delivery, particularly for underserved populations.

Medicare-Medicaid Plans (MMP): MMPs are health plans that integrate Medicare and Medicaid services for dual-eligible individuals under the Financial Alignment Initiative. These plans aim to simplify care delivery, reduce costs, and improve outcomes by combining the benefits and services of both programs into one plan.

An in-depth analysis of integrated care options for dually eligible individuals can be found here.

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