Centers for Medicare & Medicaid Services (CMS)
Office of the National Coordinator for Health Information Technology (ONC)
Department of Health & Humans Services (HHS)
Office of the Secretary

January 21st, 2026

Re: Proposed Rule CMS-4212-P

Dear Sir/Madam,

We are pleased to respond to your request for comments on the **Proposed Rule CMS-4212-P**. We are health policy experts who study the economics and delivery of health care for Medicare and Medicaid beneficiaries, including dual-eligible beneficiaries. In prior work, we have produced research examining coverage changes for dual-eligible beneficiaries, drivers of utilization and spending, and quality of care in integrated and non-integrated coverage models.

Based on our expertise, we have prepared responses that focus on specifically on CMS' request for information on dual-eligible beneficiaries' enrollment into C-SNPs **(CMS-4212-P B.5)**. As noted in the proposed rule, enrollment into C-SNPs has grown rapidly among the dual-eligible population. In the enclosed response, we describe this trend, discuss how it may be compromising enrollment into MA products that coordinate and integrate care for dual-eligible individuals, and outline potential policy considerations to address these concerns.

We would be pleased to discuss these suggestions further and address any other questions that you may have. Thank you for your consideration of our responses.

Sincerely,

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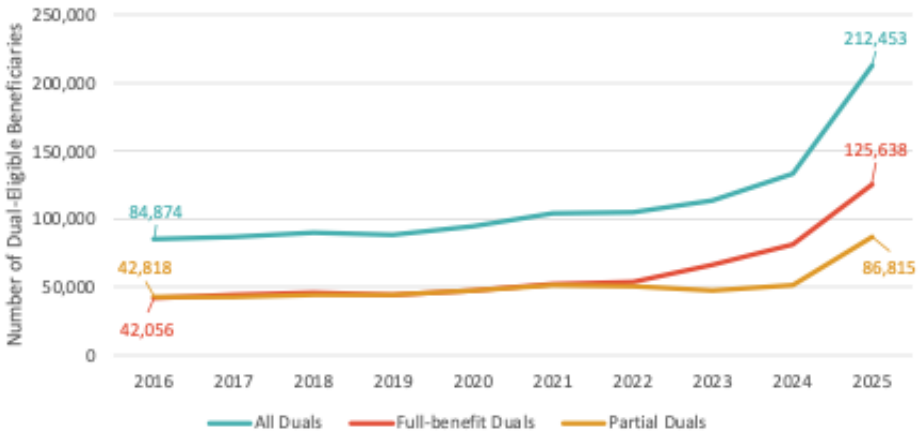
C-SNP Enrollment Growth Among Dual-Eligible Beneficiaries

As noted in the proposed regulation, there has been substantial enrollment growth in D-SNPs among the dual-eligible population, which was particularly pronounced between 2023 and 2025 (**Figure 1**).[1] Concerningly, in a recent study, we found that, in 2025, 27.5% of new C-SNP dual-eligible enrollees were enrolled during the prior year in plans that offered some level of Medicare-Medicaid integration.[1] These findings suggest that C-SNPs are compromising federal and state efforts to better integrate care for the dual-eligible population.

We believe the growth in C-SNP enrollment among dual-eligibles is partially driven by MA insurer responses to the 2023 CMS policy to terminate "D-SNP look alike plans." Starting in 2023, CMS implemented a regulation to terminate contracts with conventional Medicare Advantage (MA) plans that disproportionately enrolled dual-eligible beneficiaries but lacked formal integration and coordination requirements of D-SNPs. However, C-SNPs and I-SNPs were exempt from this look-alike termination policy. In a recent study that used a causal inference approach,[2] we found that the CMS look-alike termination policy in 2023 was not associated with increases in dual-eligible enrollment into plans that offered high-level Medicare-Medicaid integration. However, dual-eligible enrollment into C-SNPs and other non-integrated MA plans increased significantly in counties with terminated look-alike plans, compared to control counties without look-alike plans.

Figure 1. Growth of Dual-Eligible Enrollment in C-SNPs, 2016-2025



Source: Authors' analysis of Medicare data from the 2016 to 2025.

These results underscore the concern raised in CMS' proposed rule that MA insurers may be circumventing requirements to coordinate and integrate care for dual-eligible beneficiaries by offering C-SNPs that attract dual-eligible enrollment but are exempt from D-SNP regulations.

[1] Stein RI, Ma Y, Phelan J, Figueroa JF. Health Affairs Forefront. 2025. https://www.healthaffairs.org/content/forefront/growth-c-snps-may-jeopardizing-medicare-medicaid-integration.
[2] Ma Y, Roberts ET, Phelan J, Johnston KJ, Orav EJ, Meara ER, Figueroa JF. JAMA Health Forum. 2026. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2843823.

Additionally, we are concerned that the increasing number of C-SNP plan offerings are exacerbating a problem of "choice overload" among the dual-eligible population. There are longstanding concerns that Medicare beneficiaries—especially those with cognitive limitations—may make suboptimal MA enrollment decisions when confronted with numerous, hard-to-differentiate plan choices.[3] The consequences of such choice overload are especially concerning for the dual eligible population, which at baseline has higher rates of cognitive impairment, intellectual and developmental disabilities, and serious mental illness, compared to other Medicare beneficiaries.[4]

Evaluation of the D-SNP Market of Dual-Eligible Beneficiaries in C-SNPs

We believe that C-SNP offerings are directly compromising the ability of dual-eligible beneficiaries to choose plans that offer moderate-to-high-level of integration between Medicare and Medicaid even when offered in the same market. To support this claim, we performed descriptive analyses of MA plan offerings in counties where full-benefit dual-eligible beneficiaries were enrolled in C-SNPs in 2025. We focused on full-benefit dual-eligible beneficiaries because they stand to benefit the most from integrated care models, including FIDE-SNPs, HIDE-SNPs, and co-D-SNPs that are applicable integrated plans (AIPs).

We examined the extent to which full-benefit dual-eligible enrollees of C-SNPs in 2025 lived in counties: (1) with any D-SNP offering, (2) with D-SNPs offered by the same parent insurer as their C-SNP, and (3) with plans that offered moderate to high-level integration with Medicaid (including FIDEs, HIDEs, or AIP co-D-SNPs).

In **Table 1** below, we find that nationwide in 2025, out of 122,913 full-benefit C-SNP enrollees, 74.5% were living in counties offering a D-SNP contract, and 62.1% were living in counties that offered D-SNPs with moderate to high-level integration. Of note, there were 30,499 C-SNP enrollees in Illinois whose counties lacked a D-SNP offering in 2025. This is likely because Illinois was operating a Medicare-Medicaid Plan (MMPs) under the CMS Financial Alignment Initiative and had not yet introduced D-SNPs. Since the MMP demonstration officially ended in December 2025, we expect this to change, as most MMP enrollees in Illinois are expected to transition into D-SNPs introduced in the state in 2026. Excluding Illinois, we find that 99.1% of C-SNP dual-eligible enrollees lived in counties that had at least 1 D-SNP contract in 2025, and 82.6% lived in counties offering D-SNPs with moderate to high-level integration.

Nationwide, only 27.5% of C-SNP dual enrollees lived in counties where there is a D-SNP contract being offered by the same parent insurer of the C-SNP enrollee. This lower number is primarily driven by California, where despite 99.8% of C-SNP enrollees living in counties with a D-SNP offering, only 24.3% are living in counties where D-SNPs are being offered by the same parent insurer. When we exclude California and Illinois, 63.6% of full-benefit dual-eligibles in C-SNPs lived in counties where a D-SNP was being offered by the same insurer.

[3] McWilliams JM, Afendulis CC, McGuire TG, Landon BE. Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those With Impaired Decision Making. Health Affairs. 2011 Sep 1;30(9):1786-94.
[4] ATI Advisory. A Profile of Medicare-Medicaid Dual Beneficiaries. 2022 Jun.

Table 1. Dual-Eligible C-SNP Enrollees Residing in Counties with D-SNP Offerings.

		D-SNP Offerings			FIDE, HIDE, or AIP co-D-SNP Offerings		
Region	**No. Full-Benefit Dual C-SNP Enrollees**	**No. in County with any D-SNP Offerings**	**% in County with any D-SNP Offering**	**% in County with D-SNP offered by same parent insurer**	**No. in County with FIDE, HIDE, or AIP co-D-SNP offerings**	**% in County with FIDE, HIDE, or AIP co-D-SNP offerings**	**% in County with FIDE, HIDE, or AIP Co-D-SNP offered by same C-SNP parent insurer**
US	122,913	91,619	74.5%	27.5%	76,320	62.1%	14.4%
US (excluding IL)	92,414	91,619	99.1%	36.6%	76,320	82.6%	19.1%
US (excluding IL+CA)	28,803	28,125	97.6%	63.6%	20,086	88.4%	28.9%
California	63,611	63,494	99.8%	24.3%	56,234	88.4%	14.7%
Illinois	30,499	0	0.0%	0.0%	0	0.0%	0.0%
Oregon	5,108	4,863	95.2%	0.0%	4,863	95.2%	0.0%
Texas	2,462	2,462	100.0%	97.4%	2,323	94.4%	55.2%
Arizona	2,374	2,374	100.0%	58.7%	2,374	100.0%	58.7%
Florida	2,123	2,123	100.0%	95.7%	2,123	100.0%	95.7%
New Mexico	1,953	1,953	100.0%	69.2%	1,953	100.0%	69.2%
South Carolina	1,709	1,709	100.0%	93.4%	0	0.0%	0.0%
Georgia	1,541	1,541	100.0%	85.7%	0	0.0%	0.0%
Idaho	1,485	1,450	97.6%	0.0%	1,450	97.6%	0.0%
Virginia	1,210	1,210	100.0%	100.0%	1210	100.0%	31.2%
Missouri	1005	1005	100.0%	100.0%	0	0.0%	0.0%
Tennessee	842	842	100.0%	95.0%	842	100.0%	77.7%
Minnesota	805	805	100.0%	0.0%	805	100.0%	0.0%
Michigan	714	714	100.0%	95.9%	0	0.0%	0.0%
Arkansas	644	644	100.0%	100.0%	0	0.0%	0.0%
Indiana	449	449	100.0%	33.4%	449	100.0%	33.4%
Oklahoma	441	441	100.0%	100.0%	0	0.0%	0.0%
North Carolina	379	379	100.0%	95.8%	0	0.0%	0.0%
Pennsylvania	379	379	100.0%	100.0%	379	100.0%	0.0%
Wisconsin	302	302	100.0%	100.0%	302	100.0%	100.0%
Vermont	286	0	0.0%	0.0%	0	0.0%	0.0%
Massachusetts	253	253	100.0%	100.0%	253	100.0%	100.0%
Nevada	240	240	100.0%	95.0%	0	0.0%	0.0%
Kansas	201	201	100.0%	23.4%	201	100.0%	23.4%
New York	199	199	100.0%	80.4%	199	100.0%	67.8%
Alabama	170	170	100.0%	100.0%	0	0.0%	0.0%
Utah	137	137	100.0%	100.0%	0	0.0%	0.0%
Kentucky	134	134	100.0%	100.0%	134	100.0%	100.0%
New Hampshire	112	0	0.0%	0.0%	0	0.0%	0.0%
Louisiana	109	109	100.0%	100.0%	0	0.0%	0.0%
Rhode Island	98	98	100.0%	100.0%	0	0.0%	0.0%
Washington	85	85	100.0%	100.0%	85	100.0%	57.6%
New Jersey	83	83	100.0%	100.0%	83	100.0%	100.0%
Iowa	58	58	100.0%	79.3%	58	100.0%	0.0%
Delaware	57	57	100.0%	100.0%	0	0.0%	0.0%
Other States Combined (OH, MS, CO, CT, MD, ND, ME)*	656	656	100.0%	97.7%	0	0.0%	0.0%

Source: Authors' analyses of 2025 Medicare Data linked with the Plan Characteristics and Plan Service Area files. CO, CT, MD, ME, MS, ND, and OH combined due to small cell sizes.

Policy solutions

1. **If C-SNPs are continued to allow enrolling a high proportion of dual-eligible individuals, C-SNPs should at minimum be subject to the D-SNP requirements to integrate and coordinate state Medicaid services with Medicare**

Currently, as noted in proposed rule, C-SNPs are not subjected to the contracting requirements applicable to D-SNPs and they typically do not offer the key elements provided in integrated care plans, including an emphasis on coordination of Medicare and Medicaid services, mitigation of potentially perverse incentives for cost-shifting, and a better patient-centered experience for dual-eligible beneficiaries.

If C-SNPs continue to exist, we agree that these plans should be held to the same requirements of D-SNPs, including having a State Medicaid Agency Contract (SMAC). This is particularly important in the states with counties that have D-SNPs available for enrollment and are subject to these requirements. We agree that such a contract would allow states to proactively coordinate their integration strategies for dual-eligible beneficiaries. We suggest that this regulation should apply to the C-SNPs enrolling 60% or more dually eligible beneficiaries, to be consistent with the threshold CMS will apply to D-SNP look-alike plans as of 2026.

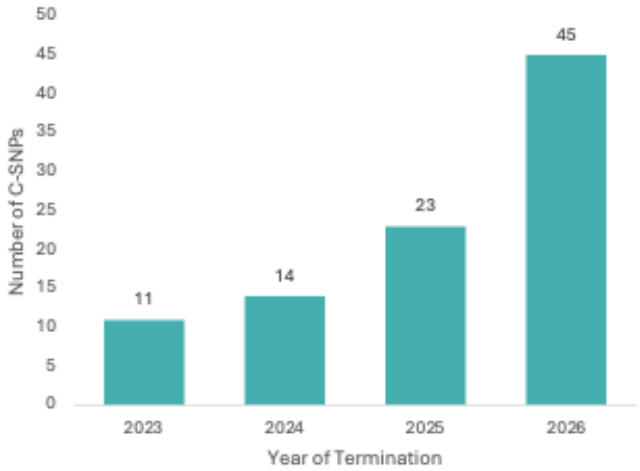
Based on our analyses, the majority of full-benefit dual eligible beneficiaries enrolled in C-SNPs already reside in counties where D-SNPs are available, including in many markets offering D-SNPs with moderate to high levels of Medicare–Medicaid integration. In a substantial share of these counties, C-SNP enrollees are also served by parent insurers that already sponsor D-SNPs and therefore operate under existing SMACs, suggesting that extending SMAC requirements to certain C-SNPs would be feasible in many markets. California represents an important exception with respect to insurer alignment, although nearly all C-SNP enrollees there still live in counties with D-SNP availability. Illinois is a temporary outlier due to its prior reliance on the MMP demonstration, and enrollment patterns are expected to shift as dually eligible beneficiaries transition into D-SNPs beginning in 2026.

2. **Application of the D-SNP look-alike termination policy may have limited effect**

In recent work, we found that there was a growing number of C-SNPs that were enrolling high proportion of dual-eligible beneficiaries that would have been terminated if CMS applied the look-alike termination policy to C-SNPs (Figure 2).[5] Our findings are largely consistent with the results presented in the proposed rule.

[5] Stein RI, Ma Y, Phelan J, Figueroa JF. Health Affairs Forefront. 2025. https://www.healthaffairs.org/content/forefront/growth-c-snps-may-jeopardizing-medicare-medicaid-integration.

Figure 2. Number of C-SNPs That would be Terminated if CMS D-SNP "Look-Alike" Regulation Applied to all SNPs, 2023-2026



Source: Authors' analysis of data from the 2022-25 CMS data. Plans with dual-eligible enrollment of 80% or more in 2022 and 2023 would be terminated in 2023 and 2024, respectively; plans with 70% or more in 2024 would face termination in 2025; and those with 60% or more in 2025 would be terminated in 2026. Plans offered outside of the 50 US States and Washington, D.C., or with fewer than 100 enrollees in January of each year were excluded from analysis.

However, as mentioned, the implementation of the first phase of the look-alike policy, which terminated conventional MA plans with 80% or more dual-eligible enrollees, was not effective at shifting dual-eligibles into plans with high levels of integration.[6] While it was associated with modest increases into plans offering low-level integration, namely the co-D-SNPs, most dual-eligible beneficiaries transitioned into other conventional MA plans even when a D-SNP was offered within the same county.

Therefore, we believe that if the look-alike policy was extended to include C-SNPs, we would observe similar results. While it may shift more enrollees into co-D-SNPs, it may also fall short into increasing enrollment into highly integrated MA plans. Therefore, we suggest that a first-order policy be requiring C-SNPs with a high proportion of dual-eligible beneficiaries (e.g., >60%) to have SMACs and face similar requirements as D-SNPs to coordinate care with Medicaid. We would support a policy to terminate C-SNPs with dual-eligible enrollment at or above such as threshold only if they fail to obtain and meet the requirements of a SMAC. Further research will then be needed to understand whether C-SNPs that also meet the regulatory requirements of D-SNPs improve the health care delivery and quality of care for dual-eligible beneficiaries.

As noted above, we would be available to discuss these suggestions further and address any other questions that you may have. Thank you for your consideration of our response.

Acknowledgment: We would like to thank Jessica Phelan (from HSPH) for their support in preparing this response.

[6] Ma Y, Roberts ET, Phelan J, Johnston KJ, Orav EJ, Meara ER, Figueroa JF. Federal Look-Alike Termination Policy and Dual-Eligible Enrollment in Integrated Care Programs, JAMA Health Forum. 2026 Jan 2;7(1):e256294.