CHAPTER 15

Mandated report: Dual-eligible special-needs plans

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Chapter summary

Individuals who qualify for both Medicare and Medicaid—known as dually eligible beneficiaries—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. Given these concerns, policymakers have taken steps to develop programs that better integrate care for these beneficiaries. These programs have largely focused on the creation of health plans that provide both Medicare and Medicaid benefits and thus have incentives to better manage and coordinate care than either program has when acting on its own. These plans also have the potential to improve the enrollee experience for dually eligible beneficiaries by integrating aspects of Medicare and Medicaid such as member materials, care planning, and the processes for handling appeals and grievances that would otherwise be separate.

However, there are several types of Medicare managed care plans that serve the dually eligible population and their level of integration with Medicaid varies. Many of these plans are particular variations of the dual-eligible special-needs plan (D–SNP), which is a specialized Medicare Advantage (MA) plan that limits its enrollment to dually eligible beneficiaries. In an effort to better understand the relative performance of plans that serve dually eligible beneficiaries, the Bipartisan Budget Act (BBA) of 2018 directs

In this chapter

the Commission to periodically compare the performance of these plans. This report is our third under the BBA of 2018 mandate.

As required by the mandate, we compared plans' performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set (HEDIS) and patient-experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) beneficiary survey. Unfortunately, we find that these data sources provide limited insight into the relative performance of D–SNPs because most HEDIS measures are not tied to clinical outcomes and because HEDIS and CAHPS scores on many measures are fairly similar across plan types. The performance of MA plans and Medicare–Medicaid Plans (MMPs), which were part of a demonstration that recently ended, often differed, but those differences could reflect structural differences between the two types of plans or differences in the types of beneficiaries enrolled. These findings are consistent with our earlier mandated reports and with other Commission analyses that have highlighted the difficulties of assessing the quality and performance of MA plans.

External researchers who have studied integrated plans have found some evidence that they produce better outcomes, but their findings have been limited and inconsistent. For example, some studies have found positive effects on certain metrics, such as fewer long-term nursing home stays and greater use of outpatient care, but found inconclusive effects on other metrics, such as hospital admissions and emergency department visits. Better data and more research are needed on the effects of integrated plans on quality and outcomes.

One challenge to developing integrated plans has been "look-alike plans," which are MA plans that are not D–SNPs but target dually eligible beneficiaries. Look-alike plans have some of the same features as D–SNPs but are not subject to the additional requirements that apply to D–SNPs, such as having a state Medicaid contract. CMS has limited the ability of insurers to use conventional MA plans as look-alike plans, but insurers appear to be responding by using another type of MA plan, the chronic-condition special-needs plan (C–SNP), as a new type of look-alike plan. C–SNPs are specialized plans that target beneficiaries who have certain chronic conditions but do not integrate Medicaid benefits. The Commission has previously expressed concern that look-alike plans can undermine states' efforts to develop integrated care programs, and policymakers may want to consider applying the current limits on look-alike plans to C–SNPs. ■

Individuals who qualify for both Medicare and Medicaid—known as dually eligible beneficiaries—may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs.[1] Given these concerns, policymakers have taken steps to develop programs that better integrate care for these beneficiaries. These programs have largely focused on the creation of health plans that provide both Medicare and Medicaid benefits and thus have incentives to better manage and coordinate care than either program has when acting on its own.

However, there are several types of Medicare managed care plans that serve the dually eligible population and their level of integration with Medicaid varies. Many of these plans are particular variations of the dual-eligible special-needs plan (D–SNP), which is a specialized Medicare Advantage (MA) plan that limits its enrollment to dually eligible beneficiaries. In an effort to better understand the relative performance of plans that serve dually eligible beneficiaries, the Bipartisan Budget Act (BBA) of 2018 directs the Commission to periodically compare the performance of these plans. In 2013, the Commission recommended that D-SNPs should be required to have a high level of integration with Medicaid (Medicare Payment Advisory Commission 2013).

The BBA of 2018 requires the Commission to provide a report every two years, starting in 2022 and continuing through 2032 (see text box, p. 584, for the legislative language of the mandate). After that, the schedule changes, with another report due in 2033 and updates required every five years. This chapter is our third report under the mandate, which we are required to submit to the Congress by March 15, 2026.

In this chapter, we provide background information on the dually eligible population and then compare plans' performance using quality measures that plans report as part of the Healthcare Effectiveness Data and Information Set (HEDIS) and patient-experience data that plans collect using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) beneficiary survey. We then examine efforts by MA insurers to develop products known as "look-alike plans" that are not D-SNPs but target dually eligible beneficiaries.

Background

Individuals must separately qualify for both Medicare and Medicaid coverage to become dually eligible beneficiaries. For these individuals, the federal Medicare program covers medical services such as hospital care, post-acute care, physician services, durable medical equipment, and prescription drugs. The federal-state Medicaid program covers a variety of long-term services and supports (LTSS), such as custodial nursing home care and community-based care, and wraparound services, such as dental benefits and transportation. Medicare is the primary payer for any services that are covered by both programs, such as inpatient care and physician services.

Roughly half of dually eligible beneficiaries first qualify for Medicare based on disability (compared with 15 percent of beneficiaries who are not dually eligible) and roughly half qualify when they turn 65. Medicaid's eligibility rules vary somewhat across states, but most dually eligible beneficiaries qualify because they receive Supplemental Security Income benefits, need nursing home care or have other high medical expenses, or meet the eligibility criteria for the Medicare Savings Programs, in which Medicaid provides assistance with Medicare premiums and cost sharing (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025). Not all individuals who are eligible for Medicaid participate in the program. In July 2024, about 12.1 million Medicare beneficiaries (18 percent of all Medicare beneficiaries) were dually eligible.

Dually eligible beneficiaries can be divided into two broad groups—"full benefit" and "partial benefit"—based on the Medicaid benefits they receive. Full-benefit dually eligible beneficiaries qualify for the full range of Medicaid services covered in their state, while partial-benefit dually eligible beneficiaries receive assistance only with Medicare premiums and, in some cases, with cost sharing. In July 2024, there were 8.7 million full-benefit dually eligible beneficiaries and 3.4 million partial-benefit beneficiaries. Unless noted otherwise, all references in this chapter to "dually eligible beneficiaries" include both full-benefit and partial-benefit dually eligible beneficiaries.

Legislative language for mandated report

Section 50311(b)(1)(E) of the Bipartisan Budget Act of 2018 reads:

(E) STUDY AND REPORT TO CONGRESS.—

(i) IN GENERAL.—Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1805, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1852(e)(3) (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified by such Commissions as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

(III) A comparison group of such plans operating within the Financial Alignment Initiative demonstration for the period for which such plan is so operating and the demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

(ii) ADDITIONAL REPORTS.—Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, shall conduct a study described in clause (i). ■

Given the role that factors such as disability and functional impairment play in becoming a dually eligible beneficiary, it is not surprising that the dually eligible population is more likely than other Medicare beneficiaries to report that they are in poor health (12 percent vs. 3 percent) or need help performing three or more activities of daily living (ADLs) (23 percent vs. 5 percent) (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025).[2] The poorer health of this population leads in turn to higher costs for both programs (Table 15-1). Measured on a per capita basis, the average annual Medicare cost for a dually eligible beneficiary in 2022 was almost $26,000, more than twice the corresponding figure for other Medicare beneficiaries. Within the dually eligible population, those eligible for full Medicaid benefits had higher Medicare costs and much higher Medicaid costs than

TABLE 15–1

Dually eligible beneficiaries had much higher per capita annual spending in 2022 than other Medicare beneficiaries

	Medicare	Medicaid	Total
Dually eligible beneficiaries			
All dually eligible	$25,871	$14,535	$40,405
Full-benefit dually eligible	26,947	19,413	46,360
Partial-benefit dually eligible	22,831	763	23,594
All other Medicare beneficiaries	11,834	N/A	11,834

Note: N/A (not applicable). Figures include all Medicare (Part A, Part B, and Part D) and Medicaid spending except Medicare or Medicaid spending on Part A, Part B, or Part D premiums. Figures for both programs include all fee-for-service payments and all payments made to health plans. The Medicaid spending for partial-benefit dually eligible beneficiaries is for coverage of Medicare cost sharing. Components may not sum to totals due to rounding.

Source: MedPAC analysis of linked Medicare-Medicaid enrollment and spending data.

those eligible for partial Medicaid benefits only. In 2022, Medicare and Medicaid together spent more than $46,000 per capita, on average, on full-benefit dually eligible beneficiaries; Medicare accounted for about 58 percent of the combined spending and Medicaid the other 42 percent.

The high Medicare costs for dually eligible beneficiaries are driven by a combination of higher utilization of all major types of services and higher per user spending for those who receive care. For example, based on beneficiaries with fee-for-service (FFS) coverage in both programs, in 2022, full-benefit dually eligible beneficiaries were more likely than other Medicare beneficiaries to use inpatient care (22 percent vs. 13 percent), and those who were hospitalized had higher inpatient costs ($28,317 vs. $22,717). The Medicaid costs for full-benefit dually eligible beneficiaries were largely for LTSS, such as nursing home care and home- and community-based waiver programs. Less than half of the full-benefit dually eligible population with FFS coverage in both programs (43 percent) used LTSS in 2022, but spending on those services accounted for almost 80 percent of this population's total Medicaid costs (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025).

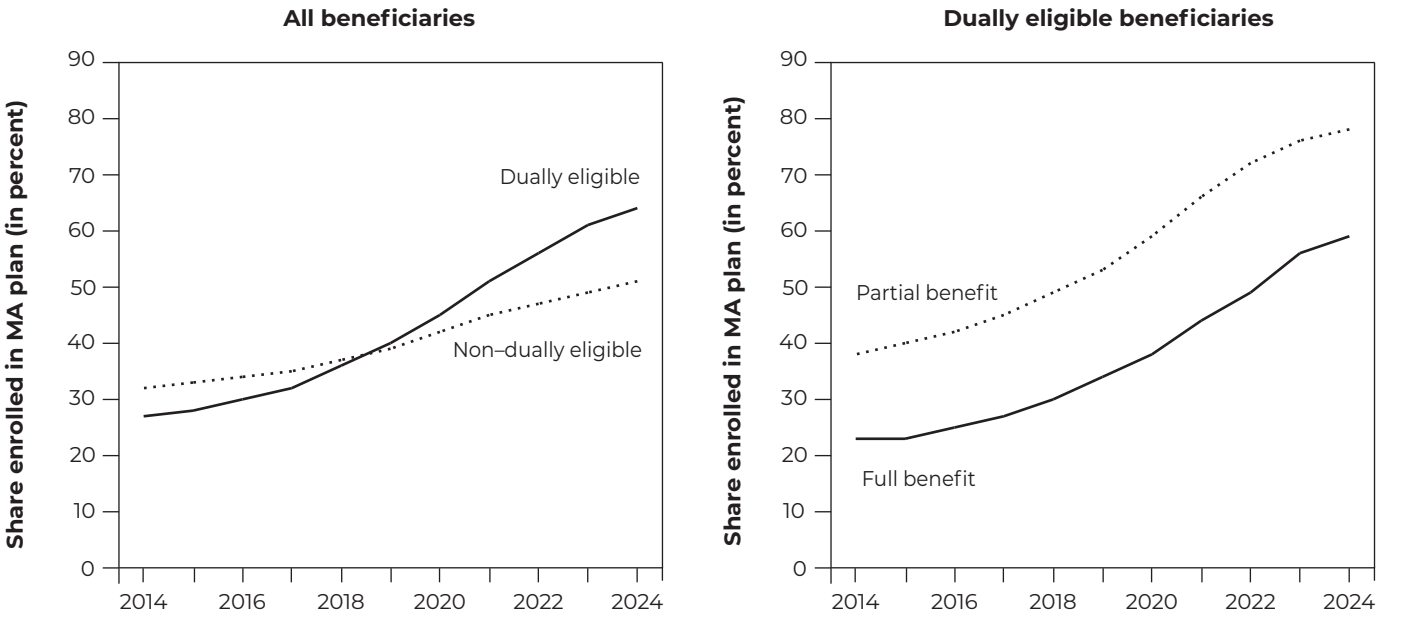
The share of dually eligible beneficiaries enrolled in MA has grown rapidly

As with other beneficiaries, the share of dually eligible beneficiaries enrolled in MA plans has grown rapidly in recent years. The left half of Figure 15-1 (p. 586) shows the share of dually eligible and non–dually eligible beneficiaries enrolled in MA from 2014 to 2024. Dually eligible beneficiaries were historically less likely than other beneficiaries to enroll in managed care plans, but that pattern reversed during this period, and the share of the dually eligible population enrolled in MA is now higher than that of non–dually eligible beneficiaries (64 percent vs. 51 percent in 2024). Within the dually eligible population, as shown on the right half of Figure 15-1, partial-benefit dually eligible beneficiaries have consistently been more likely than full-benefit dually eligible beneficiaries to enroll in MA plans. Between 2014 and 2024, the MA participation rate for both groups more than doubled, and a substantial majority are now enrolled in MA. The participation rate for partial-benefit dually eligible beneficiaries is particularly high (78 percent).

It is worth noting that Figure 15-1 does not include enrollment in plans that are not part of the MA program, such as cost plans, Medicare–Medicaid Plans (MMPs), and the Program of All-Inclusive Care for

FIGURE 15–1

The share of dually eligible beneficiaries enrolled in MA plans more than doubled between 2014 and 2024



Note: MA (Medicare Advantage). Figures are based on enrollment in July of each year. Full-benefit dually eligible beneficiaries qualify for the full range of Medicaid services covered in their state, while partial-benefit dually eligible beneficiaries receive assistance only with Medicare premiums and, in some cases, with Medicare cost sharing. Figures do not include beneficiaries who did not have both Part A and Part B coverage or lived in the U.S. territories. Figures do not include beneficiaries who were enrolled in health plans that are not part of the MA program (stand-alone Part D plans, cost plans, Medicare–Medicaid Plans, and the Program of All-Inclusive Care for the Elderly).

Source: MedPAC analysis of Medicare enrollment and eligibility data.

the Elderly. In 2024, about 3 percent of dually eligible beneficiaries were enrolled in those plans (largely in MMPs, which were capitated, highly integrated plans for full-benefit dually eligible beneficiaries that operated under a Center for Medicare & Medicaid Innovation demonstration between 2013 and 2025), compared with less than 1 percent of non–dually eligible beneficiaries.

Integration requirements for D–SNPs

D–SNPs are based on the rationale that dually eligible beneficiaries will receive better care from a specialized MA plan that is tailored to meet their distinct care needs than they would from a conventional MA plan. The extent to which D–SNPs must integrate the delivery of Medicare and Medicaid services has evolved over time. When D–SNPs were first authorized in 2003, they did not have to meet any specific requirements for integration. The Congress enacted the first requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Since 2010, MIPPA has required D–SNPs to have Medicaid contracts that meet certain minimum requirements, such as specifying the plan's service area, the Medicaid services the plan provides (if any), and the plan's responsibility to coordinate the delivery of Medicaid services for its enrollees.

Later, with the Affordable Care Act of 2010, the Congress added requirements for plans that wanted to qualify as a fully integrated dual-eligible SNP (FIDE–SNP). These plans must be offered by an entity that has a capitated Medicaid contract to provide

both institutional and community-based LTSS, and they can receive higher Medicare payments if their enrollees have high levels of functional impairment.

The BBA of 2018 built on the MIPPA standards by requiring D–SNPs, starting in 2021, to meet one of three additional criteria for integration:

- The plan meets a minimum set of requirements, determined by the Secretary, to coordinate the delivery of LTSS, behavioral health, or both for plan enrollees. CMS specified through regulation that these plans must notify the state about admissions to inpatient hospitals and skilled nursing facilities for at least one group of "high-risk" full-benefit dually eligible beneficiaries, which is defined by the state. CMS refers to these plans as coordination-only D–SNPs; they have the lowest level of integration because they do not have to provide any Medicaid services (plan enrollees instead receive those services through a Medicaid fee-for-service (FFS) program or a separate Medicaid managed care plan).
- The plan qualifies as either (1) a highly integrated dual-eligible SNP (HIDE–SNP) by having a capitated Medicaid contract to provide LTSS, behavioral health, or both; or (2) a FIDE–SNP. HIDE–SNPs fall somewhere in the middle in terms of their integration with Medicaid: They are more integrated than coordination-only plans because they provide some Medicaid services, but less integrated than FIDE–SNPs because their Medicaid contracts may not be as extensive and they can use a wider variety of contracting arrangements with states. FIDE–SNPs have the highest level of integration because they provide a broad range of Medicaid services, including substantial LTSS coverage.
- The plan assumes "clinical and financial responsibility" for both Medicare and Medicaid benefits provided to its enrollees. CMS has defined these plans as HIDE–SNPs or FIDE–SNPs that have exclusively aligned enrollment, which means that enrollment in the D–SNP is limited to dually eligible beneficiaries who receive their Medicare and Medicaid benefits from the same insurer. Based on a separate BBA of 2018 provision, these plans must have a unified process for handling appeals and grievances (instead of separate processes for Medicare-covered and Medicaid-covered services).[3] The use of exclusively aligned enrollment also allows plans to integrate other aspects of the enrollee experience, such as member materials.

In addition to the requirements for Medicaid integration, D–SNPs must complete annual health risk assessments for their enrollees, have an approved evidence-based model of care, and report certain additional quality measures. Otherwise, they are largely subject to the same rules as conventional MA plans. For example, they can require enrollees to receive care from in-network providers, employ utilization-management tools like prior authorization, and offer supplemental benefits that FFS Medicare does not cover.

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

Like conventional MA plans, D–SNPs are now widely available. In 2026, they are offered in 47 states and the District of Columbia, and we estimate that 98 percent of beneficiaries live in counties where at least one D–SNP is available. The only states without D–SNPs are Alaska, New Hampshire, and Vermont.

Table 15-2 (p. 588) shows the enrollment distribution for dually eligible beneficiaries (both full benefit and partial benefit) in 2024. Overall, 33 percent of these beneficiaries were enrolled in FFS Medicare, 64 percent were enrolled in MA plans, and 3 percent were enrolled in non-MA plans. (See text box, pp. 590–591, for a summary of important recent and upcoming changes to health plans that serve dually eligible beneficiaries.)

Nearly half of dually eligible beneficiaries (46 percent) were enrolled in D–SNPs. Most of those enrollees (27 percent of all dually eligible beneficiaries) were in coordination-only D–SNPs, followed by 15 percent in HIDE–SNPs and 3 percent in FIDE–SNPs. The majority of D–SNP enrollees were thus in plans with the lowest level of integration with Medicaid, while the share enrolled in FIDE–SNPs, which have the highest level of integration, was low. Although overall D–SNP enrollment has grown substantially in recent years, the relative shares enrolled in the different types of D-SNPs have been fairly stable.

TABLE 15–2

Enrollment of dually eligible beneficiaries, by type of coverage and the comparison groups specified in the Bipartisan Budget Act of 2018, July 2024

Type of coverage	Beneficiaries (thousands)	Share	Comparison group
Fee-for-service	**3,832**	**33%**	
Medicare Advantage plans:			
Dual-eligible special-needs plans			
Coordination-only	3,205	27	Group A
HIDE–SNPs	1,771	15	*See below*
FIDE–SNPs	402	3	*See below*
Subtotal, D–SNPs	*5,378*	*46*	
Conventional plans	1,835	16	Group E
All other Medicare Advantage plan types	323	3	Group E
Subtotal, all Medicare Advantage plans	**7,536**	**64**	
Non–Medicare Advantage plans:			
Medicare–Medicaid Plans	256	2	Group D
Program of All-Inclusive Care for the Elderly	60	1	
Cost plans	6	<1	
Subtotal, all non–Medicare Advantage plans	**323**	**3**	
Total dually eligible beneficiaries	**11,691**	**100**	
Detail on HIDE–SNPs and FIDE–SNPs			
Without aligned enrollment			
HIDE–SNPs	1,748	15	Group B
FIDE–SNPs	67	1	Group B
With aligned enrollment			
HIDE–SNPs	23	<1	Group C
FIDE–SNPs	335	3	Group C

Note: HIDE–SNP (highly integrated dual-eligible special-needs plan), FIDE–SNP (fully integrated dual-eligible special-needs plans), D–SNP (dual-eligible special-needs plan). Figures are based on July 2024 enrollment. Figures do not include beneficiaries who did not have both Part A and Part B coverage or beneficiaries who lived in the U.S. territories. Components may not sum to totals due to rounding. Groups A through E correspond with the five plan types, as shown from left to right, in Tables 15-3, 15-4, 15-5, 15-6, and 15-A1.

Source: MedPAC analysis of Medicare enrollment and eligibility data and health plan data.

Aside from D–SNPs, another 16 percent of dually eligible beneficiaries were enrolled in conventional MA plans, while 3 percent were enrolled in other MA plan types, such as institutional special-needs plans, chronic-condition special-needs plans, or employer-sponsored plans.

Available data provide limited insight into relative performance of D–SNPs

The BBA of 2018 directs the Commission to periodically examine how D–SNPs "perform among each other" using Healthcare Effectiveness Data and Information Set (HEDIS) quality measures or other data sources, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) beneficiary survey or plan encounter data, as appropriate.

To the extent feasible, these reports must compare five types of plans that serve dually eligible beneficiaries. Table 15-2 shows which plans are in each comparison group. The first three groups, referred to as Groups A, B, and C, are made up of D–SNPs that have been divided based on the BBA of 2018's integration criteria. These comparison groups differ somewhat from the coordination-only, HIDE–SNP, and FIDE–SNP categories because they also account for whether HIDE–SNPs and FIDE–SNPs have exclusively aligned enrollment. As shown at the bottom of Table 15-2, in 2024, the differences between the two methods for categorizing D–SNPs were relatively modest since nearly all HIDE–SNP enrollees were in plans that did not have exclusively aligned enrollment and most FIDE–SNP enrollees were in plans that did have exclusively aligned enrollment. The fourth group (Group D) are MMPs, while the fifth group (Group E) are other MA plans (looking only at the dually eligible beneficiaries in those plans). Most beneficiaries in Group E are enrolled in conventional MA plans.

Another logical comparison group would be dually eligible beneficiaries who are enrolled in FFS Medicare, although the mandate does not require this comparison. However, the Commission has previously noted that efforts to compare FFS and MA performance are hindered by several data limitations (such as a lack of clinical data for FFS enrollees and discrepancies between plans' HEDIS data and encounter data) and the challenges of adjusting for differences between the FFS and MA populations (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019b). Given these challenges, we determined in our March 2023 report to the Congress that rigorous comparisons of quality and outcomes between MA and FFS could not be made at this time (Medicare Payment Advisory Commission 2023).

For this report, we analyzed two types of HEDIS measures—clinical quality measures and risk-adjusted utilization measures—and CAHPS patient experience measures.

- On the clinical quality measures, we found that each plan type performed better on some measures and worse on others. While the differences between the scores on a given measure were often relatively small, HIDE–SNPs and FIDE–SNPs with exclusively aligned enrollment had the best overall performance of the five plan types, while other MA plans had the worst overall performance.
- On the risk-adjusted utilization measures, HIDE–SNPs and FIDE–SNPs that did not have aligned enrollment had the best overall performance, while MMPs had the worst overall performance.
- As for the CAHPS measures, we found that the five comparison groups had very similar scores, with coordination-only D–SNPs performing slightly better than the other plan types.

Drawing broader conclusions about plan performance from this analysis is challenging because other factors, such as differences in the characteristics of the dually eligible beneficiaries who enroll in each plan type, may contribute to the variation in scores. Table 15-3 (p. 592) illustrates some of those differences. For example, the share of enrollees who were under age 65 was relatively low for HIDE–SNPs and FIDE–SNPs with aligned enrollment (20 percent) because some FIDE–SNPs were available only to beneficiaries who are 65 or older or need LTSS. Two plan types (HIDE–SNPs and FIDE–SNPs with aligned enrollment and MMPs) were limited to full-benefit dually eligible beneficiaries, while partial-benefit dually eligible beneficiaries accounted for a substantial share of the enrollment in the other three plan types. The share of enrollees who lived in urban versus rural areas and the racial/ethnic composition of enrollees also varied across the five plan types due to the fact that some plan types are offered only in certain states.

As a group, dually eligible beneficiaries are also quite heterogeneous and include subgroups that may have very distinct care needs, such as beneficiaries who are under age 65 and have a behavioral health condition versus beneficiaries who are in their 80s and have multiple functional impairments. This variation

Important recent and upcoming changes to the landscape of health plans that serve dually eligible beneficiaries

The figures in Table 15-2 (p. 588) do not reflect the impact of several important changes that will affect the landscape of health plans that serve dually eligible beneficiaries:

Additional requirements for plans to qualify as fully integrated dual-eligible special-needs plans (FIDE-SNPs)

Before 2025, FIDE–SNPs were required to have capitated Medicaid contracts to provide primary care, acute care, and long-term services and supports. Starting in 2025, CMS added new requirements aimed at ensuring that all FIDE–SNPs have a high level of integration with Medicaid. CMS now requires that the Medicaid contracts for FIDE–SNPs cover a broader set of services and that FIDE–SNPs have exclusively aligned enrollment. Some plans that had been FIDE–SNPs did not meet these new requirements and were reclassified as highly integrated dual-eligible special-needs plans (HIDE–SNPs) in 2025. These plans had about 110,000 enrollees.

Changes to special enrollment periods

Medicare largely prohibits beneficiaries from changing their coverage (switching from fee-for-service (FFS) to Medicare Advantage (MA), from MA to FFS, or changing their MA or stand-alone Part D plan) outside of an annual enrollment period. However, before 2025, dually eligible beneficiaries could use a special enrollment period (SEP) to make any change to their coverage once per calendar quarter during the first nine months of the year.[4]

Starting in 2025, CMS replaced this SEP with a pair of new SEPs: the first SEP allows dually eligible beneficiaries to switch from an MA plan to a stand-alone Part D plan or change their stand-alone Part D plan on a monthly basis, while the second SEP allows full-benefit dually eligible beneficiaries to enroll in certain integrated dual-eligible special-needs plans (D–SNPs) on a monthly basis.[5] These changes limit the ability of dually eligible beneficiaries to enroll in or change MA plans outside of the annual enrollment period, and they may lead to slower enrollment growth in coordination-only D–SNPs (which are largely ineligible for the new integrated-care SEP) relative to HIDE–SNPs and FIDE–SNPs (which are eligible).

Closure of Medicare–Medicaid Plans (MMPs)

The MMPs were part of a demonstration in which CMS and certain states tested the use of capitated, highly integrated plans for full-benefit dually eligible beneficiaries. At their peak, MMPs operated in 10 states and had between 400,000 and 450,000 enrollees, making the demonstration one of the largest specifically aimed at the dually eligible population.[6]

CMS ended the demonstration in 2025, and this year most MMPs converted into D–SNPs. CMS

(continued next page)

makes it challenging for health plans to manage this population and to assess plan performance.

External researchers who have studied integrated plans have found some evidence that they produce better outcomes, but their findings have been limited and inconsistent. One recent literature review surveyed all evaluations of FIDE–SNPs, MMPs, and the Program of All-Inclusive Care for the Elderly (PACE) that were published between 2010 and 2023 (Roberts et al. 2024).[7] According to the review, those studies have found some evidence that FIDE–SNPs and MMPs have positive effects on certain metrics, such as reductions in long-term nursing home stays and greater use of outpatient

Important recent and upcoming changes to the landscape of health plans that serve dually eligible beneficiaries (cont.)

tied its decision to end the demonstration to such factors as Congress's decision to make D-SNPs a permanent part of the MA program, greater flexibility for MA plans in offering supplemental benefits, and regulatory changes that incorporate some MMP features into D-SNPs. The Commission's review of evaluations of the demonstrations found that they tended to result in statistically significant increases in Medicare spending and had mixed effects on service use (Medicare Payment Advisory Commission 2024b). Based on July 2025 enrollment, we estimate that 66 percent of MMP enrollees (about 160,000 people) were moved into FIDE–SNPs and 18 percent (about 45,000 people) were moved into HIDE–SNPs. The remaining 16 percent (about 40,000 people) were in MMPs that closed without converting into D–SNPs; most of these enrollees will likely switch to D–SNPs offered by other insurers, which in many cases include HIDE–SNPs or FIDE–SNPs. The transition from MMPs to D–SNPs will thus increase the share of beneficiaries enrolled in more highly integrated D–SNPs relative to the less-integrated coordination-only plans.

Implementation of requirements to more closely align D–SNPs and Medicaid managed care plans

Many states now have Medicaid managed care programs that serve dually eligible beneficiaries, making it feasible to use health plans to provide integrated care (either by enrollment in a single plan that covers both Medicare and Medicaid benefits or enrollment in separate Medicare and Medicaid plans offered by the same insurer). In 2024, CMS finalized a new policy that aims to more closely align the D–SNP and Medicaid managed care markets.

Under this policy, starting in 2027, insurers that have a Medicaid plan that serves full-benefit dually eligible beneficiaries will be limited to offering a single D–SNP for those beneficiaries in the Medicaid plan's service area. Insurers that now offer multiple D–SNPs for full-benefit dually eligible beneficiaries in those areas will need to consolidate their plans. In addition, any new enrollment in these D–SNPs will be limited to beneficiaries who are also enrolled in the insurer's companion Medicaid plan. In 2030, these D–SNPs must disenroll any remaining beneficiaries who are not also enrolled in the insurer's companion Medicaid plan. At that point, all of these D–SNPs will have exclusively aligned enrollment with their companion Medicaid plan.

This policy will apply only in states with Medicaid managed care programs that serve full-benefit dually eligible beneficiaries, and there are some exceptions that would allow insurers to offer more than one D–SNP. For example, a state could require an insurer to offer more than one D–SNP if the state has multiple Medicaid managed care programs that serve distinct populations (such as one for beneficiaries under 65 and another for beneficiaries who are 65 and older). States can also allow insurers to offer a separate D–SNP for partial-benefit dually eligible beneficiaries.[8] ■

care, but found "limited and inconclusive" effects on other metrics, such as hospital admissions and emergency department visits. Another review of the literature on integrated care programs concluded that "findings across all domains tended to be mixed," and noted that one particular challenge for researchers was controlling for the effects of selection (which results from the fact that these programs are not available in all areas and may target certain subsets of the dually eligible population, and from the fact that enrollment in these programs is typically voluntary) (Smith et al. 2021). However, one recent study found that full-benefit dually eligible beneficiaries enrolled in FIDE–SNPs had lower disenrollment rates (voluntary changes

TABLE 15–3

The dually eligible beneficiaries enrolled in the five plan types specified in the Bipartisan Budget Act of 2018 differed in several respects, 2024

Beneficiary characteristic	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Number of enrollees (in thousands)	3,622	2,042	412	301	2,760
Age					
Under 65	35%	27%	20%	46%	24%
65 and older	65	73	80	54	76
Sex					
Female	60	60	63	56	60
Male	40	40	37	44	40
Race/ethnicity					
White, non-Hispanic	48	37	35	50	56
Black	30	19	20	25	18
Hispanic	14	29	27	15	17
Asian	6	9	12	5	6
Other/unknown	3	6	6	5	3
Type of Medicaid eligibility					
Full benefits	68	69	98	99	54
Partial benefits	32	31	2	1	46
Residence					
Urban area	76	90	92	90	82
Rural area	24	10	8	10	18
Nursing home resident	2	1	4	10	10
Died during the year	4	4	5	5	6

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), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage). Enrollment figures are based on beneficiaries who had at least one month during 2024 where they were both (1) dually eligible for Medicare and Medicaid, and (2) enrolled in one of the five plan types shown in the table. Figures do not include beneficiaries in the U.S. territories. Beneficiaries were counted as nursing home residents if there was at least one month where they had been in a nursing home for 90+ days. Components may not sum to 100 due to rounding.

Source: MedPAC analysis of Medicare enrollment and eligibility data and health plan data.

to another type of coverage) than full-benefit dually eligible beneficiaries enrolled in other types of D–SNPs or in other types of MA plans, suggesting that enrollees in more highly integrated plans may be more satisfied with their care (Meyers et al. 2025). Better data and more research are needed on the effects of integrated plans on quality and outcomes.

HEDIS measures

For this report, we analyzed person-level HEDIS data for measurement year 2024, the most recent available. HEDIS is a set of quality measures that has been developed by the National Committee for Quality Assurance (NCQA) to evaluate health plans. For 2024, CMS required both MA plans and MMPs to collect

and report data for a subset of HEDIS measures. The person-level HEDIS data have both beneficiary and plan identifiers, which we used to identify beneficiaries enrolled in D–SNPs, MMPs, and other MA plans and to determine which beneficiaries were dually eligible. We divided the D–SNP enrollees into three groups based on the BBA integration criteria that each plan met in 2024.

We analyzed two types of HEDIS measures: clinical quality measures and risk-adjusted utilization measures. We examined clinical quality measures in our previous mandated reports, while the analysis of risk-adjusted utilization measures is new. While HEDIS measures are often used to assess health plans, they do have some limitations. For example, the clinical quality measures are largely process measures that do not directly measure actual outcomes, and many measures exclude beneficiaries who live in nursing homes, who account for about 10 percent of all full-benefit dually eligible beneficiaries. Similarly, the specifications for the utilization measures may exclude a significant amount of service use.[9]

Clinical quality measures

For each comparison group, we calculated scores for 28 HEDIS measures with a total of 56 associated rates. Some measures have more than one associated rate: For example, a measure on follow-up after an emergency department visit for substance abuse has two rates, one for 7-day follow-up and one for 30-day follow-up. The number of observations that were used to calculate each rate varied depending on the enrollment in each plan type and the demographic and clinical specifications for each measure. We did not include four measures—blood pressure control for patients with diabetes, controlling high blood pressure, glycemic status assessment for patients with diabetes, and transitions of care—where some plans report administrative data and some plans report data collected from a sample of enrollee medical records.

Each plan type performed better on some measures and worse on others. In many cases, the differences between the scores on a given measure were relatively small and may not be very meaningful to beneficiaries, even if they are statistically significant. (See Table 15-A1, pp. 606-608, in this chapter's appendix, for the scores on each measure we used in our analysis.)

We tested our results for statistical significance by comparing each plan type's score on a given rate with the unweighted average of the scores for the five plan types and found that 83 percent of the scores were significant at the 95 percent confidence level. CMS has addressed this challenge in some analyses by requiring scores to differ by at least 3 percentage points to have "practical significance" (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2023b).

We applied the concept of practical significance to our analysis by looking for cases where a plan type's score on a rate differed from the unweighted average of the scores for the five plan types by at least 3 percentage points. Table 15-4 (p. 594) groups the 56 rates that we analyzed into three care domains—access/availability of care, effectiveness of care, and measures reported using electronic clinical data systems (ECDS)—and shows the number of rates where each plan type had better performance (top half of the table) or worse performance (bottom half of the table). All of the differences shown in Table 15-4 were statistically significant at the 95 percent confidence level. Using this approach, we found the following:

- HIDE–SNPs and FIDE–SNPs with exclusively aligned enrollment had the best overall performance, doing better on 14 rates and worse on only 1 rate. For effectiveness of care, they performed better on four rates related to behavioral health. Among the ECDS measures, they performed better on three rates related to screening for social needs and two rates related to immunizations.
- Other MA plans had the worst overall performance of the five plan types, doing better on 4 rates and worse on 15 rates. For effectiveness of care, they performed better on two rates related to care for osteoporosis and worse on six rates related to behavioral health. Among the ECDS measures, they performed worse on six rates related to screening and intervention for social needs.
- MMPs had the greatest variation in performance of the five plan types, doing better on 17 rates and worse on 11 rates. In the area of access/availability of care, they performed better on four rates related to initiation of and engagement with treatment

TABLE 15–4

Relative performance on HEDIS clinical quality measures for measurement year 2024, by plan type

Measure domain	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs: Unaligned	HIDE–SNPs and FIDE–SNPs: Aligned	MMPs	Other MA plans
Number of rates where the score for the plan type was better than the overall average and the difference was practically significant:					
Access/availability of care (7 rates)	1	0	1	4	0
Effectiveness of care (35 rates)	2	3	6	8	3
Measures reported using electronic clinical data systems (14 rates)	4	4	7	5	1
Total (56 rates)	**7**	**7**	**14**	**17**	**4**
Number of rates where the score for the plan type was worse than the overall average and the difference was practically significant:					
Access/availability of care (7 rates)	0	3	0	1	1
Effectiveness of care (35 rates)	7	4	0	6	7
Measures reported using electronic clinical data systems (14 rates)	3	4	1	4	7
Total (56 rates)	**10**	**11**	**1**	**11**	**15**

Note: HEDIS (Healthcare Effectiveness Data and Information Set), 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), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage). Figures do not include plans in the U.S. territories. Figures indicate the number of rates where the score for the plan type was better or worse than the unweighted average of the scores for all five plan types and the difference was 3+ percentage points. All differences were statistically significant at the 95 percent confidence level.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2024 and D–SNP integration data for 2024.

for substance use disorder. For effectiveness of care, they performed better on six rates related to behavioral health, but worse on three rates related to diabetes care and two rates related to care for osteoporosis. Among the ECDS measures, they performed better on three rates related to interventions for enrollees with social needs, but worse on two rates related to breast cancer and colorectal cancer screening and on two rates related to screening for social needs.

- Coordination-only D–SNPs performed better on a total of 7 rates and worse on a total of 10 rates. In the area of effectiveness of care, these plans performed worse on six rates related to behavioral health, such as follow-up after a hospitalization for mental illness. Among the ECDS measures, these plans performed better on three rates related to screening for enrollees' social needs (food, housing, and transportation) but worse on three rates related to providing assistance for those identified with social needs.
- HIDE–SNPs and FIDE–SNPs without exclusively aligned enrollment performed better on 7 rates and worse on 11 rates. In the area of access/availability of care, these plans performed worse on three rates related to initiation of and engagement with treatment for substance use disorder. For effectiveness of care, they performed better on two rates related to screening for and management of osteoporosis and worse on two rates related to behavioral health. Among the ECDS measures, they performed better on rates related to screening for

breast cancer, colorectal cancer, and some social needs, but performed worse on two rates related to immunizations.

Drawing broader conclusions about plan performance from this analysis is challenging because other factors may contribute to the variation in scores. For example, in 2024, over 99 percent of beneficiaries lived in counties where at least one MA plan was available and 95 percent lived in counties where at least one D–SNP was available, but some plan types were not widely available. The most highly integrated plans in particular had more limited availability: MMPs and FIDE–SNPs were available in only 8 states and 14 states, respectively. Thus, differences in HEDIS scores across the five comparison groups could be influenced by factors such as regional differences in state Medicaid eligibility requirements, disease prevalence, access to care, and physician practice patterns.

Another factor could be structural differences between MMPs and MA plans. MMPs were part of a demonstration and operated outside of the MA program. The two plan types differed in many ways, and differences in their enrollment models and quality incentives could have affected their relative performance on HEDIS measures. In MA, almost all beneficiaries enroll voluntarily, while in MMPs, many beneficiaries were passively enrolled by states. MMPs might have had more difficulty engaging with passive enrollees, which could have contributed to their poor performance on some measures. Both types of plans had quality incentives, but the incentive for MA plans was structured as a bonus (higher payments for plans with a rating of 4 stars or better), while the incentive for MMPs was structured as a quality withhold (lower payments for plans that do not meet performance thresholds), and they were not evaluated on the same HEDIS measures. Seven measures that we included in our analysis (breast cancer screening, colorectal cancer screening, eye exam for patients with diabetes, follow-up after emergency department visit for people with multiple high-risk conditions, kidney health evaluation for patients with diabetes, osteoporosis management in women who had a fracture, and statin therapy for patients with cardiovascular disease) were used in the MA star ratings but not the MMP quality withhold, and MA plans performed noticeably better than MMPs on six of the eight rates associated with those measures. Conversely, two measures (depression screening and follow-up, follow-up after hospitalization for mental illness) were used in the MMP quality withhold but not the MA star ratings, and MMPs performed noticeably better than MA plans on three of the four rates associated with those measures. Some of the differences in HEDIS scores may thus reflect differences in plans' financial incentives to focus on certain measures over others.

The challenges of using HEDIS measures to assess performance also reflect larger difficulties in assessing the quality and performance of MA plans (both in terms of how well individual plans perform compared with each other and how well MA plans perform compared with the FFS program). Most HEDIS measures are process measures that are not tied to clinical outcomes, but the Commission holds that measures tied to clinical outcomes and patient experience are more suitable for quality payment programs (Medicare Payment Advisory Commission 2018). CMS includes some process measures in the calculation of the MA star ratings, accounting for about 25 percent of a plan's overall star rating for 2026, but it gives more weight to outcomes and patient-experience measures (Centers for Medicare & Medicaid Services 2025b).

Risk-adjusted utilization measures

The NCQA has developed several utilization measures that focus on services provided by hospitals. CMS required MA plans and MMPs to report four of those measures: acute hospital discharges, emergency department visits, all-cause 30-day readmissions, and hospitalizations for potentially preventable conditions. The measure for potentially preventable hospitalizations has two rates: one for certain acute conditions (bacterial pneumonia, urinary tract infections, cellulitis, and severe pressure ulcers) and one for certain chronic conditions (short-term and long-term complications from diabetes, uncontrolled diabetes, diabetic patients who have had a lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, and heart failure).

When plans report these measures, they report both actual service use and an estimate of expected service use for enrollees who meet the measure's HEDIS specifications. Plans calculate the expected service use by applying a set of risk-adjustment models that are

TABLE 15–5

Performance on HEDIS risk-adjusted utilization measures for measurement year 2024, by plan type

		HIDE–SNPs and FIDE–SNPs			
	Coordination-only D–SNPs	Unaligned	Aligned	MMPs	Other MA plans
Acute hospital discharges					
Observed amount	406,845	240,327	64,044	37,093	362,777
Risk-adjusted expected amount	346,004	224,529	49,351	29,729	297,862
Observed-to-expected ratio	1.18	1.07	1.30	1.25	1.22
Emergency department visits					
Observed amount	999,221	542,046	118,724	77,299	642,117
Risk-adjusted expected amount	679,958	414,432	85,096	67,415	514,478
Observed-to-expected ratio	1.47	1.31	1.40	1.15	1.25
All-cause readmissions					
Observed amount	63,461	35,373	9,190	6,240	57,844
Risk-adjusted expected amount	60,872	34,622	8,476	5,603	54,811
Observed-to-expected ratio	1.04	1.02	1.08	1.11	1.06
Hospitalizations for potentially preventable conditions: Acute conditions					
Observed amount	19,288	11,561	3,933	1,505	20,968
Risk-adjusted expected amount	13,602	10,893	2,620	929	14,041
Observed-to-expected ratio	1.42	1.06	1.50	1.62	1.49
Hospitalizations for potentially preventable conditions: Chronic conditions					
Observed amount	38,961	23,867	7,673	2,994	35,676
Risk-adjusted expected amount	25,875	19,077	4,567	1,755	25,019
Observed-to-expected ratio	1.51	1.25	1.68	1.71	1.43

Note: HEDIS (Healthcare Effectiveness Data and Information Set), 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), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage). Figures do not include plans in the U.S. territories. We tested these results for statistical significance by comparing the score for each plan type to the unweighted average of the scores for all five plan types and using a *t*-test; we found that all but two scores (the scores for coordination-only D–SNPs on the two rates related to hospitalizations for potentially preventable conditions) were significant at the 95 percent confidence level.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2024 and D–SNP integration data for 2024.

developed by NCQA and predict an enrollee's service use based on such factors as age, sex, and the presence of various clinical comorbidities. (These models are different from the risk-adjustment models that CMS uses to adjust payments to MA plans to account for differences in enrollees' health status.)

Table 15-5 shows the observed and risk-adjusted expected amounts for each measure plus the ratio of the two amounts. An observed-to-expected ratio lower than 1 means the plan type had lower utilization than expected given the demographics and clinical conditions of their enrollees, while a ratio greater than 1 means plans had higher utilization than expected. However, the ratios for every measure and plan type shown in Table 15-5 are greater than 1, which suggests that the underlying risk-adjustment models for these measures have some limitations. Those models

are calibrated on a broad sample of MA enrollees—meaning that the observed-to-expected ratio across the entire sample should equal 1.0—and may not be as accurate for a subset of enrollees such as dually eligible beneficiaries. For example, the ratio of 1.47 for emergency department visits for coordination-only D–SNPs may suggest that the expected utilization for that service is underestimated. If the inaccuracies of the risk adjustment models affect all plan types equally, then comparing the ratios across the five plan types is still meaningful. However, if the models are more accurate for some plan types than others, the comparisons will not provide an accurate picture of relative plan performance.

Notwithstanding this limitation, HIDE–SNPs and FIDE–SNPs that did not have aligned enrollment had the best performance (lowest observed-to-expected ratio) on four of the five utilization metrics, including both rates for potentially avoidable hospitalizations. Conversely, MMPs had the poorest performance on three of the five metrics, although the differences between their scores and the scores for other plan types were relatively small. As with the clinical quality measures, drawing broader conclusions from this analysis is challenging because other factors (such as differences in plan availability, inaccuracies in risk adjustment, and structural differences between MMPs and MA plans) may contribute to the variation in scores.[10]

CAHPS patient experience measures

We also analyzed results from the CAHPS beneficiary survey, which was developed by the Agency for Healthcare Research and Quality (AHRQ) to assess patient experience with the health care system. Patient experience measures are an important source of information about overall quality because they measure enrollees' perspectives on the services provided by their health plan.

How we analyzed the survey results

Each year, CMS requires MA plans (and MMPs when they were in operation) to administer a version of the survey to a sample of enrollees. The agency selects the sample and requires plans to hire an approved outside vendor to conduct the surveys. The surveys are usually conducted in the spring of each year and ask enrollees about their experience during the previous six months. For this report, we analyzed results from the surveys conducted in 2024, the most recent available. The responses to the survey thus refer to care that enrollees received in late 2023 and early 2024. Across all MA plans, about 33 percent of the enrollees who were selected for the 2024 survey responded (Centers for Medicare & Medicaid Services 2025a).

The MA version of the CAHPS survey has more than 60 questions, which makes it impractical to report the results for each question. We instead focused on scores for six composite measures, which combine the scores on groups of closely related individual measures, and on scores for five measures for which enrollees give an overall rating (from 0 to 10) of a key feature of their health care experience. For example, the composite measure for "how well doctors communicate" is based on four individual questions that ask if the enrollee's personal doctor explained things in a way that was easy to understand, listened carefully to the enrollee, showed respect for what the enrollee had to say, and spent enough time with the enrollee. We also present scores for one individual measure—the share of enrollees who received a flu shot—that is part of both the MA and MMP quality incentives. Our focus on a limited number of measures is consistent with AHRQ guidance and similar to the approach CMS uses to incorporate CAHPS scores in the MA star ratings (Agency for Healthcare Research and Quality 2015, Centers for Medicare & Medicaid Services 2024).[11]

We used beneficiary and plan identifiers, as we did with the HEDIS data, to determine which CAHPS respondents were dually eligible beneficiaries and to assign them to the five comparison groups specified in the BBA mandate. We divided the D–SNP enrollees based on the integration criteria that each plan met in 2024. We also adjusted survey responses to account for differences in case mix, using the same factors that CMS applies when it adjusts CAHPS responses to calculate the MA star ratings. Finally, we converted the scores on each measure to a scale of 0 to 100 (from low to high) for ease of interpretation.

There was little variation in CAHPS scores across the five comparison groups

The CAHPS scores for each comparison group are shown in Table 15-6 (p. 598). Instances in which the difference between the score for a given plan type and the average score for all plan types were statistically significant using a *t*-test are marked with a plus sign (+) when the

TABLE 15–6

CAHPS scores from 2024 surveys, by plan type

	Overall average for all plan types	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs		MMPs	Other MA plans
			Unaligned	Aligned		
Composite measures						
Getting care quickly	82	83 (+)	83 (+)	79 (–)	82	82
Getting needed care	78	80 (+)	79 (+)	76 (–)	78	78
How well doctors communicate	90	91 (+)	90	89	89	89
Customer service	83	84 (+)	84	83	83	83
Care coordination	85	86 (+)	85	83	85	85
Getting needed prescription drugs	89	89 (+)	89	87	88	89
Enrollee ratings						
All health care	84	85	85 (+)	84	84 (–)	84
Personal doctor	90	91 (+)	91 (+)	90	90 (–)	90
Specialist	89	89	89	89	88	90 (+)
Health plan	89	90 (+)	90 (+)	89	87 (–)	87 (–)
Drug plan	90	92 (+)	91 (+)	91	90	89 (–)
Individual measure						
Received annual flu shot	65	62 (–)	64	71 (+)	64	66

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems), 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), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage). All scores have been converted to a 0-to-100 scale (from low to high) for ease of interpretation and, except for the flu-shot measure, have been case-mix adjusted for response bias. Figures do not include plans in the U.S. territories.
(+) Score is better than overall average and difference is statistically significant ($p < 0.05$).
(–) Score is worse than overall average and difference is statistically significant ($p < 0.05$).

Source: MedPAC analysis of CAHPS person-level data and D–SNP integration data for 2024.

plan type performed better and a minus sign (–) when the plan type performed worse.[12] We found that two plan types—coordination-only D–SNPs and HIDE–/FIDE–SNPs that do not have aligned enrollment—had higher scores on many measures. In particular, the coordination-only D–SNPs had higher scores on all of the composite measures and three of the five enrollee ratings. In contrast, the other three plan types had lower scores on two or more measures, with MMPs having lower scores on three of the five enrollee ratings.

However, the differences between the scores for the various plan types were often small in absolute terms—only a few percentage points for most measures—and may not be very meaningful for beneficiaries.

As discussed above, CMS has used a difference of 3 percentage points, as it has with HEDIS scores, as a threshold for "practical significance" in some analyses (Centers for Medicare & Medicaid Services 2023b). Using this threshold, there were only six measures with meaningful differences between the highest-scoring and lowest-scoring plans (getting care quickly, getting needed care, care coordination, health plan rating, drug plan rating, and the flu-shot measure), with the coordination-only D–SNPs performing better on four of those measures, and only one measure with a meaningful difference between the highest-scoring plan and every other plan type (the flu-shot measure, where HIDE–/FIDE–SNPs with aligned enrollment performed better).

Other analyses have also found that CAHPS scores for many measures vary relatively little. For example, the Commission identified the lack of variation as one weakness of the MA star-rating system and noted that the minimal differences in scores may not provide a reasonable basis for deciding which plans should receive a quality bonus (Medicare Payment Advisory Commission 2019b). Similarly, a study that used CAHPS data from 2015 to 2019 found relatively small differences in the scores for dually eligible beneficiaries enrolled in D–SNPs versus other MA plans (Haviland et al. 2021). Another study that used CAHPS data from 2015 to 2018 to compare the experience of dually eligible beneficiaries in FIDE–SNPs, other D–SNPs, and other MA plans found relatively small differences in the scores for those plan groupings (Meyers et al. 2023).

The growing use of chronic-condition special-needs plans as D–SNP "look-alike" plans

The MA program allows insurers to offer three types of special-needs plans: D–SNPs, which enroll beneficiaries who have both Medicare and Medicaid; institutional special-needs plans (I–SNPs), which enroll beneficiaries who need the level of care provided in a nursing home; and chronic-condition special-needs plans (C–SNPs), which enroll beneficiaries with certain chronic conditions, such as diabetes, chronic lung disease, or chronic kidney disease.

Enrollment in all three types of SNPs has grown in recent years, but the increase for C–SNPs has been particularly rapid. Between 2021 and 2025, total enrollment more than tripled, rising from about 394,000 to 1.3 million beneficiaries. (For comparison, total enrollment in D–SNPs increased from 3.6 million to 6.2 million during the same period.) In this section, we discuss how some of this growth—about 10 percent—appears to be due to the growing use of C–SNPs as look-alike plans, which are MA plans that are not D–SNPs but still target dually eligible beneficiaries. Other factors, such as increased interest among MA insurers in using C–SNPs rather than conventional plans as a vehicle to offer extra benefits that are tailored to beneficiaries with specific diseases or conditions, may play a larger role in explaining the overall growth in C–SNPs.

The rationale for offering look-alike plans is that MA insurers find it profitable to enroll dually eligible beneficiaries. The growth in the D–SNP market provides a clear indicator of their attractiveness to insurers: Between 2020 and 2025, the number of plans increased from 539 to 903, and enrollment more than doubled, rising from 3.0 million to 6.2 million beneficiaries. This year, the number of D–SNPs will reach a new high—a total of 1,019 plans are being offered—and 98 percent of beneficiaries have access to at least one D–SNP.

While insurers might prefer to target dually eligible beneficiaries using D–SNPs, states' efforts to develop integrated care programs can limit the ability of some insurers to offer these plans. As noted earlier, all D–SNPs must have a state Medicaid contract, but states are not obligated to sign contracts with every insurer that wants to offer a D–SNP. States can thus control access to their D–SNP markets by contracting selectively with insurers. Several states have used this flexibility to promote integrated care by limiting the ability to offer D–SNPs to insurers that also offer Medicaid managed care plans that serve the dually eligible population. This approach promotes greater integration by developing a group of insurers that have the capacity to provide both Medicare and Medicaid benefits.

However, these restrictions give insurers that do not have access to the D–SNP market an incentive to find other ways to enroll this population. One strategy has been to use other types of MA plans (traditionally conventional plans but increasingly C–SNPs) as look-alike plans, which have some of the same features as D–SNPs. Based on the annual focus groups that the Commission conducts with dually eligible beneficiaries, D–SNPs are appealing largely due to their coverage of extra benefits rather than their ability to offer a product that integrates Medicare and Medicaid coverage. These extra benefits are financed using the rebates that plans receive under the MA payment system—Medicaid funding plays no role—so insurers can develop look-alike plans with coverage similar to that offered by D–SNPs. And since look-alike plans do not have to meet the extra requirements that apply to D–SNPs (such as the statutory requirement that all D–SNPs must have a state Medicaid contract), insurers

TABLE 15–7 **Impact of restrictions on use of conventional MA plans as look-alike plans, 2023–2026**

	2023	2024	2025	2026
Look-alike threshold	80%	80%	70%	60%
Number of affected plans (closed at end of prior year because they exceeded the threshold)	47	12	23	21
Enrollment in affected plans (thousands)	206	20	51	52
Postclosure coverage for enrollees in affected plans				
Other MA plans/MMPs	98%	97%	N/A	N/A
Fee-for-service	2	3	N/A	N/A

Note: MA (Medicare Advantage), MMP (Medicare–Medicaid Plan), N/A (not available). Figures for enrollment in affected plans are for January of the prior year, when CMS determines whether plans are complying with the look-alike threshold. Figures for shares of enrollees who were subsequently enrolled in MA or fee-for-service are based on January enrollment (i.e., the month after the look-alike plan closed).

Source: CMS data on look-alike plans and MedPAC analysis of Medicare enrollment data.

can use look-alike plans to circumvent any restrictions that states might apply to their D–SNP markets as part of their efforts to develop integrated care programs.

The prevalence of look-alike plans began to increase in the mid-2010s; much of the initial growth occurred in California as a response to the state's MMP demonstration but then spread to other states.[13] The Commission examined the growth of look-alike plans and expressed concern that they could undermine states' efforts to enroll more dually eligible beneficiaries in integrated care (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018).

CMS has since issued regulations aimed at limiting the ability of MA insurers to use conventional plans as look-alike plans. Starting in 2023, insurers were not allowed to operate a conventional plan if dually eligible beneficiaries accounted for more than 80 percent of the plan's total enrollment. The look-alike threshold has since been lowered, to 70 percent in 2025 and 60 percent starting in 2026. CMS enforces this requirement by calculating, for each plan, the share of enrollees who are dually eligible in January of each year; plans that exceed the look-alike threshold are required to close at the end of the year. When a look-alike plan is closed, the insurer can transfer its enrollees to another MA plan that meets certain requirements (such as having Part D drug coverage and a $0 premium for enrollees who receive the Part D low-income subsidy). Depending on the other plans an insurer offers, a closure may result in enrollees being transferred to another conventional plan, a D–SNP, a C–SNP, or (if the insurer does not have any plans that meet the requirements) to FFS Medicare.

Since 2023, these restrictions have cumulatively resulted in the closure of 103 look-alike plans (second row, Table 15-7). The largest number of closures—47 plans with a total of 206,000 enrollees—occurred in 2023, when the restrictions first took effect. Following these closures, nearly all of the beneficiaries in the affected plans have switched to other health plans (either because they were automatically transferred to another plan offered by the same insurer or because they affirmatively chose a new plan).

In response to these restrictions, insurers have begun using C–SNPs as a vehicle for offering look-alike plans. Table 15-8 shows the number of conventional plans and C–SNPs offered between 2019 and 2024, stratified by the share of enrollees who were dually eligible. The share of enrollees who were dually eligible was

TABLE 15–8

Conventional MA plans and C–SNPs, stratified by the share of enrollees who were dually eligible, 2019–2024

	2019	2020	2021	2022	2023	2024
Conventional MA plans						
0%–20%	2,237	2,571	2,868	3,148	3,414	3,485
21%–40%	287	311	392	377	373	317
41%–60%	43	52	82	103	111	103
61%–80%	27	46	56	68	73	45
81%–100%	63	66	74	60	17	11
Total	2,657	3,046	3,472	3,756	3,988	3,961
C–SNPs						
0%–20%	94	119	143	169	200	202
21%–40%	18	26	35	55	52	44
41%–60%	3	4	7	9	11	15
61%–80%	4	6	6	8	9	12
81%–100%	8	8	11	17	26	31
Total	127	163	202	258	298	304

Note: MA (Medicare Advantage), C–SNP (chronic-condition special-needs plan). Enrollment figures are for July of each year. We calculated the share of enrollees who were dually eligible using both full-benefit and partial-benefit dually eligible beneficiaries.

Source: MedPAC analysis of Medicare enrollment and plan data.

relatively low in most plans—less than 20 percent, which is roughly in line with the overall figure for the Medicare population—but much higher for a subset of plans. As the number of conventional plans with a high share of dually eligible enrollees (60 percent or more) has decreased due to the restrictions on look-alike plans, the number of C–SNPs with a high share of dually eligible enrollees has increased, from 17 plans in 2021 to 43 plans in 2024.[14]

The fact that a large share of the enrollees in a particular C–SNP are dually eligible does not, by itself, mean that the plan is a look-alike plan. In some C–SNPs, the share of enrollees who are dually eligible is likely to be high due to the characteristics of the beneficiaries targeted by the plan. For example, in 2024, 10 of the 43 C–SNPs in which more than 60 percent of enrollees were dually eligible were plans that targeted beneficiaries who have end-stage renal disease (ESRD). About half of the ESRD population is dually eligible, so C–SNPs that target them may often be close to or above the look-alike threshold. However, given the small size of the ESRD population (about 1 percent of all beneficiaries), these C–SNPs will not attract a significant number of enrollees.

However, for C–SNPs overall, the vast majority of enrollees (about 95 percent) are in plans that target three conditions that are relatively common among Medicare beneficiaries: cardiovascular disease (CVD), chronic heart failure (CHF), and diabetes. The C–SNPs that target these conditions are typically open to beneficiaries who have any one of the three conditions. The higher prevalence of these conditions, combined with the fact that insurers can target all three conditions with the same C–SNP, makes these C–SNPs

better suited to serve as look-alike plans. In 2024, most C–SNPs that exceeded the look-alike threshold (31 of 43) targeted CVD, CHF, and diabetes.

Another indication that some C–SNPs are being used as look-alike plans is the fact that most plans with a large share of enrollees who are dually eligible are clustered in certain states. In 2024, among the 31 plans that (1) exceeded the look-alike threshold and (2) targeted beneficiaries with CVD, CHF, and diabetes, 29 plans were offered in six states (Arizona, California, Idaho, Illinois, Indiana, and New Mexico) that limit participation in their D–SNP market to insurers that also offer a Medicaid managed care plan for dually eligible beneficiaries in their state.

The C–SNPs that target dually eligible beneficiaries also appear to have distinctive benefit designs. Figure 15-2 shows the relationship in 2024 between the share of C–SNP enrollees who were dually eligible and three important plan features—the MA out-of-pocket limit on Part A and Part B cost sharing (top left panel), the deductible for Part D drug coverage (top right panel), and the monthly Part D premium (lower left panel).[15] These scatterplots are based on C–SNPs that targeted beneficiaries with CVD, CHF, or diabetes and exclude plans that had fewer than 100 enrollees; each dot is an individual C–SNP. The figure shows clear differences between C–SNPs that had a high share of dually eligible beneficiaries (above the 60 percent look-alike threshold) and other C–SNPs:

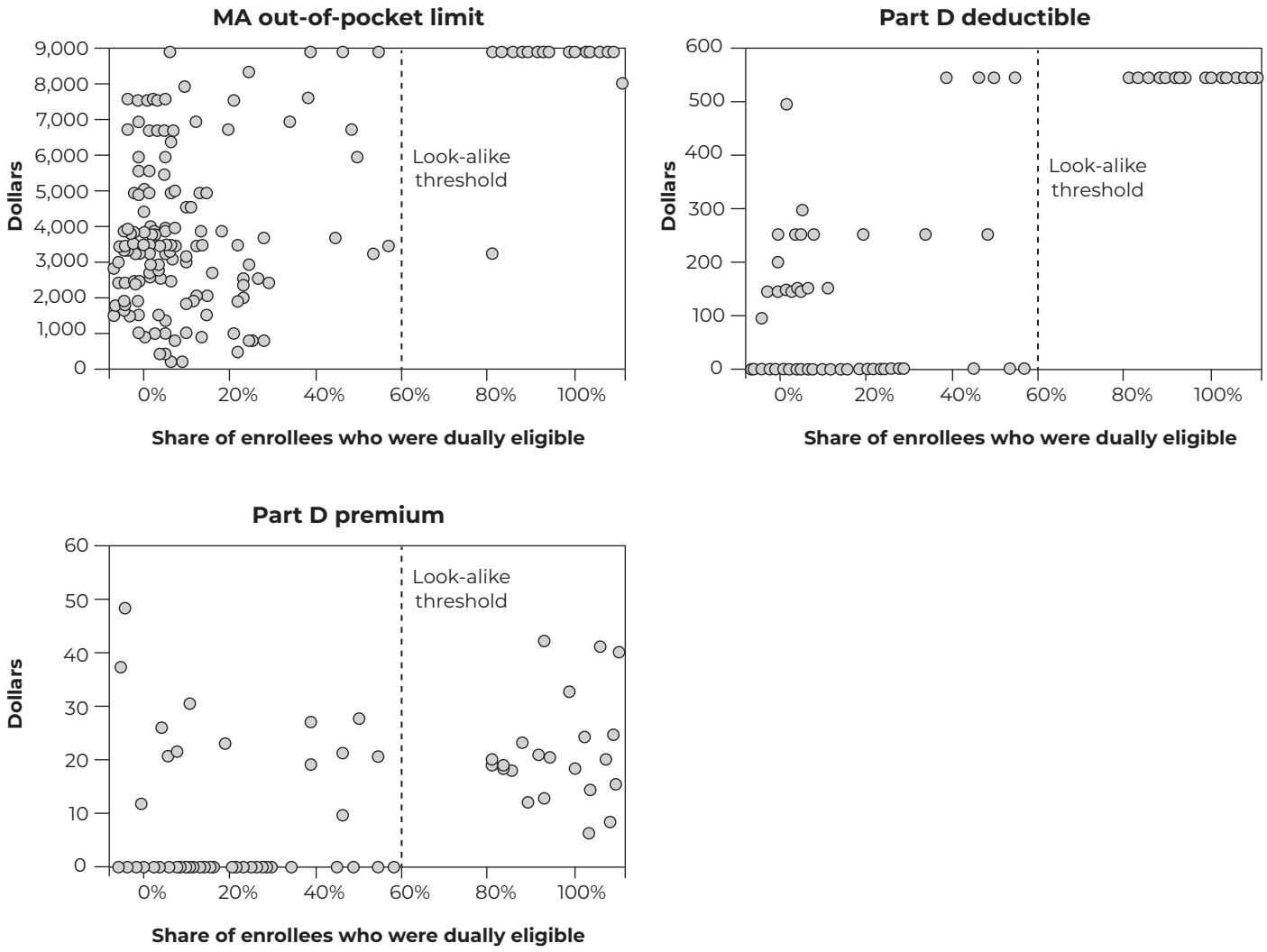
- Most C–SNPs with a high share of dually eligible beneficiaries had the highest possible out-of-pocket limit ($8,850), while other C–SNPs tended to have much lower limits, often $4,000 or less. Most dually eligible beneficiaries do not benefit from a lower limit because Medicaid covers their Part A and Part B cost sharing, so insurers that seek to attract them have an incentive to have a higher out-of-pocket limit and focus instead on offering other features such as richer coverage of non-Medicare supplemental benefits. At the same time, a higher out-of-pocket limit will be unattractive to many non–dually eligible beneficiaries, who can typically enroll in other MA plans (including conventional plans) that have lower limits.
- Every C–SNP with a high share of dually eligible beneficiaries had the highest possible Part D deductible ($545), while the other C–SNPs largely did not have a deductible. The C–SNPs that primarily serve non–dually eligible beneficiaries face competitive pressure to reduce or eliminate the deductible to attract enrollment, but the same does not hold true for C–SNPs that target the dually eligible because the Part D low-income subsidy covers the deductible for them.
- Every C–SNP with a high share of dually eligible enrollees charged a premium for Part D coverage, while most other C–SNPs had a $0 premium. Zero-premium drug coverage is one of the most popular features in MA plans, so many conventional plans and C–SNPs use a portion of their MA rebates to cover the premium that enrollees would otherwise pay. However, C–SNPs that target the dually eligible do not have the same incentive because the low-income subsidy covers premiums up to a benchmark amount. These plans simply need to ensure that their premium is less than or equal to the benchmark amount, rather than eliminate it entirely.

We can use beneficiary-level enrollment data to identify C–SNPs with high shares of dually eligible enrollees through 2024 (the most recent year available), but we cannot provide precise figures for 2025 and 2026. For those two years, we instead estimated the number of C–SNPs that may be functioning as look-alike plans by identifying plans with features similar to those highlighted in Figure 15-2. We counted C–SNPs as potential look-alike plans if they targeted beneficiaries with CVD, CHF, or diabetes and had (1) a high out-of-pocket limit for Part A and Part B cost sharing, (2) the maximum Part D deductible, (3) a nonzero Part D premium, and (4) a Part D premium that was fully covered by the low-income subsidy.

Using this approach, we estimate that the number of C–SNPs that may be functioning as look-alike plans has grown from 5 plans in 2021 to 92 plans in 2026, with a particularly large increase in 2026 (Table 15-9, p. 604). Overall enrollment in these plans has increased as well, from 70,000 in 2021 to 113,000 in 2025. The growth in enrollment is larger than those figures would suggest because the 2021 figure includes three C–SNPs that operate as regional preferred provider organization (RPPO) plans. Enrollment in RPPO-style plans has declined rapidly in recent years, largely because other MA plans tend to offer more generous extra benefits.

FIGURE 15–2

C–SNPs that largely served dually eligible beneficiaries had different features than other C–SNPs, 2024



Note: C–SNP (chronic-condition special-needs plan), MA (Medicare Advantage). Figures are based on C–SNPs that targeted beneficiaries with one or more of the following conditions: cardiovascular disease, chronic heart failure, and diabetes. Figures do not include C–SNPs in Puerto Rico. The share of enrollees who were dually eligible is based on July enrollment. The MA out-of-pocket limit applies to in-network care; the maximum limit in 2024 was $8,850. The maximum Part D deductible for 2024 was $545. *N* = 198 plans.

Source: MedPAC analysis of Medicare enrollment, plan landscape, and MA bid data.

Total enrollment in the three RPPO plans fell from 61,000 in 2021 to 16,000 in 2024, and the share of enrollees that were dually eligible declined as well, from 80 percent to 47 percent. By 2023, none of the plans exceeded the look-alike threshold of 60 percent. If these three plans were excluded from Table 15-9 (p. 604), the overall increase in enrollment between 2021 and 2025 would be larger, about 100,000 beneficiaries. CMS has also expressed concern about the recent growth in C–SNPs where a large share of enrollees are dually eligible beneficiaries (Centers for Medicare & Medicaid Services 2025c).

TABLE 15–9

The number of C–SNPs that appear to function as look-alike plans has grown substantially, 2021–2026

	2021	2022	2023	2024	2025	2026
Number of C–SNPs that may function as look-alike plans	5	17	21	31	41	92
Annual growth rate		240%	24%	48%	32%	124%
Enrollment (thousands)	70	62	51	89	113	N/A
Annual growth rate		–11%	–18%	76%	27%	N/A

Note: C–SNP (chronic-condition special-needs plan), N/A (not available). Figures are based on C–SNPs that targeted beneficiaries with one or more of the following conditions: cardiovascular disease, chronic heart failure, and diabetes. Figures do not include C–SNPs in Puerto Rico. For 2021–2024, we counted C–SNPs as potential look-alike plans if dually eligible beneficiaries represented more than 60 percent of their overall enrollment. For 2025–2026, we counted C–SNPs as potential look-alike plans if their benefit designs had four features: (1) a Medicare Advantage out-of-pocket limit that was within $1,000 of the maximum allowed amount, (2) a Part D deductible equal to the maximum allowed amount, (3) a Part D premium that was greater than $0, and (4) a Part D premium that was fully covered by the Part D low-income subsidy. Enrollment figures are for July of each year.

Source: MedPAC analysis of Medicare enrollment and plan benefit data.

Interest in using C–SNPs as a new type of look-alike plan may continue to grow due to regulatory changes that should increase the number of dually eligible beneficiaries who receive integrated care but will also, to some degree, limit the ability of MA insurers to offer and market D–SNPs. Like conventional plans, C–SNPs that target dually eligible beneficiaries undermine state efforts to develop integrated care programs.

Policymakers may thus want to consider broadening the current restrictions on look-alike plans to cover C–SNPs. As part of this change, policymakers could include limited exceptions for C–SNPs that target conditions such as ESRD, HIV/AIDS, and chronic and disabling mental health conditions, where a very high share of the affected beneficiaries are dually eligible. ■

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APPENDIX A

Scores on HEDIS clinical quality measures

TABLE 15–A1

Scores on HEDIS clinical quality measures for measurement year 2024, by plan type

Measure	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Access/availability of care					
Adults' access to preventive/ambulatory health services	96.3%	96.2%	97.3%	91.6%	95.6%
Initiation and engagement of substance use treatment					
Alcohol use disorder					
Initiation	43.7	41.0	40.4	47.2	44.3
Engagement	6.5	5.9	6.0	8.7	5.9
Opioid use disorder					
Initiation	35.4	31.8	37.3	44.6	35.6
Engagement	9.0	6.7	14.7	14.0	7.1
Other substance use disorder					
Initiation	39.9	27.9	34.2	43.6	35.1
Engagement	5.5	3.5	6.5	8.1	4.3
Effectiveness of care: Behavioral health					
Adherence to antipsychotic medications for individuals with schizophrenia	78.3	79.2	83.7	82.8	79.8
Antidepressant medication management					
Effective acute phase treatment	79.3	79.8	79.6	77.4	82.1
Effective continuation phase treatment	62.9	63.3	65.1	64.1	66.6
Follow-up after emergency department visit for mental illness					
7-day follow-up	31.4	32.7	49.4	55.5	32.3
30-day follow-up	48.5	51.1	65.5	69.6	47.9
Follow-up after emergency department visit for substance use					
7-day follow-up	23.9	28.8	31.3	34.2	24.6
30-day follow-up	38.9	43.5	47.4	50.2	39.3
Follow-up after hospitalization for mental illness					
7-day follow-up	27.1	31.5	35.0	40.9	26.0
30-day follow-up	47.7	52.1	57.6	61.7	45.4
Pharmacotherapy for opioid use disorder	34.0	31.7	32.7	35.6	30.7
Effectiveness of care: Cardiovascular conditions					
Cardiac rehabilitation					
Attended 2+ sessions within 30 days	4.1	2.7	4.3	3.7	4.2
Attended 12+ sessions within 90 days	5.3	3.7	4.2	5.3	5.5
Attended 24+ sessions within 180 days	4.9	3.6	4.2	5.6	5.1
Attended 36+ sessions within 180 days	2.1	1.7	1.8	3.1	2.3
Persistence of beta-blocker treatment after a heart attack	65.7	66.3	63.4	68.0	65.4
Statin therapy for patients with cardiovascular disease					
Received statin therapy	86.5	87.4	87.8	85.4	86.6
Statin adherence 80%	84.5	85.9	84.5	81.0	85.1

TABLE 15–A1 **Scores on HEDIS clinical quality measures for measurement year 2024, by plan type** *(cont.)*

Measure	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Effectiveness of care: Care coordination					
Follow-up after emergency department visit for people with multiple high-risk chronic conditions	57.1	61.7	63.4	59.8	56.6
Effectiveness of care: Diabetes					
Eye exam for patients with diabetes	79.4	75.9	77.6	64.3	75.7
Kidney health evaluation for patients with diabetes	59.3	66.3	57.9	46.3	62.8
Statin therapy for patients with diabetes					
Received statin therapy	80.3	81.9	82.9	76.8	80.7
Statin adherence 80%	83.5	84.4	82.9	80.5	84.0
Effectiveness of care: Musculoskeletal conditions					
Osteoporosis screening in older women	52.9	55.9	53.5	40.2	54.8
Osteoporosis management in women who had a fracture	39.4	42.2	37.0	19.6	40.8
Effectiveness of care: Overuse/appropriateness (lower scores indicate better performance)					
Nonrecommended PSA-based screening in older men	30.0	37.8	27.5	24.4	28.0
Potentially harmful drug-disease interactions in older adults					
Chronic kidney disease	13.6	14.8	13.6	11.1	9.9
Dementia	45.7	48.7	44.9	40.6	41.8
History of falls	47.6	43.8	43.0	41.3	44.5
Use of high-risk medications in older adults	23.8	23.3	24.3	19.5	20.0
Use of opioids at high dosage	5.0	7.3	7.6	4.3	5.5
Use of opioids from multiple providers					
Multiple pharmacies	1.9	1.7	2.0	2.3	1.6
Multiple prescribers	15.7	14.5	17.3	18.6	15.9
Multiple prescribers and pharmacies	1.0	0.9	1.2	1.4	0.8
Effectiveness of care: Respiratory conditions					
Pharmacotherapy management of COPD exacerbation					
Bronchodilator	87.2	87.7	89.9	88.3	85.5
Systemic corticosteroid	76.0	73.8	74.0	76.0	74.8
Measures reported using electronic clinical data systems					
Adult immunization status					
Herpes zoster	19.6	19.0	22.4	18.7	19.8
Influenza	37.4	35.2	44.2	37.4	37.4
Pneumococcal	56.1	50.0	58.6	56.2	55.4
TDAP	35.3	33.3	37.3	40.5	33.8
Breast cancer screening	71.8	73.8	72.6	60.8	71.0
Colorectal cancer screening	69.5	71.8	70.0	54.6	68.4

TABLE 15–A1 **Scores on HEDIS clinical quality measures for measurement year 2024, by plan type** *(cont.)*

Measure	Coordination-only D–SNPs	HIDE–SNPs and FIDE–SNPs		MMPs	Other MA plans
		Unaligned	Aligned		
Depression screening and follow-up					
Screening	19.5	9.4	13.1	23.8	11.7
Follow-up on positive screen	66.3	70.3	63.8	68.1	72.2
Social need screening and intervention					
Food screening	17.5	22.0	19.2	9.4	3.7
Food intervention	2.3	18.4	18.0	29.8	12.6
Housing screen	19.1	13.2	21.2	16.3	9.0
Housing intervention	1.0	6.4	19.6	28.9	8.2
Transportation screen	22.0	23.5	22.6	12.3	7.3
Transportation intervention	2.7	15.5	15.3	35.2	6.4

Note: HEDIS (Healthcare Effectiveness Data and Information Set), 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), MMP (Medicare–Medicaid Plan), MA (Medicare Advantage), PSA (prostate-specific antigen), COPD (chronic obstructive pulmonary disease), TDAP (tetanus, diphtheria, and acellular pertussis). Figures do not include plans in the U.S. territories.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2024 and D–SNP integration data for 2024.

Endnotes

1 Throughout this chapter, we use the term "dually eligible" to refer to beneficiaries who are actually enrolled in both Medicare and Medicaid. There are some Medicare beneficiaries who are eligible for Medicaid in the sense that they meet the program's eligibility requirements but have not actually enrolled, either because they are unaware of their eligibility or because they do not want to enroll.

2 ADLs include eating, using the toilet, personal hygiene, and transferring (being able to move from one setting to another, such as getting in and out of a chair). Most states require Medicaid beneficiaries to need help with two or three ADLs to qualify for nursing home care or community-based forms of long-term care.

3 CMS also requires coordination-only D–SNPs to have a unified process for handling appeals and grievances if they have exclusively aligned enrollment and provide a minimum set of Medicaid-covered services. The various types of D–SNPs that are required to have a unified process for handling appeals and grievances are collectively referred to as "applicable integrated plans."

4 The quarterly SEP was in effect from 2019 through 2024. Prior to 2019, dually eligible beneficiaries had a different SEP that allowed them to change their coverage on a monthly basis.

5 The new integrated-care SEP can only be used to enroll in FIDE–SNPs, HIDE–SNPs, or coordination-only plans that qualify as applicable integrated plans (meaning that the plan provides at least a limited set of Medicaid services and has aligned enrollment). In addition, the new SEP can only be used to align a beneficiary's enrollment between their D–SNP and their Medicaid managed care plan.

6 We examined the MMP demonstrations in depth in our June 2016 and June 2018 reports (Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2016).

7 PACE plans serve beneficiaries who are age 55 or older and need the level of care provided in a nursing home. The program aims to keep people living in the community instead of going into nursing homes, and it uses a distinctive model of care based on adult day-care centers that are staffed by interdisciplinary teams that provide therapy and medical services. PACE plans provide all Medicare- and Medicaid-covered services. The program is relatively small, covering about 63,000 Medicare beneficiaries in 2024.

8 Many such plans already exist. As of July 2025, about 10 percent of all D–SNPs (88 out of 903) were limited to partial-benefit dually eligible beneficiaries; those plans had nearly 250,000 enrollees.

9 In an earlier analysis, the Commission found that, across all MA enrollees, the specifications for one of the utilization measures (all-cause readmissions) excluded 45 percent of index hospitalizations and 71 percent of readmissions (Medicare Payment Advisory Commission 2024a).

10 One type of variation that we investigated was the share of enrollees who qualify for full or partial Medicaid benefits. In 2024, partial-benefit dually eligible beneficiaries accounted for about 50 percent of the dually eligible beneficiaries enrolled in other MA plans and about 30 percent of HIDE–SNP and coordination-only D–SNP enrollees, but only 2 percent of FIDE–SNP enrollees and less than 1 percent of MMP enrollees (see Table 15-3, p. 592). When we calculated scores for the HEDIS risk-adjusted utilization measures using data for full-benefit dually eligible beneficiaries only, the effects on our findings were relatively modest.

11 As part of the MA star ratings, CMS uses five of the six composite measures, three of the five measures in which enrollees rate their health care experience, and the flu shot measure.

12 We measured statistical significance by comparing the score for each plan type with the unweighted average of the scores for all plan types. As a sensitivity test, we also measured statistical significance using the enrollment-weighted average of the scores for all plan types. Using this approach, the number of measures where coordination-only D–SNPs and HIDE-/FIDE–SNPs without aligned enrollment performed better decreased and the number of measures where MMPs and HIDE-/FIDE–SNPs with aligned enrollment performed worse increased.

13 California's demonstration had several features that spurred insurers to offer look-alike plans. First, participation in the demonstration was limited to insurers that had Medi-Cal managed care contracts. Second, the state froze enrollment in its D–SNPs to encourage dually eligible beneficiaries to enroll in MMPs. (Insurers that offered both MMPs and D–SNPs had to transfer any D–SNP enrollees who were eligible for the demonstration to their MMP.) Third, the state did not allow any new insurers to enter the D–SNP market. Fourth, MMPs were not allowed to pay commissions, so efforts to shift enrollment from D–SNPs (which, like all MA plans, could pay commissions) to MMPs reduced incomes for agents and brokers.

14 As shown in Table 15-8, there can still be situations where conventional plans exceed the look-alike threshold. For example, in 2024, there were 11 plans in which the share of enrollees who were dually eligible was greater than 80 percent (the threshold in effect at the time). Conventional plans can still exceed the threshold in three situations. First, a plan that complied with the threshold in earlier years may later exceed the threshold if the share of enrollees who are dually eligible increases. Second, the restrictions on look-alikes include an exception for new plans, which are defined as plans that are in their first year of operation and have fewer than 200 enrollees. Third, the restrictions on look-alikes do not apply to plans offered in states that do not have any D–SNPs or MMPs (in 2024, there were five such states). Plans in the first situation must close at the end of the plan year, while plans in the second situation will be closed at the end of their second year of operation if they continue to exceed the threshold. Plans in the third situation can continue to operate as long as their state does not have any D–SNPs.

15 This approach is similar to the one we used in our June 2019 report to examine the growth in the number of conventional plans that were being used as look-alike plans (Medicare Payment Advisory Commission 2019a).

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