ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

BRIEF

September 29, 2025

Approaches to Dementia Care in Special Needs Plans

Special needs plans can address the unique care requirements of people living with dementia, but research on their effectiveness is limited.

Jennifer Counts, Melissa Hunter, Elizabeth Gould, and Nicholas Rios Villacorta

KEY POINTS

- Special Needs Plans (SNPs) can address the unique care requirements of people living with dementia (PLWD) and their caregivers by facilitating increased engagement and personalized care and offering supplemental benefits to support enrollees' non-medical needs.
- SNPs that target the needs of PLWD offer a variety of care approaches and benefits to address their complex health concerns, including providing some caregiver supports and requiring dementia-specific training for associates and providers. However, few SNPs focus on PLWD or offer a comprehensive set of benefits designed to support PLWD.
- Few studies examine outcomes for PLWD who enroll in SNPs. More research is needed to determine whether PLWD experience better outcomes when enrolled in SNPs versus standard Medicare Advantage plans or traditional fee-for-service Medicare.

INTRODUCTION

Dementia. Dementia encompasses a range of neurodegenerative conditions with symptoms such as memory loss, spatial awareness issues, trouble with planning and organizing, confusion, and personality changes. The effects of dementia on brain function typically worsen over time. Alzheimer’s disease is the most common form of dementia. Other types of dementia include vascular, Lewy body, and frontotemporal dementia, among others. An estimated 13.8 million Americans will be living with dementia by the year 2060.[1]

People living with dementia (PLWD) often experience an array of symptoms that require more complex care. PLWD frequently have higher rates of co-occurring medical issues[2] and functional limitations (e.g., difficulties with activities of daily living [ADLs] and management of behavioral symptoms). PLWD are approximately four times as likely as older adults not living with dementia to need a caregiver’s help with a personal ADL, like bathing or grooming[3] and they are more likely to rely on multiple unpaid caregivers.[1] Many PLWD need long-term services and supports (LTSS) to address the variety of chronic symptoms that accompany dementia and to assist them in maintaining their quality of life over time. Home and community-based services (HCBS) can help meet these needs and are intended to support people outside of an institutional setting.[4] Care coordination and caregiver respite are two types of HCBS that may be helpful to PLWD and their caregivers, but they are often difficult to access.[5] One reason for this is that although traditional Medicare provides reimbursement for medical care, it often does not cover non-medical supportive services. Medicaid, on the other hand, may provide eligible individuals with LTSS, including HCBS, but people must meet income and functional eligibility criteria. Further, the types of Medicaid services that are available and eligibility requirements differ by state.[6] Only a subset of PLWD is dually eligible for both Medicare and Medicaid. One cross-sectional study of more than 60 million Medicare beneficiaries found that 19% were dually eligible.[7] Using claims data, those who were identified as “likely” or “highly likely” to be living with dementia had higher rates of dual-eligibility (29.6% and 36.7%, respectively).[7] In 2023, the Centers for Medicare & Medicaid Services Innovation Center launched a new model of care for PLWD that includes caregiver training and support called the Guiding an Improved Dementia Experience (GUIDE) model, but the demonstration program is only available in limited locations.

Special Needs Plans. Medicare special needs plans (SNPs) were introduced in 2006 as an option through Medicare Advantage (MA) to provide “targeted care” to people with complex health conditions.[10] Private insurance companies, hereafter referred to as Medicare Advantage Organizations (MAOs), offer SNPs to MA participants who meet certain eligibility criteria. SNPs provide the standard coverage of Medicare Part A and Part B plus additional services and benefits designed to meet the needs of the groups they cover. Three types of SNPs may potentially serve PLWD. Dual Eligible SNPs (D-SNPs) enroll people who are dually eligible for Medicare and Medicaid. Chronic Condition SNPs (C-SNPs) are designed for people with one or more specific chronic conditions, including dementia.[8] Institutional SNPs (I-SNPs) serve people who live in institutional settings or who live in the community but qualify for an institutional-equivalent level of care.[9]

Three types of SNPs may potentially serve PLWD. Dual Eligible SNPs (D-SNPs) enroll people who are dually eligible for Medicare and Medicaid. Chronic Condition SNPs (C-SNPs) are designed for people with one or more specific chronic conditions, including dementia.[8] Institutional SNPs (I-SNPs) serve people who live in institutional settings or who live in the community but qualify for an institutional-equivalent level of care.[9]

SNPs are increasingly popular among MA participants, with 7.3 million people, or approximately 21% of all MA beneficiaries, enrolled as of February 2025.[11,12] PLWD often need care coordination of the type SNPs are designed to provide. In theory there is an opportunity for plans to realize savings by providing PLWD with better care coordination. However, it is unclear how many SNPs offer dementia care, the extent to which PLWD and their caregivers are aware of these plans, and how effectively these plans address the needs of PLWD. For example, whereas dementia care could be covered through C-SNPs, only one MAO offered a plan focused on dementia in 2025.[13] D-SNPs offer three levels of Medicare-Medicaid integration, ranging from “Coordination-Only” to “Fully Integrated.” A recent study by Xu et al.[14] found that, relative to PLWD who were not enrolled in a D-SNP, only those MA participants who were part of fully integrated D-SNP plans realized improved outcomes. All the above points to the need to develop a clearer understanding of which supports are being offered to PLWD through SNPs, how many SNPs are offering them, and which approaches result in better outcomes.

The purpose of this project was to understand current SNP practices in delivering dementia care. We conducted an environmental scan and a series of key informant interviews to address the following research questions:

RESEARCH QUESTIONS

1. What approaches to care are MA SNPs utilizing to support PLWD?
2. What types of supplementary benefits are SNPs offering to better support PLWD and how many SNPs are offering such services?
3. What is the evidence about differences in outcomes (e.g., access to care, service utilization, patient care ratings/satisfaction, and adverse medical events such as avoidable emergency department visits and ambulatory care sensitive hospitalizations) among PLWD who are enrolled in SNPs compared to those enrolled in other MA plans or traditional Medicare?

METHODS

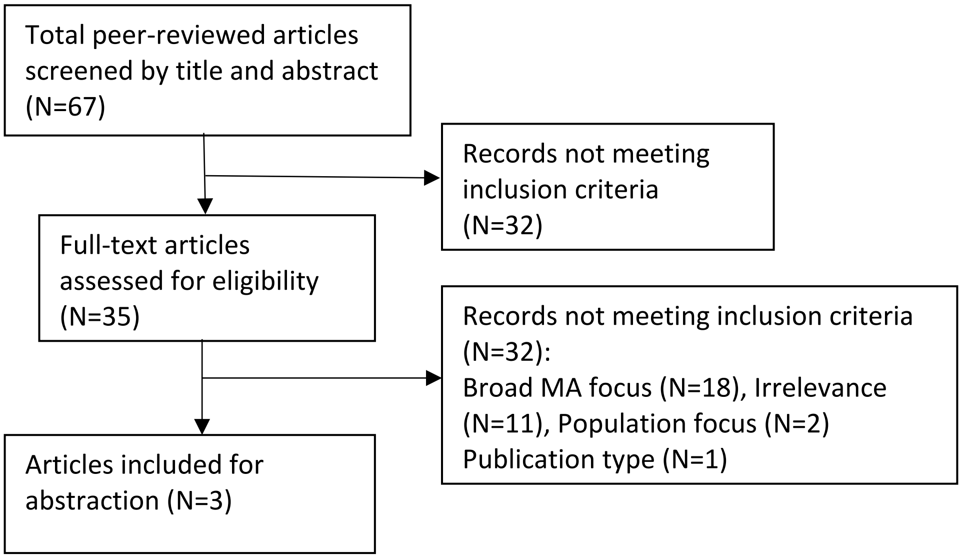
Environmental Scan

In March 2025 we conducted a high-level search of peer-reviewed and grey literature from the past 7 years to understand the current context of dementia care provided by MAOs through SNPs. The environmental scan focused on information relating to the variety of approaches being implemented, the extent of program implementation, and findings regarding the outcomes for PLWD. We used a search term algorithm that included a combination of keywords related to dementia, MA and SNPs, and services such as care coordination, supplemental benefits, and health care access and outcomes (see Appendix A). We performed searches in PubMed, Web of Science, and CINAHL databases. Sources were limited to English language, U.S.-based publications from 2018 to March 2025 that included selected keywords. For grey literature, we conducted targeted online searches and reviewed websites of known authorities, organizations, and stakeholders in the field. We applied the same language, geographic, and timeframe parameters as with the peer-reviewed literature search.

The initial search of peer-reviewed literature resulted in 67 articles, which underwent a title and abstract screening for relevance, population focus, and publication type. We then conducted a full-text review of the resulting 35 articles to filter for focus on research questions and population. Figure 1 displays the number of records filtered from the initial search to the final abstraction. Three peer-reviewed articles met the inclusion criteria for abstraction along with 15 sources included from the identified grey literature. The identified grey literature sources described the following:

- Four SNPs that reported implementing specific care approaches and offering supplemental benefits to meet the needs of PLWD
- Two states (California and Indiana) whose State Medicaid Agency Contracts (SMACs) mandate dementia care approaches for D-SNPs operating in-state

Figure 1. Peer-reviewed article selection



Key Informant Interviews

We conducted key informant interviews with five representatives from SNPs (“SNP interviewees”) and four representatives from health care research and advocacy organizations (“stakeholder interviewees”). We recruited interviewees through a combination of email and phone outreach during May and June 2025. We developed a unique interview guide for each informant group. Some questions were similar across groups (e.g., asking generally about the health plan-related needs of PLWD), but we tailored most questions to the specific informant group. Key topics included discussion of best practices for meeting the needs of PLWD through SNPs, the specific benefits or approaches tailored to address the needs of PLWD, efforts to raise awareness of and enrollment in dementia-specific plans, perceived outcomes of PLWD enrolled in SNPs, and barriers and facilitators to designing effective care plans for PLWD. We conducted interviews virtually from May through July 2025, each lasting no more than 1 hour. Some interviews included more than one interviewee (e.g., an interview with two colleagues who were knowledgeable about their organization's approach to supporting PLWD). An interviewer and note-taker attended each interview. We then cleaned the interview notes and identified key themes using a modified rapid qualitative analysis approach.

RESULTS

Our environmental scan uncovered information on a small number of SNPs that feature approaches to care specifically designed to support PLWD. Although there may be other SNPs that are targeted toward PLWD, sources identified in our scan, and interviews with SNP representatives and other stakeholders, suggest that such plans remain scarce in the MA market. Below we present findings from the environmental scan and key informant interviews regarding each of the project's three research questions and ideas for future directions in policy and research.

SNP Care Approaches to Support PLWD

According to the sources identified in the environmental scan and key informant interviews, SNPs most frequently use the following **care approaches** to address the needs of PLWD: identifying PLWD, care coordination, interdisciplinary care teams, offering dementia-specific training, providing enrollees with medication management, and utilizing partnerships with community-based organizations.

Identifying PLWD. Identifying dementia is the first step in creating a personalized care plan to meet the needs of PLWD. Any person enrolled in a SNP is required to participate in a health risk assessment (HRA). The mandatory HRA helps interdisciplinary care teams identify enrollees' needs and create individualized care plans.[15] The environmental scan and interviews revealed that some SNPs incorporate questions related to cognitive impairment in their HRAs to help identify beneficiaries who may be living with dementia and need additional support.[16]

- In California, for example, D-SNPs use HRAs to identify whether a person may need additional dementia screening.[17] California requires that "D-SNPs must ensure their HRA identifies …populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease".[17] The California State Medicaid Agency Contract (SMAC) that establishes requirements for D-SNPs also offers specific resources that can be used to help detect cognitive impairment. In California, even if a person has not been formally diagnosed with dementia, D-SNPs must offer a dementia care specialist if enrollees have documented care needs that might be related to dementia (i.e., wandering, home safety issues).[17]
- HealthPartners, an integrated insurer and health care provider in Minnesota, developed a dementia-friendly care model for their dually eligible beneficiaries with dementia who were enrolled in a D-SNP known as Minnesota Senior Health Options.[18] HealthPartners provides ongoing assessments based on enrollee and caregiver needs and develops a person-centered dementia care plan.[18]

Multiple stakeholders may contribute to identifying SNP enrollees with cognitive decline or who are living with dementia. According to interviewees, a plan's care coordinators often play a pivotal role in noticing early signs of cognitive changes. Care coordinators tend to have regular contact with enrollees, which positions them well to recognize enrollees' changing needs. Interviewees added that insurance brokers can also be important intermediaries of enrollee information, given their long-term relationships with enrollees. When a broker learns that a client has been diagnosed with dementia, for example, they can refer the enrollee to a health plan that caters to the specific needs of PLWD.

SNPs also rely on health care providers, caregivers, and enrollee self-reports for identification of cognitive decline. This approach comes with challenges, however. As noted by multiple interviewees, dementia remains a highly stigmatized condition with limited treatment for symptoms and no cure. For these reasons, doctors may be less likely to diagnose dementia, and enrollees may be less willing to disclose their own cognitive changes, making enrollee identification challenging.

Just as multiple stakeholders may take part in identifying PLWD, plans may consult various data sources to determine whether an enrollee needs dementia care. In addition to conducting HRAs, some SNP interviewees reported reviewing Medicare claims data for signs of cognitive decline.

As noted by multiple interviewees, dementia remains a highly stigmatized condition with limited treatment for symptoms and no cure. For these reasons, doctors may be less likely to diagnose dementia, and enrollees may be less willing to disclose their cognitive changes.

Care Coordination. Care coordination means deliberately organizing and facilitating care for a patient across health and community-based settings according to their health needs.[19] All SNPs include some level of care coordination for enrolled beneficiaries.[20] A “care coordinator” is typically assigned to each enrollee to help manage service access and act as a point person between the enrollee and the rest of the care team.[21,22] Care coordination can be particularly helpful for PLWD and their caregivers, because they have complex needs and often experience fragmented care.[21] Care coordinators also play a role in creating personalized care plans for PLWD.

Two states identified in the environmental scan, Indiana and California, outlined expanded care coordination requirements for PLWD in D-SNPs.

- D-SNPs in Indiana are required to “make good faith efforts to enroll all enrollees having a diagnosis of dementia into case management and to designate an assigned D-SNP care manager who provides longitudinal care coordination”.[23]
- Similarly, California requires a trained dementia care manager to help coordinate care for PLWD enrolled in D-SNPs.[17] They also specify that care coordinators must use health risk assessment results and caregiver needs and preferences to inform the development of care plans.[17] The care plan should also document how the care coordinator will facilitate access to referrals.[17]

Fully integrated dual-eligible SNPs (FIDE SNPs), a specific type of D-SNP that is required to cover both Medicare and Medicaid benefits under a single legal entity,[24] have the potential to better coordinate care between acute care needs (Medicare) and LTSS needs (Medicaid).

HealthPartners’ care coordinators work with PLWD to create dementia care plans and take a flexible approach to follow-up, determining the needs and preferences of both the enrollee and the caregiver and tailoring their approach to what they learn.[18] Of note, HealthPartners’ integrated system allows care coordinators to work in the same medical records system as providers, so they can easily alert other members of the care team to changes in condition, care transitions, and overall health status.[18]

HealthPartners’ integrated system allows care coordinators to work in the same medical records system as providers, so they can easily alert other members of the care team to changes in enrollee condition, care transitions, and overall health status.

“Care managers are key when it comes to people with dementia,” said one SNP interviewee. Another interviewee said care coordinators are a plan’s “eyes and ears.” According to interviewees, care coordinators serve as trusted sources of information and referrals for enrollees and families. They facilitate the development and implementation of care plans for PLWD. The care coordinator is central to personalizing the care plan through their efforts to establish familiarity with the enrollee and connect them to relevant services. SNP interviewees emphasized the importance of such individualized approaches to care for PLWD. “Everybody experiences this type of disease process differently,” said one interviewee. “So, depending on where they’re at, [the care plan is] individualized completely.”

*Interdisciplinary Care Teams***.** SNPs are required to have interdisciplinary care teams that meet on a regular basis to discuss enrollee needs and care plans.[25,26] A variety of health care providers can be included on a person's care team, as can the enrollee, their informal caregiver, and community-based organizations.[19,26] A successful care team is one that is collaborative and includes professionals who can address the variety of symptoms and needs that arise for PLWD and caregivers.[27] For example, a primary care physician can manage ongoing health needs; a social worker may help people access community-based supports; a nutritionist can assist with ensuring a proper diet, even as appetites or swallowing abilities change; and occupational therapists can help with home safety and changes in functional ability. A care team that is interdisciplinary in nature may be especially beneficial for PLWD, whose health issues necessitate treatment from an assortment of medical specialists and whose social support needs, and those of their caregiver, are often elevated.

CareMore—now called Carelon Health—effectively deployed interdisciplinary care teams for enrollees living with dementia. CareMore piloted its Brain Health Program in 2011 after they found that PLWD were often hospitalized because of limited understanding of the disease by both caregivers and patients.[28] Program participants were cared for by a team that included a neuropsychologist, psychiatrist, neurologist, pharmacist, dietician, and social worker.[28] This team of specialists was well suited to monitor disease progression, prevent drug interactions, assess dietary changes, and evaluate risks.[28] They also helped caregivers better understand safety risks associated with dementia, which in turn led to fewer falls and emergency department visits.[28] Having a specialized interdisciplinary care team that was attuned to the specific needs of PLWD and their caregivers led to improved health outcomes.

When interviewees were asked to list which of the plans' approaches to care were important to PLWD and their caregivers, a few described the importance of engaging a variety of providers, although only one specifically named the members of the interdisciplinary care team. This interviewee shared that an enrollee's team may include the care coordinator, primary care provider, and social work team. They also noted the importance of involving caregivers in the care team and reported that their SNPs offered training to staff to facilitate better engagement with caregivers. Another interviewee championed the importance of bringing together an enrollee's case management team, primary care provider, and caregiver with community providers who can support the enrollee's needs.

Dementia-Specific Training. Training can improve the skills, knowledge, and confidence of dementia professionals.[29,30] It is important to ensure that people who are working directly with PLWD, including care coordinators, receive dementia-specific training so they better understand the condition and know how to best serve these enrollees. The examples identified in our environmental scan and interviews focused on building a baseline understanding of dementia and its progression, and how dementia impacts caregivers and what local resources are available to help address needs. The two states we identified in the environmental scan with special care requirements for PLWD in D-SNPs offer the following resources and guidance on training:

- In California, dementia care specialists supporting D-SNP enrollees receive "specialized training in Alzheimer's disease and related dementias, including understanding and managing symptoms and behaviors, supporting caregivers, and connecting enrollees and their caregivers to community resources" (ATI Advisory, 2024, p. 11). California also offers Dementia Care Aware training for all providers serving D-SNP enrollees. Dementia Care Aware helps providers learn how to screen for dementia and talk with patients and caregivers about what resources are available and what to do after a positive result.
- Indiana requires its D-SNP care coordinators to undergo dementia training related to advance directives, services available through the aging network, service coordination, caregiver support, and "the 4Ms" (What Matters, Mentation, Medications, Mobility).[23]

HealthPartners' care coordinators receive training on the clinical considerations of dementia, behavior management, challenges faced by dementia caregivers, medication management, and cultural humility.[18]

Interviewees described offering a variety of dementia-related training. Within one SNP, all associates who support enrollees were required to complete training on topics including communication techniques, medication management, provider collaboration, mental health screening, and family support. One interviewee's SNP trained their dental providers on dementia to help them be more effective in treating PLWD. Receiving dental care can be difficult for PLWD; the behavioral and psychological symptoms (e.g., depression and aggression) that many PLWD experience, along with the decline of cognitive abilities, can make ongoing dental care difficult. Training was not reserved for professionals, however. One SNP interviewee emphasized the importance of providing education about dementia symptoms to enrollees and their caregivers to facilitate better communication with providers and to improve the diagnosis process. Another SNP produced an educational podcast for caregivers, PLWD, providers, and the public featuring dementia care experts.

Medication Management. PLWD are often older adults with coexisting chronic conditions, which puts them at increased risk of polypharmacy, or using multiple drugs to treat health conditions.[31-33] Polypharmacy can lead to adverse health reactions and worsen cognitive impairment.[32] Medication adherence can also be more difficult for PLWD.[34]

To address the risks of polypharmacy, some SNPs include medication management as a component of their support for PLWD. Indiana requires medication management for PLWD enrolled in D-SNPs, including the creation of a medication action plan, a medication list, a summary of recommendations, and medication refill reminders (Indiana Family & Social Services Administration, n.d.). CareMore included a pharmacist on their interdisciplinary care team to "ensure optimal use of drugs and prevent drug interactions".[28] Acknowledging the increased risk of polypharmacy within this population, one interviewee shared that their SNP's medication management program specifically focused on deprescribing. Deprescribing is an approach to "tapering, stopping, discontinuing, or withdrawing" medication to improve patient outcomes and overall safety.[35]

Partnerships With Community-Based Service Providers. Although health care providers can help PLWD manage many aspects of their care, some needs are better met through community-based service providers. These include resources like support groups, education on dementia topics, and respite programs.[22] Our environmental scan and interviews revealed that SNPs may rely on assistance from community-based organizations to meet a variety of non-medical needs expressed by enrollees.

SNPs can play a key role in getting PLWD connected to community-based services.[16] D-SNPs in Indiana and California are required to refer PLWD to community-based service providers.[17,23] Indiana requires D-SNPs to offer a referral to the local Area Agency on Aging (Indiana Family & Social Services Administration, n.d.); California requires D-SNP care coordinators to document how they are helping PLWD access referrals to community-based services, including to local Alzheimer's organizations.[17] My Choice Wisconsin, which offers D-SNPs focused on care coordination and community partnerships, noted that fostering partnerships with local organizations is integral to the success of their SNPs and encourages plan leaders to participate in local dementia coalitions and other task forces to develop those relationships with community partners and identify contacts.[36]

Most interviewees described collaborating with or referring to community-based organizations to provide supports for PLWD and their caregivers. For example, one SNP maintained a list of support groups throughout their state to which they could refer enrollees' caregivers. Another SNP interviewee described connecting enrollees to centers in the community that offered education and respite care.

Supplementary Benefits to Better Support PLWD

Unlike the embedded approaches to care described above, "supplementary" or "supplemental" benefits are those optional services that a SNP offers to enrollees to meet their non-medical, health related needs. MA was originally designed to include all services offered by traditional Medicare and coverage for additional services in addition to vision, hearing, and dental care. In 2018 CMS expanded what plans were allowed to cover to include a broader set of non-medical, primarily health related benefits, such as adult day services, caregiver supports, and non-emergency medical transportation. These benefits tend to be offered in SNPs more frequently than in other types of MA plans, reflecting the more complex care needs of SNP enrollees.[37] Beginning in 2020, supplemental benefits were expanded even further, and plans were able to provide services that were not limited to “primarily health related benefits” through Special Supplemental Benefits for Chronically Ill.[38] These benefits include non-medical transportation, food and produce, and home modifications, among others. The primary aim of providing these supplemental benefits is improving the quality of life for enrollees living with specific chronic conditions, including dementia.[39]

Our environmental scan and interviews indicated that few SNPs offer supplemental benefits specifically for PLWD. However, some benefits that SNPs offer—such as caregiver support services and in-home assistance—are not specifically intended for or exclusively available to PLWD but may be particularly beneficial to this population.[39] Data are available to measure the overall number of SNPs offering supplemental benefits, including those LTSS-type benefits that are thought to benefit PLWD. In plan year 2025, 11% of D-SNPs, 31% of I-SNPs, and 32% of C-SNPs offered in-home services and supports, and 4% of D-SNPs, 10% of I-SNPs, and 15% of C-SNPs offered caregiver supports.[40] Despite these services being important for PLWD, the percentage of plans offering them is low and, in many cases, trending downward.[40,41] A recent study found that after several years of growth, the share of MA plans that currently offer LTSS-like benefits is roughly the same as in 2019, when the benefits category was introduced. Meanwhile, the proportion of enrollees participating in such plans has declined.[42] The authors offer several potential explanations, including that LTSS benefits may not be financially feasible for MA plans, they may not appeal to enrollees, plans may be responding to reductions in relevant MA benchmarks, and workforce shortages may be limiting the availability of such services.[42]

Our environmental scan and key informant interviews identified the following **supplemental benefits** offered by some SNPs as beneficial for PLWD: home modifications/assistive devices, caregiver supports, in-home supports and personal care, enhanced supports in other settings, and flexible spending options.

Types of Supplemental Benefits Offered

Home Modifications/Assistive Devices. Home modifications are important for many adults as they age, but PLWD often face additional challenges with loss of memory, balance, and coordination that elevate the importance of home safety.[39] According to a recent systematic review, use of home modifications “resulted in improved function, increased ability to provide care, and decreased falls for people with a broad range of impairments”.[43] Home modifications can include updates to the bathroom (e.g., transfer benches, grab bars, walk-in bath); personal assistive devices (e.g., easy-grip cutlery, walking sticks, wheelchairs); and other safety items (e.g., signage to identify areas of the home, extra lighting, personal emergency response systems).

Multiple plans identified through the environmental scan provided some coverage for home safety assessments, modifications, or personal assistive devices. HealthPartners offers enrollees coverage for home modifications to prevent falls, including improved lighting and bathroom safety equipment.[18] Sonder Health’s Mind Matters C-SNP includes a free home safety assessment and a $325 monthly allowance that can be used cover a variety of benefits, including to reduce the costs of home modifications.[44]

Caregiver Supports. Caregiver support-related supplemental benefits are particularly important for PLWD.[45,46] After receiving a dementia diagnosis, PLWD and their caregivers often have extensive information and resource needs. As the disease progresses, caregiving often evolves to include significant help with instrumental activities of daily living for PLWD.[46]

California requires that “assessment of caregiver support needs should be included as part of the D-SNPs assessment process”.[17] D-SNPs operating in the state are instructed to use validated tools, such as the Benjamin Rose Caregiver Strain Instrument,[47] to determine caregiver needs. Recognizing the role caregivers play in supporting PLWD, some SNPs include supplemental benefits to meet caregiver needs. Caregiver support can include coaching, counseling, respite, adult day services, in-home or app-based education, and caregiver skills training.[18,37] Respite programs can offer caregivers much needed, short-term, time away from caregiving tasks.[48] Adult day services offer a safe environment outside of the home with activities, healthy meals, and behavior management for the enrollee and respite for the caregiver.

Sonder Health and HealthPartners are two examples of MAOs that have offered SNPs with supplemental benefits to address the needs of caregivers. HealthPartners offers “support for caregivers, including coaching, counseling, short-term respite care and psychotherapy, plus transportation support for these services”.[49] Through its Mind Matters C-SNP, Sonder Health provides up to 208 hours per year for caregiver training, respite care, and in-home support services, exceeding the average offered by all C-SNPs.[41,44] As noted above, Sonder Health also offers up to $325 per month to cover adult day care, home modifications, internet/cell phone coverage, and pet supplies.[44]

In-Home Supports and Personal Care. In-home supports and non-medical home care include services like nutritional counseling, companionship, assistance with personal care, and homemaker services. According to KFF, in 2023, more than twice as many SNPs as standard MA plans offered in-home supports (Freed et al., 2022).[50]

HealthPartners offers tablets that include brain training programs, dementia-friendly exercise guidance, and falls prevention education for enrollees, along with caregiver support apps and preloaded resources from the Alzheimer’s Association; to support enrollee use of the tablets, HealthPartners offers technical assistance to users.[18] HealthPartners also offers animatronic pets to provide companionship to enrollees.[18] Sonder Health likewise offers coverage for in-home supports, including support for ADLs.[44]

Enhanced Supports in Other Settings. For enrollees who cannot safely remain at home, a SNP can offset a portion of the cost of staying in a memory care or assisted living setting.[39] Residents of these settings may also have access to enhanced programs to promote healthier outcomes.

I-SNPs have traditionally partnered with skilled nursing providers.[39,51] An I-SNP from Longevity Health covers a “karaoke-like” music therapy program and enhanced companionship services for PLWD in institutional settings.[51] Both benefits were developed by the MAO based on requests from their institutional partners and the presumed clinical gains associated with providing these supports to PLWD.

Other Supplemental Benefits. In addition to the aforementioned supplemental benefits, interviewees from SNPs described offering financial help with accessing over-the-counter medications, meals, and groceries; transportation; legal services; and advanced directive planning.

Supplemental Benefit Selection, Uptake, and Challenges

Beyond reporting on the types of supplemental benefits offered to support PLWD through their SNPs, interviewees offered information about supplemental benefit decision-making, the uptake of supplemental benefits, and challenges of designing plans to meet the needs of PLWD and their caregivers.

> One SNP interviewee said that choosing which supplemental benefits to offer is “*really a team effort*” and that they consult with physicians, enrollees, and community organizations such as the Alzheimer’s Association to understand what would be most beneficial.

Supplemental Benefit Decision-Making. Interviewees offered important insights into how MAOs decide which benefits to offer to PLWD. Several interviewees said that while some supplemental benefits might not have been created specifically for PLWD, they are still beneficial to these enrollees and their caregivers. One interviewee noted that choosing which supplemental benefits to offer is “really a team effort” and that they consult with physicians, enrollees, and community organizations such as the Alzheimer’s Association to try to understand what would be the most beneficial. Another interviewee described their plans’ efforts to prioritize the holistic needs of enrollees living with dementia, including supports for housing, transportation, and mental and behavioral health. When selecting benefits to offer in each market, one SNP interviewee explained that their MAO relies on data collected through the HRA and aggregated at the population level, inclusive of PLWD. Of note, according to one interviewee, MAOs may seek to capitalize on economies of scale when selecting supplemental benefits, prompting plans to choose benefits that are more easily distributed or widely available. Although this approach may prove to be cost-effective, it is unclear the extent to which these benefits are able to meet the specialized needs of PLWD. All SNP interviewees recognized the importance of caregiver involvement for PLWD. As such, many offered supplemental benefits tailored to supporting and providing training to caregivers. “We think it’s important to give support to the caregiver,” said one interviewee, “which is why we have so many benefits within the plan [focused on that].”

Other, non-SNP stakeholders we interviewed offered perspectives on SNP benefit-related decision-making based on their observation and collaboration with MAOs. Stakeholder interviewees repeated the notion that plans often select their benefits to meet enrollee demand across a broader population, rather than concentrate on enrollees with a specific medical diagnosis. This may explain in part the shortage of plans with benefits more narrowly targeted toward PLWD. All stakeholder interviewees reported that financial considerations, including competitive advantage, likely factored prominently into SNPs’ decision-making. One interviewee contended that there are some benefits, like over-the-counter drug cards and flex cards, that are so popular that plans must offer these to be competitive, although they were uncertain of their utility among PLWD. Although SNPs often seek to attract new enrollees through supplemental benefits, one stakeholder interviewee suspected that a SNP may prefer not to become known for specializing in dementia care, saying “it’s probably not going to be on the front page of their marketing.” One stakeholder interviewee maintained that, when selecting benefits, SNPs consider what the research literature says about which benefits are effective. In this stakeholder’s estimation, the factors driving SNP benefit-related decision-making can be sorted into three buckets: research evidence, what enrollees say they want, and what competitors are offering. According to the interviewee, SNPs may consider “what they have to offer to keep their enrollees happy, and then, what they think would be the best clinical and value to the health of the enrollee.”

Supplemental Benefit Uptake by Enrollees. SNP interviewees had varying feedback on which supplemental benefits enrollees used most often and which benefits they used less frequently. None of the SNP interviewees provided data on the utilization of benefits by enrollees living with dementia. Most said they currently had limited or no ability to track benefit utilization by this group of enrollees. Other research has found similar gaps in the availability of supplemental benefit utilization data.[52] An independent survey of 3,280 Medicare enrollees by the Commonwealth Fund found that most MA enrollees considered supplemental benefits important, but approximately 3 in 10 did not use them.[53] One SNP interviewee suggested that enrollees were most interested in benefits to meet immediate needs, like food delivery, transportation to appointments or other services, adult day programs, and in-home support for ADLs. Other SNP interviewees agreed that transportation benefits are highly utilized, although this was true among all enrollees of their SNPs, not just enrollees living with dementia. Across other types of supplemental benefits, SNP interviewees expressed different perspectives about which benefits were accessed most frequently. A benefit to assist enrollees in preparing advance directives was said to be highly utilized by one plan’s enrollees, while another plan’s enrollees seemed less inclined to use their legal services benefit. One SNP interviewee listed durable medical equipment as a popular benefit, while another said it was one of the least used benefit options. As a SNP interviewee noted, the lower use of some benefits may be tied to a lack of awareness or complexity of use, along with a lower perceived immediate value.

Interviews with other stakeholders produced similar feedback about the most and least popular supplemental benefits among plan enrollees. Stakeholder interviewees observed that some of the most popular or most utilized benefits appeared to be those that offer some flexibility, such as flexible spending cards for food or over-the-counter medications. Interviewees noted that CMS would require plans to collect cost and utilization data within the next year, which would help to address the issue of having incomplete benefit utilization data.

> MA organizations weigh the competitive advantage of offering specialized, dementia-related benefits with the difficulty of attracting sufficient enrollees to a plan designed for a condition that is both stigmatizing and underdiagnosed.

Challenges With Targeting Plan Benefits to PLWD. Although interviewees suggested that SNPs may be uniquely positioned to meet the needs of PLWD through higher levels of enrollee engagement and coordination, many pointed out challenges, including low enrollment and high costs. According to interviewees, when selecting benefits, MAOs weigh the competitive advantage of offering specialized, dementia-related benefits with the difficulty of attracting sufficient enrollees to a plan designed for a condition that is both stigmatizing and underdiagnosed. Interviewees shared that many enrollees and their caregivers may lack information about the condition, which hinders their willingness and ability to access needed resources. Fear of accepting cognitive changes also affects enrollment. As one SNP interviewee noted, "it scares people off" to admit to cognitive decline, adding that, "No one is going to raise their hand and say, 'There is a program here for memory loss? Sign me up!'" However, plans with specialized benefits may appeal to caregivers who recognize the need for enhanced support. One SNP interviewee shared that they succeeded in offering specialized care approaches and supplemental benefits for PLWD by emphasizing the advantages, including reduced enrollee institutionalization, of providing support to caregivers.

One SNP interviewee shared that educating enrollees on benefits can be difficult for a dementia-targeting SNP because plans must often find and connect with a caregiver. This interviewee's MA plan described using a hyperlocal, "grassroots" approach to build relationships and raise awareness of their SNP, conducting regular outreach to churches, senior centers, adult day services, and local Alzheimer's Association chapters. To raise awareness of plan options, one stakeholder interviewee recommended improvements to Medicare Plan Finder, which they indicated currently lacks necessary and accurate information about benefits. Medicare Plan Finder is a free online tool offered by CMS to help Medicare beneficiaries compare and choose Medicare plans. For example, Star Ratings could be used to provide information about plans' specific benefits for PLWD to help beneficiaries and caregivers with plan selection. CMS issues Star Ratings to MA plans based on several key metrics, including enrollees' reviews, customer service, the plan's performance, and enrollees' health outcomes.

As one SNP interviewee related, launching any new plan involves considerable costs, and plans designed for PLWD, although worthwhile, may be particularly slow growing. Another interviewee said that trying to "convince an actuary to start a plan for people with Alzheimer's" can be difficult given the often extensive, long-term health care needs of PLWD. For these reasons, MAOs may hesitate to invest in plans or specialized benefits targeted toward PLWD. However, as revealed in the environmental scan and interview findings, many supplemental benefits that meet the needs of PLWD may also be of value to beneficiaries who are not living with dementia.

Impact of SNP Enrollment on Outcomes for PLWD

This project also sought to understand research on how SNPs affect the outcomes among PLWD. Available research is limited on outcomes among PLWD enrolled in SNPs compared to those enrolled in other MA plans or traditional Medicare. Our environmental scan revealed that a few recent studies have begun to explore differences in outcomes for PLWD enrolled in SNPs, but overall, there is a paucity of research. One study found no significant differences in preventable hospitalizations or avoidable emergency department visits between beneficiaries with dementia enrolled in D-SNPs versus non-SNP MA plans; however, further analyses of enrollees in different types of D-SNPs revealed that PLWD enrolled in FIDE SNPs had statistically significant lower rates of preventable hospitalizations and readmissions.[14] Another study reported that in counties where aligned D-SNPs were offered, dual eligible beneficiaries who did not enroll in an aligned D-SNP (like FIDE SNPs) were less likely to be PLWD and less likely to receive long-term institutional care when available.[54] This may mean that PLWD are more likely to enroll in aligned D-SNPs when they are available. A third study found no improvements in care for PLWD enrolled in D-SNPs, and worse self- or proxy-reported care experiences compared to D-SNP enrollees without dementia.[55] Together, these findings suggest some potential differences in outcomes by plan type but emphasize the need for more comprehensive research to fully understand the impact of SNP enrollment on the care outcomes among PLWD.

No SNP interviewees reported having compared health outcomes for PLWD enrolled in SNPs with outcomes for PLWD enrolled in other types of MA plans. One SNP interviewee noted that they assumed satisfaction would be higher for caregivers of PLWD enrolled in SNPs because the plans have supplemental services that are intended to help caregivers, such as training and coverage for respite care, but they did not have data to confirm this assumption. Stakeholder interviewees were similarly unable to comment on how outcomes for PLWD who are enrolled in SNPs differ from those in other MA plans and traditional Medicare. They reported either not having access to these data or not having looked at the data in that way. One stakeholder interviewee said that while their state should begin receiving specific D-SNP data in 2026, they do not currently have the necessary data that would allow them to compare outcomes based on a dementia diagnosis.

At least one stakeholder was able to point to other types of outcomes for PLWD who were enrolled in SNPs. They shared that there was a large increase in referrals to community-based aging organizations among enrollees of D-SNPs in their state following the implementation of a requirement for D-SNPs to make a referral for each enrollee diagnosed with dementia. This interviewee also remarked that, after instituting a number of care requirements for D-SNPs, their state had observed more dually eligible people receiving LTSS through HCBS instead of entering nursing homes, achieving a major “rebalancing” goal to help people age in place. Although this shift applied to all older adults, according to this interviewee the trend “in large part” reflected changes in how PLWD access services.

POLICY OPTIONS TO STRENGTHEN CARE FOR PLWD

PLWD have complex health care needs,[56] and their caregivers often face health and social challenges related to the demands of the role.[57] Based on the findings of this study, we identified three policy options to strengthen supports for PLWD in MA plans:

- MA plans could better define how they will serve PLWD through their models of care (MOCs).
- States could require D-SNPs to meet the needs of these enrollees through SMACs.
- State and federal government agencies, through SNP requirements and technical assistance, could encourage more MAOs to prioritize care approaches and benefits targeted toward PLWD.

Below we expand on each of these potential approaches suggested by interviewees or environmental scan sources.

SNPs are required to develop and get approval from CMS for MOCs that outline how they will meet the needs of the populations they serve.[58,59] They are expected to use data from their service area to identify populations with higher needs.[60] It is not clear how many SNPs currently choose PLWD as a target population when creating their MOCs. CMS could explore requiring a focus on PLWD in all MOCs. If PLWD were included as a target population, MOCs could provide an opportunity for SNPs to further understand their needs and develop a framework for how to best meet them. Given the importance of caregivers to PLWD, one interviewee suggested that CMS could leverage their approval of MOCs to ensure that SNPs address caregiver needs. Similarly, the MOC approval process could provide an opportunity to encourage SNPs to demonstrate their plans for meeting the needs of PLWD.

D-SNPs are unique because they are required to have SMACs with each state in which they operate.[61] As previously described, some states, including California and Indiana, are choosing to include enhanced requirements related to serving PLWD in their SMACs.[17,23] Other states may also have these kinds of requirements in their SMACs but were not identified in our environmental scan. A fuller policy scan of SMACs, as available, could be beneficial. In general, states have leverage to improve care for PLWD enrolled in D-SNPs through their SMACs. States can use SMACs to promote coordination between Medicaid and Medicare services and encourage plans to better meet the needs of PLWD. One stakeholder interviewee recommended that states push aligned care and try to ensure that Medicaid and Medicare services are provided through the same entity, as much as possible, which is supported by the research evidence. In fact, recent CMS final rules for contract years 2025 and 2026 include provisions to encourage increased integration of Medicare and Medicaid services for dually eligible individuals.[62,63] Another interviewee noted that when state legislatures have strategic plans focused on the impact of dementia and how they plan to address it, that focus can elevate dementia care and support for caregivers more broadly.

To spur innovation in the SNP market, one interviewee suggested that CMS could designate a supplemental benefit category specifically for PLWD and impose fewer restrictions for those benefits. To complement state efforts, another interviewee suggested that national policy should be more prescriptive about D-SNPs identifying PLWD as one of their highly vulnerable populations and implementing specific adjustments, like caregiver support and education, similar to what is included in the current GUIDE model for traditional Medicare users. Furthermore, MAOs could be encouraged to develop C-SNPs that focus on dementia. C-SNPs are a small but growing type of MA plan.[64] As previously stated, in 2025, only one C-SNP targeted dementia as a chronic condition.[13] According to one article, "MAOs may be exiting the market for these C-SNP types due to unmanageable medical costs or low enrollment".[64] Two interviewees expressed the need to provide higher payments to help meet the needs of PLWD, to ensure that plans do not face the prospect of losing money by offering specialized benefits and care approaches.

Two stakeholder interviewees thought that it would be useful for states and SNPs to regularly receive examples of what works best for serving PLWD, such as MOCs that effectively encourage care approaches for PLWD, information on screening tools, or the latest research on dementia. One interviewee noted that for-profit plans are unlikely to share benefit-related information they consider proprietary, so it would be up to CMS and researchers to disseminate the results of effectiveness and implementation studies more widely. Interviewees suggested that states could use more training and guidance related to how to effectively write SMACs that improve care for PLWD. Finally, one interviewee noted that with new data reporting requirements being implemented, such as additional encounter data and data on supplemental benefits, now is the time to begin longitudinal research related to the impact of SNPs on PLWD.

DISCUSSION

SNPs are designed to meet the needs of Medicare recipients with more complex health issues and, therefore, hold promise as a means to address the unique care requirements of PLWD and their caregivers. SNPs can facilitate more extensive engagement with enrollees and their caregivers and increase personalization of care. SNPs have more flexibility to build plans capable of supporting PLWD living at home and in institutional care settings with the supplemental benefits flexibilities. Some SNPs are specifically designed for PLWD; others ensure that their SNPs offer approaches to care and supplemental benefits that meet the needs of PLWD, such as medication management, in-home services, and caregiver supports. However, to date, few SNPs fall into either of these categories. Among the small number of plans that have made progress toward meeting the needs of PLWD, the supports they offer may remain modest compared to the level of need. This is particularly true regarding supports for caregivers. Across all MA plans, just 6% offered caregiving benefits in 2025.[40]

Research and key informant interviews suggest that state and federal policy can be leveraged to encourage broader distribution of dementia-friendly benefits by MAOs through SNPs. By instituting requirements for MOCs and SMACs to more intentionally and comprehensively address the needs of PLWD and their caregivers, and by offering enhanced technical assistance, federal and state policymakers can help to ensure that SNPs offer PLWD and caregivers access to a level of care that supports their well-being. Meanwhile, further research is needed to better understand how different Medicare plan types affect outcomes such as access to care, service utilization, patient satisfaction, and avoidable adverse events among the specific population of PLWD.

LIMITATIONS

Our research has important limitations. Our findings rely heavily on published case studies or articles describing four SNPs designed to meet the needs of PLWD and on information shared in interviews by representatives of MAOs and other stakeholders. The small number of MAOs represented in our interviews partly reflects the limited number of plans focused on PLWD but means a large portion of MAOs' perspectives are not included. Searching all state SMACs for dementia-supportive policies was also beyond the scope of this project. A more complete search may yield additional information about whether and how other states are encouraging D-SNPs to approach care for PLWD and their caregivers. Crucially, these results reflect neither the perspectives of beneficiaries and caregivers who are enrolled in these plans, nor their care providers. Although some recent research has gathered beneficiaries' feedback on supplemental benefits,[40] we found no such research that has been conducted specifically with PLWD and their caregivers. This is an important research gap to be filled.

APPENDIX: ENVIRONMENTAL SCAN SEARCH TERMS

(“people living with dementia” OR “persons living with dementia” OR “dementia” OR “PLWD” OR “cognitive* impair*” OR “cognitive decline” OR “memory loss” OR “neurocognitive disorder” OR “ADRD” OR “Alzheimer*”)

AND

(“SNP” OR “Special Needs Plan” OR “C-SNP” OR “Chronic Condition Special Needs Plan” OR “D-SNP” OR “Dual Eligible Special Needs Plan” OR “HIDE-SNP” OR “Highly Integrated Dual Eligible Special Needs Plan” OR “FIDE-SNP” or “Fully Integrated Dual Eligible Special Needs Plan” OR “I-SNP” OR “Institutional Special Needs Plan” OR “Medicare Advantage” or “MA”)

AND

(“supplement* benefit” OR “supplement* service” OR “care coordination” OR “support* service” OR “support program” OR “integrated care” OR “home and community based” OR “HCBS” OR “long term service and support” OR “LTSS” OR “managed care” OR “service use” OR “service utilization” OR “access to care” OR “patient satisfaction” OR “patient care rating” OR “outcome” OR “medical event” OR “nonmedical” OR “non-medical” OR “model of care” OR “MOC”)

REFERENCES

1. Alzheimer's Association. 2025 Alzheimer's disease facts and figures. *Alzheimer's and Dementia.* 2025;21(4):e70235. doi:https://dx.doi.org/10.1002/alz.70235
2. Nelis SM, Wu YT, Matthews FE, et al. The impact of co-morbidity on the quality of life of people with dementia: findings from the IDEAL study. *Age Ageing.* 2019;48(3):361-367. doi:https://dx.doi.org/10.1093/ageing/afy155
3. Alzheimer's Association. Fact sheet: Alzheimer's disease caregivers. https://act.alz.org/site/DocServer/caregivers_fact_sheet.pdf?docID=3022. Published 2020. Accessed Sept 24, 2025.
4. Centers for Medicare & Medicaid Services. Home & community based services. https://www.medicaid.gov/medicaid/home-community-based-services. Published n.d.a. Accessed Sept 24, 2025.
5. ATI Advisory. *Opportunities for D-SNPs to improve access to and experience with HCBS.* ATI Advisory; 2024, November. Available from: https://atiadvisory.com/resources/wp-content/uploads/2024/11/Opportunities-for-DSNPs-to-Improve-HCBS.pdf
6. Medicaid and CHIP Payment and Access Commission (MACPAC). Home- and community-based services. https://www.macpac.gov/subtopic/home-and-community-based-services/. Published 2024a. Accessed Sept 24, 2025.
7. Gianattasio KZ, Wachsmuth J, Murphy R, et al. Case Definition for Diagnosed Alzheimer Disease and Related Dementias in Medicare. *JAMA Netw Open.* 2024;7(9):e2427610. doi:https://dx.doi.org/10.1001/jamanetworkopen.2024.27610
8. Centers for Medicare & Medicaid Services. (n.d.c). Chronic Condition Special Needs Plans (C-SNPs). https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/chronic-conditions. Published n.d.c. Accessed Sept 24, 2025.
9. Centers for Medicare & Medicaid Services. (n.d.d). Institutional Special Needs Plans (I-SNPs). https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/institutional. Published n.d.d. Accessed Sept 24, 2025.
10. Centers for Medicare & Medicaid Services. Special Needs Plans. https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans. Published n.d.b. Accessed Sept 24, 2025.
11. Centers for Medicare & Medicaid Services. Special Needs Plan data. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/special-needs-plan-snp-data. Published n.d.e. Accessed Sept 24, 2025.
12. Ochieng N, Freed M, Biniek JF, et al. Medicare Advantage in 2025: Enrollment update and key trends. https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/. Published 2025. Accessed Sept 24, 2025.
13. Freed M, Biniek J, Damico A, et al. Medicare Advantage 2025 spotlight: First look. https://www.kff.org/medicare/medicare-advantage-2025-spotlight-a-first-look-at-plan-offerings/. Published 2024, November 15. Accessed Sept 24, 2025.
14. Xu W, Raver E, Carlin C, et al. Outcomes for Dual-Eligible Beneficiaries With Dementia in Special Needs Plans and Other Medicare Advantage Plans. *JAMA Netw Open.* 2025;8(2):e2461219. doi:https://dx.doi.org/10.1001/jamanetworkopen.2024.61219
15. National Committee for Quality Assurance (NCQA). Model of care scoring guidelines for contract year 2025. https://snpmoc.ncqa.org/static/media/CY2025SNP_MOC_Scrng_Gdlns_508.4c71d8c17b37b33ff079.pdf Published 2025. Accessed Sept 24, 2025.
16. Resources for Integrated Care. Tip sheet: Applying promising practices to advance care for individuals dually eligible for Medicare and Medicaid with dementia.
17. California Department of Health Care Services. *Calaim Dual Eligible Special Needs plan policy guide, CY 2025.* California Department of Health Care Services; 2025, April. Available from: https://www.dhcs.ca.gov/es/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide-2025.pdf.
18. Resources for Integrated Care. *Building a dementia-friendly care model: Spotlight on HealthPartners.* 2022, February 18.
19. Agency for Healthcare Research and Quality (AHRQ). Care coordination measures atlas, chapter 2. What is care coordination? https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html. Published 2014. Accessed Sept 24, 2025.
20. Centers for Medicare & Medicaid Services. Special Needs Plans (SNP). https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP. Published n.d.f. Accessed Sept 24, 2025.

21. Hughes S, Lepore M, Wiener JM, et al. *Research on care coordination for people with dementia and family caregivers (Background Paper).* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; 2017. Available from: https://aspe.hhs.gov/reports/research-care-coordination-people-dementia-family-caregivers-0.
22. Hunter M, Counts J, Stapleton M, et al. *Bridging healthcare and social services for people living with dementia and their caregivers.* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation; 2024. Available from: https://aspe.hhs.gov/reports/bridging-healthcare-social-services-plwd-their-caregivers.
23. Indiana Family & Social Services Administration. 2024 State Medicaid Agency Contract. https://www.in.gov/medicaid/partners/files/CY2024INSMACAmendment.pdf. Published n.d.
24. Weir Lakhmani E. Definitions of different Medicare Advantage dual eligible special needs plan (D-SNP) types in 2023 and 2025 (Tip Sheet). https://integratedcareresourcecenter.com/sites/default/files/ICRC_DSNPDefinitions_2023-2025_0.pdf Published 2022. Accessed Sept 24, 2025.
25. Centers for Medicare & Medicaid Services. *Special Needs Plans (SNP) frequently asked questions (FAQs).* Baltimore, MD: CMS; n.d.g. Available from: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Special_Need_Plans_SNP_Frequently_Asked_Questions-FAQ.pdf.
26. Philip AM, Herman Soper M. *Interdisciplinary care teams for Medicare-Medicaid enrollees: Considerations for states (issue brief).* 2016. Available from: https://www.chcs.org/media/INSIDE_ICTs_for_Medicare-Medicaid_Enrollees-012216.pdf
27. Galvin JE, Valois L, Zweig Y. Collaborative transdisciplinary team approach for dementia care. *Neurodegener Dis Manag.* 2014;4(6):455-469. doi: https://dx.doi.org/10.2217/nmt.14.47
28. Hostetter M, Klein S, McCarthy D. CareMore: Improving outcomes and controlling health care spending for high-needs patients. https://www.commonwealthfund.org/publications/case-study/2017/mar/caremore-improving-outcomes-and-controlling-health-care-spending-0 Published 2017, March 28. Accessed Sept 24, 2025.
29. National Council of Certified Dementia Practitioners (NCCDP). The empowering benefits of dementia training for caregivers. https://www.nccdp.org/the-empowering-benefits-of-dementia-training-for-caregivers/. Published n.d. Accessed Sept 24, 2025.
30. Rasmussen BM, Andersen PT, Waldorff FB, et al. Effectiveness of dementia education for professional care staff and factors influencing staff-related outcomes: An overview of systematic reviews. *International Journal of Nursing Studies.* 2023;142:104469. doi: https:/doi.org/10.1016/j.ijnurstu.2023.104469
31. Esumi S, Ushio S, Zamami Y. Polypharmacy in Older Adults with Alzheimer's Disease. *Medicina (Kaunas).* 2022;58(10). doi:https://dx.doi.org/10.3390/medicina58101445
32. National Institutes of Health. The dangers of polypharmacy and the case for deprescribing in older adults. https://www.nia.nih.gov/news/dangers-polypharmacy-and-case-deprescribing-older-adults. Published 2021. Accessed Sept 24, 2025.
33. Zhao M, Chen Z, Xu T, et al. Global prevalence of polypharmacy and potentially inappropriate medication in older patients with dementia: a systematic review and meta-analysis. *Front Pharmacol.* 2023;14:1221069. doi:https://dx.doi.org/10.3389/fphar.2023.1221069
34. Lim RH, Sharmeen T. Medicines management issues in dementia and coping strategies used by people living with dementia and family carers: A systematic review. *Int J Geriatr Psychiatry.* 2018;33(12):1562-1581. doi:https://dx.doi.org/10.1002/gps.4985
35. Thompson W, Farrell B. Deprescribing: what is it and what does the evidence tell us? *Can J Hosp Pharm.* 2013;66(3):201-202. doi: https://dx.doi.org/10.4212/cjhp.v66i3.1261
36. Resources for Integrated Care. Community Care Plans - Spotlight on My Choice Wisconsin.
37. ATI Advisory. *Expanded primarily health-related benefits in 2023 Medicare Advantage plans.* ATI Advisory; 2022, November. Available from: https://atiadvisory.com/resources/wp-content/uploads/2022/11/Data-Insight-Expanded-Primarily-Health-Related-Benefits-in-Plan-Year-2023.pdf
38. Kornfield T, Kazan M, Frieder M, et al. *Medicare Advantage plans offering expanded supplemental benefits: A look at availability and enrollment.* The Commonwealth Fund; 2021. Available from: https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits
39. Dementia Care Central. Medicare Advantage plans with benefits designed for Alzheimer’s and dementia. https://www.dementiacarecentral.com/medicare-advantage-benefits/. Published 2023, June 25. Accessed Sept 24, 2025.

40. ATI Advisory. *Advancing beneficiary choice in Medicare Advantage: Shaping the future of nonmedical supplemental benefits.* ATI Advisory; 2025, July. Available from: https://atiadvisory.com/resources/wp-content/uploads/2025/07/ATI_Advancing-Beneficiary-Choice-in-Medicare-Advantage_Shaping-Future-of-Nonmedical-Benefits.pdf
41. ATI Advisory. *Chartbook: 2024 nonmedical supplemental benefits in Medicare Advantage.* ATI Advisory; 2024, January. Available from: https://atiadvisory.com/resources/wp-content/uploads/2024/01/Chartbook-of-Dual-Eligible-Individuals-with-Behavioral-Health-Needs-ATI-Advisory.pdf.
42. Bhaumik D, Grabowski DC. Long-Term Services and Supports in Supplemental Benefits in Medicare Advantage Plans. *JAMA Netw Open.* 2025;8(8):e2526406. doi:https://dx.doi.org/10.1001/jamanetworkopen.2025.26406
43. Stark S, Keglovits M, Arbesman M, et al. Effect of Home Modification Interventions on the Participation of Community-Dwelling Adults With Health Conditions: A Systematic Review. *Am J Occup Ther.* 2017;71(2):7102290010p7102290011-7102290010p7102290011. doi:https://dx.doi.org/10.5014/ajot.2017.018887
44. Sonder Health Plans. Sonder Chronic Special Needs Plans. https://sonderhealthplans.com/2025-sonder-chronic-special-needs-plans/ Published n.d.
45. Vandepitte S, Van Den Noortgate N, Putman K, et al. Effectiveness of Supporting Informal Caregivers of People with Dementia: A Systematic Review of Randomized and Non-Randomized Controlled Trials. *J Alzheimers Dis.* 2016;52(3):929-965. doi:https://dx.doi.org/10.3233/jad-151011
46. Whitlatch CJ, Orsulic-Jeras S. Meeting the Informational, Educational, and Psychosocial Support Needs of Persons Living With Dementia and Their Family Caregivers. *Gerontologist.* 2018;58(suppl_1):S58-S73. doi:https://dx.doi.org/10.1093/geront/gnx162
47. Bass DM, Noelker LS, Rechlin LR. The moderating influence of service use on negative caregiving consequences. *J Gerontol B Psychol Sci Soc Sci.* 1996;51(3):S121-131. doi:https://dx.doi.org/10.1093/geronb/51b.3.s121
48. Roberts E, Struckmeyer KM. The Impact of Respite Programming on Caregiver Resilience in Dementia Care: A Qualitative Examination of Family Caregiver Perspectives. *Inquiry.* 2018;55:46958017751507. doi:https://dx.doi.org/10.1177/0046958017751507
49. HealthPartners. Health insurance plans. https://www.healthpartners.com/insurance/ Published n.d. Accessed Sept 24, 2025.
50. Freed M, Biniek J, Damico A, et al. Medicare Advantage 2023 spotlight: First look. https://www.kff.org/report-section/medicare-advantage-2023-spotlight-first-look-data-note/. Published 2022, November 10.
51. Marselas K. Nursing homes finally seeing benefits of Medicare Advantage supplemental services. *McKnight's Long-Term Care News.* 2023, January 30.
52. Medicare Payment Advisory Commission (MedPAC). *June 2025 Report to the Congress: Medicare and the health care delivery system.* MedPAC; 2025. Available from: https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/#.
53. Gupta A, Jacobson G, Leonard F. How much do Medicare Advantage enrollees value and use their supplemental benefits? Published 2025, February
54. Johnston KJ, Hendricks M, Dabas M, et al. Nationwide Availability of and Enrollment in Medicare and Medicaid Dual-Eligible Special Needs Plans With Exclusively Aligned Enrollment. *JAMA Health Forum.* 2024;5(10):e243546. doi:https://dx.doi.org/10.1001/jamahealthforum.2024.3546
55. Meyers DJ, Rivera-Hernandez M, Kim D, et al. Comparing the care experiences of Medicare Advantage beneficiaries with and without Alzheimer's disease and related dementias. *J Am Geriatr Soc.* 2022;70(8):2344-2353. doi:https://dx.doi.org/10.1111/jgs.17817
56. Scharf A, Kleinke F, Michalowsky B, et al. Sociodemographic and Clinical Characteristics of People Living with Dementia and Their Associations with Unmet Healthcare Needs: Insights from the Baseline Assessment of the InDePendent Study. *J Alzheimers Dis.* 2024;99(2):559-575. doi:https://dx.doi.org/10.3233/JAD-231173
57. Vu M, Mangal R, Stead T, et al. Impact of Alzheimer's Disease on Caregivers in the United States. *Health Psychol Res.* 2022;10(3):37454. doi:https://dx.doi.org/10.52965/001c.37454
58. Services CfMM. Model of Care (MOC). https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/model-care. Published n.d.h. Accessed Sept 24, 2025.
59. Klein S, Hostetter M. Taking stock of Medicare Advantage: Special Needs Plans. *Improving Health Care Quality* Vol 2025: The Commonwealth Fund; 2022, March 31. https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-special-needs-plans

60. Centers for Medicare and Medicaid Services, National Committee for Quality Assurance. SNP Approval Models of Care Training, Elements 1 and 2 [PowerPoint Slides]. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/MOCElements1-2Training.pptx. Published 2016. Accessed July 15, 2025.
61. Medicaid and CHIP Payment and Access Commission (MACPAC). *Chapter 2: Optimizing State Medicaid Agency Contracts.* 2024b. Available from: https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-2-Optimizing-State-Medicaid-Agency-Contracts.pdf.
62. Centers for Medicare & Medicaid Services. Medicare and Medicaid programs; CY 2025 payment policies under the physician fee schedule and other changes to Part B payment and coverage policies; Medicare shared savings program requirements; Medicare prescription drug inflation rebate program; and Medicare overpayments. *Federal Register, 42 CFR Parts 401, 405, 410, 411, 414, 423, 424, 425, 427, 428, and 491, 97710-99057.* 2024.
63. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; CY 2026 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. *Federal Register, 42 CFR Parts 417, 422, 423, and 460, 15792-15921.* 2025.
64. Yeh M. Chronic condition special needs plans: 2024 market landscape and future considerations. https://www.milliman.com/en/insight/chronic-condition-special-needs-plans-2024-market-landscape Published 2024. 2025.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue SW, Mailstop 447D
Washington, D.C. 20201

For more ASPE briefs and other publications, visit:
https://aspe.hhs.gov/reports

ABOUT THE AUTHORS
Jennifer Counts, MPH; Melissa Hunter, MSW; Elizabeth Gould, MSW, LCSW; and Nicholas Rios Villacorta, BSPH work at RTI International

ACKNOWLEDGMENT
Maria-Theresa Okafor, PhD, MCG (HHS/ASPE) and Jhamirah Howard, MPH (HHS/ASPE) contributed to the design of the work and supervised the project. All authors and contributors reviewed and discussed the findings and provided input and edits to this brief.