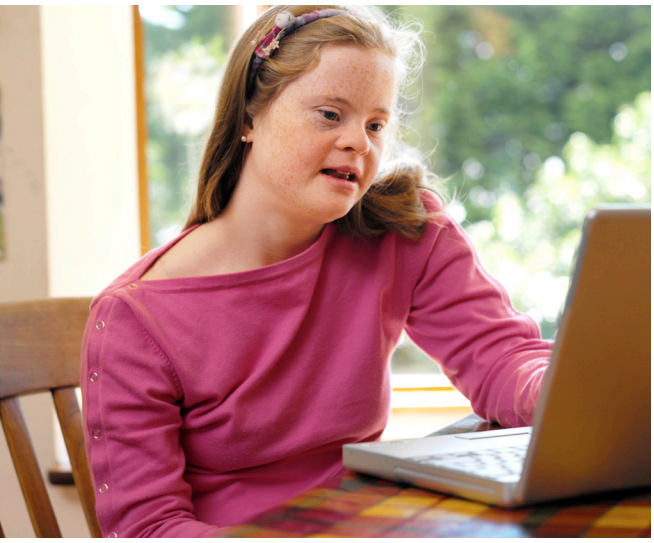
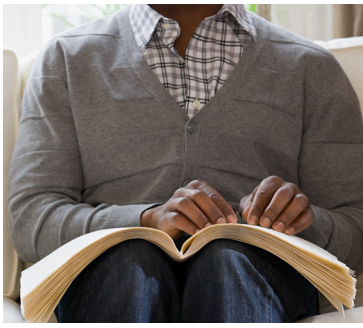
MEDICARE-MEDICAID COORDINATION OFFICE

Fiscal Year 2025

Report to Congress / July 2026





Introduction

Federal statute established the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office, hereinafter MMCO) within the Centers for Medicare & Medicaid Services (CMS) to improve the coordination between the federal government and states to enhance access to quality services for individuals dually eligible for both Medicare and Medicaid benefits (dually eligible individuals). This report to Congress is required annually.[1]

Medicare and Medicaid are distinct programs with different rules for eligibility, covered benefits, and payment, and the programs have operated separately despite a growing number of people who depend on both Medicare and Medicaid for their health care. Better aligning of these programs can improve outcomes and experiences for dually eligible individuals, while reducing administrative burden for individuals, providers, health plans, and states.

About Dually Eligible Individuals

During FY 2025, nearly 12.5 million individuals were concurrently enrolled in Medicare and Medicaid.[2] These individuals navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports, certain behavioral health services, and for help with Medicare premiums and cost-sharing.

Dually eligible individuals must meet the eligibility requirements for both Medicare (e.g., age, disability, or having end-stage

renal disease) and Medicaid (e.g., income and other eligibility factors). Individuals may first qualify for one program or the other but are considered dually eligible when they meet the eligibility criteria for both.

They may also be *full-benefit* dually eligible individuals, who qualify for full coverage of Medicaid services, or *partial-benefit* dually eligible individuals, who receive assistance only with Medicare premiums and, in most cases, assistance with Medicare cost-sharing through the Medicare Savings Programs (MSPs), which includes four groups.[3] Full-benefit dually eligible individuals often also qualify for assistance with Medicare premiums and cost-sharing through the MSPs.

Of the 12.5 million dually eligible individuals, 72 percent were eligible for full Medicaid benefits, whereas 28 percent were eligible for partial Medicaid benefits.Dually eligible individuals have higher medical needs than the average Medicare beneficiary:[4]

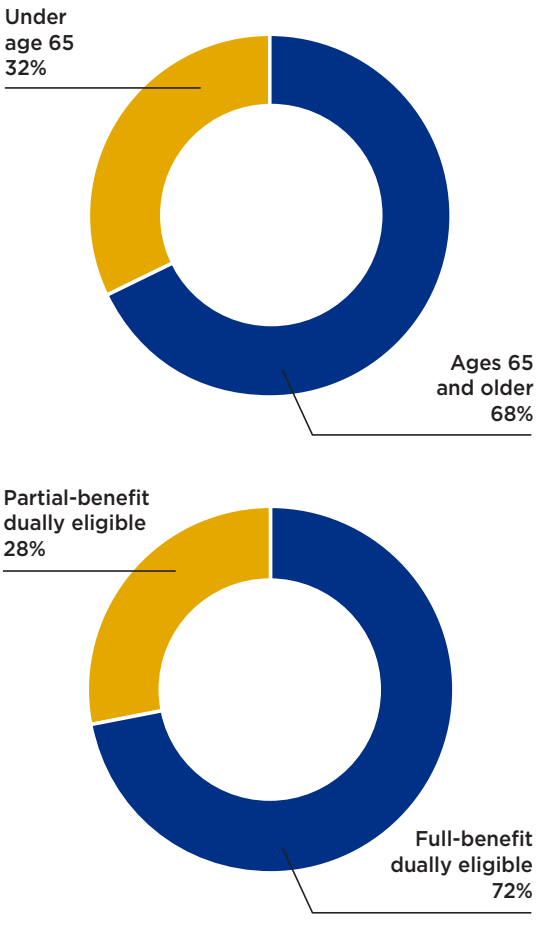
- 63 percent of full-benefit duals had three or more chronic conditions;
- 64 percent had a behavioral health diagnosis;
- 37 percent used long-term services and supports (LTSS).

Dually eligible individuals have disproportionately high spending across

Medicare and Medicaid, representing 19 percent of Medicare enrollees who account for 35 percent of Medicare spending. Similarly, dually eligible individuals represent 13 percent of Medicaid enrollment and account for 27 percent of Medicaid spending.[5]

- 72 percent of Medicaid enrollees using LTSS are dually eligible individuals
- 32 percent of dually eligible individuals are under the age of 65 and typically have a disability

Dually Eligible Individuals by Age and Type of Benefit



Source: CMS Analysis of FY 2025 data

- **Most dually eligible individuals are 65+, but a significant portion are under 65.**
- **Most dually eligible individuals qualify for full coverage of Medicaid services, but 28% qualify only for assistance with Medicare costs.**

Medicare Advantage Dual Eligible Special Needs (D-SNPs) Plans

There are three types of special needs plans (SNPs), which are a type of Medicare Advantage (MA) plan. Chronic condition SNPs (C-SNPs) serve beneficiaries with one or more severe or disabling chronic conditions, Institutional SNPs (I-SNPs) serve beneficiaries who need an institutional level of care, and D-SNPs are designed to exclusively serve and meet the specific needs of both partial and full benefit dually eligible beneficiaries. In 2025, D-SNPs represented 63 percent of SNPs. Originally authorized as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), D-SNPs began operating in 2006. Legal authority was made permanent in the Bipartisan Budget Act of 2018 (P.L. 115-123). D-SNPs are required to contract with states, but states are not required to contract with D-SNPs. These contracts are annually reviewed and approved by CMS. The contracts at a minimum must cover several requirements from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P. L. 110-275), such as the MA organization's responsibilities—including financial obligations—to provide or arrange for Medicaid benefits and cost-sharing protections covered under the D-SNP.[6]

Advancing Aligned Care for Dually Eligible Individuals Enrolled in Managed Care

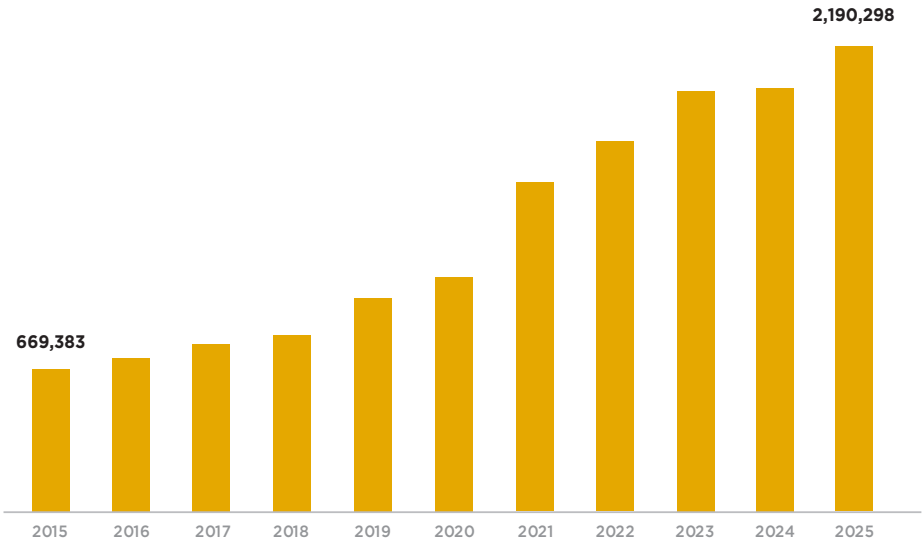
Medicare and Medicaid were created as distinct programs with different purposes and operate as separate systems despite a growing number of people who depend on both programs for their health care needs. This can lead to fragmented care for dually eligible individuals, misaligned incentives for payers and providers, and administrative inefficiencies and programmatic burdens for all.

Aligned care can support delivery system and financing approaches that maximize Medicare-Medicaid care coordination and mitigate cost-shifting incentives, including through total-cost-of-care accountability across Medicare and Medicaid. Most importantly, it means a seamless experience for individuals.

In 2025, about 25 percent of full-benefit dually eligible individuals were enrolled in aligned care.[7] In 2015, over 669,000 individuals were enrolled in aligned care, compared to over 2 million in 2025. Of those, over 1.5 million were in programs where all enrollees receive Medicare and Medicaid services through the same organization, known as exclusively aligned enrollment (EAE). The chart below summarizes the increase by aligned health plan or program type between 2015 and 2025. The paragraphs that follow provide more detail on the FAI demonstrations, integrated D-SNPs, and enrollment in PACE.[8]

Aligned care includes Program of All-Inclusive Care for the Elderly (PACE), Financial Alignment Initiative (FAI) demonstrations, and managed care arrangements where the same organization covers both Medicare and Medicaid services.

Total Aligned Enrollment Increased Significantly since 2015, Reaching More Than 2 Million in 2025



Financial Alignment Initiative Demonstrations

As of July 2025, more than 240,000 dually eligible individuals in eight states were enrolled in Medicare-Medicaid Plans (MMPs), the fully aligned health plans that are part of the capitated model of the Financial Alignment Initiative (FAI).[9] As the demonstration comes to a close, MMCO has been working with the eight states currently operating capitated financial alignment model demonstrations under the FAI to transition the MMPs to integrated D-SNPs effective January 1, 2026. As of December 31, 2025, MMCO helped successfully transition over 178,000 individuals from MMPs into integrated D-SNPs.[10]

D-SNPs Paired with Medicaid Managed Care

Over the past several years, MMCO has strengthened integration standards for D-SNPs to ensure that the growing number of dually eligible individuals enrolled in these health plans receive quality, coordinated care. MMCO is working with state partners to promote greater alignment between Medicare and Medicaid health plans. Total aligned enrollment includes individuals enrolled in highly integrated dual eligible special needs plans (HIDE SNPs) and coordination-only dual eligible special needs plans (CO D-SNPs) with affiliated Medicaid MCOs and exclusively aligned enrollees (i.e., individuals enrolled in fully integrated dual eligible special needs plans (FIDE SNPs), Medicare-Medicaid Plans (MMPs), Program of All-Inclusive Care for the Elderly (PACE), and applicable integrated plan (AIP) HIDE SNPs).[11] As of July 2025, over 1.2 million individuals were enrolled in D-SNPs with EAE—in which all D-SNP enrollees are in an affiliated Medicaid MCO—compared to about 977,000 in 2024.[12]

D-SNPs that are AIP D-SNPs operate with EAE. This means an AIP D-SNP's membership is limited to individuals whose Medicaid benefits are covered under a Medicaid MCO contract between the applicable state and the D-SNP's MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. Enrollees in AIPs are provided descriptions of coverage through integrated materials, which make it easier for enrollees to understand the full scope of Medicare and Medicaid benefits covered by the D-SNPs. Additionally, AIP enrollees are provided unified appeals and grievances, which create a single appeal pathway at the plan level for all Medicare Part C and Medicaid benefits. They also benefit from the continuation of benefits pending appeal. More information on AIPs can be found in regulation[13] and in the Medicare Managed Care Manual.[14]

Default Enrollment

Default enrollment was authorized in section 1851(c)(3) of the Social Security Act as part of the Balanced Budget Act of 1997. In 2018, CMS finalized regulations permitting affiliated D-SNPs to enroll an organization's Medicaid managed care enrollees into an affiliated D-SNP upon the individual's initial eligibility for Medicare, if the receiving plan meets certain criteria, and enrollees do not elect to receive Medicare coverage in another way.[15] States can allow or require

D-SNPs that meet certain requirements to use default enrollment to align Medicare and Medicaid coverage for dually eligible individuals. Under default enrollment, D-SNPs may automatically enroll individuals who are enrolled in a comprehensive Medicaid MCO offered by the same parent organization as the D-SNP when those individuals first become eligible for Medicare Parts A and B (at the same time) due to age, disability, or having end-stage renal disease. MMCO provides technical assistance to interested states on an ongoing basis. As of December 2025, MMCO approved 82 D-SNPs in 15 states and Puerto Rico to use the default enrollment mechanism.[16] For 2025, nearly 40,000 enrollees had been default-enrolled into approved D-SNPs.[17] MMCO is working with states to maximize the use of default enrollment where plans are eligible.

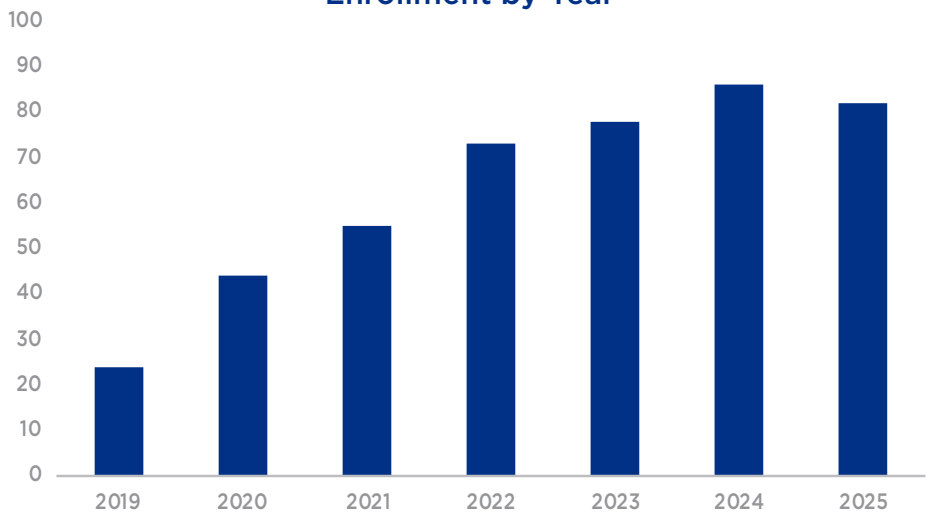
Integrated Care Special Enrollment Period (SEP)

In the CY 2025 Medicare Advantage and Part D final rule, MMCO finalized a provision creating a new integrated care Special Enrollment Period (SEP) which allows dually eligible individuals to elect to enroll during any month into an AIP. Dually eligible individuals qualify for integrated care SEPs when enrollment would result in aligned enrollment, meaning the individual is enrolled in, or in the process of enrolling in, an affiliated managed care plan.[18] The integrated care SEP was first available for use in January 2025. As of November 2025, 146 individuals enrolled in D-SNPs were eligible to receive enrollment under the integrated care SEP. Of the nearly 300,000 enrollees who used this integrated care SEP from January through October 2025, approximately one-third used it to transition from a plan that was not an AIP D-SNP.[19] MMCO continually monitors use of this SEP to spot issues and assess enrollment trends.

PACE

The vast majority of PACE participants are dually eligible individuals. PACE organizations deliver the full range of Medicare and Medicaid services for participants aged 55 and older who live in an area served by a PACE program and are certified as eligible for a nursing facility level of care by a state Medicaid agency.[20] As of July 2025, more than 70,000 dually eligible older adults were enrolled in 198 PACE organizations in 33 states and the District of Columbia, an increase of about 10 percent from July 2024.[21]

Number of D-SNPs Approved for Default Enrollment by Year



Updates to State Buy-in and Medicare Savings Programs

The state payment of Medicare premiums (state buy-in) process has been in existence for several decades and has enabled states to enroll certain Medicaid beneficiaries in Medicare and to pay the premiums and, in many cases, cost-sharing on their behalf. As of October 2025, states pay Medicare Part B premiums each month for over 11 million individuals and Part A premiums for over 900,000 individuals. State buy-in promotes access to integrated care and coverage, including eligibility for aligned plans (e.g., MA, D-SNPs, PACE plans, and Part D Low-Income Subsidy (LIS) coverage.) Integrated care options can improve care coordination and manage health care costs for this clinically complex population.

MMCO is working to improve the data exchanges between the states, CMS, and the Social Security Administration (SSA) to facilitate state buy-in. By reducing system rejections, MMCO can reduce delays in coverage and access to care for beneficiaries while also reducing administrative burden for state and federal agencies. To do so, MMCO provides targeted and data-driven technical assistance to reduce erroneous submissions and troubleshoot those that occur. MMCO also provides technical assistance to states transitioning from a group payer arrangement to a Part A buy-in agreement, which simplifies the Medicare enrollment and data exchange processes by eliminating the need for beneficiaries to first enroll in conditional Part A through SSA before the state can establish buy-in. With the addition of California as of January 1, 2025, 37 states and DC are Part A buy-in states.

Efforts to ensure the efficient and accurate operation of the state buy-in process further CMS' goals of reducing improper payments and ensure eligible individuals are enrolled in Medicare Parts A and B, to align spending and value. State buy-in promotes access to Medicare coverage for low-income older adults and people with disabilities. It also promotes payment accuracy and program integrity by ensuring that Medicare is the first and primary payer for Medicare-covered services for dually eligible beneficiaries.

Implementing the Working Families Tax Cut (WFTC) Legislation's Moratorium on the MSP Final Rule

Section 71101 of Public Law 119-21, which CMS refers to as the WFTC legislation, temporarily prohibits CMS from implementing, administering, or enforcing specific amendments made by the provisions of the "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" final rule published on September 21, 2023 (hereafter referred to as the MSP final rule) that had a compliance date after July 4, 2025, the date the WFTC legislation was enacted. The MSP final rule instituted new

requirements for states to expand eligibility and streamline enrollment processes for the MSPs. Under the rule, CMS outlined a phased-in approach for states to come into compliance with each provision between 2024 and 2026. The WFTC legislation's moratorium on specific amendments made by the provisions of the MSP final rule ends on September 30, 2034.[22] CMS provided guidance on implementing the WFTC legislation in a Center for Medicaid and CHIP Services Information Bulletin published on November 18, 2025.[23] CMS provided guidance that while the moratorium is in effect, CMS will, in general, revert to the regulations in place prior to the MSP final rule, for sections of the regulation subject to the moratorium. CMS continues to analyze the impact of the moratorium on MSP eligibility and enrollment processes and expects to provide additional information to states in future guidance.

Recent Rulemaking

Throughout 2025, MMCO worked with states and plans to prepare for the implementation of a policy finalized in the CY 2025 MA and Part D final rule to increase the percentage of dually eligible managed care enrollees who receive Medicare and Medicaid services from the same organization. This policy was finalized in conjunction with the integrated care SEP, discussed above, as part of a broader effort to align enrollment for dually eligible individuals. This portion of the provision will go into effect in 2027 and limits enrollment in certain D–SNPs to those individuals who are also enrolled in an affiliated Medicaid MCO, and limits the number of D–SNP plan benefit

packages an MA organization, its parent organization, or entity that shares a parent organization with the MA organization, can offer in the same service area as an affiliated Medicaid MCO.[24]

NOTE: *This document contains links to non-United States Government websites. CMS is providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. CMS cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. CMS is providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.*

Notes

[1] This report to Congress is required annually by 42 USC §1315b(e). 42 U.S.C. 1315(e) states that the annual report contain recommendations for legislation included in the President's budget that would improve care coordination and benefits for dual eligible individuals. As MMCO continues to evaluate this issue area, this year's report does not include legislative recommendations.

[2] 12.5 million represents the average number of total dual eligibles during the year; however, according to CMS analysis, there were nearly 14 million unique dual eligibles that were enrolled at any point over the course of 2025.

[3] The MSP eligibility groups are: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI), and Qualified Disabled and Working Individuals (QDWI). The QMB group, which has been in existence since the late 1980s, provides the most benefits of all the MSP groups, covering Part A and B premiums and cost-sharing for low-income Medicare beneficiaries. States are required to cover the QMB group.

[4] Medicare Monthly Enrollment Dataset: https://data.cms.gov/resources/medicare-monthly-enrollment-methodology

[5] Medicare Monthly Enrollment Dataset: https://data.cms.gov/resources/medicare-monthly-enrollment-methodology

[6] MACPAC analysis on Medicare Advantage D-SNPs programs and CMS' Chapter 16b of the Medicare Managed Care Manual for more information: https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/ and https://www.cms.gov/files/document/r131mcm.pdf

[7] MMCO Enrollment Snapshots (Quarterly Release—the number of FBDE individuals in Puerto Rico was not available and therefore not included in the denominator.)

[8] Integrated care enrollment includes only aligned Medicare and Medicaid enrollment for full-benefit dually eligible (FBDE) individuals—not total enrollment in state programs that may include both aligned and unaligned enrollees. Aligned enrollment refers to situations in which FBDE individuals receive both Medicare and full Medicaid benefits from: (1) a single legal entity, or (2) affiliated or aligned Medicare Advantage D-SNPs and Medicaid managed care plans that are owned or operated by the same parent company. Aligned enrollment data were collected as of July of each year unless otherwise specified.

[9] https://www.integratedcareresourcecenter.com/resource/monthly-integrated-care-exclusively-alignedenrollment-report-dually-eligible-individuals, as of July 2025.

[10] Internal CMS analysis.

[11] https://www.integratedcareresourcecenter.com/resources-by-topic/exclusively-aligned-enrollment

[12] CMS analysis, reflecting enrollment in D-SNPs with EAE in 50 states, D.C., and Puerto Rico in July 2025 compared to July 2024.

[13] More information on AIPs can be found in regulation at 42 C.F.R. Part 422, Subparts C, M, and V.

[14] Medicare Managed Care Manual, Chapter 16b. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf

[15] Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-F; 83 FR 16495).

[16] Internal CMS analysis.

[17] Default Enrollment Activity Detail Report.

[18] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024—Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and PACE (CMS-4205-F; 89 FR 30675).

[19] Internal CMS analysis.

[20] https://www.medicare.gov/sign-up-change-plans/different-types-of-medicare-health-plans/pace

[21] CMS Monthly Enrollment Reports by Contract, July 2025. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-enrollment-plan

[22] The regulations impacted are 42 C.F.R. § 406.21(c)(5), 435.4, 435.601(e), 435.911(e) and 435.952(e).

[23] https://www.medicaid.gov/federal-policy-guidance/downloads/cib11182025.pdf

[24] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024—Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and PACE (89 FR 30675).