MEDPAC

Advising the Congress on Medicare issues

Mandated report: Dual-eligible special-needs plans

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Introduction

- About 12 million people are dually eligible for both Medicare and Medicaid
  - More likely to be in poor health, have higher costs than other beneficiaries
  - May receive care that is fragmented or poorly coordinated
- Policymakers have developed several types of health plans that aim to better integrate care for these beneficiaries by providing both Medicare and Medicaid benefits
- Most of these plans are specialized Medicare Advantage (MA) plans known as dual-eligible special-needs plans (D-SNPs)

Nearly half of dually eligible beneficiaries are enrolled in D-SNPs

- Share enrolled in D-SNPs grew from 14% in 2014 to 46% in 2024
- D-SNPs vary in their level of integration with Medicaid (the extent to which they also provide Medicaid benefits)
- Most enrollment is in plans with relatively low integration
  - Coordination-only D-SNPs → Lowest level of integration (27% of dually eligible beneficiaries)
  - HIDE SNPs → Medium level of integration (15%)
  - FIDE SNPs → Greatest level of integration (3%)

Note: D-SNP (dual-eligible special-needs plan), HIDE SNP (highly integrated dual-eligible special-needs plan), FIDE SNP (fully integrated dual-eligible special-needs plan).

The statutory requirements for D-SNP integration have gradually become more extensive

- 2003: Creation of D-SNPs; no specific requirements for integration (effective in 2006)
- 2008: D-SNPs must have state Medicaid contracts that meet certain requirements (effective in 2010)
- 2010: Creation of FIDE SNPs (effective in 2011)
- 2018: D-SNPs must meet coordination-only, HIDE SNP, or FIDE SNP standards (effective in 2021)

→ In 2013, MedPAC recommended that D-SNPs be required to have a level of integration

Note: D-SNP (dual-eligible special-needs plan), FIDE SNP (fully integrated dual-eligible special-needs plan), HIDE SNP (highly integrated dual-eligible special-needs plan).

The BBA of 2018 directs MedPAC to periodically assess D-SNP performance

- Compare 5 types of plans that serve dually eligible beneficiaries
  - 3 types of D-SNPs, divided based on the BBA's integration standards
  - Medicare-Medicaid Plans (MMPs; these plans closed at the end of 2025)
  - Other MA plans
- Mandate language lists HEDIS, CAHPS, and encounter data as potential data sources
- Provide a report every 2 years from 2022 to 2032 and then every 5 years starting in 2033
- This is our third report under the mandate

Note: BBA (Bipartisan Budget Act), D-SNP (dual-eligible special-needs plan), HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems).

Analytic approach for mandated report

- Conducted 3 separate analyses
  - HEDIS clinical quality measures
  - HEDIS risk-adjusted utilization measures (new analysis for this report)
  - CAHPS patient-experience surveys
- Used person-level HEDIS data for measurement year 2024 and results from 2024 CAHPS surveys
- Assessed plans' performance using both statistical and practical significance (based on a difference of 3+ percentage points, a threshold CMS has used in some analyses)

Note: HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems).

Each plan type performed better on some HEDIS clinical quality measures and worse on others

- Calculated scores for 28 measures
- Most of these measures are process measures and provide limited insight into plan performance
- HIDE / FIDE SNPs with aligned enrollment had the best overall performance
- Other MA plans had the worst overall performance
- MMPs showed the greatest variation in performance

Note: HEDIS (Healthcare Effectiveness Data and Information Set), HIDE SNP (highly integrated dual-eligible special-needs plan), FIDE SNP (fully integrated dual-eligible special -eeds plan), MA (Medicare Advantage), MMP (Medicare-Medicaid Plan).

HEDIS risk-adjusted utilization measures focus on different aspects of hospital use

- Separate measures for inpatient discharges, ED visits, all-cause readmissions, and potentially avoidable admissions
- Scores are risk adjusted using models developed by NCQA; these models are calibrated on a broad sample of MA enrollees and may be less accurate for dually eligible beneficiaries
- HIDE / FIDE SNPs without aligned enrollment had the best overall performance
- MMPs had the poorest overall performance

Note: HEDIS (Healthcare Effectiveness Data and Information Set), ED (emergency department), NCQA (National Committee for Quality Assurance), MA (Medicare Advantage), HIDE SNP (highly integrated dual-eligible special -eeds plan), FIDE SNP (fully integrated dual-eligible special-needs plan), MMP (Medicare-Medicaid Plan).

Relatively little variation in CAHPS scores across plan types

- We focused on composite measures (which combine scores on groups of closely related individual measures) and enrollee ratings
- Coordination-only plans and HIDE / FIDE SNPs without aligned enrollment had the best overall performance
- But differences in scores were relatively small in absolute terms and may not be very meaningful for beneficiaries
  - Scores for rating of health plan ranged from 87 to 90
- Other analyses have found that CAHPS scores for many measures cluster within a narrow range

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems), HIDE SNP (highly integrated dual-eligible special-needs plan), FIDE SNP (fully integrated dual-eligible special-needs plan).

Drawing broader conclusions about relative D-SNP performance is challenging

- More highly integrated plans were available in fewer states
- Enrollee characteristics may differ across the five plan types
- MMPs had different quality incentives than MA plans
- Recent reviews of the literature on integrated care models have:
  - Found mixed results
  - Noted that controlling for the effects of selection (due to limited plan availability and differences in enrollee characteristics) is a particular challenge

Note: D-SNP (dual-eligible special-needs plan), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage).
Sources: Roberts, E. T., C. Duggan, R. Stein, et al. 2024. Quality, spending, utilization, and outcomes among dual-eligible Medicare-Medicaid beneficiaries in integrated care programs. *JAMA Health Forum* 4, no. 9 (September 1); Smith, L. B., T. A. Waidmann, and K. J. Caswell. 2021. *Assessment of the literature on integrated care models for people dually enrolled in Medicare and Medicaid: Approaches used and priorities for future research*. Washington, DC: Urban Institute.

Look-alike plans are MA plans that are not D-SNPs but target dually eligible beneficiaries

- State efforts to develop integrated care programs may limit the number of insurers that can offer D-SNPs
- Some insurers have responded by offering look-alike plans as an alternative to D-SNPs
  - Look-alikes have some of the same features as D-SNPs
  - Availability of look-alikes may undermine efforts to promote integrated care
- MedPAC expressed concern about look-alikes in 2019
- CMS has limited look-alike plans by requiring insurers to close a conventional plan if more than 60% of enrollees are dually eligible

Note: MA (Medicare Advantage), D-SNP (dual-eligible special-needs plan).

Chronic condition special-needs plans (C-SNPs) can also be used as look-alike plans

- C-SNPs are specialized MA plans for beneficiaries with certain chronic conditions
- Broader C-SNP market has grown rapidly in recent years
  - Total enrollment grew from about 400K in 2021 to 1.3 million in 2025
  - Vast majority of enrollees (~95%) are in plans for beneficiaries with three relatively common conditions: cardiovascular disease, chronic heart failure, or diabetes
- We estimate that the use of C-SNPs as look-alikes accounts for about 10% of overall C-SNP growth

Note: MA (Medicare Advantage).

Several factors suggest that some C-SNPs are being used as look-alike plans

- Number of C-SNPs that exceed the 60% look-alike threshold has been growing since the limits on look-alikes began taking effect
- Initial growth clustered in states that limit their D-SNP markets to insurers that also offer Medicaid managed care plans
- C-SNPs that target dually eligible beneficiaries appear to have features that differ from other C-SNPs (high MA out-of-pocket limit, maximum Part D deductible, non-zero Part D premium)
  - These features are not attractive to non-dually eligible beneficiaries but are less important for dually eligible beneficiaries due to Medicaid and Part D's low-income subsidy

Note: C-SNP (chronic condition special needs plan), D-SNP (dual-eligible special-needs plan), MA (Medicare Advantage).

CMS may want to broaden the restrictions on look-alike plans to include C-SNPs

- We estimate that the number of C-SNPs that function as look-alike plans increased from 5 in 2021 to 92 in 2026
  - Enrollment in these plans grew by ~100K between 2021 and 2025
  - These figures are based only on plans that target CVD, CHF, and diabetes
- As with conventional plans, using C-SNPs as look-alike plans may undermine state efforts to promote integrated care
- There could be exceptions for C-SNPs that target conditions where the share of affected beneficiaries who are dually eligible is very high (ESRD, HIV/AIDS, mental health conditions)

Note: C-SNP (chronic condition special-needs plan), CVD (cardiovascular disease), CHF (chronic heart failure), ESRD (end-stage renal disease).

Discussion

- This report will appear as a chapter in our March 2026 report to the Congress
- Questions about this presentation
- Comments on potential future work related to D-SNPs or dually eligible beneficiaries

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