TOPIC: DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) LOOK-ALIKES

Background

D-SNPs are a type of MA plan designed for individuals who qualify for both Medicare and Medicaid.[1] These plans operate under a CMS-approved Model of Care, which requires the coordination and integration of services across both programs.[2] D-SNPs are also required to establish contracts with state Medicaid agencies that define responsibilities for benefit coordination and alignment.[3] CMS has implemented D-SNP integration policies with the aim of coordinating Medicare and Medicaid services, reducing cost-shifting incentives between Medicare and Medicaid, and facilitating a seamless experience for enrollees.[4]

Key Points

- D-SNPs plans are designed for individuals who are dually eligible for Medicare and Medicaid. They operate under a CMS-approved Model of Care requiring coordination and integration of services across both programs and are subject to specific regulatory requirements, including formal contracts with state Medicaid agencies.
- D-SNP look-alike plans are standard MA plans and present risks of FWA if they mislead beneficiaries about the integrated coverage offered or if MA organizations are avoiding the costs of complying with D-SNP requirements designed to protect beneficiaries and payers.
- Mitigation options include limiting dual eligible enrollment in non-D-SNP plans, increasing integration requirements for look-alike plans, limiting enrollment of dually eligible beneficiaries to D-SNPs, and limiting deceitful marketing strategies by look-alike plans.

Potential for FWA

Some standard MA plans, referred to as D-SNP look-alikes or "mirror" plans, primarily enroll dual-eligible individuals but are not officially recognized as D-SNPs.[5] Look-alike plans are not subject to the same regulatory requirements as D-SNPs, such as care coordination or formal contracts with state Medicaid agencies. Look-alike plans may present risks of FWA if plans mislead beneficiaries about the integrated coverage offered or if MA organizations are gaming the system by avoiding the costs of complying with D-SNP requirements designed to protect beneficiaries and payers from unnecessary, duplicative, or missed services that can occur in the absence of integrated care.

Chronic Condition Special Needs Plans (C-SNPs) that primarily enroll dually eligible beneficiaries are similarly exempt from some of the coordination requirements that apply to D-SNPs but also are exempt from look-alike termination policies if they enroll a high proportion of dually eligible beneficiaries.[6] Both the number of C-SNP plans and C-SNP enrollment among dually eligible beneficiaries have increased significantly in recent years.[7,8] Dually eligible beneficiaries also comprise around 90% of enrollees in Institutional Special Needs Plans (I-SNPs), but I-SNP plan offerings and enrollment patterns have remained more consistent in recent years.[9] I-SNPs are for beneficiaries needing long-term care in facilities like nursing homes for more than 90 days.[10] There is a risk that MA organizations could mislead dually eligible beneficiaries about integration of coverage offered under C-SNPs or I-SNPs or promote these plans to avoid the costs of complying with CMS and state requirements that apply only to D-SNPs.[11,12]

Mitigation Approaches

Limit dual eligible enrollment in non-D-SNP plans. CMS will not renew or enter into a contract with an MA plan if its projected total enrollment is 70% or more dually eligible beneficiaries unless the plan is a designated and approved D-SNP. (C-SNPs and I-SNPs are exempt from this requirement.) This threshold decreased to 60% in 2026.[13] To help MA organizations meet this threshold, CMS has allowed look-alike plans to transition members into a true D-SNP or MA plan with $0 cost sharing by the same sponsor. One policy option is to lower the threshold even further—for example, to 50%.[14,15] This would still exceed the proportion of beneficiaries who are dually eligible nationally (16% in 2025).[16] As an alternative, the threshold could be indexed to the proportion of beneficiaries who are dually eligible at a county level to account for geographic differences in dual eligibility. CMS could also apply the threshold to C-SNPs and I-SNPs, only count beneficiaries with full dual benefits toward the threshold, or exempt plans in states with no D-SNPs.[17,18] Lowering the dual eligible enrollment threshold makes it harder for majority-dual plans to pose as D-SNPs while not adhering to all D-SNP requirements. However, lowering the dual eligible enrollment threshold would result in plan terminations that could disrupt beneficiary access to care.

Increase integration requirements for C-SNPs and I-SNPs. Given the high enrollment of dual eligible beneficiaries in C-SNPs and I-SNPs, policies to increase integration requirements for these plans could be less disruptive than prohibiting them from having high dual enrollment. For example, CMS could require C-SNPs and I-SNPs with 60% or more dually eligible enrollees to contract with state Medicaid agencies to ensure benefit integration, or CMS could introduce care coordination requirements for C-SNPs and I-SNPs consistent with requirements for D-SNPs.[19] These approaches could reduce waste and abuse by minimizing duplicative services and the potential for cost shifting.

Automatically enroll dually eligible beneficiaries in D-SNPs. Another option is for states to automatically enroll beneficiaries who are dually eligible in a D-SNP.[20] As demonstrated in the Financial Alignment Initiative, this could increase enrollment and retention in integrated plans.[21] However, automatic enrollment or locking enrollees in to a D-SNP restricts beneficiary choice and can disrupt continuity of care and create unmet need.[22] Automatic enrollment also may not be appropriate given mixed evidence regarding whether D-SNPs produce better outcomes for enrollees.[23] In addition, this policy option may only be viable in counties where there are multiple D-SNPs,[24] and it would be difficult to determine which plan to assign if there are multiple options in a county.

A variant of this option is to nudge dually eligible beneficiaries toward D-SNPs via Medicare Plan Finder and other sources of information. For example, if visitors to Medicare Plan Finder indicate that they are eligible for Medicaid, the filters are set automatically to show only D-SNPs if any are available in that area. To make it more difficult to mislead beneficiaries, CMS could require similar choice architecture in other information sources such as agents, brokers, and industry versions of Medicare Plan Finder. Just as beneficiaries can adjust the filters on Medicare Plan Finder if they wish to consider other options, they could also ask agents and brokers for additional options if this option were implemented. As noted earlier, D-SNPs may not be the best choice for all beneficiaries given that it is unclear whether D-SNPs provide better outcomes or reduce spending relative to other MA plans or TM.

Limit deceitful marketing strategies by look-alike plans. A 2022 study of MA marketing practices found that dually eligible beneficiaries, who are allowed to switch plans more often than other MA beneficiaries, were being targeted disproportionately with aggressive marketing tactics.[25] In the years following the publication of this report, CMS prohibited look-alike plans from claiming their plans are for dually eligible individuals in their marketing efforts.[26,27]In addition, starting in contract year 2024, CMS restricted the marketing of plans that mislead using the Medicare name, the CMS logo, or information issued by the federal government.[28] The intent of these marketing limitations is to increase transparency and reduce confusion for dually eligible beneficiaries.[29] Limiting deceitful marketing strategies by look-alike plans makes it harder for majority-dual plans to pose as D-SNPs. It is not yet clear if these policy changes have been effective. Another policy option is to implement other recommendations from the Senate Finance Committee's report such as the use of regular proactive oversight of MA marketing materials to ensure compliance with CMS rules.[30]

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[2] The degree of coordination and integration varies depending on the type of D-SNP. The minimum requirements for D-SNPs are written in the Medicare Improvements for Patients and Providers Act of 2008. Highly integrated D-SNPs (HIDE SNPs) have a higher level of integration than a typical D-SNP. HIDE SNPs have contracts with Medicaid agencies and include coverage of long-term services and supports benefits for behavioral health. Fully integrated D-SNPs (FIDE SNPs) provide the highest level of integration with all Medicare and Medicaid benefits managed by a single organization.

[3] Requirements for dual eligible special needs plans, 42 C.F.R. § 422.107 (2026). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.107

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