Elevance Health | Public Policy Institute

Improving Integration in Dual Eligible Special Needs Plans

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Contents

Key Takeaways

- Dual eligible beneficiaries experience more health challenges and health-related social needs than Medicare-only beneficiaries, yet they often experience fragmentation of care.
- Integration of benefits and care through Dual Eligible Special Needs Plans can reduce fragmentation, improve member experience and care continuity, and boost quality and outcomes.
- As states adopt integrated models, they should consider opportunities to implement aligned enrollment, ensure stability of plan options for beneficiaries, encourage beneficiary enrollment in integrated options, and incorporate non-medical benefits.

Overview

Individuals who qualify for both Medicare and Medicaid are referred to as dual eligible beneficiaries. As a result of having to navigate two different benefit programs, they often experience fragmentation of care, worse outcomes, and uncertainty around covered benefits and providers.[1]

Over the last two decades, in partnership with health plans and other stakeholders, federal and state policymakers have undertaken numerous initiatives and policy reforms to improve the coordination and integration of dual eligible beneficiaries' healthcare and experience. Increasingly, these efforts have focused on integrated managed care models—in particular, Dual Eligible Special Needs Plans (D-SNPs), a type of Medicare Advantage (MA) plan which more seamlessly integrates Medicare and Medicaid benefits, financing, and care management. This greater alignment across benefits can improve beneficiary experience and outcomes, simplify care coordination and beneficiary communications, support more consistent patient-provider relationships, and reduce duplicative administrative processes.

This paper illustrates how D-SNPs improve the experience and health outcomes for members who are dually eligible and highlights opportunities for states to adopt managed care models that integrate care beyond minimum regulatory requirements.

Dual Eligible Beneficiaries

To qualify as dually eligible, individuals must meet eligibility requirements for both Medicare and Medicaid.

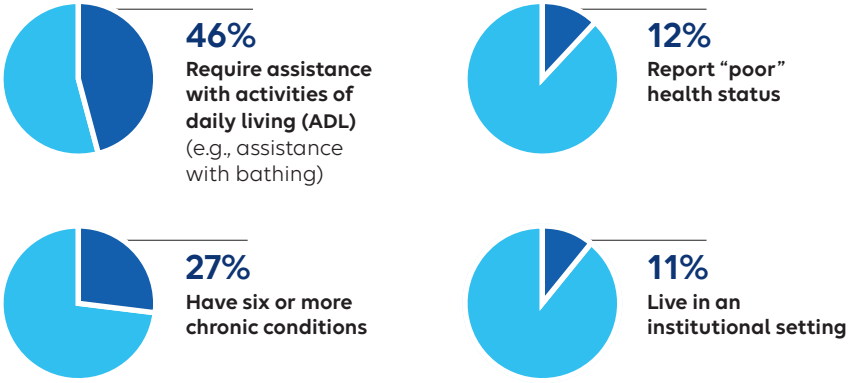
Full-benefit dual eligible beneficiaries receive the full range of Medicaid services available in their state in addition to Medicare coverage and usually also receive assistance with Medicare premiums and cost sharing through the Medicare Savings Programs (MSPs). Partial-benefit dual eligible beneficiaries are also enrolled in Medicare and receive assistance with Medicare premiums and/or cost sharing through the MSPs, but they do not receive other Medicaid services.[2]

Medicare serves as the primary payer for most medical care, including hospital services, post-acute care, physician visits, medical equipment, and prescription drugs. Medicaid finances non-Medicare services such as long-term services and supports (LTSS), including home- and community-based services (HCBS); certain types of behavioral healthcare; and other wraparound benefits, such as non-emergency medical transportation.[3,4]

In 2025, approximately 11.9 million Medicare beneficiaries were dually eligible, including 8.5 million full-benefit duals and 3.4 million partial-benefit duals.[5] More than one-third are younger than age 65. Compared with Medicare-only beneficiaries, dual eligible individuals are more likely to be Black or Hispanic, have low incomes, be unmarried, and not have a high school diploma. They also experience higher rates of food insecurity, limited English proficiency, and housing instability.[6]

Figure 1

Percent of Dual Eligible Beneficiaries Experiencing Health Challenges



Note. Each percentage reflects the proportion of the total dual eligible population with the indicated characteristic. Categories are not mutually exclusive.
Sources. Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. (2025, December). Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid; and Centers for Medicare & Medicaid Services. (2023, March). People Dually Eligible for Medicare and Medicaid.

Dual eligible individuals also have significantly greater health challenges compared to their non-dual eligible Medicare counterparts.[7–9] About a quarter of dual eligible beneficiaries have six or more chronic conditions compared to 15 percent of non-dual beneficiaries, 46 percent vs. 17 percent report having limitations with activities of daily living (e.g., assistance with bathing), 12 percent vs. 3 percent report having poor health status, and 11 percent vs. 2 percent live in an institutional setting (Figure 1).

Because dual eligible beneficiaries must navigate two often uncoordinated programs, they frequently experience fragmented care, barriers to access, and worse health outcomes, contributing to disproportionately higher spending across Medicare and Medicaid.[10] Although dual eligible beneficiaries account for only 16 percent of Medicare fee-for-service (FFS) enrollment and 14 percent of Medicaid enrollment, they comprise 31 percent of Medicare FFS spending and 29 percent of Medicaid spending.[11] Much of this spending reflects the complex medical and long-term care needs of this population, including the use of Medicaid LTSS. Over one-third of individuals who are dually eligible use some type of LTSS, and 27 percent receive HCBS, which is generally a more cost-effective alternative to comparable institutional care.[12]

Options for Integration

There are numerous Medicare and Medicaid coverage arrangements for dual eligible beneficiaries.[13] They have the option to select Medicare FFS (also known as Traditional Medicare) or a Medicare Advantage managed care plan, and depending on the state, they may be enrolled in or permitted to choose between Medicaid FFS or a Medicaid managed care organization (MCO).

Historically, Medicare and Medicaid benefits were administered separately with limited tools for coordination across programs.[14] However, efforts to better coordinate care for dual eligible beneficiaries have evolved significantly over the past two decades. The Medicare Modernization Act (MMA) of 2003 established Special Needs Plans (SNPs) to allow plans to focus care improvement and coordination efforts on certain groups of beneficiaries. One type, D-SNPs, offer an MA option tailored to individuals eligible for both Medicare and Medicaid.[15] Subsequent legislation and regulation strengthened integration requirements such as by requiring D-SNPs to contract with state Medicaid agencies, creating a formal mechanism for states to influence care coordination, benefit alignment, and Medicaid service delivery.[16, 17]

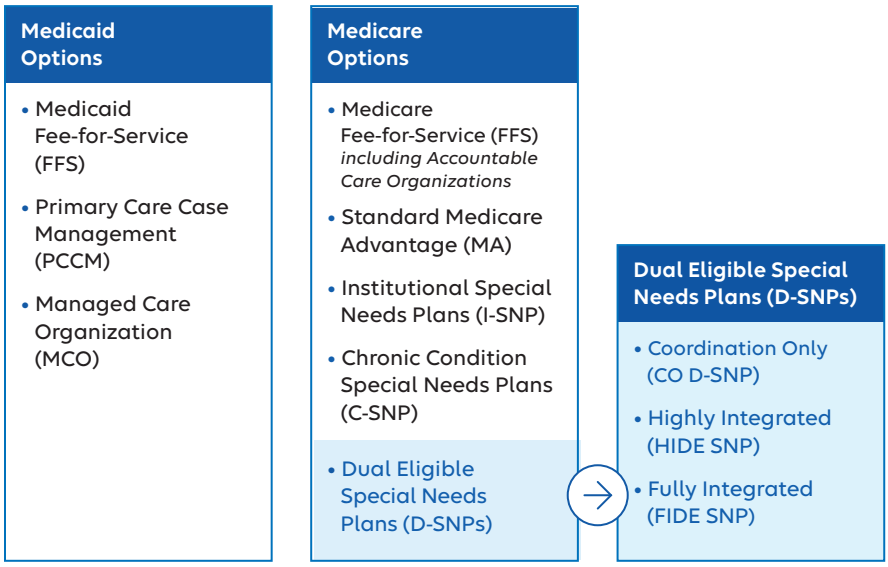
The Affordable Care Act (ACA) of 2010 advanced these efforts by codifying a more integrated version of D-SNPs, known as Fully Integrated D-SNPs (FIDE SNPs) (Figure 2). These plans deliver Medicare and Medicaid benefits, including LTSS and behavioral healthcare, while streamlining administrative functions through unified contracts and integrated appeals and grievance procedures.

The ACA also established an office within the Centers for Medicare & Medicaid Services (CMS) focused specifically on dual eligible beneficiaries.[18] Through the Medicare-Medicaid Coordination Office, CMS launched the Financial Alignment Demonstration, which created Medicare-Medicaid Plans (MMPs) and managed fee-for-service demonstrations intended to align financing, care delivery, and beneficiary experience across Medicare and Medicaid; the demo concluded in 2025, after which the seven remaining MMP states developed transition strategies to move enrollees into integrated D-SNPs.[19,20]

At the same time, CMS further distinguished among D-SNP plan types and integration standards. CMS regulation created Highly Integrated D-SNPs (HIDE SNPs) as a pathway for plans to integrate Medicaid LTSS or behavioral health services alongside Medicare benefits, while FIDE SNPs must include both benefit types (Figure 2). Federal rules limit FIDE SNP enrollment to full-benefit dual eligible beneficiaries, excluding partial-benefit duals because these individuals do not receive the full scope of Medicaid services necessary for full financial integration.[21]

Figure 2

Medicaid and Medicare Coverage Options for Dual Eligible Beneficiaries



Recent federal regulations have placed greater emphasis on aligning beneficiary enrollment across Medicare and Medicaid coverage, reflecting CMS's broader goal of reducing fragmentation. This is referred to as exclusively aligned enrollment (EAE), meaning beneficiaries are enrolled in MA plans and Medicaid MCOs offered by the same parent organization. CMS is limiting enrollment in certain D-SNPs to those individuals who are also enrolled in an affiliated Medicaid MCO beginning in 2027, with the goal of achieving full EAE in these D-SNPs by 2030.[22,23] Leading up to this transition, exclusively aligned enrollment has been optional for coordination only (CO) D-SNPs and HIDE SNPs, whereas FIDE SNPs have always been required to maintain exclusively aligned enrollment as a defining feature of the model.

Dual eligible individuals have also benefited from changes to the Medicare Advantage program that weren't specifically aimed at improving integrated care. For instance, changes to allowable supplemental benefit offerings, including the Special Supplemental Benefits for the Chronically Ill (SSBCI) and the Value-Based Insurance Design (VBID) model (which concluded in 2025), gave MA plans greater flexibility to offer benefits addressing health-related social needs and tailor benefits for chronically ill populations, including dual eligible members.[24]

In addition, the Program of All-Inclusive Care for the Elderly (PACE) has long served as a highly integrated care model for certain dual eligible individuals (as well as non-dual eligible individuals) with long-term care needs. To qualify, individuals must be 55 years of age or older, need a nursing home level of care but be able to live safely in the community, and reside in a PACE organization service area.[25] PACE organizations receive capitated Medicare and Medicaid payments to provide comprehensive medical care, behavioral healthcare, and LTSS through an interdisciplinary care model focused on helping individuals remain in the community rather than enter institutional care settings.[26]

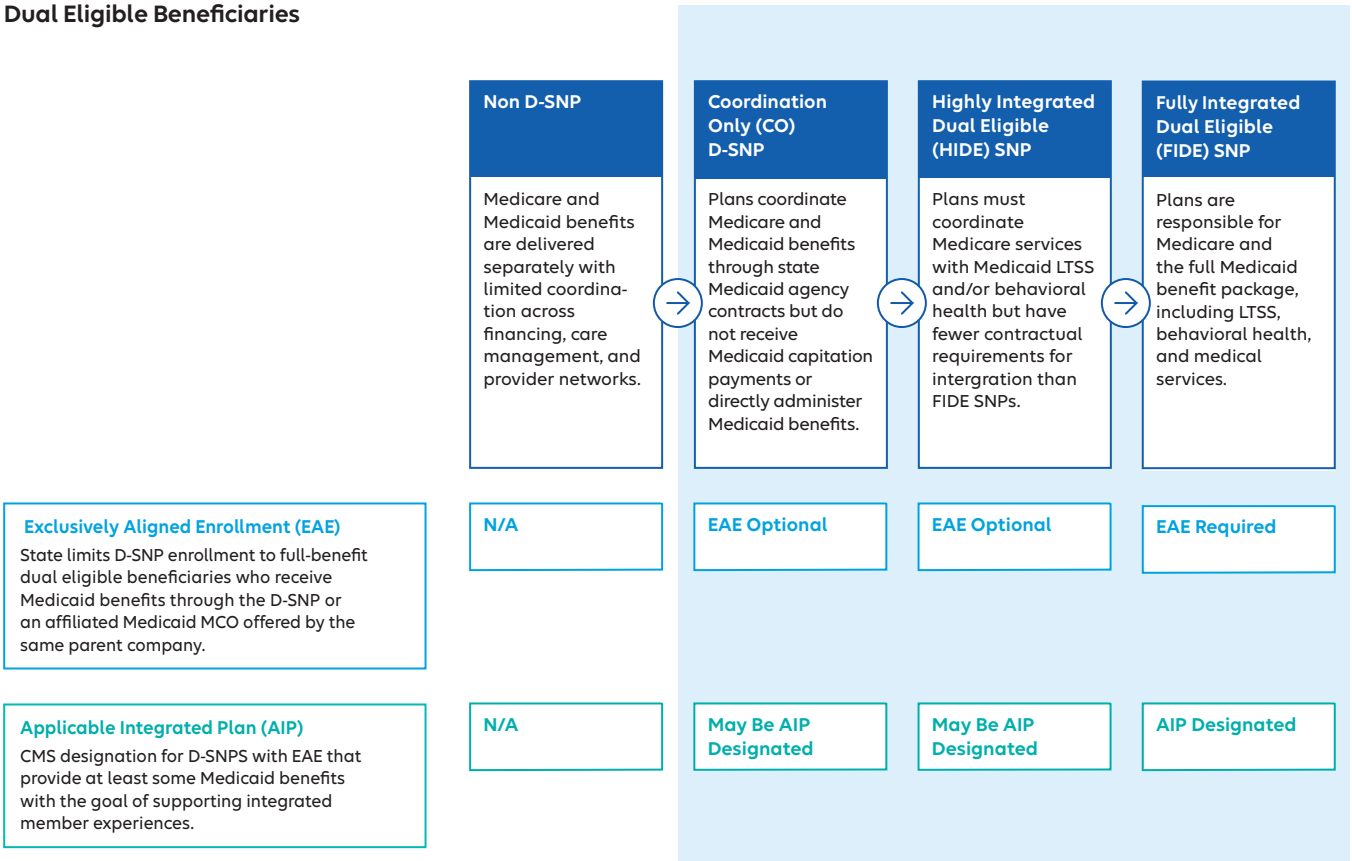
Pathways for States

As noted above, over time, CMS and states have pursued a variety of approaches to deepen integrated care through D-SNP models.

Importantly, this offers states multiple starting points rather than requiring a single model of integration. For example, a state may choose to start by aligning Medicare and Medicaid enrollment through EAE arrangements, and then later incorporate Medicaid LTSS and/or behavioral health services through HIDE SNPs. A state starting with HIDE SNPs may later choose to fully integrate finances, benefits, and services through FIDE SNPs. This graduated approach allows states to advance integration in a manner that reflects and complements their existing delivery systems while continuing to improve coordinated care delivery for dual eligible beneficiaries (Figure 3).

Figure 3

Continuum of Medicare-Medicaid Integration for Dual Eligible Beneficiaries



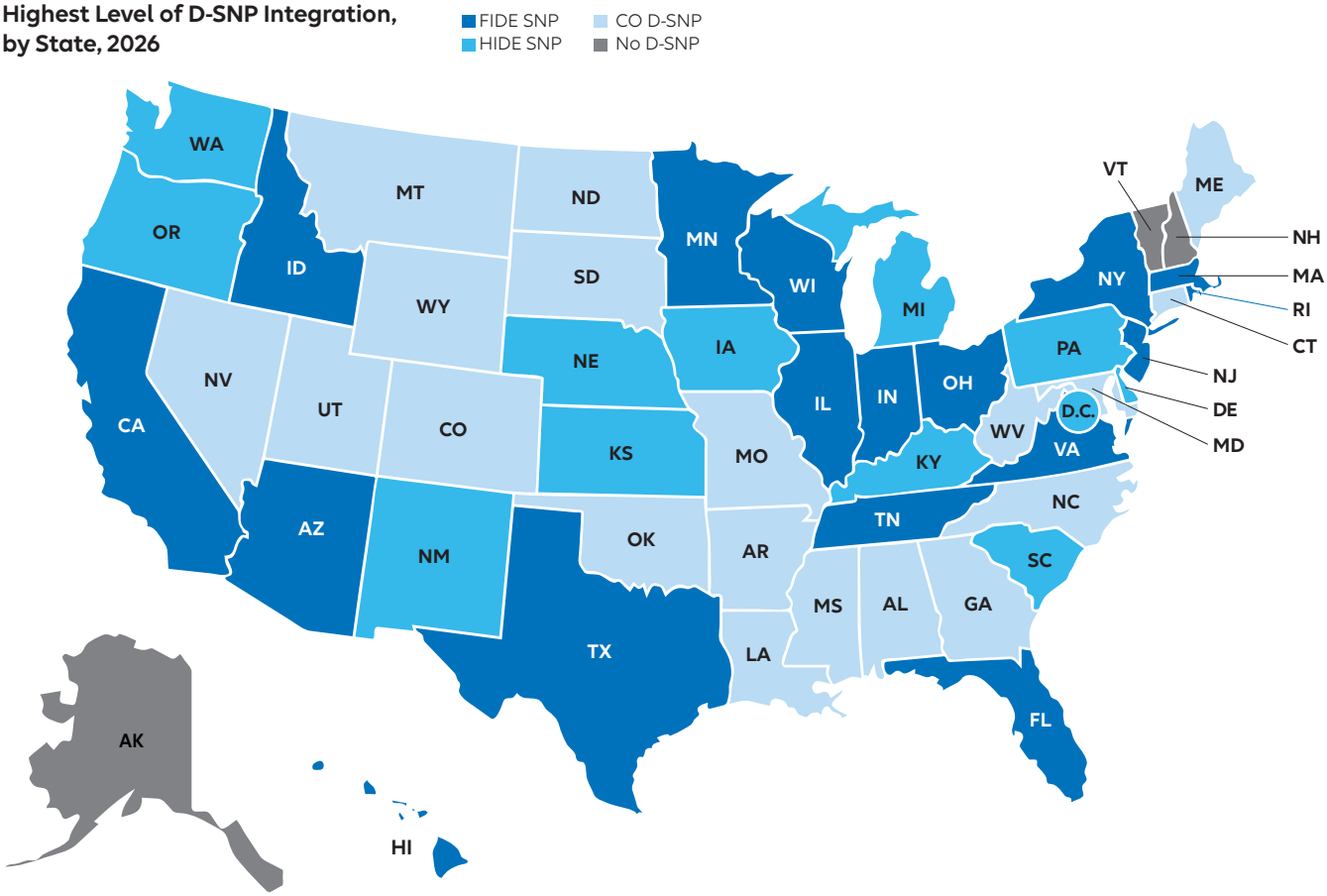
Note. D-SNP = Dual Eligible Special Needs Plan. SNP = Special Needs Plan. LTSS = Long-Term Services and Supports. MCO = Managed Care Organization.

Together, these policy changes appear to signal a shift away from demonstration models and toward permanent integration pathways embedded within MA and Medicaid managed care. States increasingly play a central role in shaping integration through D-SNP contracting requirements, Medicaid managed care alignment strategies, and enrollment policies.[27]

As integrated plan offerings grow nationwide (Figure 4), enrollment in the most highly integrated products remains relatively limited. As of 2026, 46 percent of dual eligible beneficiaries are enrolled in D-SNPs—with 15 percent in HIDE SNPs and 3 percent in FIDE SNPs.[28] However, recent years have seen substantial growth in D-SNP enrollment, with the strongest gains occurring in the most integrated models, reflecting the market's continued shift toward greater Medicare-Medicaid integration (Figure 5).

Figure 4

Highest Level of D-SNP Integration, by State, 2026

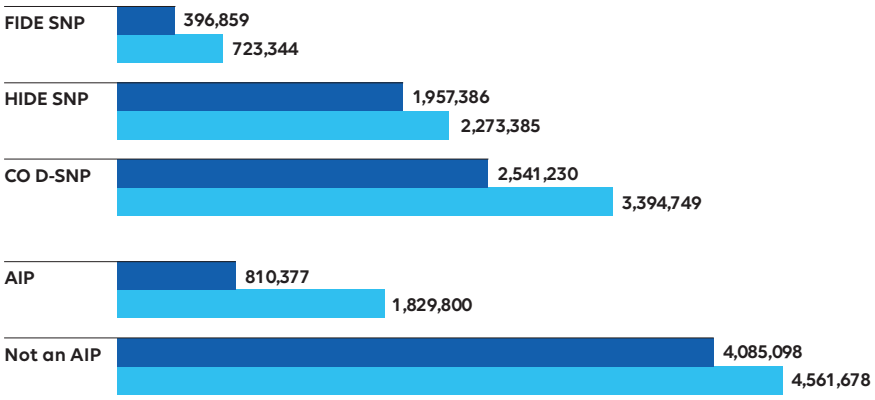


Note. D-SNP = Dual Eligible Special Needs Plan. FIDE SNP = Fully Integrated Dual Eligible Special Needs Plan. HIDE SNP = Highly Integrated Dual Eligible Special Needs Plan. CO D-SNP = Coordination-Only Dual Eligible Special Needs Plan.

Source. Centers for Medicare & Medicaid Services. (2026). CY 2026 Integrated D-SNPs List.

Figure 5

Enrollment by D-SNP Integration Type, 2023 and 2026



Note. D-SNP = Dual Eligible Special Needs Plan. FIDE SNP = Fully Integrated Dual Eligible Special Needs Plan. HIDE SNP = Highly Integrated Dual Eligible Special Needs Plan. CO D-SNP = Coordination-Only Dual Eligible Special Needs Plan. AIP = Applicable Integrated Plan.

Source. Centers for Medicare & Medicaid Services (CMS). Integration Status for Contract Year 2023 D-SNPs & Integration Status for Contract Year 2026 D-SNPs; Monthly Enrollment by Plan (January 2023 and January 2026). Author's analysis of CMS public use files.

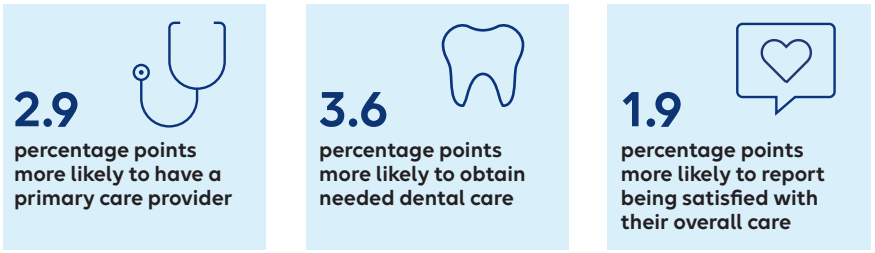
Value of Integration

For states weighing the return on investing in integrated plans, a growing body of research suggests that D-SNPs and other integrated care models can improve care coordination, strengthen beneficiary experience, and support higher-quality care for dual eligible individuals.

Compared with beneficiaries enrolled in Medicare FFS, dual eligible individuals enrolled in D-SNPs experience greater access to care, use of preventive services, and satisfaction with care (Figure 6).[29] Furthermore, D-SNPs and other MA plans outperform Medicare FFS on several quality measures for dual eligible beneficiaries, including certain cancer screenings, diabetes care, osteoporosis management, and rheumatoid arthritis treatment adherence.[30]

Figure 6

Access to and Satisfaction with Care Among D-SNP Enrollees vs. Dual Eligible Beneficiaries in Traditional Medicine



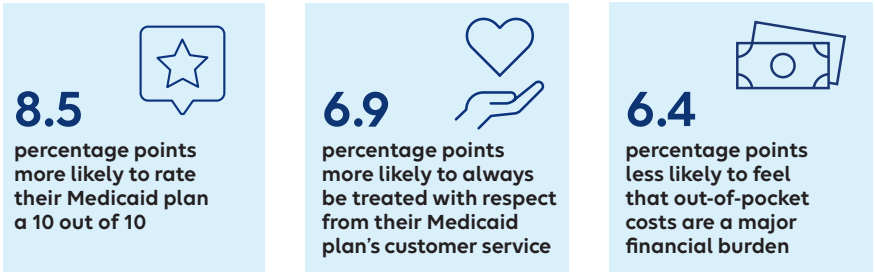
Note. Adjusted differences were statistically significant at $p < 0.10$. D-SNP = Dual Eligible Special Needs Plan.

Source. Roberts, E.T., & Mellor, J.M. (2022, September 6). Differences In Care Between Special Needs Plans and Other Medicare Coverage for Dual Eligibles. *Health Affairs 41*(9).

Research also indicates that higher levels of integration and enrollment alignment may further strengthen beneficiary experience and continuity of care. Beneficiaries using HCBS enrolled in D-SNPs with EAE have reported more positive experiences on selected plan measures including being more likely to rate their Medicaid plan a perfect 10 and receive respectful treatment by their Medicaid health plan representatives (Figure 7).[31] More integrated products may also promote greater stability in coverage and care relationships. For example, FIDE SNPs have demonstrated higher member retention rates than less integrated models, which may reflect stronger beneficiary satisfaction and engagement over time.[32]

Figure 7

Healthcare Experience of Dual Eligible Users of HCBS in D-SNPs with EAE vs. in Traditional Medicare



Note. Adjusted differences were statistically significant at $p < 0.05$. HCBS = Home and Community-Based Services. D-SNPs = Dual Eligible Special Needs Plan. EAE = Exclusively Aligned Enrollment.

Source. Mellor, J.M., et al. (2024, June 7). Beneficiary Experience of Care by Level of Integration in Dual Eligible Special Needs Plans. *JAMA Health Forum 5*(6).

Supplemental benefits, including SSBCI and those previously offered through the VBID model, have become an increasingly important feature of integrated MA products serving dual eligible beneficiaries. By 2024, the vast majority of D-SNPs participated in the VBID demonstration, using supplemental benefits to support individuals with chronic conditions and/or socioeconomic risk factors.[33] Evaluations of the model and VBID-specific supplemental benefits found evidence of improvements in certain quality measures, preventive screening adherence, medication adherence, and beneficiary affordability.[34–36]

In addition to improvements in beneficiary experience, care quality, and outcomes, integrated D-SNP models can create efficiencies for providers, states, and the broader healthcare system. Greater integration can support more coordinated care delivery, reduce fragmentation across Medicare and Medicaid, and help beneficiaries receive care in more appropriate settings. Integrated models may also reduce administrative complexity for providers by improving alignment across financing and care management systems. Emerging evidence suggests that higher D-SNP penetration may be associated with lower Medicare spending for dual eligible beneficiaries, while potential state Medicaid savings may result from better coordination of LTSS, reductions in avoidable acute care utilization, and greater use of community-based services.[37, 38]

Policy Considerations

D-SNPs provide states with a flexible pathway to strengthen Medicare-Medicaid integration over time, allowing states to implement integration in a manner that reflects state-specific variation in delivery of Medicaid benefits as well as adapts to their existing systems, infrastructure, and policy priorities.

As states pursue pathways to integration for dual eligible beneficiaries, state and federal policymakers may want to consider the following:

Opportunities to transition to EAE will vary across states based on existing Medicaid delivery systems and program structures.

In particular, states that continue to deliver Medicaid benefits through FFS rather than Medicaid managed care face inherent limits in advancing integration. Without an affiliated Medicaid managed care plan, these states generally cannot progress beyond CO D-SNPs to more highly integrated models, such as HIDE SNPs or FIDE SNPs, that rely on aligned Medicaid managed care enrollment. Although CO D-SNPs in Medicaid FFS states are not expected to lose their ability to operate as EAE requirements are fully implemented,[39] adopting Medicaid managed care for dual eligible beneficiaries would provide states with greater opportunities to achieve deeper Medicare-Medicaid integration over time.

Stable and adequate MA and Medicaid MCO rates are crucial to sustaining integrated care models for dual eligible beneficiaries.

Predictable funding supports stability of beneficiary plan options, consistent provider networks, an ongoing care coordination infrastructure, robust supplemental benefits, and operational investments needed to serve individuals with complex medical, behavioral health, and long-term care needs. Stakeholders have also emphasized the importance of administrative alignment across Medicare and Medicaid programs and federal and state requirements, noting that misaligned enrollment timelines, duplicative reporting requirements, overlapping beneficiary notices, and inconsistent implementation requirements can increase administrative burden and beneficiary confusion.[40]

Integration requirements should encourage enrollment in highly integrated plans.

Over time, CMS has taken steps to restrict D-SNP "lookalike" plans that offer benefits designed to attract and disproportionately enroll dual eligible beneficiaries, without meeting the same requirements as D-SNPs. As lookalike approaches continue to evolve, policymakers should carefully evaluate integration requirements to ensure they encourage enrollment in highly integrated plans and avoid encouraging enrollment in plans, such as C-SNPs, that may not be designed to serve people who are dually eligible and their unique needs.

Dual eligible beneficiaries derive value from access to non-medical supplemental benefits.

The end of the VBID demonstration raises important questions about continued access to non-medical supplemental benefits for dual eligible beneficiaries, which research has found to improve utilization and quality outcomes for beneficiaries. While many of these services may continue to be offered through SSBCI (or other regulatory flexibilities), eligibility for SSBCI requires diagnosis of a chronic condition, attested to by a provider; socioeconomic status is not a qualifying condition. As a result, some beneficiaries who previously received supports for health-related social needs under VBID may no longer qualify or they may face new administrative barriers and delays in accessing these services, even if they have the same needs.

Conclusion

D-SNPs offer states flexible pathways to increase integrated care and improve the care delivery experience and health outcomes of dual eligible beneficiaries.

Expanding and strengthening Medicare-Medicaid integration—particularly through more aligned and highly or fully integrated models—can help improve care coordination, support individuals with complex needs including LTSS, and create a more streamlined and effective system for beneficiaries, providers, and states alike.

Looking ahead, approaches that preserve state flexibility while promoting greater Medicare-Medicaid alignment may be most effective in advancing integrated care for dual eligible beneficiaries. Continued attention to financing, administrative coordination, and beneficiary access to integrated coverage options will be needed to ensure ongoing, consistent access to integrated options for dual eligible beneficiaries.

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