

Integrated Care Programs for Dually Eligible Individuals: Current Evidence and Opportunities for Future Research

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Summary

Over the last several decades, policymakers have developed three major programs designed to integrate Medicare and Medicaid benefits for people who are dually eligible for both programs: (1) Programs of All-Inclusive Care for the Elderly (PACE), (2) Financial Alignment Initiative demonstrations, and (3) state-based programs leveraging Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). Researchers have studied the effects of these programs on enrollee experience, service use, and program costs, as well as factors influencing program enrollment. So far, this research has shown:

- **Generally positive enrollee experiences**, with care coordination playing an important role in enrollees' satisfaction. In some cases, enrollees have been unaware of their care coordinator or faced challenges using care coordination services.
- **Mixed results regarding performance on certain quality measures**, including D-SNP and Financial Alignment Initiative Medicare-Medicaid Plan (MMP) performance on Medicare Advantage (MA) Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- **Reductions in hospitalizations, hospital readmissions, and in some cases, long-term care nursing facility use among integrated care program enrollees** (in comparison to dually eligible individuals in fee-for-service and/or other managed care programs), with mixed results for other types of services, such as primary care, specialty care, and home and community-based services (HCBS).
- **Little evidence of cost reductions for Medicare or Medicaid.** Most studies show little or no Medicare savings. Data limitations have hindered assessment of programs' influence on Medicaid costs, but newly available Medicaid data will help to fill this gap in evidence.
- **A variety of factors influence enrollment in integrated care plans.** Factors that encourage enrollment include use of passive enrollment, positive care coordinator–enrollee relationships, strong provider networks, collaboration with trusted community-based organizations, emphasis on particular outreach messages, access to well-informed, unbiased assistance, and the ability to receive additional benefits not traditionally covered by Medicare or Medicaid. Factors inhibiting enrollment include competition from other types of plans, confusion about passive enrollment, density and complexity of enrollment-related communications, and lack of knowledge and misconceptions about the benefits of integrated care. Use of Medicaid eligibility deeming periods can help to maintain enrollment among current enrollees.
- **Certain subgroups are more likely to enroll in integrated care plans, but they may not always be the most well served.** One study showed that Black and Hispanic dually eligible individuals, as well as individuals in urban areas and people ages 65 and older, were more likely to enroll in integrated care plans (PACE organizations, MMPs, and fully integrated D-SNPs [FIDE SNPs]) than their white, rural, and younger counterparts. However, another study found that D-SNP enrollment was associated with fewer and smaller improvements in care among dually eligible individuals of color than among non-Hispanic white enrollees.

More research should help to explain contradictory findings from past studies, fill gaps in current research, and reflect how ongoing regulatory updates for D-SNPs have affected desired outcomes. In particular, future research should aim to understand (1) variance in the experiences of particular subgroups of integrated care plan enrollees, such as members of different racial and ethnic groups; (2) variation in outcomes for enrollees in D-SNPs of different levels of integration; (3) plan performance on additional measures designed to assess person-centered care and enrollee experiences, as well as achievement of other outcomes that reflect enrollee priorities; (4) specific care coordination methods and approaches that achieve desired outcomes; and (5) the extent to which these programs are able to truly achieve desired cost savings for Medicare and/or Medicaid. In examining these topics, researchers should use rigorous methodologies and study designs that suit the specific topics and outcomes examined. ▲

Background

For several decades, federal and state policymakers have sought to improve care and reduce Medicare and Medicaid program expenditures for people dually eligible for both programs, typically referred to as “dually eligible individuals.” This population has a particularly high prevalence of chronic conditions, behavioral health conditions, functional needs, and social risk factors,¹ and they account for approximately one-third of Medicare and Medicaid spending, despite accounting for just 19 and 13 percent of Medicare and Medicaid program enrollees, respectively (MedPAC and MACPAC 2024).² Additionally, more dually eligible individuals belong to a non-white racial or ethnic group (47 percent) than their counterparts with only Medicare coverage (18 percent) (MedPAC and MACPAC 2024), and more than 20 percent of dually eligible individuals speak limited English (Proctor et al. 2018).

Because Medicare and Medicaid operate as separate programs with different benefits and coverage, navigating both programs simultaneously can be challenging, particularly for people dealing with an array of physical health, behavioral health, and/or social needs. To reduce this fragmentation and increase coordination of Medicare and Medicaid benefits, the Centers for Medicare & Medicaid Services (CMS) and states have developed three programs aimed at integrating Medicare and Medicaid coverage for dually eligible individuals (see Appendix A for key dates and activities in the development and ongoing operation of each of these programs):

/ **Programs of All-Inclusive Care for the Elderly (PACE).** PACE is a model through which non-profit, for-profit, or public entities cover a comprehensive set of medical and social services for participants in exchange for monthly capitated payments.³ To be eligible for PACE, an individual must be age 55 or older, certified by their state as eligible for care in a long-term care facility, but living safely in a community setting at the time of enrollment. More information about PACE is available at <https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/program-all-inclusive-care-elderly-pace>.

/ **Financial Alignment Initiative demonstrations.** The Financial Alignment Initiative was established under the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148). Since 2013, 12 states have partnered with CMS to launch demonstration models under this initiative, with two states (Colorado and Washington) implementing demonstrations using fee-for-service payment models, nine states (California, Illinois, Massachusetts, New York, Ohio, Rhode Island, South Carolina, Texas and Virginia)

¹ 70 percent of dually eligible individuals have three or more chronic conditions (Integrated Care Resource Center [ICRC] 2022); 41 percent have a behavioral health condition (ICRC 2022); 47 percent need help with at least one activity of daily living (MedPAC and MACPAC 2024), and more than 40 percent use long-term services and supports (ICRC 2024). Additionally, 37 percent of dually eligible individuals live alone and 64 percent have a high school diploma or less (MedPAC and MACPAC 2024).

² In 2019 and 2020, dually eligible individuals have accounted for 34 percent of Medicare spending and 30 percent of Medicaid spending (MedPAC and MACPAC 2022, MedPAC and MACPAC 2023). In 2021, they accounted for 35 percent of Medicare spending and 27 percent of Medicaid spending (MedPAC and MACPAC 2024). The decrease in the proportion of Medicaid spending attributable to dually individuals in 2021 is likely related to the continuous enrollment provision in the Families First Coronavirus Response Act, which prevented states from disenrolling most Medicaid beneficiaries during the COVID-19 pandemic. As a result, between February 2020 and March 2023, Medicaid enrollment increased by 35 percent—more than 22 million enrollees (CMS 2023a).

³ In “capitated” models, health care providers, insurance companies, or other organizations taking responsibility for coverage of health care benefits are paid a predictable, set amount of money up front to cover the predicted cost of their patients’ or members’ health care services for a certain period of time (CMS n.d., “Capitation and Pre-payment”).

initiating capitated payment model demonstrations through which Medicare-Medicaid plans (MMPs) cover substantially all Medicare and Medicaid benefits for enrollees, and one state (Minnesota) operating an administrative alignment demonstration through which the state and CMS have streamlined certain administrative processes within the state's Minnesota Senior Health Options (MSHO) program.⁴ As of 2024, four states have ended their demonstrations (California, Colorado, New York,⁵ and Virginia), leaving seven states with capitated model demonstrations and Washington with its fee-for-service model. All of these demonstrations will end on December 31, 2025, after which the states with capitated model demonstrations intend to transition to models leveraging Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).

/ **State-based integrated care programs leveraging D-SNPs.** D-SNPs are specialized Medicare Advantage plans that only enroll dually eligible individuals. They were established through the Medicare Modernization Act of 2003, began operating in 2006, and were permanently authorized by the Bipartisan Budget Act of 2018. In 2013, CMS began requiring D-SNPs to hold contracts with state Medicaid agencies, enabling states to impose state-specific requirements, such as requiring D-SNPs to cover Medicaid benefits for their enrollees, either through the D-SNP or through an affiliated Medicaid managed care plan operated by the same parent company as the D-SNP.⁶ Several states have also used their contracts with D-SNPs to demand specific care coordination activities, streamline enrollee communications, and/or require D-SNP reporting of certain types of data to facilitate monitoring of D-SNP quality and performance (Weir Lakhmani et al. 2021). As of 2024, 11 states, the District of Columbia (D.C.) and Puerto Rico all have at least some D-SNPs operating with "exclusively aligned enrollment," meaning the D-SNPs only enroll full-benefit dually eligible individuals who receive their Medicaid benefits from the D-SNP or the D-SNP's affiliated Medicaid managed care plan (Shea et al. 2023). In addition to delivering Medicare and Medicaid benefits through a single parent organization, D-SNPs that operate with exclusively aligned enrollment can also offer streamlined communication materials, integrated benefit determinations and unified plan-level appeal and grievance processes, a single enrollee identification card and customer service hotline for both Medicare and Medicaid coverage, consolidated provider billing, and other benefits for enrollees and providers.

In April 2024, nearly half of the dually eligible individuals in the United States are enrolled in a D-SNP, MMP, or PACE organization (Exhibit 1).⁷ However, only about 8 percent of dually eligible individuals are in a plan that covers both Medicare and Medicaid benefits and operates with exclusively aligned enrollment (an exclusively aligned D-SNP, an MMP, or a PACE organization). With significant room for growth in enrollment in the most integrated plans, additional research is needed to more clearly understand factors influencing program enrollment and disenrollment, as well as the extent to which these programs improve

⁴ Minnesota originally launched the MSHO program in 1997 as part of a demonstration with CMS (Kane et al. 2001). Since its original inception, MSHO has been expanded to additional counties, and MSHO plans now operate as fully integrated Dual Eligible Special Needs Plans (FIDE SNPs) that cover Medicare and Medicaid benefits for enrollees.

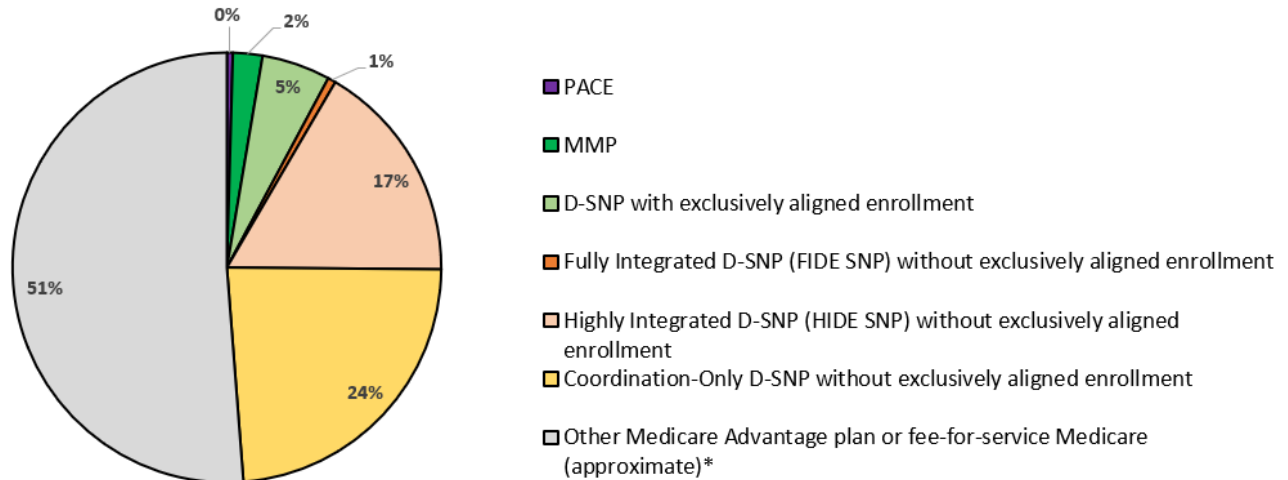
⁵ New York launched two capitated model demonstrations under the Financial Alignment Initiative. It ended one demonstration in 2019, but the state has maintained a specialized demonstration for individuals with intellectual and developmental disabilities.

⁶ D-SNPs and Medicaid managed care plans operated by the same parent company in the same or overlapping service areas are referred to as "affiliated" plans.

⁷ The data used in Exhibit 1 excludes data from Puerto Rico, where more than 300,000 dually eligible individuals are enrolled in D-SNPs with exclusively aligned enrollment.

outcomes for their enrollees, whether certain programs perform better than others, and areas for improvement.

Exhibit 1. Dually eligible individuals’ Medicare plan enrollment, April 2024 (50 states and District of Columbia)



Sources: CMS 2023b, CMS 2024b, Integrated Care Resource Center 2024

Notes: Coordination-only D-SNPs are D-SNPs that do not qualify as a FIDE SNP or a HIDE SNP. Outside of California, these D-SNPs do not cover any Medicaid benefits. For information about the different types of D-SNPs, see the Integrated Care Resource Center’s tip sheet on D-SNP definitions at <https://integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023>.

*The author calculated the number of dually eligible individuals enrolled in regular Medicare Advantage plans or fee-for-service Medicare by subtracting total enrollment in PACE, MMPs, and D-SNPs from the total number of dually eligible individuals nationwide. However, the data for PACE, MMP and D-SNP enrollment is from April 2024 and the total number of dually eligible individuals nationwide is from June 2023. Therefore, this number is approximate.

Since the inception of these three types of integrated care programs, researchers have studied their effects on enrollee experience, service use, and costs. Some researchers have also examined factors influencing enrollment in certain types of programs and compared difference in outcomes between the most basic form of D-SNPs—coordination-only (CO) D-SNPs—and highly and fully integrated D-SNPs (HIDE SNPs and FIDE SNPs).⁸

This brief summarizes the results of previous research on these models. It is organized into four sections, based on the four major foci of existing studies: (1) enrollee experiences in integrated care plans, (2) the effects of integrated care models on enrollees’ use of certain health care services, (3) the effects of these models on Medicare and Medicaid costs, and (4) factors that influence enrollment in integrated care programs. The brief concludes with suggestions for future research based on gaps in existing findings and topics that remain unexplored.

⁸ For details regarding these three different types of D-SNPs, see the Integrated Care Resource Center’s tip sheet on D-SNP definitions at <https://integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023>.

Enrollee Experiences with Care and Coverage

As the Medicare Payment Advisory Commission (MedPAC) noted in its March 2024 Report to Congress (MedPAC 2024), measures of enrollee experience are critical to evaluating the quality and effectiveness of integrated care programs. Researchers from a variety of academic and non-academic institutions have studied the experiences of dually eligible enrollees in these programs, and in some cases, they have also compared the experiences of dually eligible individuals in integrated care plans with those in other types of Medicare and Medicaid coverage arrangements. Some studies have used qualitative interviews or focus groups to elicit information about enrollees' experiences, while others have examined quantitative experience measures or used a mixed methods approach.

Qualitative evidence

Since 2022, Mathematica has conducted qualitative studies with dually eligible individuals about their experiences with their health care services and coverage. We have found that dually eligible enrollees of integrated care plans in three states (Massachusetts, Michigan, and Rhode Island) have had mixed levels of satisfaction with their plans' care coordinators and care coordination services (Beaver et al. 2023, Whicher, Spiering, et al. 2022, Whicher, Nguyen, et al. 2022). Interviewees who reported consistent contact with the same care coordinator tended to report higher satisfaction with care coordination services and their plan. Interviewees were generally satisfied with their access to medical care and home and community-based services (HCBS), but some interviewees faced challenges accessing durable medical equipment, specialists, or supports for health-related social needs, such as food, housing, or transportation. Many interviewees said they get help from family or friends when they need help accessing a service or filing an appeal.

Mathematica's findings align with those from the Financial Alignment Initiative demonstration evaluations conducted by RTI International.⁹ In these evaluations, researchers from RTI have reported that MMP enrollees generally appreciate having (1) a single plan with a single identification card, (2) no copayments for health care services, and (3) access to additional (supplemental) benefits that they would not otherwise have under fee-for-service Medicare. In addition, the researchers have found that MMP enrollees have generally shared positive feedback about their MMPs' care coordination services, as well as general satisfaction with their plans. Examples of ways that MMP care coordinators have assisted enrollees include (1) helping enrollees to access health care services, medical equipment, and other supports for health-related social needs, (2) helping enrollees to improve their health, and (3) resolving billing issues. That said, in at least some states, some MMP enrollees continue to report not knowing their care coordinator or not having one, an issue that sometimes varies by subgroups of enrollees (for example, Spanish versus English speakers). (Chepaitis et al. 2021; Gattine et al. 2023; Griffin, Tyler, et al. 2023; Griffin, Hodge, et al. 2023; Holladay, Howard, et al. 2022; Holladay, Stockdale, et al. 2022; Howard et al. 2023; Kandilov et al. 2023; Khatuskay et al. 2023; Toth et al. 2023)

Other care coordination challenges identified in demonstration evaluations include (1) mixed reviews regarding care coordinator responsiveness, (2) confusion generated by turnover in care coordinator relationships, (3) challenges with coordination of Medicaid benefits that are carved out of MMP coverage, and (4) care coordinators' inability to reach plan enrollees to conduct assessments and engage them in

⁹ Both Mathematica's studies and RTI International's evaluations of the Financial Alignment Initiative demonstrations have been conducted on behalf of the Centers for Medicare & Medicaid Services (CMS).

other care management activities. For example, in Illinois, the proportion of enrollees that MMPs have been unable to reach in recent demonstration years averaged 25-30% (Holladay, Stockdale et al. 2022). The COVID-19 public health emergency also limited care coordinators’ ability to engage with enrollees in at least some states, especially when enrollees resided in nursing facilities. States and MMPs leveraged telehealth during this period to maintain continuity of care for members, an option that has mitigated access to care challenges. (Chepaitis et al. 2021; Gattine et al. 2023; Griffin, Tyler, et al. 2023; Griffin, Hodge, et al. 2023; Holladay, Howard, et al. 2022; Holladay, Stockdale, et al. 2022; Howard et al. 2023; Kandilov et al. 2023; Khatusky et al. 2023; Toth et al. 2023)

Quantitative evidence

Researchers have also assessed enrollee satisfaction with their health plans and the health care services they receive by examining results from Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan surveys. Evaluations of the Financial Alignment Initiative demonstrations show that MMP CAHPS scores have increased over time across all demonstration states, but the proportion of MMP enrollees rating their plans highly has varied by state. In the most recent evaluations, the proportion of demonstration enrollees rating their MMP a 9 or a 10 (on a scale of 10) ranged from 62 percent in Virginia to 76 percent in Rhode Island (Exhibit 2).

Exhibit 2. Average proportion of MMP CAHPS survey respondents who rated their plan a 9 or a 10 in the most recent year of data included in demonstration evaluations

	CA	IL	MA	MI	OH	RI	SC	TX	VA
Average proportion of MMP enrollees who rated their MMP 9 or 10 (10-point scale)	66%	64%	70%	71%	68%	76%	72%	66%	62%

Source: RTI International evaluations and CMS At-A-Glance reports from states’ Financial Alignment Initiative evaluations, 2023. <https://www.cms.gov/priorities/innovation/innovation-models/financial-alignment>.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare and Medicaid Services; MMP = Medicare-Medicaid Plan.

Researchers have also compared CAHPS survey results from D-SNP enrollees with results from dually eligible individuals enrolled in regular Medicare Advantage (MA) plans, and in some cases, with results from dually eligible individuals in fee-for-service Medicare with stand-alone Part D plans (Haviland et al. 2021, MedPAC 2024, Meyers et al. 2023). At least two studies have also compared CAHPS results from enrollees in coordination-only D-SNPs, enrollees in more integrated D-SNPs (HIDE SNPs and FIDE SNPs), and enrollees in regular MA plans (MedPAC 2024, Meyers et al. 2023). The findings from each of these studies have been mixed, both within individual studies and across them all. The two studies that isolated integrated D-SNPs both found that those D-SNPs performed better than regular MA plans on at least some measures, but the findings were inconsistent across the studies.

One study compared Medicare Current Beneficiary Survey (MCBS) results from 2015–2019 for access to care, use of preventive care, use of emergency department services, and satisfaction with care among D-SNP enrollees, dually eligible individuals enrolled in regular (non-D-SNP) MA plans, and dually eligible individuals in fee-for-service Medicare (Roberts and Mellor 2022). The researchers found that, when compared to dually eligible individuals in fee-for-service Medicare, D-SNP enrollees reported (1) better access to care on two of the three access measures examined, (2) higher rates of satisfaction on four of six measures, and (3) greater likelihood of receiving preventive services. However, when compared to dually

eligible individuals enrolled in regular MA plans, D-SNP enrollees only reported (1) better access to dental care and (2) higher rates of satisfaction on out-of-pocket expenses and availability of care from specialists. The researchers found no statistically significant differences between these two groups in their reported use of preventive care or emergency department services. Perhaps most importantly, these researchers found that D-SNP enrollment was associated with fewer and smaller improvements in care among dually eligible individuals of color than among non-Hispanic white enrollees.

Integrated Care Program Effects on Service Use

Several evaluations of particular states' integrated D-SNP programs have showed promising results regarding desired changes in enrollees' use of certain types of health care services, including reductions in hospitalizations, hospital readmissions, and long-term nursing facility care (Medicaid and CHIP Payment and Access Commission [MACPAC] 2020). For example, researchers found that enrollees in Minnesota Senior Health Options (MSHO) integrated FIDE SNPs were significantly less likely to have hospital stays, emergency department visits, and assisted living stays than their counterparts in the state's stand-alone Medicaid managed care program, even though enrollees in both programs receive some form of care coordination (Anderson et al. 2016). In addition, MSHO enrollees were 2.7 times more likely to have a primary care physician visit than dually eligible individuals in the Medicaid-only program (Anderson et al. 2016). Evaluations of fully integrated D-SNP models in California, Massachusetts, and New York had similar results (MACPAC 2020), and a study from Oregon showed that enrollees with aligned Medicare and Medicaid coverage had lower rates of emergency department visits and hospitalization and higher rates of primary care service use than their unaligned counterparts (Kim et al. 2019). The results of studies on aligned enrollment between D-SNPs and Medicaid managed care plans in Tennessee and Pennsylvania were more mixed, however (Keohane et al. 2022, Roberts et al. 2023).

Researchers have also examined service use among D-SNP enrollees at a national level. In a comparison of 2015 service use by enrollees in D-SNPs, PACE organizations, and regular MA plans, Feng et al. (2021) found that full-benefit dually eligible individuals enrolled in D-SNPs, FIDE SNPs, or PACE programs—when compared to their counterparts in regular MA plans—were significantly less likely to be institutionalized. D-SNP and FIDE SNP enrollees were also significantly more likely to use HCBS and less likely to die,¹⁰ and PACE and D-SNP enrollees were also less likely to be hospitalized (Exhibit 3). However, FIDE SNP enrollees were more likely to be hospitalized than enrollees in regular MA plans, and D-SNP and FIDE SNP enrollees were more likely to have emergency department visits, while PACE enrollees were less likely to have emergency department visits (Exhibit 3). Researchers from Mathematica and Elevance have also found that D-SNP enrollment may be associated with reductions in hospitalization and institutionalization among partial-benefit dually eligible individuals, as well as increased use of primary care services and HCBS (Elevance Health Public Policy Institute 2023, Zhu et al. 2023).

¹⁰ PACE enrollees were excluded from the HCBS service use comparison in this study.

Exhibit 3. Results from a study comparing service use among enrollees in D-SNPs, FIDE SNPs, PACE, and regular MA plans, 2015

Exhibit ES-1. Multivariate regression associations between integrated care plan enrollment and service utilization and mortality among dual eligible beneficiaries in 2015, compared to a regular MA plan			
	D-SNP	FIDE-SNP	PACE
Any inpatient hospitalization	– †	+ ††	– †
Any ED visit	+ ††	+ ††	– †
Any institutional use	– †	– †	– †
HCBS use	+ †	+ †	n/a
Mortality	– †	– †	–

– indicates *lower* odds of an outcome associated with an integrated plan type, compared to a regular MA plan.
 + indicates *higher* odds of an outcome associated with an integrated plan type, compared to a regular MA plan.

Legend:

†	= Favorable association, statistically significant ($p < 0.05$)
††	= Unfavorable association, statistically significant ($p < 0.05$)
n/a	= Not applicable (PACE excluded from regression model of HCBS use)
–	= Statistically not significant ($p > 0.05$)

Source: Feng et al . 2021. <https://aspe.hhs.gov/reports/comparing-outcomes-dual-eligibles>.

D-SNP = Dual Eligible Special Needs Plans; ED = emergency department; FIDE SNP = fully integrated D-SNPs; HCBS = home and community-based services; MA = Medicare Advantage; PACE = Programs of All-Inclusive Care for the Elderly.

Although Feng et al.’s study showed entirely positive results for PACE, other studies have shown mixed results. At least four older studies showed PACE to be associated with reductions in inpatient hospital use, but PACE study findings have varied on use of nursing facilities and other services, as well as on findings regarding mortality (MACPAC 2020, Arku et al. 2022, Ghosh et al. 2014).



Evaluations of seven states’ Financial Alignment Initiative demonstrations have examined the effects of these demonstrations on service use. The results from these evaluations have been mixed, possibly at least in part due to the methodology used.¹¹ The evaluators found greater use of physician evaluation and management services among demonstration-eligible individuals, in comparison to a control group, in four of the seven states (with no significant results in the other three states), as well as decreases in long-stay nursing facility use among demonstration-eligible individuals in four states (with statistically significant increases in two states, and insignificant results in one). For other services, results were varied, with some

¹¹ For these service use comparisons, the researchers used an intent-to-treat design to reduce the potential influence of selection bias. To execute this design, the researchers included both demonstration enrollees and full-benefit dually eligible individuals who were *eligible* for a particular state’s demonstration—but not *enrolled* in a Medicare-Medicaid plan—in the intervention sample. Demonstration participation rates range from approximately 8 percent in New York to 59 percent in South Carolina. These participation rates are lower than originally anticipated, and dually eligible individuals who are eligible for but not enrolled in a demonstration plan may not experience the care coordination services by which MMPs would be expected to affect service utilization. As a result, the high proportions of eligible-but-not-enrolled individuals in the study samples could affect the lack of clear results regarding service use.

states showing favorable results, some states showing unfavorable results, and some states with no significant results (Exhibit 4).¹²

Exhibit 4. Comparison of service utilization results from evaluations of seven states’ capitated model Financial Alignment Initiative demonstrations

State	Physician E&M visits	Admissions for ambulatory care sensitive conditions	Any emergency department (ED) visit	Preventable ED visits	Inpatient admissions	30-day all-cause readmissions	30-day follow-up visit after a mental health discharge	SNF admission	Long stay nursing facility use
Illinois	↑		↑		↑			↑	↑
Massachusetts	↑	↑			↑	↑		↑	↓
Michigan	↑								↑
Ohio			↑	↑	↓	↓	↑	↓	↓
Rhode Island	↑								
South Carolina		↓			↓	↓		↓	↓
Texas			↑	↑		↑		↓	↓

 = Favorable result
 = Unfavorable result

Source: Mathematica analysis of RTI International evaluations and CMS At-A-Glance reports from states’ Financial Alignment Initiative evaluations, 2023. <https://www.cms.gov/priorities/innovation/innovation-models/financial-alignment>.

Note: The following CMS At-a-Glance evaluation reports used to produce Exhibit 4: Illinois third evaluation report, Massachusetts preliminary fifth evaluation report, Michigan second evaluation report, Ohio third evaluation report, Rhode Island third evaluation report, South Carolina third evaluation report, Texas preliminary third evaluation report and Virginia combined years 1-3 report. The researchers did not assess service utilization in the evaluations of the demonstrations in California, New York, or Virginia.

CMS = Centers for Medicare and Medicaid Services; ED = emergency department; E&M = evaluation and management; SNF = skilled nursing facility.

The Medicare Payment Advisory Commission (MedPAC) compared plans’ performance on several Healthcare Effectiveness Data and Information Set (HEDIS) measures in its 2022 and 2024 reports to Congress, including measures that assess enrollees’ use of particular services (MedPAC 2022, MedPAC 2024). MedPAC’s analyses showed mixed results for coordination-only D-SNPs, HIDE SNPs and FIDE SNPs with and without exclusively aligned enrollment,¹³ MMPs and regular MA plans. In its 2024 report, MedPAC acknowledged that most HEDIS measures are process measures, meaning they focus on accomplishment of particular steps in health care delivery, as opposed to measuring specific clinical outcomes (such as reductions in avoidable hospitalizations and long-term nursing facility stays) of concern to policymakers. As a result, these measures may not provide a clear indication of programs’ effectiveness. MedPAC also noted that financial incentives could play a role in particular plans’ HEDIS

¹² In these evaluations, *increased* likelihood of use of physician evaluation and management (E&M) services and follow-up within 30 days of a mental health discharge were considered favorable, while a favorable result for the following services was *decreased* likelihood of service use: inpatient admissions and admissions for ambulatory care sensitive conditions, emergency department visits and preventable emergency department visits, 30-day all-cause readmissions, skilled nursing facility (SNF) admissions, and long-term nursing facility stays.

¹³ MACPAC chose to isolate FIDE SNPs and HIDE SNPs with exclusively aligned enrollment in this analysis because exclusively aligned enrollment enables the most Medicare and Medicaid integration within a D-SNP.

measure results, as certain measures are part of the MA star rating bonus payment system (which offers financial incentives to MA plans and D-SNPs for high performance on particular measures), while different measures are often used in MMPs' quality withholds.¹⁴ Not surprisingly, plans tended to perform better on measures associated with financial incentives.

Cost Reduction

Another important consideration for policymakers is the extent to which integrated care programs reduce costs for Medicare and/or Medicaid. To date, no research has examined whether integrated D-SNPs save money for Medicare or Medicaid, but one study revealed an association between the proportion of dually eligible individuals enrolled in D-SNPs in a geographic area and a reduction in per-member, per-month Medicare spending (Zhang and Diana 2018). This study examined data from 2007–2011, so changes in recent years warrant an updated examination of the association between D-SNP enrollment and program spending. CMS now demands increased coordination from D-SNPs through new federal regulations (CMS 2019, CMS 2022a, CMS 2024a), and the proportion of dually eligible individuals enrolled in D-SNPs has nearly tripled between 2010 and 2021 from 11 percent to 29 percent (Freed et al. 2024).

Estimations of PACE's impact for Medicaid spending have been varied, with some studies demonstrating increases in Medicaid spending, and others finding Medicaid savings. This may be at least in part due to whether PACE enrollees are compared to nursing facility residents or HCBS users (MACPAC 2020). However, in an extensive literature review conducted in 2014, researchers from Mathematica found that the evidence from studies with the strongest research designs showed that PACE has no significant effect on Medicare costs, but is "associated with significantly higher Medicaid costs, with the Medicaid spending gap between PACE and matched comparison enrollees decreasing over time" (Ghosh et al. 2014).

With the exception of Washington's fee-for-service demonstration model, which has achieved gross Medicare Part A and B savings of \$385 million over six years (CMS 2022b), Financial Alignment Initiative demonstration evaluations have not shown Medicare or Medicaid cost savings. Among the 10 capitated model states from which potential cost savings could be assessed (Exhibit 5), eight states showed statistically significant increases in Medicare costs among beneficiaries eligible for the demonstrations when compared with a comparison group in another state. The other two states had statistically insignificant results. Researchers were unable to assess Medicaid cost changes in most states due to data limitations, but of the four states for which researchers could generate estimates of Medicaid costs, two showed cost increases, whereas the other two had statistically insignificant results.¹⁵

¹⁴ In all of the states with capitated model Financial Alignment Initiative demonstrations, a portion of the MMPs' capitation payments is withheld until the MMPs demonstrate that they meet specified benchmarks on designated quality measures.

¹⁵ [As previously noted](#), the methodology of these studies may have affected the results.

Exhibit 5. Cumulative Medicare and Medicaid cost differences between demonstration-eligible populations in Financial Alignment Initiative demonstration states and comparison groups

State	Demonstration Model Type	Cumulative difference in Medicare costs	Cumulative difference in Medicaid costs
California	Capitated model	↑	↑
Illinois	Capitated model	↑	<i>Not measured</i>
Massachusetts	Capitated model	↑	↑
Michigan	Capitated model	↑	<i>Not measured</i>
New York (FIDA-IDD demonstration)	Capitated model	No statistically significant difference	No statistically significant difference
Ohio	Capitated model	↑	<i>Not measured</i>
Rhode Island	Capitated model	↑	<i>Not measured</i>
South Carolina	Capitated model	↑	<i>Not measured</i>
Texas	Capitated model	No statistically significant difference	No statistically significant difference
Virginia	Capitated model	↑	<i>Not measured</i>
Washington	Fee-for-service model	↓	N/A*

Source: Mathematica analysis of RTI International evaluations and CMS At-A-Glance reports from states’ Financial Alignment Initiative evaluations, 2023. <https://www.cms.gov/priorities/innovation/innovation-models/financial-alignment>.

Notes: Red arrows indicate an unfavorable result (increased costs), while green arrows indicate a favorable result (decreased costs). The researchers did not assess the association between the demonstrations and Medicaid costs in Illinois, Michigan, Ohio, Rhode Island, South Carolina or Virginia due to data challenges. Because Washington’s demonstration is a fee-for-service model, the demonstration has aimed to reduce Medicare costs, but reduced Medicaid costs have not been a measured outcome. Therefore, Washington is marked with an “N/A” for Medicaid costs, while these other states are marked with “Not measured.”

CMS = Centers for Medicare and Medicaid Services; FIDA-IDD = Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities.

Factors Influencing Enrollment in Integrated Care Plans

Researchers have found a variety of factors to play a role in initial and ongoing enrollment in integrated care plans. For example, in Financial Alignment Initiative demonstrations, Lipson et. al. (2018) found the following factors to promote enrollment in MMPs: use of passive enrollment, state alignment of integrated care programs with Medicaid managed care programs, positive care coordinator–enrollee relationships, strong provider networks, state and plan collaboration with trusted community-based organizations, and emphasis on certain outreach messages (such as zero-dollar cost sharing, getting access to extra plan benefits, and having a single card for both Medicare and Medicaid benefits). Provider influence (from providers that had chosen not to participate in integrated care plan networks), the

complexity of enrollment notices, and competition from other types of health plans were all found to inhibit MMP enrollment, while MMPs' use of Medicaid eligibility deeming periods help to maintain enrollment among people already enrolled in the plans (Lipson et al. 2018).¹⁶ Other researchers have also found that care coordination and provider participation promote MMP enrollment, while the density and complexity of enrollment-related communications and beneficiary confusion about passive enrollment inhibit enrollment (Kandilov et al. 2023, Khatuský et al. 2023, Graham et al. 2018, Ptaszek et al. 2017). In addition, especially in the early years of the demonstrations, beneficiaries and providers often lacked important knowledge about integrated plan benefits and processes, which generated misconceptions and—in at least some cases—potentially unfounded concerns (Graham et al. 2018, PerryUndem 2015).

Through interviews and focus groups with dually eligible individuals from four states, Community Catalyst's Center for Consumer Engagement in Health Innovation identified four factors that were important to interviewees and likely to cause them to enroll or stay enrolled in an MMP: (1) continuity of access to existing providers, (2) receiving accessible materials to support informed decisions, (3) the ability to speak with a knowledgeable person for assistance, and (4) the potential to receive additional or supplemental benefits from the MMP, beyond what they would receive otherwise (Brill et al. 2021).

Mathematica analyzed voluntary plan disenrollment rates between 2015 and 2018 and found that voluntary disenrollment rates in D-SNP-dominant MA contracts had statistically significant associations with certain quality measure ratings—namely, enrollees' ratings of the health plan, complaints about the health plan, and completion of flu vaccinations among adult plan enrollees. In the same study, we found mixed results regarding the association between voluntary disenrollment rates and D-SNPs' degree of integration with Medicaid. However, qualitative interviewees from state Medicaid agencies, health plans, and beneficiary advocacy organizations suggested that state Medicaid policies play a role in voluntary disenrollment from D-SNPs, albeit a complex one that may be mediated by other factors, such as local market competition and individual beneficiary characteristics, such as health conditions, need for LTSS, and age (Lipson et al. 2021).

Researchers have also found variance in integrated care plan enrollment and opt-out rates across racial, ethnic, and language-speaking groups (McBride et al. 2017, Velasquez et al. 2023). Opt-out rates from the early years of California's Financial Alignment Initiative demonstration showed that opt-out rates among speakers of non-English languages tended to be higher than county averages (California Department of Health Care Services 2016). On the other hand, while certain Asian populations opted out at higher rates than White Californians in some counties, Black and Hispanic populations had consistently lower opt-out rates than their White counterparts (California Department of Health Care Services 2016). This observation aligns with recent research by Velasquez et al. (2023) showing that integrated care plan (PACE, MMP, and FIDE SNP) enrollees are more likely to be Black and Hispanic than their counterparts in fee-for-service Medicare. The same study showed that integrated plan enrollees were also less likely to reside in rural areas or be younger than 65.

¹⁶ D-SNPs and some MMPs have used eligibility deeming periods to maintain enrollment for short periods of time for enrollees who temporarily lose Medicaid coverage. For information about how eligibility deeming periods can help to prevent unnecessary enrollment churn within integrated care plans, see the Integrated Care Resource Center's tip sheet on this topic at <https://integratedcareresourcecenter.com/resource/preventing-and-addressing-unnecessary-medicaid-eligibility-churn-among-dually-eligible>.

Opportunities for Further Research

Researchers have been building an increasingly useful base of evidence regarding integrated care programs, but additional research is needed to understand mixed findings from previous studies, as well as to explore yet-unexamined topics of relevance to improving care for dually eligible individuals.

In particular, future research should aim to:

- / **Understand the potentially varied experiences of subgroups of integrated plan enrollees**, such as those who are ages 65 and older, those who are eligible for Medicare due to a disability, members of different racial and ethnic populations, dually eligible individuals who speak limited English, those who need or use LTSS, and those with multiple (or specific) chronic conditions. One study found differences in self-reported experiences with care between D-SNP enrollees of color and their White counterparts (Roberts and Mellor 2022). These differences are particularly important to understand because certain subgroups are more likely to be enrolled in integrated care plans than others (Velasquez et al. 2023). If integrated care plans achieve positive outcomes for some enrollees but not others, they could exacerbate disparities rather than advancing equity. Researchers could follow the model established by the CMS Office of Minority Health in examining disparities in health care in Medicare Advantage in assessing disparities in quantitative measures of enrollee experience and clinical care access among D-SNP enrollees,¹⁷ as well as between D-SNP enrollees and dually eligible enrollees in regular MA plans,¹⁸ while also using qualitative studies to understand more nuanced discrepancies in enrollee experiences.
- / **Determine whether quality measure performance, service use, and enrollee experiences vary across D-SNPs of different levels of integration.** The vast majority of D-SNP research has used data from years preceding the implementation of important new federal requirements for D-SNPs (CMS 2019, CMS 2022a, CMS 2024a), including regulations that have established increasing levels of integration from FIDE SNPs and HIDE SNPs. Ongoing research will be needed to understand whether these regulatory changes produce positive outcomes for D-SNP enrollees.
- / **Assess integrated care plan performance on measures designed to assess person-centered care and enrollee experience.** Existing research on integrated care program quality has largely used CAHPS and HEDIS measures, both of which have limitations in this context. In particular, although CAHPS measures capture self-reported information about enrollee experiences, they were originally designed to capture patient experience in health care settings. As a result, even the CAHPS surveys designed for health plans focus heavily on enrollees' experiences with providers, rather than on aspects of care delivery directly managed by the health plan, such as plan-sponsored care coordination activities.¹⁹ As

¹⁷ The CMS Office of Minority Health assesses disparities in health care among sub-groups of Medicare Advantage plan enrollees on an annual basis. The April 2024 report is available at <https://www.cms.gov/files/document/national-stratified-final.pdf>.

¹⁸ In conducting research on enrollee experiences of care, it is especially important to compare dually eligible enrollees of one plan/type of plan with dually eligible enrollees in other plans/types of plans, rather than comparing dually eligible D-SNP enrollees to all Medicare Advantage plan enrollees, for example. This is because existing research has already shown disparities between the experiences of dually eligible and non-dually eligible Medicare Advantage enrollees (CMS and the RAND Corporation 2023).

¹⁹ The care coordination composite measure in the 2023 MA-CAHPS survey is made up of enrollees' responses to the following survey questions, all of which focus on the enrollee's interactions with a primary care physician's office, as opposed to care coordination the enrollee has received from the health plan: "*In the last 6 months... (1) When you*

MedPAC has noted (2024), most HEDIS measures are process measures that assess completion of particular steps in health care delivery, rather than clinical outcomes of interest to policymakers. In addition, plan performance on HEDIS and CAHPS measures tends not to vary greatly across health plans, which impedes assessment of meaningful differences. Developing new quality measures specifically designed for integrated care programs may be helpful. In the meantime, researchers, states, and health plans could use measures from the CMS HCBS quality measure set to assess person-centeredness in HCBS delivery, an aspect of integrated care that has yet to be examined.

- / **Measure outcomes that reflect enrollee priorities.** To develop meaningful new measures for integrated care programs, researchers should use qualitative research with dually eligible individuals to understand their priorities in using an integrated care plan for health coverage. By establishing a strong set of foundational priorities (for example, as Brill et al. did in their 2021 study), researchers and policymakers can work together to establish tested, validated measures to assess how well plans attend to those priorities.
- / **Identify specific care coordination methods and approaches that achieve desired outcomes for enrollees.** Research has identified care coordination as an important, influential factor in enrollee satisfaction with an integrated care plan. However, integrated care plans vary widely in their specific care coordination approaches and practices, and the communication styles and behaviors of individual care coordinators within a single plan often vary, as well. Some research has established the idea that different care coordination practices may lead to different outcomes for plan enrollees (Zurovac et al. 2014), but existing research has not yet pinpointed the precise structures, practices, and behaviors that promote desired outcomes.
- / **Better understand whether these programs can truly achieve desired cost savings for Medicare and Medicaid.** Thus far, research has rarely demonstrated significant cost savings from integrated care programs, despite observing reductions in hospitalizations, readmissions, and long-term care facility stays. It is possible that these observed decreases in use of hospital and nursing facility services have simply not made up for other program costs, such as care coordination and/or use of other types of health care services, like outpatient physician visits. The specific methodologies used in previous studies could also play a role, as could factors for which researchers were unable to control, such as differences in functional status needs between integrated care program enrollees and others included in control groups. Additionally, only a few studies have examined integrated care programs' effects on Medicare costs, and very few have been able to examine Medicaid costs due to data limitations that have now been addressed. Therefore, more research is needed to fully understand the cost implications of these programs, in addition to their effect on enrollees' health outcomes, quality of care and satisfaction.

visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? (2) When your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? (3) When your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them? (4) How often did you and your personal doctor talk about all the prescription medicines you were taking? (5) Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? (6) How often did your personal doctor seem informed and up-to-date about the care you got from specialists?" (MA-CAHPS survey instruments and specifications are available at <https://www.ma-pdpcahps.org/en/survey-instruments-and-specifications/>.)

In analyzing the effects of integrated care programs for dually eligible individuals, researchers should also **select rigorous study methodologies and designs that suit the specific topics and outcomes assessed**. Because a randomized control trial methodology is essentially impossible, due to the voluntary nature of enrollment in integrated care programs and the ethical challenges associated with randomly assigning people to an integrated care plan or program, quantitative studies should at least use quasi-experimental designs whenever possible and take careful steps to identify and control for potential confounding variables. Qualitative researchers should also take steps to promote investigative rigor, such as using random selection to identify interviewees, rather than convenience sampling techniques that may introduce unnecessary layers of selection bias.

Conclusion

While current evidence suggests some positive results from the implementation of PACE programs, Financial Alignment Initiative demonstrations, and D-SNP-based integrated care programs, many studies have had mixed results, and several important topics remain unexamined. Additional research is needed to help explain contradictory findings from past studies, fill gaps in current research, and reflect how ongoing regulatory updates for D-SNPs affect desired outcomes.

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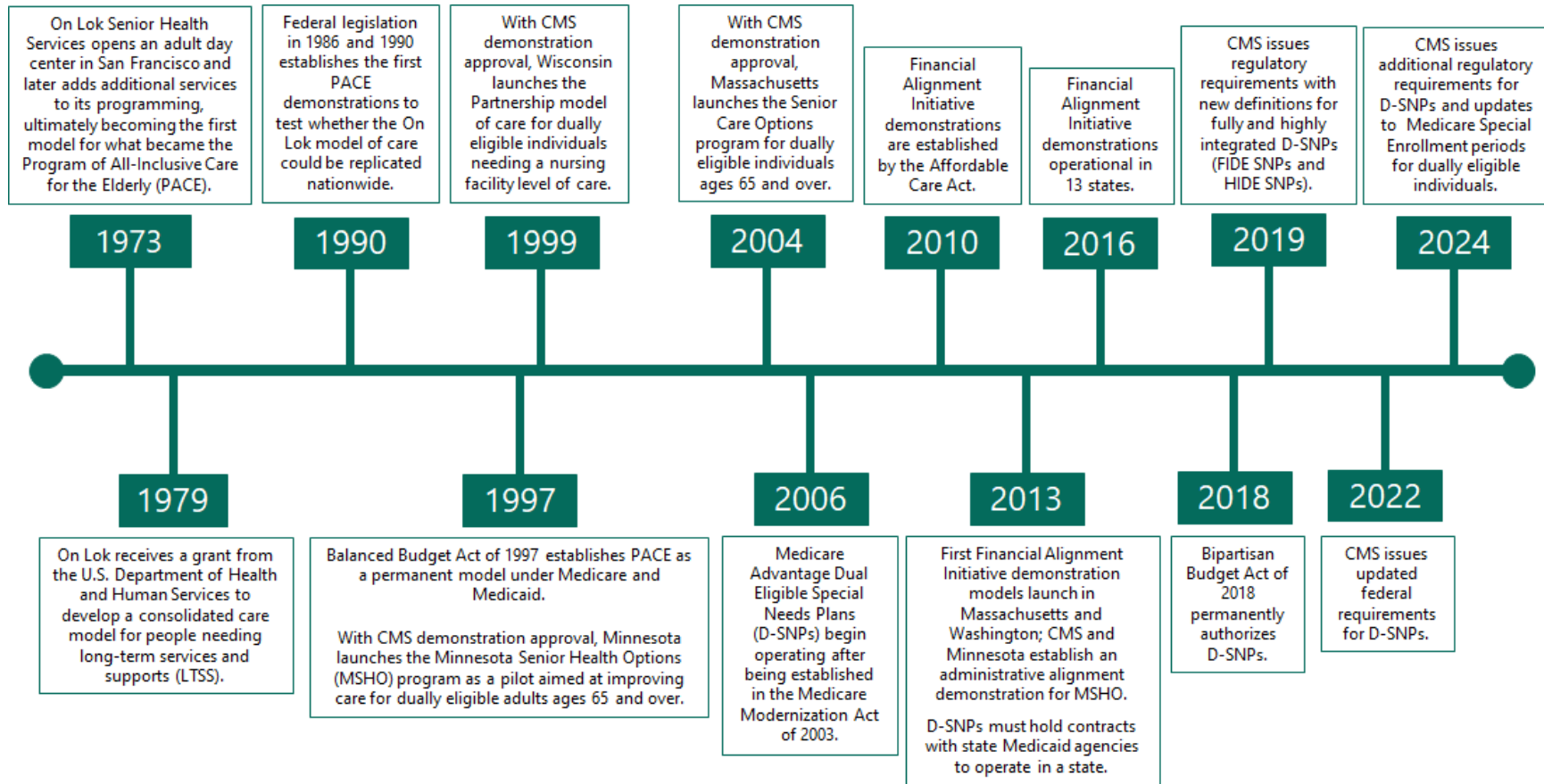
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Appendix A. Key Dates in the Development and Evolution of Integrated Care Programs

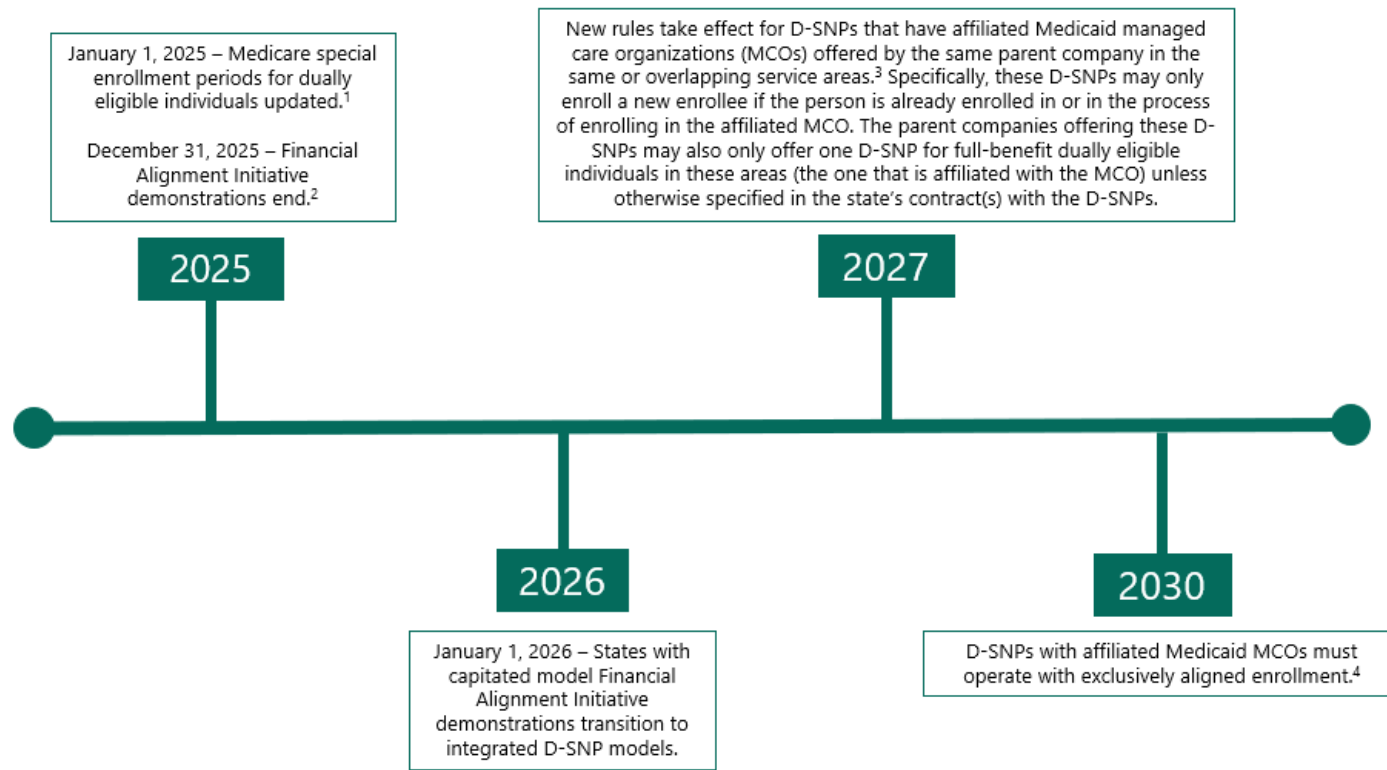
The two timelines in this appendix (Exhibit A.1 and Exhibit A.2) summarize key dates in the history of development of integrated care programs for dually eligible individuals, as well as key future dates in the evolution of these programs.

Exhibit A.1. Key dates in the development of integrated care models for dually eligible individuals



Sources: CMS 2011, CMS 2019, CMS 2022a, CMS 2024a, CMS Massachusetts Senior Care Options Program Fact Sheet (n.d.), CMS Wisconsin Partnership Program Fact Sheet (n.d.), Kane et al. 2001, Lipson et al. 2018 (appendices), National PACE Association (n.d.)

Exhibit A.2. Future steps in the evolution of integrated care models for dually eligible individuals



Source: CMS 2024a

- Notes:
1. Beginning January 1, 2025, the current quarterly Medicare Special Enrollment Period (SEP) for dually eligible individuals and people enrolled in the Medicare Part D Low-Income Subsidy (LIS) program will end; instead, these individuals will have a monthly SEP to enroll in fee-for-service Medicare with a standalone Part D plan (or switch Part D plans). Anyone who wishes to enroll in a regular Medicare Advantage plan or coordination-only D-SNP will only be able to do so during standard enrollment periods or via another SEP. At the same time, CMS will also launch a new integrated care SEP for full-benefit dually eligible individuals who wish to enroll in an integrated D-SNP. To use this new monthly SEP, the full-benefit dually eligible individual will need to be already enrolled in or in the process of enrolling in the D-SNP’s affiliated Medicaid managed care plan. (See note 3 for a definition of “affiliated” Medicaid managed care plans.)
 2. The following states already ended their demonstrations prior to 2025: California, Colorado, New York (ended one demonstration in 2019; one is ongoing), and Virginia.
 3. A Medicaid managed care plan is “affiliated” with a D-SNP if it is operated by the same parent company as the D-SNP in the same or overlapping service areas as the D-SNP.
 4. A D-SNP operates with exclusively aligned enrollment when it only enrolls full-benefit dually eligible individuals who receive Medicaid benefits from the D-SNP or the D-SNP’s affiliated Medicaid managed care plan.

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