

Key insights into 2026 Medicare Advantage D-SNP landscape

D-SNP enrollment growth remains low outside of MMP transitions while the number of dual eligible enrollees in C-SNPs is rising amid broader Medicare Advantage market and regulatory changes

Nick Johnson, FSA, MAAA
Annie Hallum, FSA, MAAA
Nick Gipe, ASA, MAAA
Logan Blank, ASA, MAAA



Recently released calendar-year (CY) 2026 Medicare Advantage (MA) data show moderately increased growth in dual eligible special needs plan (D-SNP) enrollment and plan count driven by transitioning Medicare-Medicaid Plans (MMPs). This white paper discusses historical and current growth, recent policies impacting D-SNPs, and additional key insights into the CY 2026 D-SNP landscape.

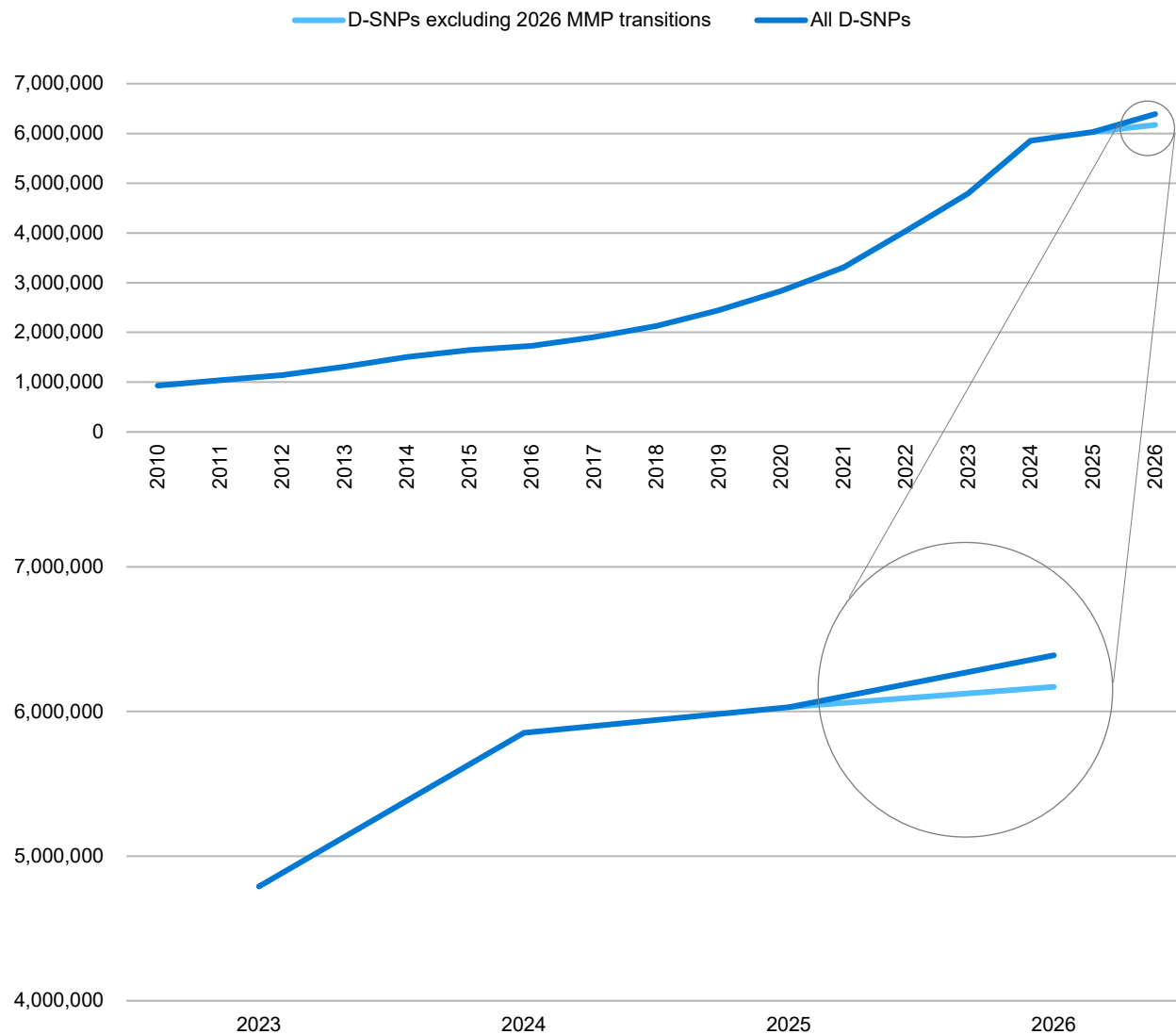
Dual eligible special needs plans, or D-SNPs, are Medicare Advantage (MA) plans that only enroll beneficiaries who are dually eligible and enrolled in both Medicare and Medicaid. D SNPs are popular among both MA organizations (MAOs) and dual eligible beneficiaries because benefit designs can be tailored to the needs of this population.

Recent federal regulations and state Medicaid policies related to D-SNPs, largely guided by a Centers for Medicare and Medicaid Services (CMS) goal of promoting integrated care through aligned Medicare and Medicaid products, have helped shape the D-SNP landscape.¹ As state Medicaid agencies have enacted policy decisions that limit D-SNP offerings in their states and CMS has curtailed the use of general enrollment plans to enroll dual eligible beneficiaries, some MAOs have responded by increasingly offering chronic condition special needs plans (C SNPs) that primarily enroll dual eligible beneficiaries. Unlike D-SNPs, C-SNPs do not need to maintain a contract with the state Medicaid agency (SMAC) to operate.

Figure 1 shows D-SNP January enrollment from CY 2010 to CY 2026 based on CMS SNP comprehensive reports. Enrollment has increased steadily over that time period and averaged 15% annual growth in the decade preceding 2024. However, D-SNP enrollment growth slowed to 3% in CY 2025, which was the lowest growth seen since CY 2016 and the first significant deceleration in growth since CY 2016. In 2026, growth increased to nearly 6%, but over half of this growth came from terminating MMPs as the Financial Alignment Initiative (FAI) model came to an end and participating states transitioned MMPs to D-SNPs.

1. Code of Federal Regulations, Title 42, § 417, 422, and 423. Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit programs. Retrieved February 23, 2026, from: <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>.

FIGURE 1: D-SNP ENROLLMENT (CY 2010–CY 2026)



CMS recently released information about CY 2026 MA plan offerings, including D-SNPs.² The remainder of this paper discusses key takeaways from a review of CY 2026 D-SNP plan offering data and the Milliman Medicare Advantage Competitive Value Added Tool (Milliman MACVAT®).

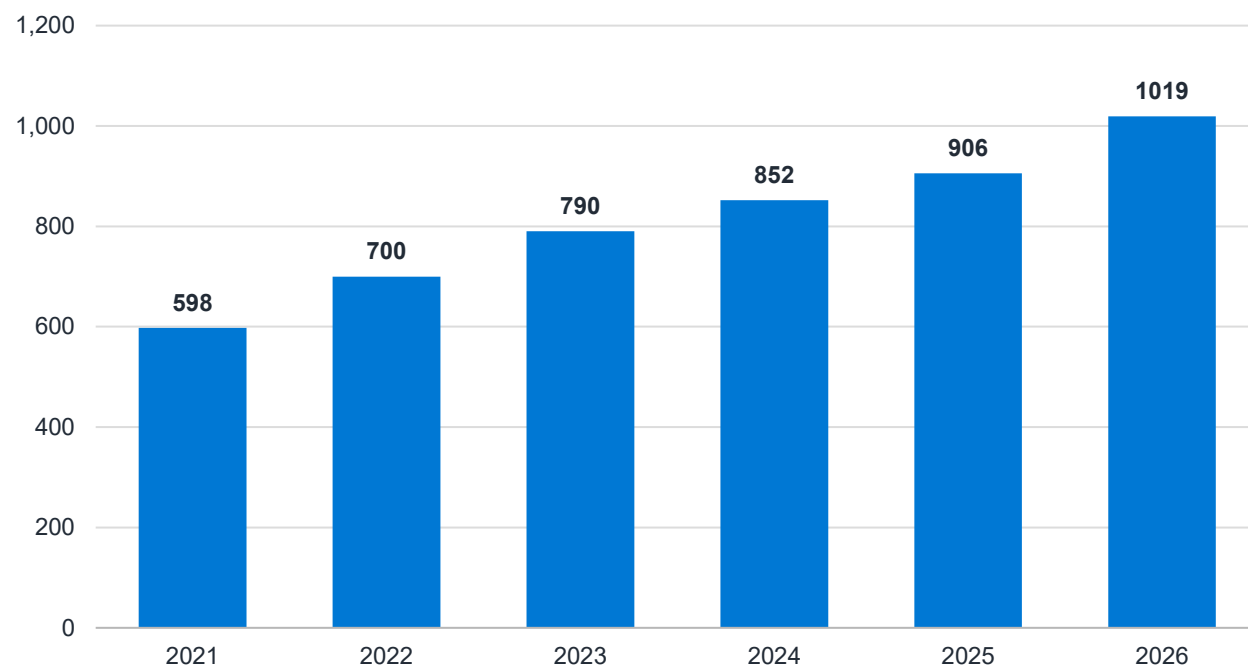
2. CMS. Prescription drug coverage – General information. Retrieved February 23, 2026, from <https://www.cms.gov/medicare/coverage/prescription-drug-coverage>.

1. The D-SNP market growth rate increased due to MMP transitions

Ten states participated in the CMS FAI capitated model, which allowed states to test models to integrate care for dual eligible beneficiaries through MMPs that provide both Medicare and Medicaid benefits through a single managed care plan. Per the CY 2023 MA Final Rule, CMS required states to sunset their MMPs by the end of CY 2025.³ Some states transitioned their MMPs early (e.g., California and Virginia), while others ended their MMP programs effective December 31, 2025.

The number of D-SNP plan offerings is increasing by 12% in CY 2026. Figure 2 shows the growth in D-SNPs over the past five years.

FIGURE 2: NUMBER OF D-SNP PLANS (CY 2021–CY 2026)

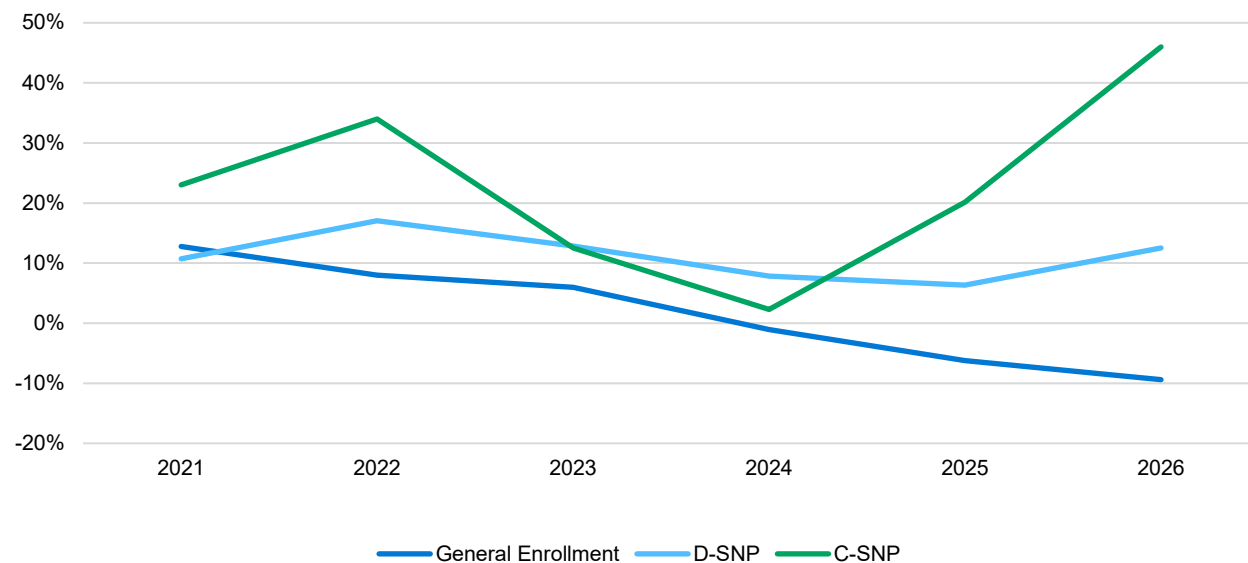


In CY 2026, the rate of growth in D-SNP offerings returned to double digits. This was in contrast to slower growth in CY 2025, which had slowed to about 6%. However, a significant portion of the CY 2026 growth comes from the required sunsetting of the FAI after 2025 and MMPs transitioning into D-SNPs. Contrast this with general enrollment, which has had three consecutive years of decreases in plan offerings, with the largest decrease coming in 2026 at -9%.

3. Code of Federal Regulations, Title 42, § 417, 422, and 423. Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit programs. Retrieved February 23, 2026, from: <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>.

Figure 3 shows the average annual growth in MA plans by year from 2021 through 2026 separately for D-SNPs, C-SNPs, and general enrollment plans. C-SNP plan growth outpaced D-SNPs in 2025 and had the largest growth rate in recent years in 2026, over a 45% increase.

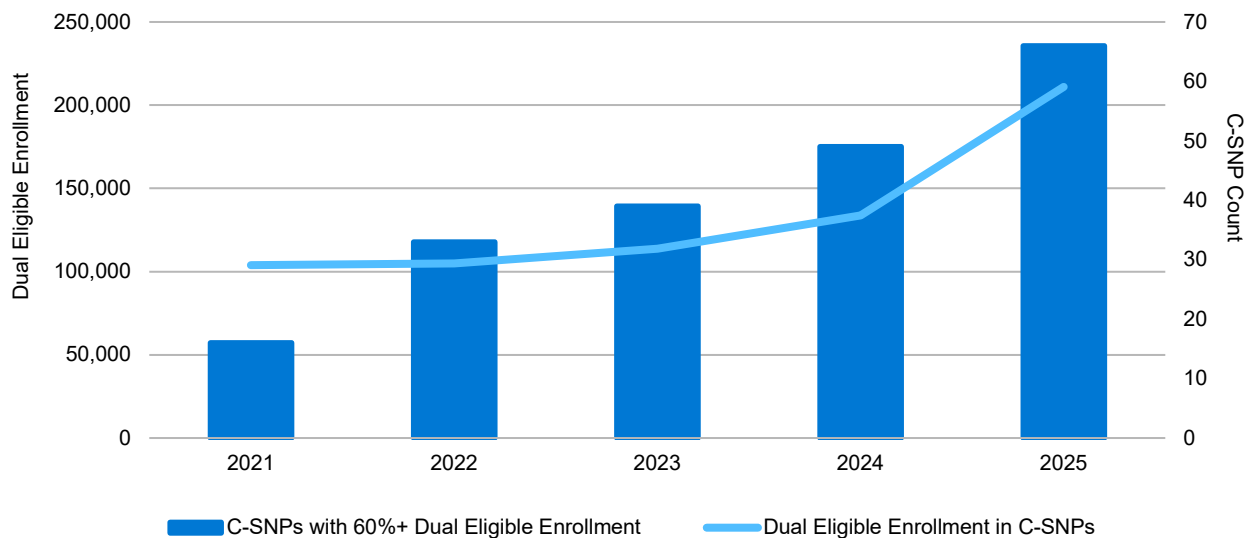
FIGURE 3: ANNUAL GROWTH IN NUMBER OF PLANS BY PLAN TYPE (CY 2021–CY 2026)



C-SNP enrollment grew by 66% from January 2024 to January 2025 and again by 50% to January 2026. Some of the C-SNP plan and enrollment growth may be a result of carriers finding new avenues to offer plans that are attractive to dual eligible beneficiaries in response to state and federal policies, such as prohibition of general enrollment D-SNP look-alike plans, which may limit some carriers' ability to offer D-SNPs. CMS acknowledged that dual eligible growth in C-SNPs has been high and requested information from stakeholders in the 2027 MA and Part D Proposed Rule.⁴ Figure 4 below illustrates this growth based on data included by CMS in the proposed rule.

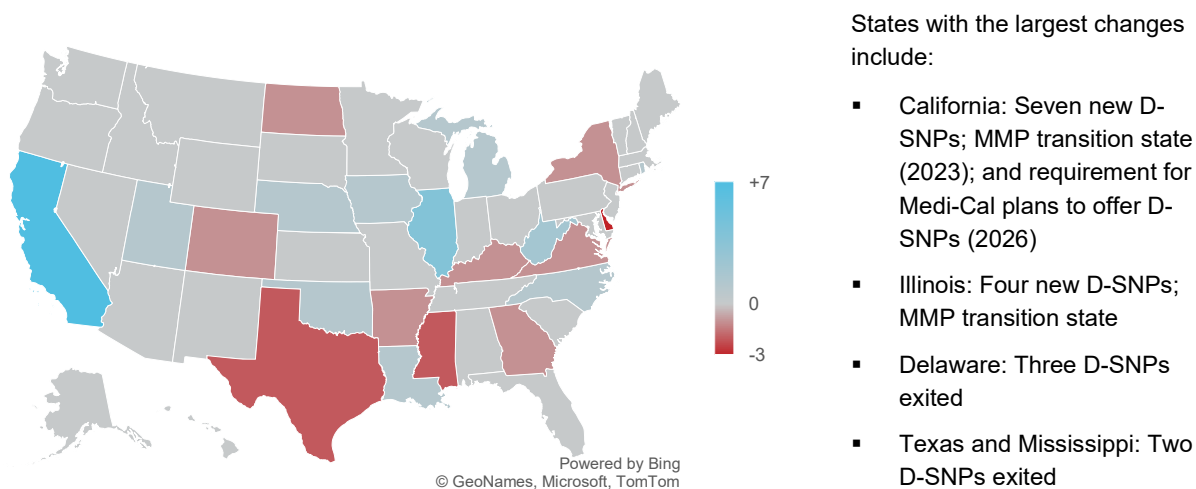
4. CMS. (November 28, 2025). Contract year 2027 policy and technical changes to the Medicare Advantage program, Medicare prescription drug benefit program, and Medicare cost plan program. 90 Fed. Reg. 5489. Retrieved February 23, 2026, from: <https://www.federalregister.gov/documents/2025/11/28/2025-21456/medicare-program-contract-year-2027-policy-and-technical-changes-to-the-medicare-advantage-program>.

FIGURE 4: DUAL ELIGIBLE ENROLLMENT IN C-SNPS (CY 2021–CY 2025)



In 2026, 11 states had an increase in the number of MAOs offering D-SNPs from 2025, and 11 states had reductions. Figure 5 shows the change in number of unique MAOs offering D-SNPs in each state from 2025 to 2026.

FIGURE 5: CHANGE IN NUMBER OF MAOS OFFERING D-SNPS BY STATE (CY 2025–CY 2026)



Like all MA plans, D-SNP service area is defined at the county level. Consistent with recent years, D-SNP availability at the local level continues to be strong. Based on our analysis of the plan data and CMS dual eligible beneficiary enrollment data, over 98% of full-benefit dual eligible beneficiaries have access to a D SNP in 2026, and 96% have access to at least three D-SNP options.⁵ These amounts are consistent with 2025. By comparison, 95% of full-benefit dual eligible beneficiaries had access to a D-SNP in 2020, and 80% had access to at least three D-SNP or MMP options.

5. CMS. MMCO statistical & analytic reports – Enrollment snapshots. Retrieved February 23, 2026, from <https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/analytics>.

2. National MAOs continue to dominate landscape

UnitedHealthcare continues to offer D-SNPs in more states and cover more D-SNP beneficiaries than any other MAO. The four MAOs with the largest D-SNP footprints are described below.

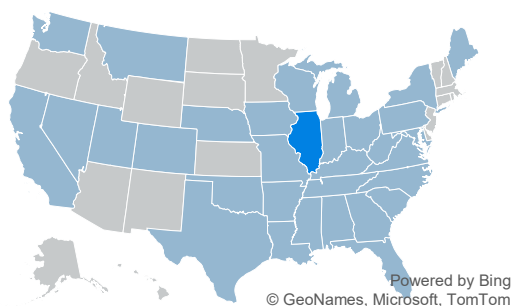
- UnitedHealthcare offers D-SNPs in 43 states, including the District of Columbia (the same as CY 2025, entering Idaho and exiting Delaware) and covers over 2.3 million D-SNP beneficiaries (37% of nationwide D-SNP enrollment) as of January 2026.
- Humana offers D-SNPs in 32 states (one fewer than CY 2025, exiting North Dakota and Puerto Rico and entering Illinois) and covers 0.9 million D-SNP beneficiaries (14% of nationwide D-SNP enrollment) as of January 2026.
- Aetna (CVS Health) offers D-SNPs in 28 states (two fewer than in CY 2025, exiting California, Delaware, and Maryland and entering Illinois) and covers 0.5 million D-SNP beneficiaries (8% of nationwide D-SNP enrollment) as of January 2026.
- Centene (Allwell) offers D-SNPs in 31 states (one more than CY 2025, entering Illinois) and covers 0.4 million D-SNP beneficiaries (6% of nationwide D-SNP enrollment) as of January 2026.

Elevance has a smaller state footprint than the four prior carriers shown (22 states), but it enrolls nearly 0.6 million beneficiaries (9% of nationwide D-SNP enrollment).

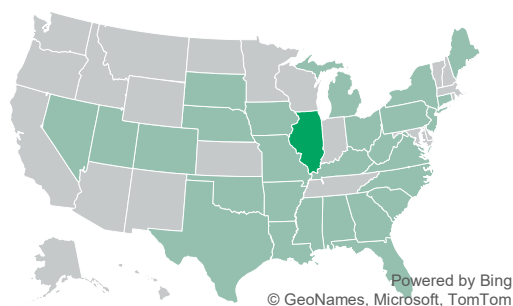
Other MAOs offering D-SNPs in at least 10 states include Molina, HCSC/Cigna, and Devoted Health. Figure 6 shows the four MAOs mentioned above with the largest D-SNP footprints. Shaded states represent current footprint, and darkest shading indicates 2026 additions.

FIGURE 6: NATIONAL MAO D-SNP FOOTPRINTS (CY 2026)

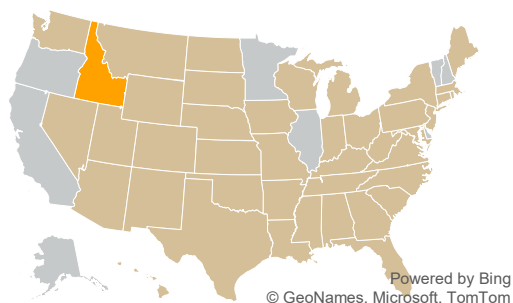
HUMANA D-SNP FOOTPRINT



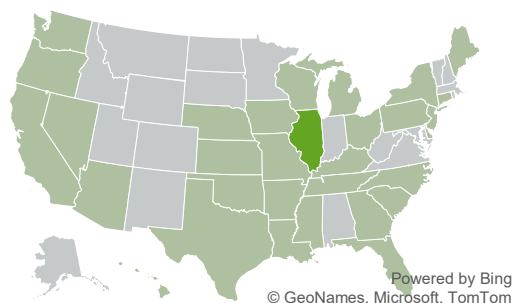
CVS/AETNA D-SNP FOOTPRINT



UNITED D-SNP FOOTPRINT



CENTENE D-SNP FOOTPRINT

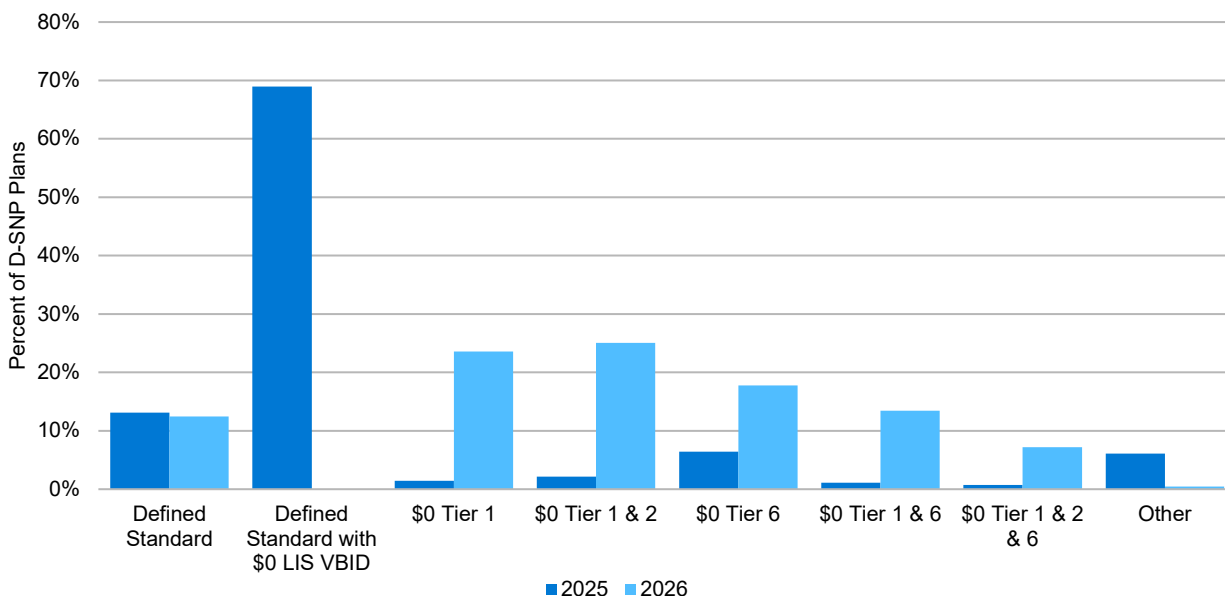


These MAOs have historically driven increases in the number of D-SNPs by offering D-SNPs in different service areas within a given state or differentiated D-SNP products within the same service area, including health maintenance organization (HMO) and preferred provider organization (PPO), separate plans for full and partial duals, or plans with different benefit packages. In 2026, all four carriers offer over 100 D-SNP plans and combined account for more than 50% of all D-SNP plan offerings.

3. The sunset of value-based insurance design (VBID) had a significant impact on Part D benefit design

In 2025, nearly 90% of members were enrolled in a D-SNP that offered reduced cost sharing for Part D drugs through the VBID program.⁶ The VBID program was terminated in 2026, eliminating the primary financially viable method for D-SNPs to offer their enrollees zero-dollar Part D cost sharing. There are a limited number of other avenues to provide this benefit, as discussed in detail in a [separate Milliman white paper](#). One of these methods, a value added service offered by the associated Medicaid plan, appears to be gaining traction, but because this offering is not contained in the Medicare plan reporting released by CMS, it is currently difficult to quantify on a national scale. Based on a review of [Milliman MACVAT](#), we see that the portion of D-SNPs offering a defined standard Part D benefit dropped from 82% to 12%. Most of these defined standard plans were offering \$0 cost sharing through the VBID in 2025. Many plans (70%) are instead now offering \$0 Tier 1, and some are offering \$0 Tier 2 and/or a \$0 Tier 6 with select drugs.

FIGURE 7: D-SNP PART D BENEFIT DESIGN (2025 AND 2026)



6. Friedman, J., Cates, J., & Bentley, C. (December 19, 2024). State of the 2025 Medicare Advantage industry: Dual-eligible plan valuation and selected benefit offerings. Milliman white paper. Retrieved February 26, 2026, from <https://www.milliman.com/en/insight/state-of-medicare-advantage-d-snp-2025>.

4. Rich D-SNP supplemental benefits decreasing

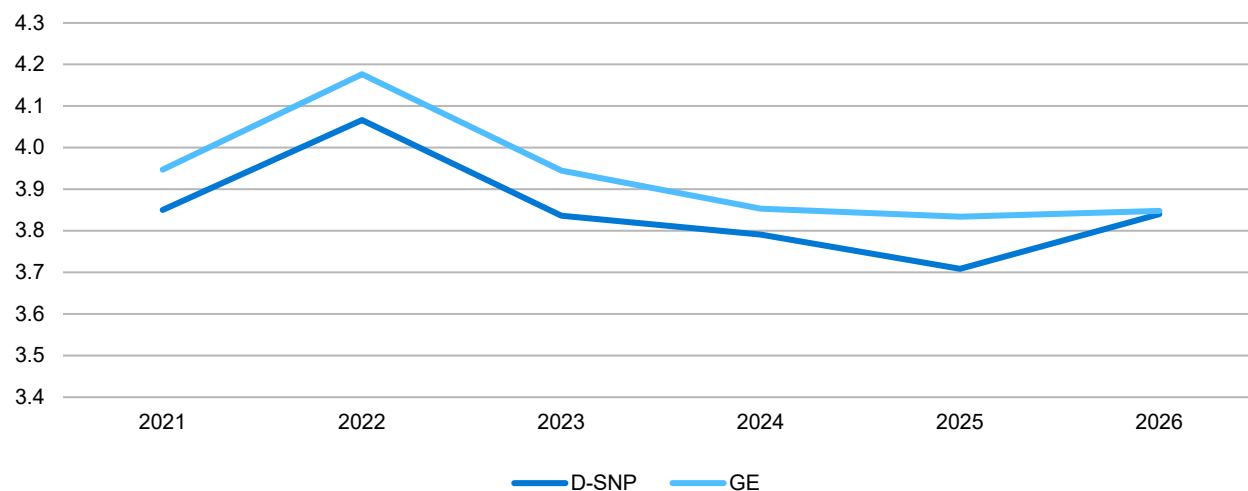
All MA plans, including D-SNPs, typically offer supplemental benefits not covered by traditional Medicare. Most D-SNPs offer dental, vision, and hearing benefits, as well as over-the-counter (OTC) benefit cards. Many offer other supplemental benefits, including special supplemental benefits for chronically ill enrollees (SSBCI).

As discussed in more detail in a separate Milliman [white paper](#), the average value added decreased from CY 2025 to CY 2026, continuing the downward trend that began in CY 2025.⁷ Benefit reductions may be a reaction to increased regulatory pressure facing the MA industry, including but not limited to star rating reductions, Part D changes associated with the Inflation Reduction Act (IRA), MA payment rates, termination of the VBID program, or other drivers impacting financial performance, such as medical trends.

5. The average star rating for D-SNPs increased in CY 2026

The average star rating among D-SNPs increased for the first time in four years in CY 2026 (impacting payment year 2027). The recent trends in D-SNP star ratings had been mostly consistent with those observed in general enrollment plans, though the average D-SNP rating was consistently lower. The general downward trend was at least partially attributable to methodological changes in star rating calculations.⁸ The 2026 increase appears to be market-wide, with national carriers and non-national carriers each having on average around a 5% star rating increase. There may be some upward pressure due to cross-walking existing D-SNPs onto new contracts with no star rating yet due to state requirements for D-SNP only contracts, but our analysis suggests this is small. Figure 8 illustrates the change in average D-SNP star ratings over the last six years.

FIGURE 8: AVERAGE D-SNP STAR RATING BY YEAR (CY 2021–CY 2026)



7. Cates, J., Friedman, J., & Booth, A. (March 17, 2026). State of the 2026 Medicare Advantage industry: Dual-eligible plan valuation and selected benefit offerings. Milliman white paper. Retrieved March 20, 2026, from <https://www.milliman.com/en/insight/state-of-medicare-advantage-d-snp-2026>.

8. Rogers, H., & Smith, M. (November 2024). Star ratings in retrograde: Decoding the 2025 decline. Milliman white paper. Retrieved January 3, 2025, from <https://www.milliman.com/en/insight/star-ratings-in-retrograde-decoding-the-2025-decline>.

Approximately 50% of D-SNPs achieved star ratings of 4.0 or greater:

- UnitedHealthcare, the largest carrier by plan offerings, has about 66% of D-SNPs achieving 4.0 star rating or greater, a decrease from about 70% of D-SNPs in 2025 and 75% of D SNPs in 2024. On average, however, UnitedHealthcare's D-SNP star ratings increased from 3.85 to 4.00.
- Humana, the second largest, increased to 43% of D-SNPs achieving 4.0 stars or greater in 2026 from 27% in 2025 but remains down from 94% in 2024.
- Aetna/CVS Health, the third largest, has about 57% of D SNPs achieving the same benchmark, a decrease from 80% in the prior year.

Note that star ratings are assigned at the contract level, and MA contracts may contain other plans, including general enrollment and other SNP types. Therefore, star ratings for D-SNPs may be influenced by performance of non-D-SNP plans within the same contract. Some states are beginning to require state-specific and/or D-SNP only contracts to achieve state policy goals, including greater transparency into D-SNP quality and financial performance. In 2026, Hawai'i, Illinois, Indiana, Massachusetts, Minnesota, and Virginia have exclusively state-specific D-SNP specific contracts. Two additional states (Idaho and Arizona) have only D-SNP specific contracts but at least one contract that is not state-specific. Twenty-five remaining states have a mix of D-SNP exclusive contracts and non-exclusive contracts, five of which (California, Delaware, Michigan, Rhode Island, and South Carolina) have a majority of state-specific D-SNP exclusive contracts. Because star ratings are calculated at the contract level, state-specific D-SNP contracts may have implications on star ratings.

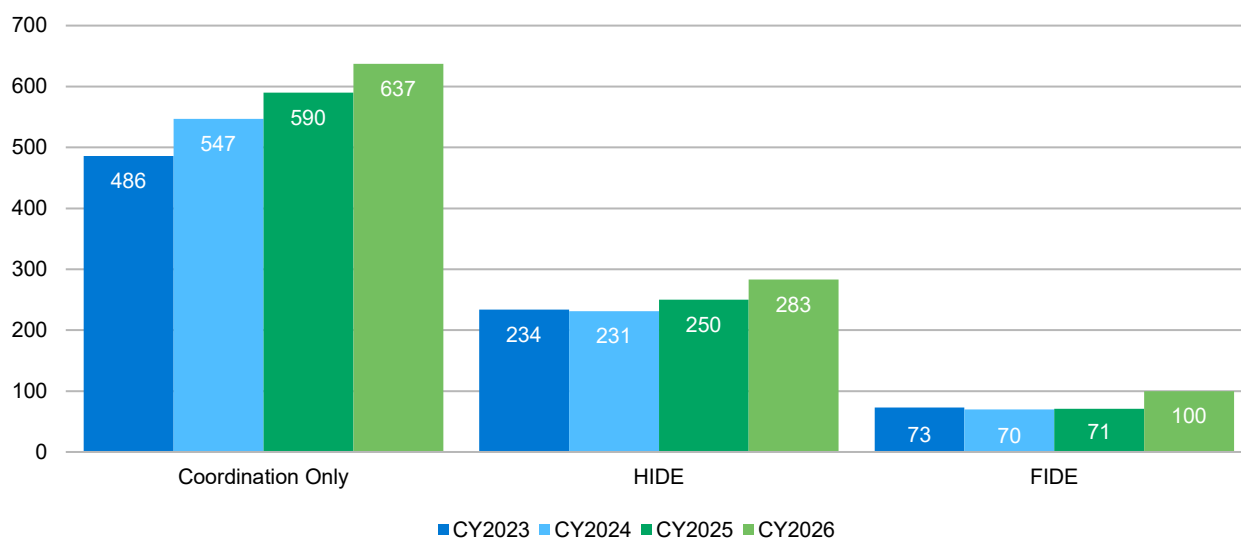
6. Integrated D-SNPs are growing, but integration requirements continue to largely be met through coordination rather than integration

Beginning in CY 2021, D-SNPs are required to meet new minimum integration standards through at least one of the three avenues listed in descending order of level of integration:

- Fully Integrated D-SNP (FIDE SNP)
- Highly Integrated D-SNP (HIDE SNP)
- An acute event notification process (“coordination-only”) between the D-SNP and the state Medicaid agency.^{9, 10}

The level of integration is primarily determined by whether the same entity holds both the Medicare and Medicaid contracts and the scope of the benefits covered via the Medicaid contract, particularly long-term services and supports and behavioral health. Figure 9 shows the growth in each type of D-SNP plan from CY 2023 to CY 2026. While coordination-only D-SNPs still make up the largest portion of all D-SNP plans (62% in 2026), HIDE and FIDE SNPs experienced material increases in the number of offerings. Much of the FIDE growth is associated with MMP transitions into FIDE plans.

FIGURE 9: NUMBER OF D-SNP PLANS BY INTEGRATION STATUS (CY 2023–CY 2026)

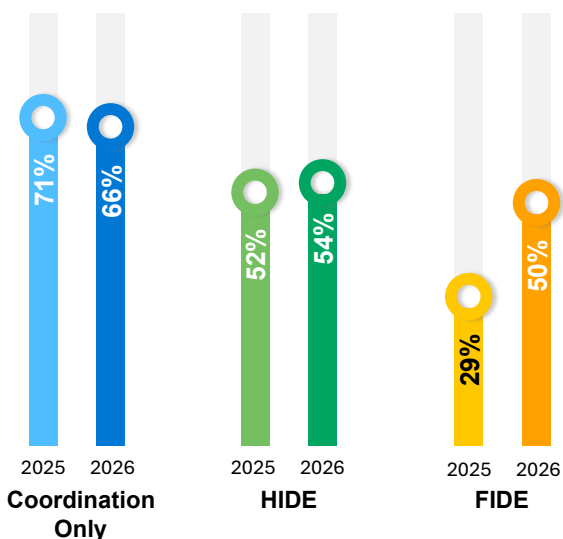


The composition of MAOs offering D-SNPs varies considerably by D-SNP integration status. Figure 10 shows the proportion of D-SNPs offered by national MAOs (UnitedHealthcare, Humana, Aetna/CVS Health, Centene/Allwell, HCSC/Cigna, Anthem, and Molina) and by local or regional MAOs (all other MAOs). The proportion of D-SNPs offered by local or regional MAOs increases with the level of integration, although in 2026 the proportion of fully integrated plans offered by national MAOs has increased significantly (from 29% to 50%). Local and regional MAOs offer 39% of coordination-only D-SNPs, 48% of HIDE SNPs, and 50% of FIDE SNPs.

9. Medicare-Medicaid Coordination Office. (October 7, 2019). CY 2021 Medicare-Medicaid integration and unified appeals and grievance requirements for dual eligible special needs plans (D-SNPs). CMS. Retrieved February 23, 2024, from <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf>.

10. Medicare-Medicaid Coordination Office. (January 17, 2020). Additional guidance on CY 2021 Medicare-Medicaid integration requirements for dual eligible special needs plans (D-SNPs). CMS. Retrieved February 23, 2024, from <https://www.cms.gov/files/document/CY2021dsnpsmedicaremedicaidintegrationrequirements.pdf>.

FIGURE 10: PERCENT OF D-SNP PLANS OFFERED BY NATIONAL MAOS BY D-SNP TYPE (CY 2025 & 2026)

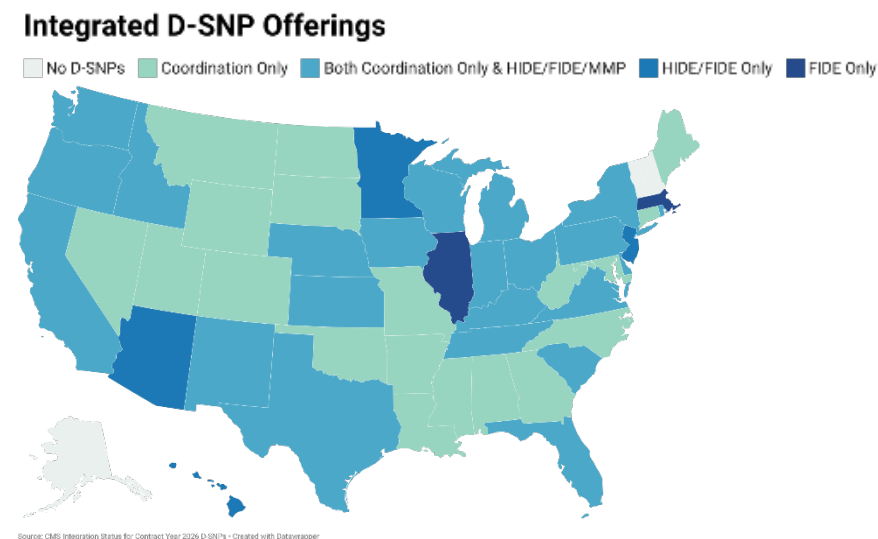


D-SNP offerings in seven states (including Puerto Rico) are limited to HIDE SNP and FIDE SNP plans, and two of these states only have FIDE SNPs. Figure 11 illustrates whether each state offers coordination-only plans, only integrated plans, or a combination of both in CY 2026.

Wisconsin and Kansas previously had no coordination-only D SNPs but will have coordination-only D-SNPs in 2026. In some states, the coordination-only plans may exist in order to enroll partial benefit dual beneficiaries.

Figure 11 also shows that in 2026, D-SNPs will be available in every state except Alaska, New Hampshire, and Vermont, which is consistent with 2025. New Hampshire is exploring the feasibility of supporting D-SNPs in the future.¹¹

FIGURE 11: CY 2026 D-SNP PLAN OFFERINGS BY STATE



11. New Hampshire DHHS. New Hampshire feasibility study for programming to promote independence and community living for dual-eligible individuals. Retrieved March 20, 2025, from <https://www.dhhs.nh.gov/programs-services/medicaid/new-hampshire-feasibility-study-programming-promote-independence-and>.

7. Regulatory changes will continue to shape the D-SNP market

CMS and states continue to shape the D-SNP market through targeted rulemaking and policy decisions. Recent federal policymaking has focused on promoting FIDE SNPs as a preferred vehicle for improving Medicare-Medicaid integration, preventing MAOs from shifting costs to Medicaid, limiting the ability of MAOs to enroll dual eligible members in general enrollment plans without a D-SNP model of care, and reducing choice overload in the D-SNP market. Many states, including those that have participated in the managed care FAI, are taking their own steps to further pursue integration to promote higher-quality care, enhance member experience for dual eligible beneficiaries, and potentially consider cost savings. Some of these efforts are discussed below.

FEDERAL REGULATORY CHANGES

Exclusively aligned enrollment

In the CY 2023 MA Final Rule, CMS implemented additional requirements for HIDE SNPs and FIDE SNPs starting in 2025, including a requirement that FIDE SNPs have exclusively aligned enrollment (i.e., enrollment is limited to dual eligible beneficiaries who are also enrolled in the MAO's associated Medicaid plan) and cover nearly all Medicaid-covered services through a capitated Medicaid contract.¹²

In the CY 2025 MA Final Rule, CMS will limit new enrollment of full-benefit duals into D-SNPs that also contract with a state as a Medicaid managed care organization (MCO) to dual eligible beneficiaries enrolled in the D-SNP's affiliated MCO, beginning in 2027. In 2030, all membership for these plans will be required to be aligned between the D-SNP and Medicaid MCO. MAOs that serve dual eligible beneficiaries through Medicaid may need to consider Medicaid and D-SNP plan design, marketing strategy, care management, and operations more holistically.

In the CY 2027 MA Proposed Rule, CMS proposed an exception to the aligned enrollment requirements that would permit certain D-SNPs to continue to enroll full-benefit dual eligible beneficiaries that are in Medicaid fee-for-service (FFS) rather than in an aligned Medicaid managed care plan. CMS finalized this proposal on April 6, 2027.¹³

Reduced plan options and choice overload

In the CY 2025 MA Final Rule, CMS is limiting certain MAOs to a single D-SNP Plan Benefit Package (PBP) within a given service area. Starting in 2027, each parent organization (including all related organizations) will only be permitted to offer a single D-SNP PBP enrolling full-benefit duals within a given service area when the MAO (or any related organization) has an affiliated Medicaid MCO enrolling dual eligible beneficiaries. Exceptions include when a state requires multiple D-SNPs for distinct beneficiary types (e.g., over or under 65) or separate D-SNPs for full and partial duals.

MAOs that serve dual eligible beneficiaries through Medicaid under the same parent organization and offer multiple D-SNP plans within a service area may need to consider how to combine D-SNPs, crosswalk members to a single D-SNP, and/or create plans for distinct beneficiary types that satisfy both federal and state requirements.

In the CY 2027 MA Final Rule, CMS amended the previous rule to allow D-SNPs that serve full-benefit dual eligible individuals in a HIDE SNP or coordination-only D-SNP to continue enrollment of full-benefit dual eligible individuals in a D-SNP in the same service area for those individuals that are enrolled in Medicaid FFS. This amendment accounts for situations where states do not mandate Medicaid managed care for all dual eligible individuals. Under the prior rule, a MAO with a Medicaid contract could not enroll Medicaid FFS beneficiaries, while a coordination-only D-SNP offered by a MAO with no Medicaid contract could enroll these beneficiaries.

12. Code of Federal Regulations, Title 42, § 417, 422, and 423. Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit programs. Retrieved February 23, 2026, from: <https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf>.

13. Medicare Program; Contract Year 2027 and Certain Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. Retrieved April 7, 2026, from: <https://www.federalregister.gov/documents/2026/04/06/2026-06600/medicare-program-contract-year-2027-and-certain-contract-year-2026-policy-and-technical-changes-to>

D-SNP look-alikes

In CY 2023, CMS began nonrenewing D-SNP look-alike plans in states with existing D-SNPs or MMPs. CMS originally identified D-SNP look-alike plans as general enrollment plans whose membership consists of over 80% dual eligible beneficiaries.¹⁴ As finalized in the CY 2025 MA Final Rule, CMS lowered this threshold to 70% in 2025 and further lowered it to 60% in 2026.¹⁵

In the CY 2027 MA Proposed Rule, CMS discussed the growth of C-SNPs and institutional SNPs (I-SNPs) that enroll primarily dual eligible beneficiaries. CMS has requested information for potential policy options that would limit the ability of C-SNPs and/or I-SNPs to enroll dual eligible beneficiaries and/or increase state Medicaid oversight. Policy options CMS is exploring include:

- Requiring SMACs for C-SNPs and I-SNPs with a high proportion of dual eligible beneficiaries
- Options to increase care coordination for dual eligible beneficiaries in C-SNPs and I-SNPs
- Applying D-SNP look-alike limitations to C-SNPs

Other market changes impacting D-SNPs

In addition to D-SNP specific policy actions, the federal government continues to propose legislation impacting the overall MA program that will also shape the D-SNP market. This includes refinements to the risk score model, the IRA, supplemental benefit requirements, and changes to star ratings. Continued changes to these elements of the MA program will influence the D-SNP market moving forward.

STATE POLICY CHANGES

State-specific policies

State Medicaid policy, including contracting requirements, facilitated enrollment into D-SNPs, and state-specific D-SNP requirements, has also influenced local D-SNP markets. Levers that states may use to shape the D-SNP market include but are not limited to:

- **Limiting the ability of certain MAOs to offer D-SNPs in the state:** To operate in a state, D-SNPs must have a contract with the state and CMS, but states do not have to offer contracts to any interested D-SNPs. An increasing number of states have leveraged these contracts to limit the number of MAOs offering D-SNPs to MAOs with affiliated Medicaid managed care plans for dual eligible beneficiaries. By 2024, nine states required D-SNPs to offer affiliated managed care plans.¹⁶ In 2026, this trend is expected to continue; states such as Nevada, Ohio, and Illinois have issued or completed competitive procurements for their D-SNP contracts. States such as New York and Massachusetts are also leveraging this flexibility to create separate benefit plans that align with state-specific eligibility criteria that differs between a state's multiple integrated programs (such as age, partial dual eligibility, or members needing a nursing facility level of care).¹⁷

14. CMS. (June 8, 2020). Dual eligible special needs plan (D-SNP) "look-alike" transitions for contract year (CY) 2021. Retrieved March 21, 2025, from <https://www.cms.gov/httpsedictcmgovresearch-statistics-data-and-systemscomputer-data-and-systemshpms-hpms-memos-archive/hpms-memo-21>.

15. CMS. (April 23, 2024). Changes to the Medicare Advantage and the Medicare prescription drug benefit program for contract year 2024-Remaining provisions and contract year 2025 policy and technical changes to the Medicare Advantage program, Medicare prescription drug benefit program, Medicare cost plan program, and programs of all-inclusive care for the elderly (PACE). Retrieved February 23, 2026, from: <https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit>.

16. Parker, P., Beaver, D., & Valentine M. (October 21, 2024). Progress towards greater integration: Trends in state contracting requirements for D-SNPs. SNP Alliance. Retrieved February 5, 2025, from <https://snpalliance.org/wp-content/uploads/2024/10/Final-Progress-Towards-Greater-Integration-Trends-in-State-Contracting-Requirements-for-D-SNPs.pptx>.

17. CMS. Frequently asked questions (FAQs) and enrollment scenarios for § 422.514(h). Retrieved March 2, 2026, from <https://www.cms.gov/files/document/cy2025madsnpsfaqs.pdf>.

- **Aligning enrollment for Medicaid enrollees in D-SNPs and Medicaid managed care plans operated by the same parent company:** In 2021, four states (Idaho, Massachusetts, Minnesota, and New Hampshire) used exclusively aligned enrollment for their D-SNPs. Given changes to federal policy, all FIDE SNPs are required to use exclusively aligned enrollment as of 2025. However, some states, such as California, have signaled their intent to require exclusively aligned enrollment for other types of D-SNPs as well. Beginning in 2027, D-SNPs offered by a Medicaid MCO in any state will not be permitted to enroll new full-benefit dual members that are unaligned. With the finalization of the CY 2027 proposed rule as described above, there are limited exceptions for some full-benefit dual eligible members. In 2030, all enrollment in these D-SNPs must be aligned.
- **Requiring D-SNP only MA contracts:** States may also choose to require D-SNPs to have their own MA contract (i.e., separate from general enrollment plans or other SNP types), which impacts star ratings and other aspects of Medicare for the D-SNP. In 2024, four states (California, Idaho, Massachusetts, and Minnesota) required D-SNP only contracts. In 2025, this increased to five states (added Virginia), and additional states are expected to be added in 2026.¹⁸
- **Requiring alignment of D-SNP and Medicaid managed care provider networks:** States may choose to require aligned provider networks for services. Indiana's 2025 SMAC includes a requirement that D-SNPs have a minimum 80% overlap with the companion Medicaid managed care network for select provider types.¹⁹
- **Requiring coverage of certain benefits through the SMAC:** States may require coverage of certain benefits as supplemental benefits in the SMAC. For example, New York began requiring its D-SNPs cover Medicaid dental benefits as a Medicare supplemental benefit in CY 2025.²⁰ California is requiring its EAE D-SNPs to cover vision benefits in CY 2026.²¹ In its ongoing CY 2027 procurement, Nevada has signaled its intent to require several supplemental benefits.²²
- **Requiring coverage of certain care management through the SMAC:** California is leveraging its SMAC to require D-SNPs include enhanced care management (ECM) in their models of care (MOCs).²³ This is intended to allow beneficiaries to receive any ECM-like services they may need through the D-SNP. Similarly, Washington state requires D-SNPs include the Medicaid Health Home model within the D-SNP MOCs.²⁴

Conclusion

The D-SNP market is continually evolving due to ongoing D-SNP policy changes and significant changes in the overall MA market. MAOs, states, and other stakeholders will need to understand the financial and competitive implications of market dynamics to effectively serve the dual eligible beneficiaries enrolling in these plans.

18. Parker, Progress towards greater integration, op. cit.

19. State of Indiana. Sample amendment to contract between Indiana Family & Social Services Administration, Office of Medicaid Policy and Planning, and contractor. Retrieved March 20, 2025, from <https://www.in.gov/medicaid/partners/files/CY2024INSMACAmendment.pdf>.

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24. Advancing Medicare & Medicaid Integration. (May 2022). Washington Department of Social and Health Services. Retrieved March 20, 2025, from <https://medicare-medicaid.org/integration-in-action/washington-department-of-social-and-health-services/>.

Limitations

The opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman.

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This information is intended to provide an overview of the CY 2026 MA D-SNP market. The list of considerations outlined in this article is not exhaustive. This information may not be appropriate and should not be used for other purposes.

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milliman.com



CONTACT

Nick Johnson
nick.johnson@milliman.com

Annie Hallum
annie.hallum@milliman.com

Nick Gipe
nick.gipe@milliman.com

Logan Blank
logan.blank@milliman.com