

Special Needs ——— ————— Plan Alliance

Summary of MedPAC March 2026 Payment Report D-SNP Chapter

On March 12, MedPAC released its March Payment Report to Congress. [Chapter 15](#) contains its statutorily required D-SNP report update. This document discusses the performance, challenges, and policy considerations related to Medicare Medicaid dual-eligible special-needs plans and integrated care programs for dually eligible beneficiaries. The Chapter contains a wide range of topics. Highlights include challenges with D-SNP performance evaluation, a discussion of 2027 and 2030 regulatory requirements, and the implications of C-SNP growth.

Overview of Dually Eligible Beneficiaries and Care Challenges

- Individuals qualifying for both Medicare and Medicaid often experience fragmented care due to navigating two complex programs.
- About 12.1 million beneficiaries (18%) were dually eligible in July 2024, with higher health needs and costs, averaging nearly \$40,405 annually per person. Full-benefit beneficiaries have higher costs and utilization, especially for long-term services and inpatient care.

Growth and Enrollment Trends in Managed Care Plans

- The share of dually eligible beneficiaries enrolled in Medicare Advantage (MA) plans increased from 2014 to 2024, reaching 64%. Nearly half (46%) are enrolled in dual-eligible special-needs plans (D-SNPs).
- Partial-benefit dually eligible beneficiaries are more likely to enroll in MA plans, with enrollment rates exceeding 78%. Enrollment in Medicare–Medicaid Plans (MMPs) remains low at about 3%.

Types and Levels of D–SNP Integration

- D–SNPs are specialized Medicare Advantage plans limited to dually eligible beneficiaries, with varying integration levels with Medicaid. They include coordination-only, highly integrated (HIDE–SNP), and fully integrated (FIDE–SNP) plans.
- FIDE–SNPs provide broad Medicaid services and have the highest integration, while coordination-only plans have minimal Medicaid coordination. Plans with aligned enrollment limit beneficiaries to those receiving both benefits from the same insurer.

Performance Data and Evaluation Challenges

- Data sources like HEDIS and CAHPS provide limited insight into plan performance due to their focus on process measures rather than outcomes. Plans with higher integration tend to perform better on some quality measures.

- Differences in beneficiary characteristics across plan types complicate performance comparisons. Variations include age, health status, and geographic distribution.

Recent and Upcoming Policy Changes

- Starting in 2025, CMS tightened requirements for FIDE–SNPs, mandating broader Medicaid coverage and exclusive enrollment alignment. Some plans previously classified as FIDE–SNPs were reclassified as HIDE–SNPs.
- Medicare introduced new special enrollment periods (SEPs) in 2025, allowing monthly plan changes for certain beneficiaries, which may slow enrollment growth in coordination-only D–SNPs.
- The Medicare–Medicaid Plans (MMPs), once a large demonstration, are being phased out, affecting highly integrated plan options for full-benefit beneficiaries.

Transition and Evolution of Medicare Plans

- CMS ended the demonstration in 2025, leading most MMPs to convert into D–SNPs, which increased the share of beneficiaries in highly integrated plans.
- The shift resulted in higher Medicare spending and mixed effects on service use, with about 66% of MMP enrollees moving into FIDE–SNPs and 18% into HIDE–SNPs by July 2025.

Policy Changes for D–SNP and Medicaid Alignment

- Starting in 2027, insurers with full-benefit Medicaid plans will be limited to one D–SNP per area, with plans required to consolidate and align enrollment with Medicaid by 2030.
- These policies aim to promote integrated care but may restrict some insurers, leading to increased use of C–SNPs as look-alike plans to serve dually eligible beneficiaries.

Growth of C–SNPs as Look-Alike Plans

- Enrollment in C–SNPs tripled from 394,000 in 2021 to 1.3 million in 2025, with about 10% growth attributed to their use as look-alike plans mimicking D–SNP features.
- Many C–SNPs targeting common conditions like CVD, CHF, and diabetes are used to attract dually eligible beneficiaries, especially in states with restrictions on D–SNPs.

Use of Regulatory Restrictions on Look-Alike Plans

- CMS imposed thresholds (initially 80%, then lowered to 70% in 2025 and 60% in 2026) on the share of dually eligible beneficiaries in conventional plans to curb their use as look-alikes.
- Since 2023, numerous plans exceeding these thresholds have closed, with insurers increasingly using C–SNPs to circumvent restrictions and target high dually eligible populations.

Plan Performance on Quality Measures

- HEDIS clinical quality scores show that HIDE–SNPs and FIDE–SNPs with aligned enrollment perform best, with better scores on measures like social needs screening and immunizations.
- MMPs generally perform worse on many clinical quality and utilization measures, partly due to structural differences and incentive models, with scores often close to expected levels but with some limitations in risk adjustment accuracy.

Patient Experience and CAHPS Scores

- CAHPS survey results from 2024 indicate minimal variation across plan types, with coordination-only D–SNPs and HIDE–/FIDE–SNPs with aligned enrollment scoring higher on many measures.
- Differences in scores are often small and may lack practical significance, with only a few measures showing meaningful differences of 3 percentage points or more.

Utilization Measures and Plan Performance

- Risk-adjusted hospital utilization measures reveal that HIDE–SNPs and FIDE–SNPs without aligned enrollment tend to perform better on avoidable hospitalizations.
- MMPs show the highest observed-to-expected ratios, indicating higher than expected utilization, but the models used for risk adjustment have limitations affecting cross-plan comparisons.

Growth of Look-Alike and C–SNP Plans

- The number of C–SNPs functioning as look-alike plans increased from 5 in 2021 to an estimated 92 in 2026, with enrollment rising from 70,000 to over 113,000.
- Many of these plans target beneficiaries with common conditions and have features like high out-of-pocket limits, maximum Part D deductibles, and premiums covered by low-income subsidies, especially in states with restrictions on D–SNPs.

Regulatory Impact and Market Dynamics

- CMS restrictions on conventional plans exceeding 80%, then 70% and 60%, of dually eligible enrollees have led to plan closures and shifts toward C–SNPs.
- Insurers use C–SNPs to serve high dually eligible populations, often targeting prevalent conditions, and cluster in certain states, which may undermine state efforts to develop integrated care programs.

Disparities in Medicare Advantage Care

- Racial, ethnic, and sex disparities exist in Medicare Advantage healthcare quality.
- 2023 report highlights persistent inequities affecting vulnerable populations.

Impact of Dual Eligibility on Healthcare

- Dual-eligible beneficiaries may experience different care quality in special needs plans.
- Studies show mixed results regarding health outcomes and care experiences for dual-eligible individuals.

Medicare Payment and Policy Reports

- Multiple reports from MedPAC analyze Medicare payment policies and healthcare delivery systems from 2013 to 2026.
- Focus on improving care quality, reducing disparities, and optimizing payment models.

Special Needs Plans and Beneficiary Experiences

- Enrollment in dual-eligible special needs plans varies, with some beneficiaries reporting better care experiences.
- Disenrollment rates and beneficiary satisfaction are key areas of study.

Research on Integrated Care Models

- Literature reviews assess approaches for dual-eligible populations.
- Emphasis on future research priorities to enhance integrated care effectiveness.