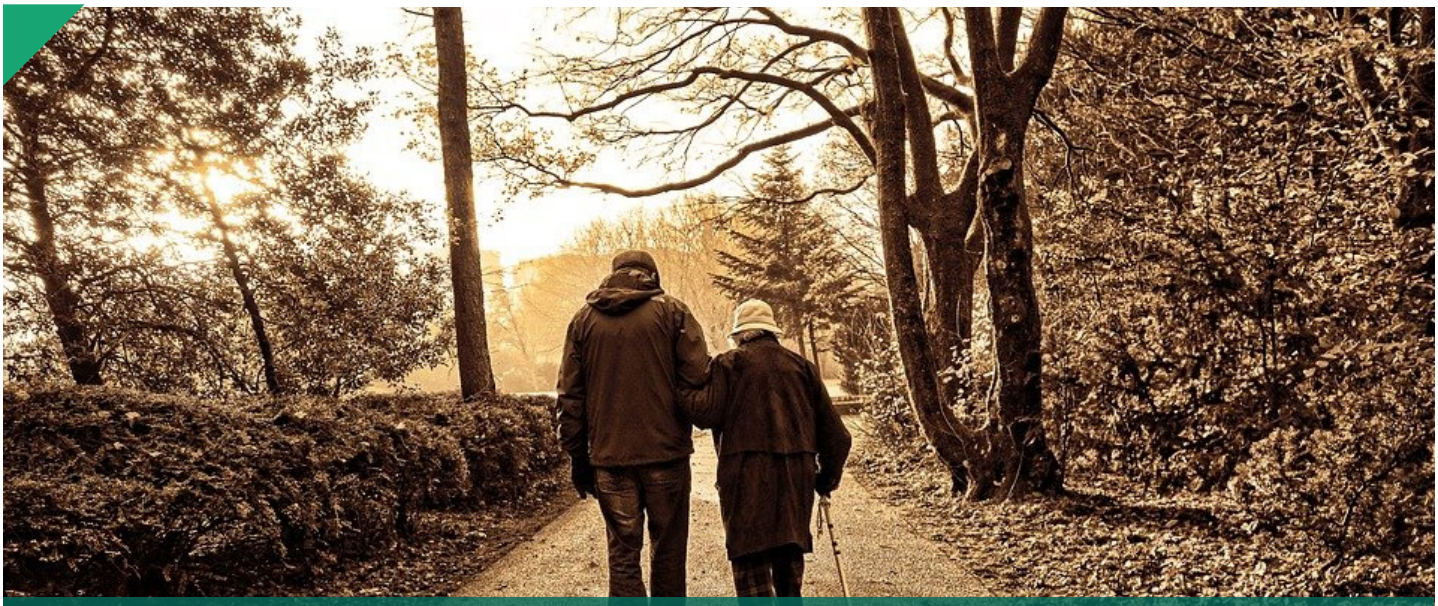

Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans

January 15, 2021

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We are indebted to more than 50 state Medicaid agency staff and health plan executives for taking time to participate in interviews and share their candid views about the factors that contribute to dually eligible beneficiaries' disenrollment from, and retention in, Medicare Advantage Dual Special Needs Plans. We are inspired by their dedication to providing members of these plans with the most appropriate services and supports to meet beneficiary needs.

The views and opinions expressed in this report are those of the authors and do not reflect the views of Arnold Ventures, Mathematica, or any others.

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Executive Summary

In 2019, about 12.2 million people in the United States were dually eligible for Medicare and Medicaid. Those who qualify for coverage under both programs have low incomes and are either age 65 and older or younger people with long-term disabilities. Due to their age or disability, the majority of dually eligible individuals have chronic health conditions, and many require long-term services and supports (LTSS) to perform activities of daily living. Because they require more health and LTSS than people who are eligible only for Medicare, dually eligible individuals account for about 33 percent of total Medicare and Medicaid spending, even though they comprise 20 and 15 percent of all enrollees in each program, respectively.

To reduce costs and improve care outcomes for dually eligible beneficiaries, federal and state policies have developed a variety of care models designed to better integrate services for this population. Among several types of integrated care programs, the largest is Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs), a type of managed care plan that enrolls only dually eligible beneficiaries. Total D-SNP enrollment has more than doubled from 850,000 in 2008 to 2.18 million in 2018. Although all D-SNPs must contract with state Medicaid agencies and coordinate Medicare and Medicaid services to some extent, only about 14 percent of enrollees that year were in D-SNPs that were fully integrated with Medicaid LTSS and behavioral health benefits covered by states.

Federal and state officials are now considering various policy options to help increase the number of dually eligible individuals enrolled in integrated care models. To achieve this goal, it is important both to attract new members and to retain existing members. The higher the disenrollment rate, the more difficult it is to grow enrollment over time. Previous studies indicate that dually eligible individuals are more likely than non-duals to disenroll from MA plans and are more likely to disenroll from MA contracts with lower MA quality and member experience ratings. But these studies did not examine disenrollment rates for MA contracts in which all, or the majority of, members were D-SNP enrollees. Nor have previous studies examined the interaction of Medicare D-SNP voluntary disenrollment rates (VDRs) with state Medicaid policies and programs, how local market competition with other MA plans affect D-SNP disenrollment rates, or how other factors influence disenrollment from D-SNPs.

Study objectives and methods. This study examines rates of voluntary disenrollment, and the factors affecting those rates, among dually eligible beneficiaries enrolled in a subset of MA contracts, which we refer to as "D-SNP dominant MA contracts"—those with at least 70 percent D-SNP enrollees. It sought to answer two key research questions. First, are MA quality and beneficiary experience measures, and level of integration with Medicaid, associated with VDRs in this subset of contracts? Second, what other factors influence differences in VDR patterns in D-SNP dominant MA contracts operating within and across states?

To answer these questions, we used a mixed-methods study design involving quantitative and qualitative analyses and a synthesis of findings. We collected and analyzed publicly reported Centers for Medicare & Medicaid Services (CMS) data on MA enrollment by contract number, plan type, and state and county during the 2015–2018 period and created a method to classify each contract's level of integration with Medicaid, ranging from none to full. We developed a linear regression model to test the association of MA quality and beneficiary experience measures, and the level of integration with Medicaid, with VDRs at the MA contract level. To explore the role of other factors that might explain differences in VDRs

across D-SNP dominant MA contracts, we interviewed 15 groups of state Medicaid officials, beneficiary counselors, and senior executives of D-SNP health plans from July to September 2020.

Key findings

1. D-SNP dominant MA contracts were more likely to be smaller than other MA contracts.

D-SNP dominant MA contracts—the focus of this study—enrolled fewer total members (10,700 on average), than MA contracts with fewer D-SNP members (74,490 on average) or no D-SNP members (41,736 members on average) during the 2015–2018 study period.

2. Voluntary disenrollment rates in D-SNP dominant MA contracts fell between that of the two other MA contract types.

The median VDR for D-SNP dominant MA contracts between 2015 and 2018 was 10.0 percent, less than the median for MA contracts with less than 70 percent D-SNP members (12.0 percent), but higher than the median for MA contracts with no D-SNP enrollees (8.0 percent). Higher median VDRs for MA contracts with *any* D-SNP enrollees, compared to contracts with no D-SNP enrollees, could be due to the fact that unlike Medicare-only beneficiaries who could change plans only once a year (with some exceptions), dually eligible beneficiaries could change plans monthly during the study period.[1]

3. VDR was associated with certain MA quality and performance measures, but not others. Although VDR is an important measure of D-SNP performance that warrants more attention and weight, VDR by itself is not a definitive measure of plan performance.

Among the D-SNP dominant MA contracts examined in this study, three of nine MA quality and experience-of-care measures had statistically significant associations with VDR in the expected direction. Better performance on member Rating of the Health Plan and Adult Flu Vaccine rates were associated with fewer members leaving the plan. Worse performance on member Complaints about the Health Plan was associated with more members leaving the plan. The other six measures either had an association in an unexpected direction or no association with VDR.

4. Level of integration with Medicaid was not associated with VDRs, but when divided by level of integration and size, two of six subgroups had an association with VDR albeit in different directions.

Overall, there was no statistically significant association between VDR and level of integration with Medicaid. When contracts were organized by size and level of integration, we found (1) full integration was associated with *lower* VDR among the largest contracts above the 75th percentile of enrollment, and (2) moderate integration was associated with *higher* VDR among D-SNP dominant contracts below the 75th percentile. The difference in the direction of the effect on VDR suggests one or both associations might be due to something in addition to (or other than) the Medicaid integration level.

[1] As of 2019, dually eligible beneficiaries can change plans once per quarter, except in the last quarter of the calendar year, so MA plans can market to them most of the year.

4. **Three interrelated sets of factors, in addition to quality ratings and level of Medicaid integration, explain some of the differences in VDRs across D-SNP dominant MA contracts: state Medicaid policies and programs, local MA market features and competitive forces, and beneficiaries' characteristics and preferences.**

Due to their status as Medicaid beneficiaries, state Medicaid policies and programs related to coverage options for dually eligible beneficiaries contribute to D-SNP VDRs. For example, several policies or programs appeared to reduce disenrollment rates and increase retention in integrated plans: (1) state contracts with Fully Integrated Dual Eligible (FIDE) SNPs, some of which began in states with long-standing CMS integrated care demonstrations and provide care coordination to enrollees; (2) state D-SNP and Medicaid contract requirements that promote aligned enrollment with Medicaid managed care and managed LTSS plans, which increase the opportunity for care coordination; (3) state Medicaid policies that automatically assign dually eligible beneficiaries into aligned plans; and (4) clear and direct state Medicaid communications with beneficiaries about their coverage options. We also found the degree and direction of influence of these state Medicaid policies and programs varies considerably across states and can be mediated by market competition and beneficiaries' characteristics.

The degree of local market competition among MA plans appears to influence VDR patterns across states and markets. Highly competitive markets with numerous MA plans might contribute to higher VDRs, whereas areas with few MA plans might contribute to lower VDRs. MA plans compete on the generosity and type of supplemental benefits and cost sharing, and Medicare cost-sharing requirements can contribute to voluntary disenrollment for some beneficiaries, especially partial-benefit dually eligible beneficiaries and those who live in highly competitive markets. The breadth and composition of managed care plan provider networks, and changes in provider networks, can also influence beneficiaries' choices to enroll and disenroll.

Certain beneficiary characteristics can influence decisions to disenroll from D-SNPs. Beneficiaries' health conditions, their need for LTSS, age, whether they qualify as full- or partial-benefit dually eligible, and relationships with or preferences for providers interact with state Medicaid policies and programs, and with local competitive forces, to influence retention or disenrollment. Changes in health or functional ability, changes in health plans' provider networks, and changes in dual status can prompt them to switch coverage.

Policy implications

Federal and state policymakers are exploring policies to increase enrollment of dually eligible individuals in integrated care models. To achieve this goal, policies and strategies designed to attract new enrollees are as important as those intended to retain existing enrollees. Based on the study findings, the following policy changes could help to increase enrollment and retention in integrated care plans.

Policy Options to Increase Retention in D-SNPs

	Policy	Rationale
	Report VDRs at the MA plan level, disaggregate VDR rates by full- vs. partial-benefit duals, share this information with state Medicaid agencies, and make the data publicly available.	CMS currently reports VDRs and other MA quality measures at the MA contract level. Disaggregating and reporting VDRs at the plan level would give state officials the ability to monitor this key indicator of plan performance and beneficiary satisfaction. It would enable them to compare D-SNP performance by level of integration with Medicaid and assess the value of such integration to beneficiaries. In addition, it would be helpful to report disenrollment by full- versus partial-benefit dual status because the factors affecting beneficiaries' decisions to disenroll can vary across these groups.
	Provide real-time data to states about dually eligible beneficiaries who disenroll from D-SNPs.	CMS currently reports VDRs for MA contracts twice each year in conjunction with release of MA Star Ratings measure scores but with a two-year lag in the data. The VDRs reported in 2020, for example, reflect plan experience in 2018. It would be more useful if CMS published VDRs monthly instead of waiting until the Star Ratings are published. States can also monitor VDRs through regular file exchanges with CMS.
	Reduce the impact of beneficiary cost sharing on disenrollment among full-benefit dually eligible beneficiaries through stronger enforcement of, and education about, the federal prohibition on balance billing.	Because of their low income, dually eligible beneficiaries are attuned to differences across plans in their liability for the out-of-pocket costs associated with Medicare deductibles, coinsurance and copayments. Although the majority of full-benefit dual eligibles are exempt from most Medicare cost sharing, there is widespread confusion about D-SNP enrollees' dual status, which is partly responsible for providers' improper balance billing of full-benefit duals. This in turn contributes to members' decisions to disenroll, in search of plans with lower cost sharing. CMS has launched initiatives to protect full-benefit duals from balance billing. But states and plans could do more to enforce the ban and educate providers and consumers, which may help to reduce its influence on disenrollment.
	Decide whether to allow D-SNPs to use default enrollment based on retention rates and performance on other MA quality measures and care coordination.	D-SNPs that receive approval from CMS and states can offer automatic (default) enrollment into their D-SNP for newly Medicare-eligible beneficiaries if those individuals are already enrolled in their affiliated Medicaid managed care plan and will remain enrolled in that plan. Because default enrollment can contribute to greater member retention in D-SNPs, it is important that CMS and states make careful choices about which plans are eligible to use default enrollment. This also applies to state Medicaid auto-assignment policies. Criteria for approving these policies could include the plan's performance on VDR in the past few years—an indication of members' satisfaction with the plan—as well as other quality-of-care and care coordination measures.

	Policy	Rationale
	Award higher MA Star Ratings based on plan-level performance on retention and measures that directly reflect member satisfaction.	The VDR is 1 of about 45 measures used to calculate MA Star Ratings, diluting its importance. It also has less weight in the calculation of MA Star Ratings than quality improvement and outcome measures. Because retention is an important indicator of plan performance, CMS intends to assign greater weight to the VDR measure in MA Star Ratings, and to other measures that directly reflect member satisfaction, starting with the 2023 Star Ratings (2021 measurement year).
	Limit enrollment of full-benefit dually eligible individuals to integrated care plans in areas where they have a choice of such plans, in addition to traditional Medicare FFS.	To increase enrollment of full-benefit dually eligible beneficiaries in MA plans that can coordinate Medicare and Medicaid services, CMS could restrict non-D-SNP MA plans from enrolling those with full benefits or limit their Medicare enrollment options to integrated care plans in areas with a minimum number of such plans, while preserving beneficiary choice to receive traditional Medicare. Such a change would be limited to full-benefit dually eligible beneficiaries who are eligible for all state Medicaid benefits because they stand to benefit more from plans' ability to coordinate Medicare and Medicaid services. Partial-benefit dually eligible beneficiaries, on the other hand, are not eligible for state Medicaid benefits other than subsidies for Medicare cost sharing and are therefore more likely to benefit from regular MA plans that offer attractive supplemental benefit packages and cost sharing reductions. Although there are pros and cons to such a change in policy, its advantages include the potential to reduce the influence of misleading marketing by non-D-SNP MA plans on disenrollment from D-SNPs, and to mitigate provider billing confusion.

Although this study focused on disenrollment, the implications are relevant to enrollment policies broadly, since the factors that cause members to stay or leave D-SNPs often mirror those that attract beneficiaries to certain types of plans or coverage models in the first place. Indeed, a lesson that emerges from this study is that one of the best ways to retain members is to ensure they enroll in highly integrated, high quality, member-centric plans from the start.

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I. Introduction

In 2019, about 12.2 million people in the United States were dually eligible for Medicare and Medicaid. Those who qualify for coverage under both programs have low incomes and are either age 65 and older or younger people with long-term disabilities. Due to their age or disability, the majority of dually eligible individuals have chronic health conditions, and many require long-term services and supports (LTSS) to perform activities of daily living. Because they generally require more health care and LTSS than people who are eligible only for Medicare, dually eligible individuals accounted for about 33 percent of total Medicare and Medicaid spending in 2013, even though they accounted for 20 and 15 percent of all enrollees in each program, respectively (Medicaid and CHIP Payment and Access Commission [MACPAC]-Medicare Payment Advisory Commission [MedPAC] 2018).

To reduce costs and improve care outcomes for dually eligible beneficiaries, federal and state policies have developed a variety of care models designed to better integrate services for this population. Evidence to date on the impact of integrated care models has shown mixed results on cost, service use, and other outcomes (MACPAC 2020a). However, policymakers have been encouraged by promising findings indicating that some integrated care programs reduced unnecessary hospital and long-term nursing home admissions by enrollees, and cost less when compared to Medicare fee-for-service (FFS) spending for similar groups of beneficiaries.

A. Types of, and enrollment in, integrated care models for dually eligible beneficiaries

In the most common integrated care model, Medicare and state Medicaid agencies contract with private managed care plans and pay them a fixed monthly rate per member (known as capitation) to provide and coordinate all benefits and services covered by each program. With fixed payments, plans have an incentive to provide more efficient care—for example, by reducing use of costly hospital and nursing home care through greater access to preventive primary care and home and community-based services (HCBS).

Three types of integrated care programs for dually eligible beneficiaries use a capitation model. Starting in 2014, 10 states implemented a capitated integrated care model in partnership with the federal government through Financial Alignment Initiative (FAI) demonstrations, which enrolled about 400,000 beneficiaries in 2018 (one state ended its demonstration in 2017). About 50,000 individuals enrolled in another type of integrated care program called the Program of All-Inclusive Care for the Elderly (PACE), which serves people with serious health conditions and functional disabilities. The third and largest integrated care model for dually eligible beneficiaries operates under the auspices of Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs), which enrolled about 2.2 million members in 2018. D-SNPs are the most common type of MA Special Needs Plan; the box at the end of this section describes all three types of SNPs.

Although every D-SNP is required to contract with the state Medicaid agency in the states in which they operate (Verdier and Chelminsky 2017), the level of D-SNP integration with Medicaid varies across states and sometimes by plan within each state. Approximately 312,000 D-SNP enrollees were served through Fully Integrated Dual Eligible SNPs (FIDE-SNPs) in 2018, which cover all Medicare benefits as well as Medicaid LTSS and other Medicaid services (Centers for Medicare & Medicaid Services [CMS] 2018). They must also and coordinate Medicare and Medicaid member communications and grievance and appeals procedures. As a result, FIDE SNPs offer a more fully integrated benefit package and

enrollee experience than other D-SNPs. Other D-SNPs offer varying levels of integration with Medicaid benefits to dually eligible individuals.

Total D-SNP enrollment has more than doubled from 2008 to 2018 (Exhibit I.1). And at the end of 2019, about 1 million, or 10 percent, of all dually eligible beneficiaries were enrolled in fully integrated care plans, five times greater than 2011 (Medicare Medicaid Coordination Office [MMCO] 2019). Yet, federal and state policymakers would like to increase the number of dually eligible beneficiaries enrolled in integrated care models even further. According to the MACPAC Report to Congress in June 2020, "more can be done to increase enrollment in integrated products, increase the availability of such models, and encourage greater levels of clinical, financial, and administrative integration" (MACPAC 2020b).

B. Voluntary disenrollment by dually eligible individuals from MA plans: Why it matters

To increase enrollment in integrated care models, it is important to both attract new members and retain existing members. The higher the disenrollment rate, the more difficult it is to grow enrollment over time. On average, about 12 percent of all MA enrollees disenrolled from MA plans in 2014; at the MA contract level, the mean disenrollment rate was 10.5 percent that year, and varied from 1 to 39 percent across MA contracts (U.S. Government Accountability Office [GAO] 2017). Several studies, however, indicate that dually eligible individuals are more likely than those who are not dually eligible to disenroll. For example, nearly 15 percent of high-need dually eligible beneficiaries enrolled in an MA plan switched to traditional Medicare in 2014 or 2015, compared to 4.6 percent of high-need non-dually eligible beneficiaries (Meyers et al. 2019). In addition, dually eligible individuals in poorer health or with higher out-of-pocket cost sharing are more likely to disenroll from a MA plan than those in better health or with lower cost sharing (GAO 2017).

Several studies have also found greater disenrollment from MA contracts with lower quality and beneficiary experience ratings. For example, MA contracts with high disenrollment rates were more likely to perform poorly on member ratings of their experience getting care from the plan, or other quality measures (DuGoff and Chao 2019; Cohen et al. 2019). Another study found that high-need dually eligible MA enrollees left plans with low-quality ratings (2.0 to 2.5-star ratings) at a higher rate than plans with the highest quality rating (5.0-star rating) (Meyers et al. 2019).

C. Contribution of this study

CMS reports voluntary disenrollment rates (VDRs) at the MA contract level annually. Each contract can include multiple MA plan types: D-SNPs, other types of SNPs, and regular (non-SNP) MA plans. This makes it difficult to determine differences in VDRs by plan type. VDRs also conflate dual and non-dual enrollees and, in some cases, combine rates for plans owned by the same company that operate in multiple states. Although previous studies have found differences in rates of disenrollment by dual and non-dual beneficiaries, none have specifically examined MA-contract level disenrollment rates for plans in which their members were all or mostly dually eligible D-SNP enrollees. This study reduces some of the noise in MA contract level VDRs by restricting the sample to MA contracts in which at least 70 percent of all members are dually eligible individuals enrolled in D-SNPs, which we refer to as D-SNP dominant MA contracts.

In addition, previous studies have not examined the interaction of Medicare D-SNP VDRs with state Medicaid policies and programs, or how local market competition with other types of MA plans affect D-SNP disenrollment rates. For example, since 2006, all Medicare-qualifying D-SNPs must also have a

contract with each state Medicaid agency in which they operate, and states have flexibility in the benefits and requirements for each contracting D-SNP. About half of all states also require certain dually eligible beneficiaries who need LTSS to enroll in a Medicaid managed LTSS (MLTSS) plan to receive those benefits. If the state restricts enrollment in D-SNPs to those enrolled in the company's affiliated Medicaid plan, any change on the Medicaid side could trigger disenrollment from the D-SNP. In addition, in states or regions with a high degree of MA market competition, dually eligible enrollees might be more likely to disenroll, even from an integrated D-SNP, due to marketing by other MA plans and independent agents and brokers.

If federal and state policymakers want to grow and retain dually eligible beneficiaries in integrated care plans, particularly D-SNPs that are fully integrated with Medicaid or those that have aligned Medicaid members, it is important to understand how beneficiaries' decisions to stay or leave these plans are influenced by (1) Medicare quality ratings; (2) level of Medicaid integration; (3) other state Medicaid policies and programs; (4) local market competitive forces; or (5) other reasons, such as provider networks, cost sharing, and supplemental benefits. Because it is a diverse group, it is also important to understand how these factors affect dually eligible beneficiaries with different characteristics, including age, chronic health conditions, disability, need for LTSS, and full- versus partial-benefit dual status.

D. Study objectives and research questions

The purpose of this study is to examine rates of voluntary disenrollment, and the factors affecting those rates, among dually eligible beneficiaries enrolled in D-SNP dominant MA contracts: those with all or mostly dually eligible D-SNP enrollees. Research questions included the following:

- Are MA quality and experience-of-care measures associated with voluntary disenrollment rates in this subset of contracts?
- Is the level of integration with Medicaid associated with voluntary disenrollment rates in this subset of contracts?
- What other factors influence differences in VDR patterns in D-SNPs operating within and across states?

E. Methods and data

We used a mixed-methods approach, involving quantitative and qualitative analyses and synthesis of both sets of findings. To identify D-SNP dominant MA contracts in the 2015–2018 study period, we used publicly available CMS data sets:

1. Special Needs Plan (SNP) Comprehensive Reports, which provide data on enrollment in MA SNPs, including D-SNPs, at the plan level, and by state in which they operate;
2. Monthly Enrollment by Contract/Plan/State/County Reports, and Monthly Enrollment Reports by Plan, which list all MA plans (including D-SNPs) by contract number, organization name, plan type, and total enrollment, by state and county.

We used these data to count the total number of enrollees in each MA contract, identify which contracts contained any D-SNP enrollees, and determine which MA plans were D-SNP dominant, defined as those with 70 percent or more D-SNP enrollees.

We used MA Star Ratings data to identify MA contract-level voluntary disenrollment rates (members choosing to leave the plan) as well as other quality and beneficiary experience measure scores. The Star Ratings data include (1) contract number; (2) scores or rates for selected quality and experience-of-care measures; (3) Part C and D Star Rating, and the overall MA Star Rating; and (4) categorical adjustment index (CAI) values, which depend on the share of low-income subsidy or dually eligible and disabled individuals enrolled in each contract. Because the most recent MA Star Ratings scores are for the 2018 measurement year, we used 2015–2018 MA contract enrollment data for the analyses.[2]

We also developed a classification system to assign a Medicaid integration level to each D-SNP dominant contract for each year of the 2015–2018 study period in which the contract operated, described further in Section II. The integration level depends on the type of Medicaid benefits covered by each D-SNP dominant contract, and the share of beneficiaries in exclusively aligned arrangements—that is, the proportion of members who receive Medicare and Medicaid benefits from plans operated by the same parent organization. We obtained information about Medicaid managed care plan types and benefits from several sources, including (1) CMS Medicaid managed care enrollment reports for 2016, 2017 and 2018; (2) state Medicaid agency D-SNP contracts; and (3) state Medicaid agency websites or web pages and resources about Medicaid managed care and integrated care policies and programs.

F. Organization of this report

Following this introduction, Section II compares selected characteristics of D-SNP dominant MA contracts to two other types of MA plans: (1) those with no D-SNP enrollees and (2) those with some D-SNP enrollees but less than 70 percent of total members. It also explains the criteria we used to assign a Medicaid integration level to each D-SNP dominant contract. Section III describes the regression model we developed to test the association of VDRs with selected MA Star Ratings quality and experience-of-care measures and level of Medicaid integration and presents key findings from the analysis.

Section IV presents findings from the qualitative analysis of the themes that emerged from interviews about the factors affecting VDRs in these plans. Section V concludes with a discussion of the implications of the results for federal and state policymakers seeking to expand enrollment of dually eligible beneficiaries in integrated care programs.

Sections III and IV provide detailed descriptions of the methods used in each analysis, as does Appendix A, which contains additional charts from the quantitative analysis.

[2] Star Ratings measures lag two years behind the current year; that is, CMS releases preliminary Star Ratings measure scores one year after the end of each measurement year (the fall release), and a final updated report the following spring. For example, final MA Star Ratings data for calendar year 2017 were available in the spring release in April 2019.

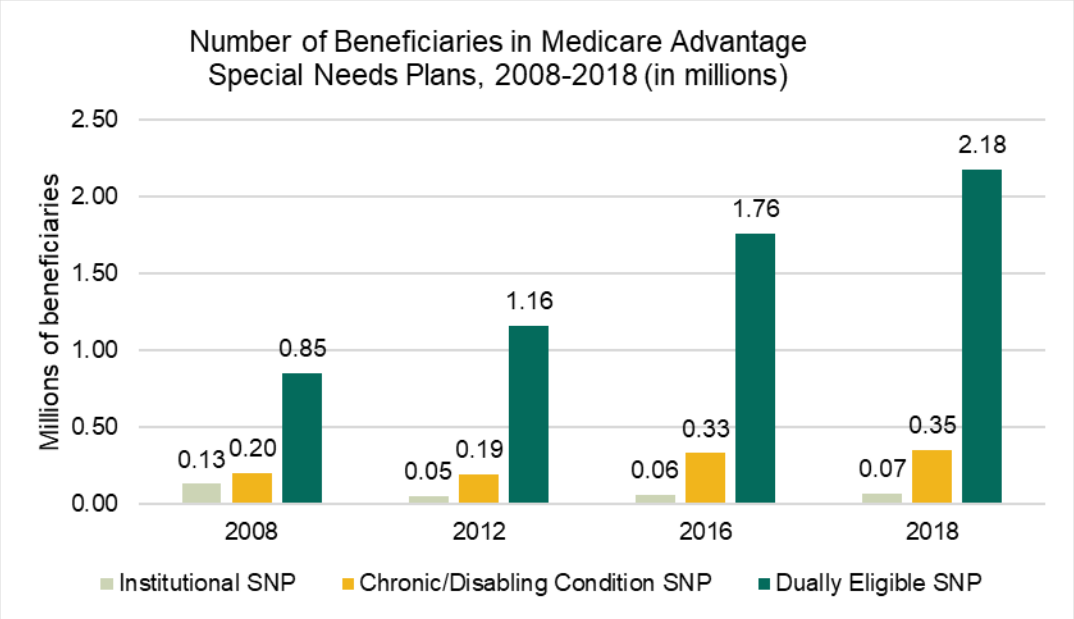
Medicare Advantage Special Needs Plans

Initially authorized by Congress in 2003, SNPs are a type of MA plan that serves targeted groups of Medicare beneficiaries with special needs. The Bipartisan Budget Act (BBA) of 2018 permanently authorized SNPs. There are three types of SNPs:

- **D-SNPs,** which can enroll only dually eligible individuals and must coordinate members' Medicare and Medicaid benefits. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required all D-SNPs to have a contract covering minimum elements with the Medicaid agencies in states where they operate, effective 2013. The contracts must specify the Medicaid benefits covered by the D-SNP, which can range from none to Medicare cost-sharing to all Medicaid-covered services including LTSS and behavioral health services. In addition, each D-SNP must develop a model of care for the dually eligible population served and establish processes for coordinating care and conducting health risk assessments for enrollees.
- **Chronic-Illness Special Needs Plans (C-SNPs),** which can enroll Medicare beneficiaries with chronic health or medically complex conditions that cause disability or are life-threatening, have a high risk of hospitalization or other adverse outcomes, and require specialized care delivery.
- **Institutional Special Needs Plans (I-SNPs),** which can enroll only Medicare-eligible enrollees who have had, or are expected to need, institutional level of care services for 90 days or more in long-term care facilities: skilled nursing facilities, nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.

Most SNP enrollees (85 percent) are in D-SNPs—the focus of this study—with the rest in C-SNPs or I-SNPs (Exhibit I.1). Enrollment in any type of SNP more than doubled from about 1.2 million in 2007 to 2.6 million in 2018, when they accounted for about 13 percent of total MA enrollment. Total D-SNP enrollment during the study period grew from 1,660,000 in 2015 to 2,177,000 in 2018.

Exhibit I.1. Enrollees in Medicare Advantage Special Needs Plans, 2008–2018



Source: Kaiser Family Foundation, Data Note: A Dozen Facts about Medicare Advantage in 2019.

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II. How D-SNP dominant MA contracts compare to other MA contracts and vary in level of integration with Medicaid

D-SNP dominant MA contracts, the focus of this study, differ from other types of MA contracts with respect to the concentration of D-SNP members, as well as size and average VDRs. This section compares these and other characteristics of D-SNP dominant MA contracts to those of other types of MA contracts to provide context about the subset of MA contracts examined in the quantitative analysis discussed in Section III. This section also explains how D-SNP dominant MA contracts selected for the analysis vary in their degree of integration with Medicaid, and the system we developed to classify D-SNP Medicaid integration level for the regression model.

A. Comparing D-SNP dominant MA contract characteristics to other MA contract types

D-SNP dominant MA contracts in this study are those in which at least 70 percent of all members enrolled in a D-SNP. Limiting the study to this group of MA contracts increases the likelihood that they are organized to meet the needs of dually eligible beneficiaries and are more alike in other ways relative to MA contracts as a whole.[3] We examined the characteristics of D-SNP dominant MA contracts relative to two other MA contract types: (1) D-SNP non-dominant, those in which D-SNPs enrollees comprised less than 70 percent of all enrollees; and (2) non-D-SNP contracts, which had no D-SNP enrollees. We compared the following characteristics:

- VDRs, which include members who disenrolled voluntarily, either returning to Medicare FFS or switching to another plan operating under a different contract[4]
- Size, measured in total number of enrollees
- Selected MA Star Ratings quality and experience-of-care measure scores
- Tax status (for-profit or nonprofit) of the parent organization

For this comparison, we counted each MA contract in each year as a separate observation. For example, a contract that existed in 2015 to 2017 but not 2018 would have three observations. After excluding observations with a missing VDR or missing number of enrollees, there were 1,499 contract-year MA observations of which 15 percent were D-SNP dominant, 25 percent were D-SNP nondominant and 60 percent were non-D-SNP contracts (Exhibit II.1).

Although the descriptive analysis that follows illustrates important differences across the three MA contract types, it is important to note that VDRs and MA quality and experience-of-care measure scores *do not control* for the demographic, health status, and functional ability of enrollees in each type of contract. Consequently, differences in VDRs and MA quality and experience-of-care measure scores by

[3] We selected 70 percent to maximize the number of MA contracts with a majority of D-SNP members while minimizing the risk of substantive differences in contract characteristics that we could not measure or control for in the regression model analyzing the association between MA quality measures, level of Medicaid integration, and VDRs. The 70 percent threshold was also a clear cut-off point in 2018 data. For example, reducing the threshold to 60 percent would have increased the sample size by just four MA contracts but raised the risk of differences in unmeasured contract characteristics that could bias the results.

[4] The numerator does not count beneficiaries enrolling in another plan offered *under the same contract* . The rates exclude beneficiaries who disenrolled involuntarily—that is, they disenrolled because they moved out of their contract service area, the contract was terminated, or they died.

contract type might be due to the mix of enrollees. Nor are the descriptive statistics adjusted to account for differences in contract characteristics, but in the regression analyses, we do control for contract size, tax status, and degree of MA market concentration in the regions where they operate. We also compare our descriptive findings on VDRs for the three groups of MA contracts with those of two recent studies, which examined voluntary disenrollment from select subsets of MA contracts. [5]

Exhibit II.1. Number of MA contract-year observations by type of D-SNP: D-SNP dominant, D-SNP nondominant, and no D-SNP enrollees, 2015–2018

	D-SNP dominant	D-SNP non-dominant	No D-SNP enrollees
Number of MA contract-year observations before exclusions	269	393	1,978
Missing voluntary disenrollment rate			
Not enough data available	46	13	369
Plan not required to report measure	0	0	255
Plan too new to be measured	0	0	418
Missing number of enrollees	0	0	40
Final MA contract-year observations in descriptive analyses for all three types of MA contracts (percentage of all contract-year observations)	**223** (15%)	**380** (25%)	**896** (60%)

Source: Mathematica's analysis of 2015–2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; VDR = voluntary disenrollment rate.

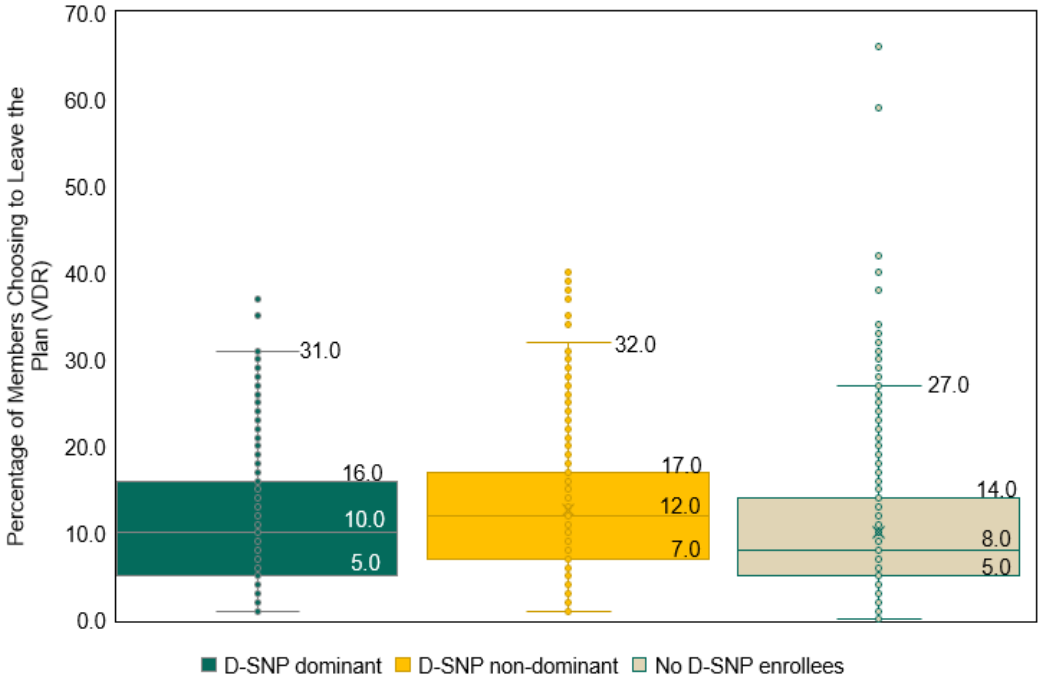
1. Voluntary disenrollment rates

Median VDR for D-SNP dominant MA contracts (10.0) fell between the median VDR rates for non-D-SNP MA contracts (8.0) and D-SNP nondominant MA contracts (12.0) in all four study years (Exhibit II.2). We found the same pattern for *mean* VDR: 10.1 for non-D-SNP contracts, 11.4 for D-SNP dominant contracts, and 12.6 for D-SNP nondominant contracts. Mean VDR among D-SNP dominant MA contracts was slightly higher in 2017 and 2018 than in 2015 but did not change for the other two types of MA contracts (see Appendix A, Exhibit A.3). Median VDR for the MA contracts in this sample (10 percent) was roughly similar to that reported by DuGoff and Chao (2019) and GAO (2017) (9 and 11 percent, respectively), regardless of MA contract type. Higher median VDRs for both types of MA contracts with *any* D-SNP enrollees, compared to contracts with no D-SNP enrollees, could be due in part

[5] Due to differences in the focus of each study, there are some differences in the inclusion criteria and years for each sample of MA contracts. DuGoff and Chao (2019) examined the relationship between disenrollment and six patient experience-of-care measures based on a sample of 1,045 MA contract-year observations from 2015 to 2017, which excluded contracts that had a missing CAI, based on the share of low-income subsidy or dually eligible and disabled individuals enrolled. We included these contracts in our study because D-SNP dominant MA contracts enroll a majority of dually eligible individuals. A GAO study (2017) examined the extent of health-biased disenrollment in MA contracts in 252 contracts in 2014 that had at least 100 disenrollees in poor health and at least 100 disenrollees in better health, focusing on 126 contracts with a VDR above the median.

to the fact that unlike Medicare-only beneficiaries who could change plans only once a year (with some exceptions), dually eligible beneficiaries could change plans monthly during the study period.[6]

Exhibit II.2. Distribution of VDRs by MA contract type, 2015–-2018



Source: Mathematica's analysis of 2015–2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

Note: This figure shows the median and the interquartile range for each group of contracts. In some cases, the medians differed from the means. For example, several D-SNP dominant contracts had a VDR that was substantially higher than the upper bound of the interquartile range, so the mean VDR for contracts was greater than the median VDR (11.4 and 10.0, respectively).

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; VDR = voluntary disenrollment rate.

2. Quality and beneficiary experience measures

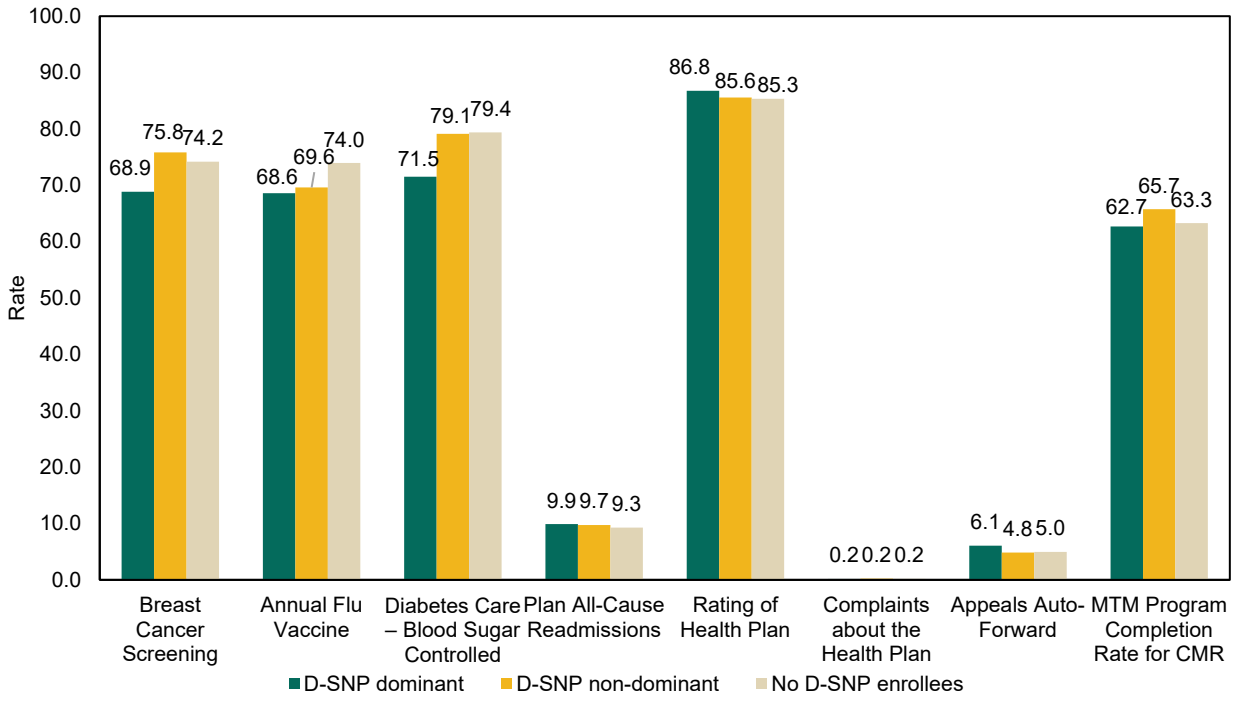
Most MA quality and experience-of-care measure scores varied little across the three contract types. The mean rating for five measures of eight MA quality and experience-of-care measures selected for this comparison had little variation. The mean rating varied moderately across the three types of contracts for breast cancer screening, annual flu vaccine, and diabetes care–blood sugar control. The last measure, diabetes control, had the most variation: average performance was higher (better) among non-D-SNP contracts and D-SNP nondominant contracts (both about 79 percent) than D-SNP dominant contracts (72 percent) (Exhibit II.3).

[6] As of 2019, dually eligible beneficiaries can change plans once per quarter, except in the last quarter of the calendar year, so plans can still market to them most of the year. Information about special enrollment periods is available at https://www.integratedcareresourcecenter.com/sites/default/files/Enroll_Periods_Reference_Tables.pdf.

2. Enrollment size

D-SNP dominant contracts were much smaller, on average, than the other two MA contract types. Mean enrollment in D-SNP dominant MA contracts (10,681) was substantially smaller than for D-SNP nondominant MA contracts (74,490) and those with no D-SNP enrollees (41,736) (Exhibit II.4). Mean enrollment was quite a bit higher than median enrollment for all three contract types due to a small subset of contracts with very large enrollment (see Appendix A, Exhibit A.4 for more detail).

Exhibit II.3. Mean performance on MA quality and experience-of-care measures by contract type, 2015–2018



Source: Mathematica's analysis of 2015–-2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

Notes: Means exclude observations that were missing data on a measure. For three measures, lower rates are better: Plan All-Cause Readmissions, Complaints about the Health Plan, and Appeals Auto-Forward. Rates of complains about the health plan were quite low; means were 0.16 for D-SNP dominant contracts, 0.22 for D-SNP nondominant contracts, and 0.19 for non-DSNP contracts. We excluded the Care for Older Adults – Functional Status Assessment measure because it is calculated only for SNP enrollees (including D-SNPs and two other types of SNPs that enroll dual and non-dual enrollees), so the measure reflects substantially different samples: all or nearly all D-SNP enrollees in the D-SNP dominant contracts compared with few or zero D-SNP enrollees in the other SNP contracts.

CMS = Centers for Medicare & Medicaid Services; CMR = Comprehensive Medication Review; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; MTM = Medication Therapy Management; VDR = voluntary disenrollment rate.

Exhibit II.4. Enrollment size, by MA contract type, 2015–2018

	D-SNP dominant (at least 70% D-SNP members)	D-SNP nondominant (less than 70% D-SNP members)	No D-SNP enrollees
Mean	10,681	74,490	41,736
Median	7,016	37,848	14,255

Source: Mathematica's analysis of 2015–2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage.

Tax status

D-SNP nondominant contracts were more likely to be for-profit than D-SNP dominant contracts. D-SNP nondominant contracts were more likely to be owned by a for-profit parent organization (72.1 percent of contracts) than either D-SNP dominant contracts (66.4 percent) or non-D-SNP contracts (63.0 percent) (Appendix A, Exhibit A.5).

B. Level of integration with Medicaid

Because state Medicaid agencies have flexibility to establish the benefits covered under D-SNP contracts, and other terms and conditions, each D-SNP contract can vary in the level of integration with Medicaid. To create a Medicaid integration variable for the regression model, we developed a set of criteria to classify the level of Medicaid integration for D-SNP dominant MA contracts that operated during the study period, 2015–2018. We used these criteria to assign an integration level in each year of the study period when the contract operated. Two criteria determined the level of Medicaid integration:

1. **Medicaid benefits,** which looks at whether the state(s) in which the D-SNP operated required D-SNPs to cover Medicaid LTSS and/or behavioral health benefits, either directly through the D-SNP or through an affiliated Medicaid managed care organization
2. **Exclusively aligned enrollment**, which means all (100 percent) of those enrolled in the D-SNP for Medicare coverage also receive Medicaid benefits through the D-SNP, or through a Medicaid managed care plan affiliated with the D-SNP and operated by the same parent organization

Using both criteria, we developed a four-point scale (0–3) to designate the level of integration in each contract, from least (0) representing no integration to full (3) integration (Exhibit II.6). Of the 34 states in which D-SNP dominant MA contracts operated during the 2015–2018 study period, 28 states' D-SNP contracting policies applied uniformly to all such contracts, whether those policies require no or full integration or somewhere in between.

In the remaining six states, state policies with respect to Medicaid integration vary by D-SNP; that is, they do not apply the same set of policies or rules to all of the state contracts with D-SNPs. For these six states (California, Minnesota, New York, Pennsylvania, Texas, and Wisconsin), we conducted a contract-level analysis. For example, Wisconsin operates a long-standing Medicare-Medicaid integrated program called Family Care Partnership, which contracts with two plans to cover both LTSS and behavioral health services, so they are fully integrated. But several Wisconsin contracts include other D-SNPs that do not cover LTSS or behavioral health services and thus, are classified as having no integration.

After assigning a level of Medicaid integration to each D-SNP dominant MA contract observation, we found about one-third of the 207 contract-year observations had no integration with Medicaid, and a similar percentage had moderate integration. About one-quarter had full integration and 10.6 percent had low integration (Exhibit II.7).

Exhibit II.6. Medicaid integration-level definitions

Medicaid integration level	Exclusively aligned enrollment	State Medicaid D-SNP benefits covered under the contract
0 (none)	No	Not required by the state(s) in which the D-SNP(s) operated to cover either Medicaid LTSS or BH benefits.
1 (low)	No	Required by the state(s) in which the D-SNP(s) operated to cover Medicaid LTSS *or* BH benefits —*but not both*— through the D-SNP, or through an affiliated Medicaid care plan for plan members enrolled with the organization for both Medicare and Medicaid benefits.
2 (moderate)	No	Required by the state(s) in which the D-SNP(s) operated to cover Medicaid LTSS ***and*** BH benefits through the D-SNP, or through an affiliated Medicaid managed care plan for plan members enrolled with the organization for both Medicare and Medicaid benefits.
3 (full)	The D-SNP contract was entirely, or almost entirely, comprised of enrollees in single FIDE SNP. All enrollees receive Medicare benefits from the D-SNP and Medicaid benefits from a managed care plan operated by the same parent organization.	To be designated a FIDE SNP, plans must cover primary, acute, and LTSS benefits and services and coordinate the delivery of all covered Medicare and Medicaid services.

BH = behavioral health; FIDE-SNP = Fully Integrated Dual Eligible Special Needs Plan; D-SNP = Dual Eligible Special Needs Plan; LTSS = long-term services and supports; MA = Medicare Advantage.

Exhibit II.7. Percentage of 207 D-SNP dominant MA contracts, by level of Medicaid integration

Level of Medicaid integration	Percentage
No integration	32.9
Low integration	10.6
Moderate integration	31.4
Full integration	25.1

Source: Mathematica's analysis of 2015–2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories. CMS Medicaid managed care enrollment reports, state Medicaid agency D-SNP contracts, and state Medicaid documents describing Medicaid managed care and integrated care policies and programs are available on state websites.

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage.

III. Association of MA quality and beneficiary experience measures and Medicaid integration level with voluntary disenrollment rates

A. Overview

To assess the relationship of MA quality and beneficiary experience measures, and level of Medicaid integration, to VDRs, we analyzed the associations using a regression model. This section explains the criteria we used to select MA contracts and the specific MA quality and experience measures for these analyses and briefly describes the model. It then describes the distribution of VDRs and MA quality and experience-of-care measure scores across the selected D-SNP dominant MA contracts and presents the results of the analysis.

Key findings

- Three of the nine MA quality and experience-of-care measures in the regression model had statistically significant associations with VDR in the expected direction: worse performance on Complaints about the Health Plan was associated with higher VDRs and better performance on member Rating of the Health Plan and Adult Flu Vaccine rates were associated with lower VDRs.
- One measure—Breast Cancer Screening Rate—had a statistically significant association with VDR in an unexpected direction: better performance on this measure was associated with higher VDRs.
- For the other five measures, associations with VDR were close to zero and not statistically significant.
- For most groups of D-SNP dominant contracts, there was no statistically significant association between VDR and level of integration with Medicaid. However, for two contract subgroups, we found (1) full integration was associated with *lower* VDR among the largest contracts at or above the 75th percentile of enrollment, and (2) moderate integration was associated with *higher* VDR among D-SNP dominant contracts below the 75th percentile of enrollment. The difference in the direction of the effect on VDR suggests one or both of the associations might be due to something in addition to—or other than—the level of Medicaid integration.

B. Methods

D-SNP dominant MA contract sample. To identify the sample of D-SNP dominant MA contract-year observations for regression analyses, we started with the 223 contract-year D-SNP dominant MA observations used for the descriptive analysis, which excluded contracts with missing VDRs (Section II). After excluding 10 observations with missing data for at least four of the MA quality and experience-of-care measures, and six D-SNP dominant contracts in Puerto Rico, there were 207 D-SNP dominant contract-year observations in the final sample for regression analyses.[7]

Selecting MA quality and experience-of-care measures. Excluding VDR, which is the dependent variable in the regression model, there are 49 MA quality and experience-of-care measures. From these 49 measures, we selected 9 that met most or all of five criteria intended to reduce bias in the results due to missing data or high correlation between two or more measures, and to ensure meaningful variation in performance scores across contracts. We also sought to include at least one or two measures from the majority of the eight Star Ratings domains to examine a range of performance indicators that are

[7] We excluded D-SNPs in Puerto Rico because we could not assign a Medicaid integration score to its contracts due to the unique nature of its Medicaid program, which does not cover LTSS benefits.

important to beneficiaries. Appendix A.1 explains the measure selection criteria in more detail and Appendix Exhibit A.1 defines the 9 quality and experience-of-care measures included in our analysis.

Analytic methods. We used a linear regression model weighted by total MA enrollment to estimate the association between VDR, the dependent variable, and the two sets of main independent variables: (1) the set of MA quality and experience-of-care measures and (2) the level of Medicaid integration. The primary regression specification controlled for several contract characteristics, including size (total enrollment); missing MA quality and experience-of-care measure rates; state-level D-SNP enrollment penetration; year; percentage of D-SNP enrollees; for-profit ownership; and degree of MA market concentration, measured by the Herfindahl-Hirschman index (HHI). Appendix A, Exhibit A.2 defines all variables and mean values. Because the descriptive analyses indicated the relationship between the level of Medicaid integration and VDR varied based on contract size, we included an interaction term between the level of Medicaid integration and whether the contract-year observation had total MA enrollment at or above the 75th percentile of all observations in the sample. We also conducted several sensitivity analyses and diagnostic checks. See Appendix A.5 for additional details on methods.

Limitations. The results of this analysis are subject to several limitations. First, the results apply only to the D-SNP dominant MA contracts in the study sample; if the 56 observations for D-SNP dominant contracts in the four study years with missing data on VDR or MA quality and experience-of-care measures differed in important ways from those with data, the results might not apply to the excluded contracts. Second, although we controlled for some contract characteristics, we did not control for differences in enrollee mix, so we cannot rule out the possibility that unobserved variables at the beneficiary or contract level could have caused bias in the estimated associations between the key independent variables and VDR. In addition, unmeasured contract-level features, such as provider network adequacy and care coordination effectiveness, could be associated with quality and experience-of-care ratings and VDRs. Omitting these factors from the model could lead to negative bias—that is, an overestimate of the hypothesized relationships: higher quality and experience ratings, and higher Medicaid integration levels, would be negatively associated with VDRs.

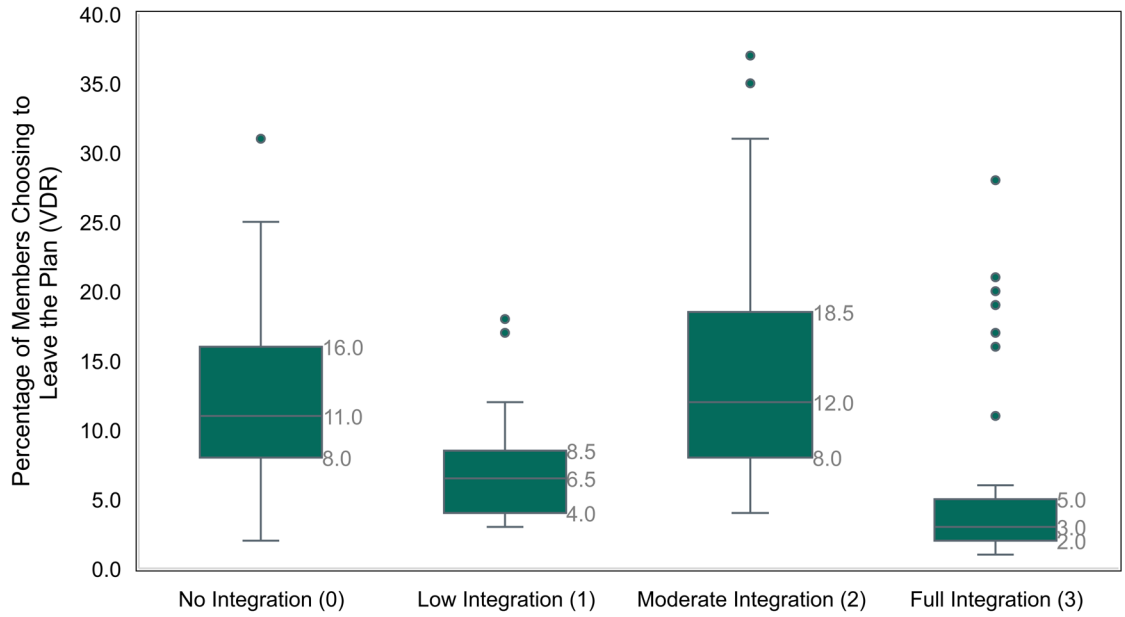
C. Distribution of VDR and MA quality and experience-of-care scores of D-SNP dominant MA contracts in the study sample

Among the 207 D-SNP dominant MA contracts included in the sample used for the regression analysis, VDR varied by Medicaid integration level over time, number of enrollees, and most notably, by state in which the D-SNP MA contract operated. Except for two of the nine measures, most of the MA quality and experience-of-care measures did not appear to correlate to VDR.

1. Variation in VDR

- **VDR varied by level of Medicaid integration.** For contracts with low or full integration, median VDR was lower than for contracts with no or moderate integration (Exhibit III.1). Fully integrated contracts had the lowest median VDR, 3 percent, and those that were moderately integrated had the highest median VDR, 12 percent. Mean VDR for contracts with full integration (5.9 percent) was twice as large as the median (3.0 percent) due to outliers that skewed the mean higher.

Exhibit III.1. Distribution of VDR by level of Medicaid integration, D-SNP dominant MA contracts, 2015–2018



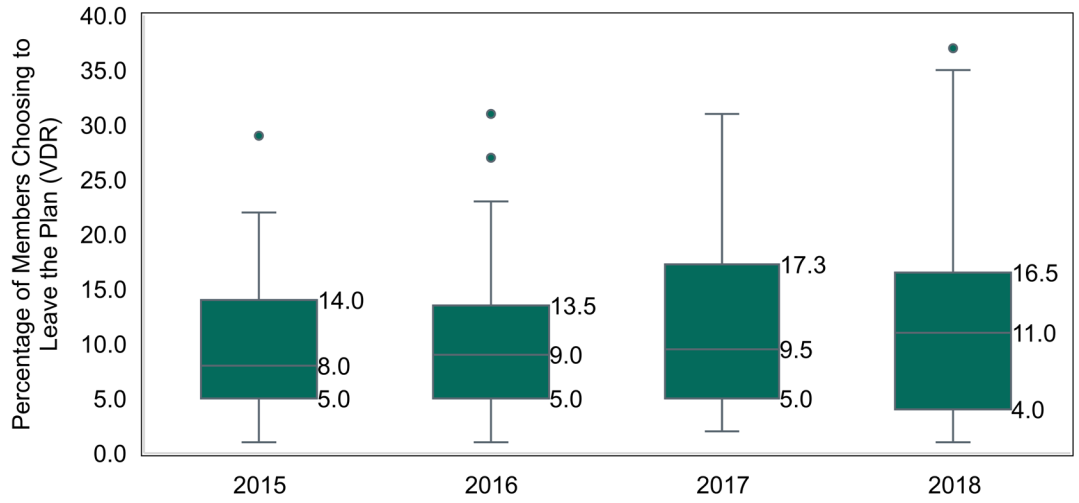
Note: This figure shows the **median** and the interquartile range for each group of contracts. The low-end whiskers in this plot extend to the minimum VDR at each level, and the high-end whiskers extend to the VDR closest to the third quartile plus 1.5 times the interquartile range. Any VDR greater than the high-end whisker length is considered an outlier.

Source: Mathematica's analysis of 2015–-2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage.; VDR = voluntary disenrollment rate.

- **VDR increased over time.** The median VDR among the 207 D-SNP dominant contracts increased over the four-year study period, from 8.0 percent in 2015 to 11.0 percent in 2018 (Exhibit III.2).
- **VDR varied by size of contract.** VDR appeared to have an inverse relationship with enrollment size. For example, the mean VDR for the 17 contract-year observations with the largest enrollments (30,000 or more enrollees) was 9.0 percent compared with 11.0 percent for all 207 contracts in the sample (Appendix A, Exhibit A.15).
- **VDR varied substantially by state.** The states with the highest mean VDR were Florida (30.4 percent), Texas (20.9 percent), and Louisiana (17.5 percent) (Exhibit III.3). The states with the lowest mean VDR were Minnesota (2.3 percent), Massachusetts (4.4 percent), and Oregon (5.0 percent).

Exhibit III.2. Distribution of VDR by year, D-SNP dominant MA contracts, 2015–2018



Source: Mathematica's analysis of 2015–2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

Note: This figure shows the **median** and the interquartile range for each group of contracts. The low-end whiskers in this plot extend to the minimum VDR for each year, and the high-end whiskers extend to the VDR closest to the third quartile plus 1.5 times the interquartile range. Any VDR greater than the high-end whisker length is considered an outlier.

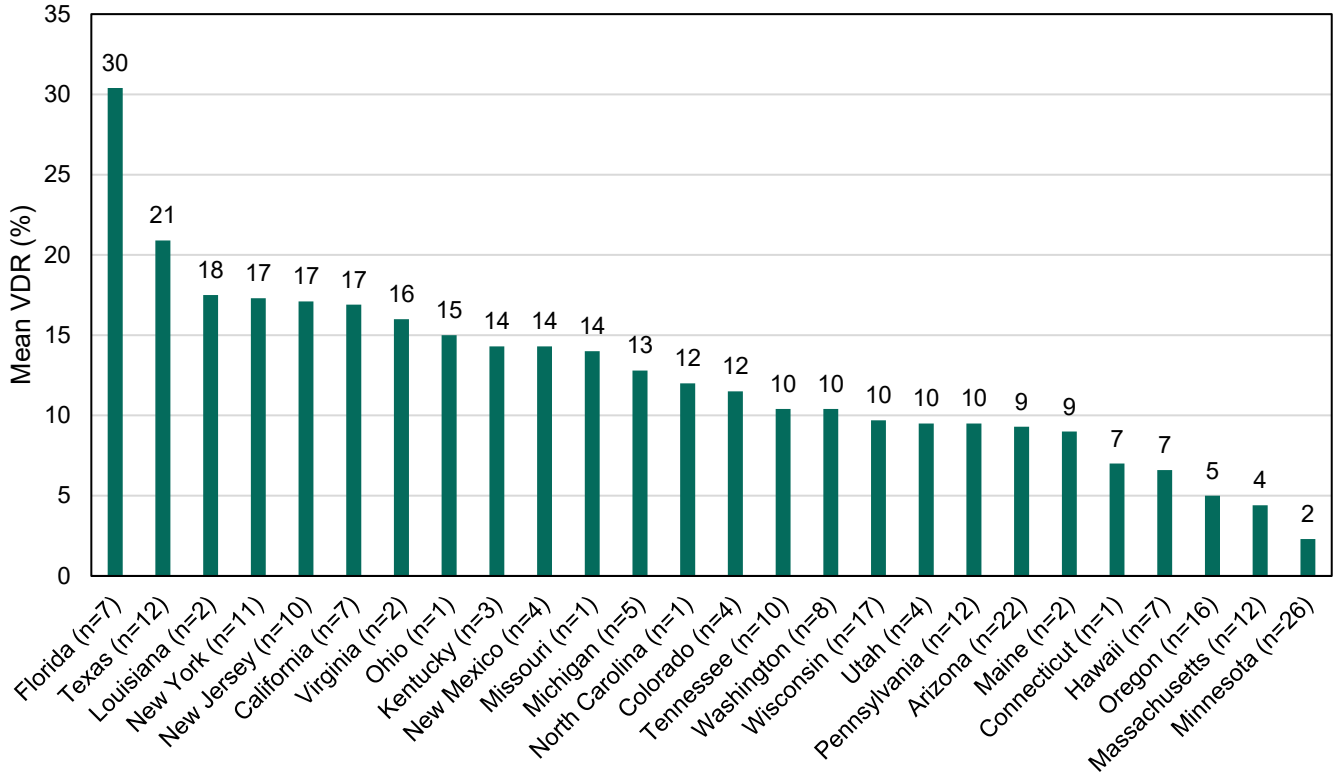
CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; VDR = voluntary disenrollment rate.

2. Distribution of MA quality and experience-of-care measure scores across D-SNP dominant MA contracts

Performance across contract-level MA quality and experience-of-care measure scores varied the most for two measures, based on the range between top and bottom quartiles: Functional Status Assessment and Medication Therapy Management Program Completion Rate (Exhibit III.4). Performance varied somewhat less for the remaining measures.

The results also suggested that before accounting for other factors that can differ across contracts and years, two of the nine measures might be related to VDR: (1) Annual Flu Vaccination Rate showed an inverse relationship with VDR; that is, a higher vaccination rate seemed to be related to lower VDR (Appendix A, Exhibit A.6); and (2) Complaints About the Health Plan, which indicated contracts having scores at or above the 75th percentile had more than twice the VDR of contracts below the 75th percentile (Appendix A, Exhibit A.11).

Exhibit III.3. Distribution of VDR by state, 2015–-2018



Source: Mathematica's analysis of 2015–2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

Note: The mean VDR for each state is calculated using all contract-year observations that had a plurality of D-SNP enrollees operating in that state. In most cases, a contract had enrollees in only one state in the year; only 11 contract-year observations had enrollees in multiple states.

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; VDR = voluntary disenrollment rate.

Exhibit III.4. Mean MA Star Rating quality and experience measure values for D-SNP dominant MA contracts, 2015–2018 (n = 207)

Measure	Mean	Distribution (interquartile range)	
		25th percentile	75th percentile
Breast Cancer Screening[a]	68.5	64.0	72.0
Annual Flu Vaccine	69.5	65.0	75.0
Care for Older Adults – Functional Status Assessment[a]	77.9	72.0	90.0
Diabetes Care – Blood Sugar Controlled	72.0	68.0	79.0
Plan All-Cause Readmissions[a,b]	9.9	8.0	11.0
Rating of Health Plan	86.6	85.0	88.0
Complaints about the Health Plan—percentage of contracts in which the rate was at or above the 75th percentile for D-SNP dominant contracts[b,c]	23.2	n.a.	n.a.
Appeals Auto-Forward—Drug plan fails to make timely decisions about appeals[a,b,d]	6.2	0.0	6.2
Medication Therapy Management Program Completion Rate for Comprehensive Medication Review	62.6	53.4	77.0

Source: Mathematica's analysis of 2015–2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

[a] Mean excludes observations missing data for this measure.

[b] Lower rates indicate better performance.

[c] In the regression analysis, we used the 75th percentile among D-SNP dominant contracts. Because we used a binary variable for this measure rather than a continuous variable, we did not calculate the estimated change in VDR associated with a 20 percent improvement in the rate.

[d] Rate of appeal cases auto-forwarded to the independent review entity because the plan exceeded decision time frames for coverage determinations or redeterminations.

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; n.a. = not applicable to this indicator variable; VDR = voluntary disenrollment rate.

D. Association of VDR with quality and experience of care

We found mixed results for the association of the MA quality and experience-of-care measures with the VDR. Three of the nine measures had statistically significant associations with the VDR in the expected direction, one had a statistically significant association with the VDR in an unexpected direction and there was no statistically significant association with the VDR for the remaining five measures (Exhibit III.5).

For eight of the nine measures, we report the estimated coefficient between the measure and VDR. In addition, we report the percentage point change in the VDR associated with a 10 percent improvement in the measure rate.[8] Translating the effect into 10 percent improvement for each measure makes it easier to compare the impacts across measures with different levels of performance, and that vary based on whether higher or lower rates indicate better performance.

[8] We calculated this impact by multiplying the rate change for a 10 percent improvement in the measure rate by the regression coefficient for each measure. This did not apply to the Complaints About the Health Plan measure, for which we used an indicator of whether the contract observation was at or above the 75th percentile rather than a continuous measure of the score.

Exhibit III.5. Estimated change in VDR associated with a 10 percent change in MA quality and experience-of-care measure rates

Measure	Mean, percentage[a]	Estimated association with VDR[b]	Change in measure performance if contract were to improve by 10 percent on this measure, percentage points[c]	Estimated change in VDR associated with 10 percent improvement in measure performance, percentage points
Breast Cancer Screening Rate	68.5	0.231***	6.9	1.6***
Annual Flu Vaccination Rate	69.5	-0.173*	7.0	-1.2*
Care for Older Adults – Functional Status Assessment	77.9	-0.015	7.8	-0.1
Diabetes Care – Blood Sugar Controlled	72.0	-0.006	7.2	0.0
Plan All-Cause Readmissions[d]	9.9	0.332	-1.0	-0.3
Rating of Health Plan	86.6	-0.757***	8.7	-6.6***
Complaints About the Health Plan at or above the 75th percentile[e]	23.2	4.539***	n.a.[e]	n.a.[e]
Appeals Auto-Forward[d]	6.2	-0.062	-0.6	0.04
Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)	62.6	-0.033	6.3	-0.2

Source: Mathematica's analysis of 2015–-2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

[a] Mean excludes observations that were missing data for this measure.

[b] Estimated coefficient from the regression. Rows with an estimated association that was not statistically significant are **shaded in grey.**

[c] These numbers reflect a 10 percent improvement in the mean score of a measure for D-SNP dominant contract year-observations in the primary regression sample (n = 207). We chose 10 percent because it would be large enough to represent a meaningful improvement in performance but small enough to be feasible. The mean was calculated excluding observations that were missing data for a particular measure. For most measures, improvement meant an increase in the rate. For the measures in which lower rates indicate better performance, improvement meant a decrease in the rate.

[d] Lower rates indicate better performance.

[e] In the regression analysis, we used the 75th percentile among D-SNP dominant contracts. Because we used a binary variable for this measure rather than a continuous variable, we did not calculate the estimated change in VDR associated with a 10 percent improvement in the rate.

* Significantly different from zero at the .10 level, two-tailed test.

** Significantly different from zero at the .05 level, two-tailed test.

*** Significantly different from zero at the .01 level, two-tailed test.

CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; n.a. = not applicable to this measure; SNP = Special Needs Plan; VDR = voluntary disenrollment rate.

For example, a 10 percent improvement in the mean rate on Annual Flu Vaccination Rate, for which higher rates indicate better performance, corresponds to a 7.0 percentage point *increase*, from a mean of 69.5 percent to 76.5 percent. For Plan All-Cause Readmissions, in which lower rates indicate better performance, a 10 percent improvement in the mean rate corresponds to a 1.0 percentage point *decrease*

in this measure, from a mean of 9.9 percent to 8.9 percent. See Appendix A, Exhibit A.6 for detailed regression results, including estimated associations between control variables and VDR.

- **Three of the nine measures had statistically significant associations with VDR in the expected direction: worse performance on Complaints About the Health Plan was associated with higher VDRs and better performance on member Rating of the Health Plan and Annual Flu Vaccine Rate was associated with lower VDRs.**
  - D-SNP dominant MA contracts with high rates of enrollee Complaints About the Health Plan (at or above the 75th percentile) had a strong association with VDR: an increase of 4.5 percentage points in the VDR.
  - The percentage of members Rating the Health Plan at the best possible score was strongly associated with lower VDR: a 10 percent improvement (increase) in this measure was associated with a decrease of 6.6 percentage points in the VDR.
  - A 10 percent improvement (increase) in the Annual Flu Vaccine Rate was associated with a 1.2 percentage point decrease in the VDR.
- **One quality measure—Breast Cancer Screening Rate—had a statistically significant association with VDR that was in an unexpected direction**.
  - An improvement (increase) of 10 percent in the Breast Cancer Screening Rate was associated with an *increase* of 1.6 percentage points in the VDR.
- **For the remaining five quality measures, associations with VDR were close to zero and not statistically significant.** These measure include (1) Care for Older Adults-Functional Status Assessment, (2) Diabetes Care – Blood Sugar Controlled, (3) Plan All-Cause Readmissions (to hospitals), (4) Appeals Auto-Forward (the rate of drug-related appeal cases auto-forwarded to the independent review entity because the plan exceeded the decision time frame), and (5) Medication Therapy Management Program Completion Rate.

E. Association of VDR with the level of Medicaid integration

The association between VDR and level of integration with Medicaid was not statistically significant for most groups of contracts. We compared the association between level of Medicaid integration and VDR for contracts with low, moderate, and full integration to those that had no integration, separating contracts that were at or above the 75th percentile of enrollment from those below this size. Exhibit III.6 shows estimated associations along with their confidence intervals; associations in which the confidence intervals, shown as green vertical lines, do not include 0 were statistically significant.

When examining the sample as whole, we found the association of integration with Medicaid and VDR varied by contract size (additional details are in Appendix A, Exhibit A.5). We then tested the association with VDR for six groups of contracts: those with low, moderate, and full integration divided by large- and small-sized contracts. For four of the six groups of contracts, the association between the level of integration with Medicaid and VDR was not statistically significantly different from zero when compared with contracts that had no integration ($p > 0.10$ in these four cases). However, for two groups of contracts, we found statistically significant associations between integration level and VDR:

- Large contracts (with enrollment above the 75th percentile) with full integration had *lower* VDRs than contracts with no integration, a 5.7 percentage point decrease on average.

- Contracts with enrollment below the 75th percentile with moderate integration had *higher* VDRs than contracts with no integration, a 4.0 percentage point increase on average.

Although it is unclear why very large, fully integrated MA contracts had lower VDRs, it might be that the parent companies had more resources to invest in services and benefits that increase member retention. However, this finding should be interpreted cautiously because it was limited to only 7 of the 207 contract-year observations, suggesting lower VDR in this subset might have been due to something other than (but perhaps related to) large size and full integration. We are not aware of any mechanism that could explain why moderately integrated contracts would raise VDR.

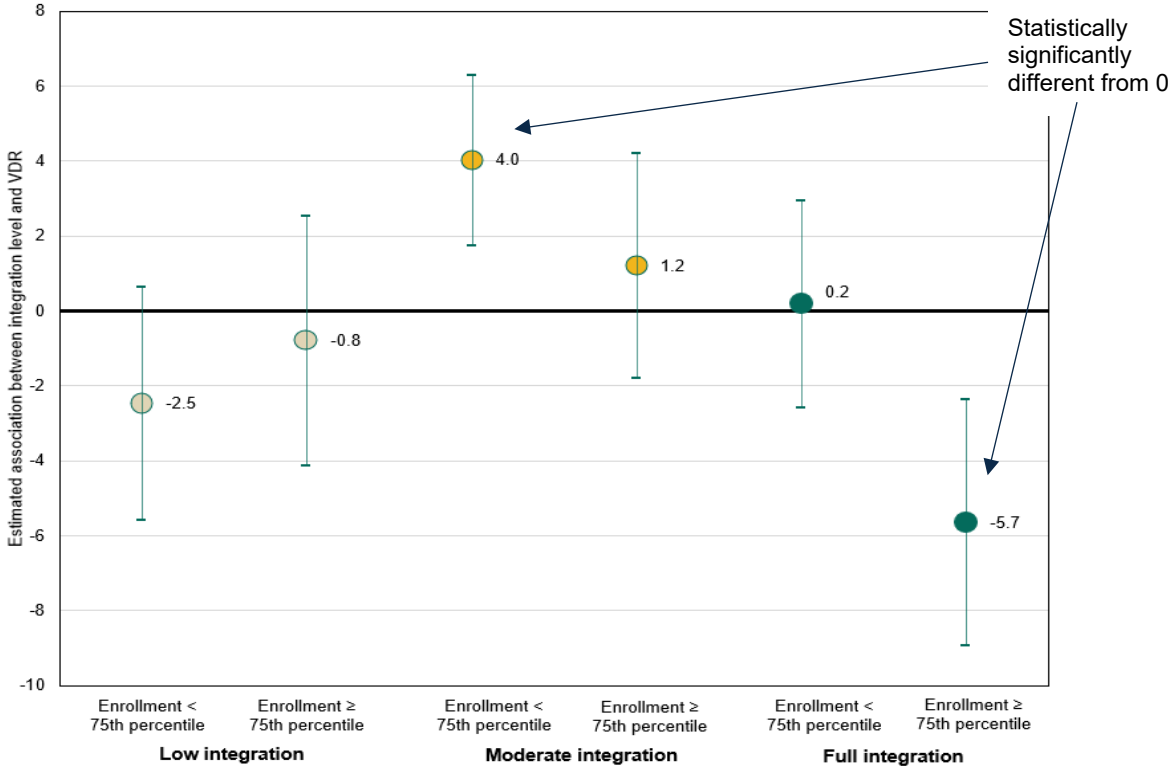
The difference in the direction of the association with VDR—that is, full integration with lower VDRs and moderate integration with higher VDRs, as well as the small number of large contracts with full integration—suggests one or both of these associations might be due to something in addition to, or other than, the level of Medicaid integration.

F. Sensitivity tests

We ran variations of the primary regression model as sensitivity analyses to determine if three factors affected the results: (1) not weighting by MA enrollment size, (2) omitting observations with a missing value for at least one quality and beneficiary experience measure, and (3) using a continuous enrollment variable instead of an indicator of whether the observation had total enrollment at or above the 75th percentile.

Results from several sensitivity analyses were generally consistent with results from the primary model for the relationship of MA quality and experience-of-care measures, and level of Medicaid integration, with VDR. The sensitivity tests did not provide strong evidence of a relationship between level of integration with Medicaid and VDR, though they continued to suggest that having full integration was associated with lower VDR among the largest contracts. For details about the sensitivity analyses, see Appendix A, Exhibit A.6.

Exhibit III.6. Estimated association of integration level with VDR at different levels of total MA enrollment



Source: Mathematica's analysis of 2015–-2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and MA Plan Directories.

Note: This exhibit shows the estimated average change in VDR for contract-year observations with a certain level of integration relative to those with no integration. The green lines show the 95 percent confidence interval; associations in which the confidence interval does *not* include 0 were statistically significant. Enrollment refers to enrollment in all MA plans in the contract in a particular year, and percentile refers to the distribution of enrollment among the 207 contract-year observations in the sample. The 75th percentile was 11,841 enrollees.

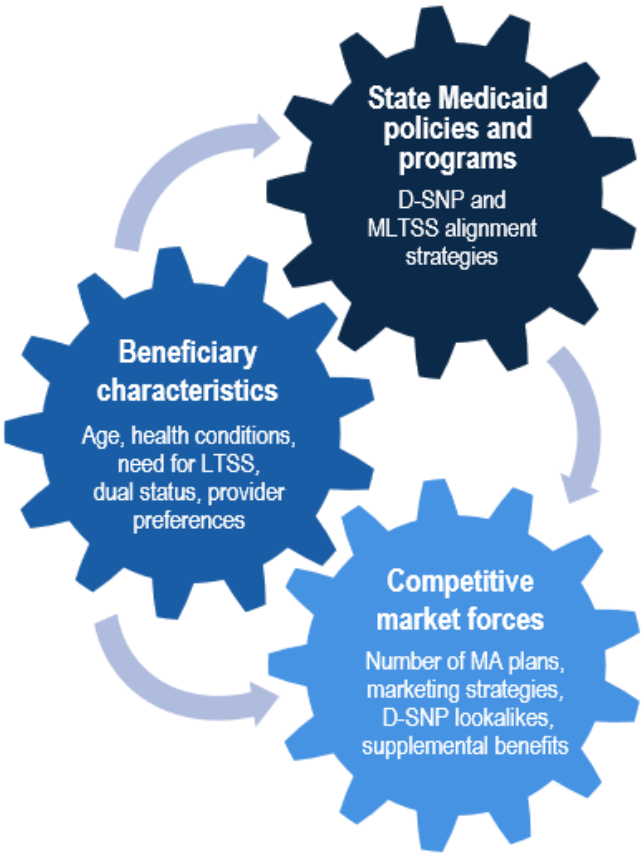
CMS = Centers for Medicare & Medicaid Services; D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; SNP = Special Needs Plan; VDR = voluntary disenrollment rate.

IV. Additional Factors Affecting Voluntary Disenrollment from D-SNP Dominant Medicare Advantage Contracts

A. Overview

To understand the factors that might explain differences in VDRs across D-SNP dominant MA contracts that cannot be easily measured, we interviewed state Medicaid officials, beneficiary counselors, and senior executives of D-SNP health plans. Based on themes that emerged from these interviews, these factors fell into three interrelated categories.

- **State Medicaid policies and programs.** Due to their status as Medicaid beneficiaries, state policies concerning Medicaid program design and options for covering dually eligible beneficiaries contribute to D-SNP VDRs. However, the degree and direction of influence of state Medicaid policies and programs varies considerably across states and can be mediated by other factors, including the degree of local market competition and beneficiaries' characteristics.
- **Local MA market features and competitive forces.** Interview respondents frequently cited the degree of local market competition among MA plans as a factor that distinguished VDR patterns across states and markets. In general, they said highly competitive markets with numerous MA plans contributed to higher VDRs among D-SNP dominant MA contracts, whereas markets with few MA plans contributed to lower VDRs. MA plans compete with one another on type and generosity of supplemental benefits and cost-sharing requirements, and the composition of provider networks, among other things.



- **Beneficiaries' characteristics and preferences.** Interview respondents cited a number of beneficiary characteristics and preferences that can prompt someone to disenroll: changes in need for LTSS or change in health conditions, change in dual status (full- or partial- benefit dually eligible), and changes in MA plans' provider networks. These characteristics and preferences can directly or indirectly determine how, and the extent to which, particular state Medicaid policies and programs and local MA market forces influence beneficiary behavior.

This section starts by describing the sample selection, interview respondents, and analytic methods. It then presents major themes about the influence of state Medicaid policies and programs on D-SNP disenrollment, followed by themes about the influence of local market features and competitive forces.

Both subsections discuss differences in beneficiaries' characteristics and preferences, and how they influence decisions to leave a plan.

B. Methods

Exhibit IV.1. VDR levels

VDR level	VDR percentage
Low	6 or less
Medium	7 to 15
High	16 or more

Sample selection. To select states and plans for interviews, we constructed a purposive sample of D-SNP dominant contracts with divergent VDRs—very high and very low VDRs—or changing VDR patterns over time within the same state and across states. Selecting contrasting cases that display maximum variation enhances our ability to understand how and why heterogenous VDR patterns have emerged and the conditions that produce such variation (Patton 2015). Using data from the same sample of 207 contract-level observations from 2015–2018 in the quantitative analysis,[9] we classified VDRs as high, medium or low (see Exhibit IV.1) and then identified three contrasting VDR patterns:

1. **Divergence across states.** Six D-SNP dominant MA contracts in three states all had low VDRs: **Massachusetts, Minnesota, and Oregon,** which contrast with four D-SNP dominant contracts in two states that had consistently high VDRs: **Florida and Texas**.
2. **Divergence within states.** In four states, D-SNP dominant MA contracts have marked differences in VDR patterns. In three states (**California, Pennsylvania, and Wisconsin**), one D-SNP dominant MA contract had low or medium VDRs and the other D-SNP dominant MA contract had high VDRs. In one state (**New York**), VDRs in both D-SNP dominant MA contracts were high, but one of the two plans had a marked decline in its VDR in 2018, indicating an outlier of interest. By selecting plans within the same state, we hold constant the effect of state Medicaid policies and programs to draw out the effects of local market forces and plan characteristics.
3. **Divergent VDRs in D-SNP dominant MA contracts across states among plans operated by national companies.** Three national firms operated 13 D-SNP dominant MA contracts in multiple states where the VDR patterns differ notably: plans in some states all had low VDRs whereas those in other states were medium or high. We requested interviews with corporate executives knowledgeable about these plans and markets to understand what could account for such differences.

Respondents and interview topics. From July through September 2020, we conducted 15 interviews with 52 participants across three respondent types; they oversaw or managed D-SNPs operating in 14 states. (Exhibit IV.2).[10]

[9] Among these 207 contract observations with D-SNP dominant MA contracts (with 70 percent or more D-SNP enrollees), we excluded MA contracts from the sample if (1) they did not have at least 70 percent D-SNP enrollees, or were not in operation, for at least three of the four years (2015–2018); (2) had medium VDR scores for all four years; or (3) were the only D-SNP dominant MA contract operating in a state.

[10] In this report, we identify the states in which D-SNP dominant MA plans with similar or divergent VDRs are located. However, we withheld the names of managed care plans interviewed and the identities of state and plan respondents to protect their confidentiality.

Exhibit IV.2. Number of interviews, by respondent type

Respondent type	# of interviews conducted	# of respondents participating
State Medicaid officials and/or State Health Insurance Program beneficiary counselors	6*	9
Local D-SNP executives	6	29
National corporate MA executives with D-SNP dominant MA contracts operating in multiple states	3	14
Total	**15**	**52**

* One SHIP representative provided written answers to questions, which counted as one interview.

D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage.

Based on previous literature about factors that affect beneficiaries' disenrollment decisions, we developed a semi-structured interview guide covering eight topics:

1. State Medicaid policies and programs
2. State outreach and communication with dually eligible beneficiaries about coverage options
3. Market competition, marketing strategies, and use of insurance agents and brokers
4. Supplemental MA benefits offered by plans
5. Breadth, composition of, and changes to provider networks
6. Care coordination of Medicare and Medicaid benefits
7. Plan characteristics, such as size, name and reputation, and length of time in operation
8. Any other factors that affect beneficiaries' decisions to disenroll or stay enrolled

Analytic methods. We coded responses through an iterative process. We first created a preliminary list of codes based on the interview topics. After coding the interview notes, we created new or different codes if the topics discussed by respondents differed from those in the interview guide, and merged codes for related topics. To identify overall themes, we grouped codes that addressed similar concepts and identified patterns across states, and across markets, by type of Medicaid policies and market features.

Limitations. The qualitative analysis has several limitations. First, by virtue of purposive sample selection, the findings do not necessarily represent the views of all states and D-SNP dominant plans. Second, due to the passage of time from the study period (2015–2018) to when we conducted the interviews in 2020, some respondents could not recall whether particular state Medicaid policies and programs were in effect, or the state of MA competitive market forces, which made it difficult to assess their effect on VDRs for specific D-SNP dominant contracts. Third, although we examined the top reasons for disenrollment reported by members in each contract who responded to CMS surveys,[11] we did not interview beneficiaries or consumer advocates to ask about their reasons for leaving. Due to these

[11] CMS surveys a sample of members who disenrolled to determine reasons for leaving, but response rates are generally poor so the results are not reported for many D-SNPs. No data were reported for contracts with fewer than 30 responses or scores with low reliability, or the plan was too new to be measured. See the Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/MAPDP_DisenrollmentSurvey.

limitations, the findings explain how each factor influences VDRs and the direction of influence (up or down), but do not quantify the degree of influence, or relative importance, of each factor's effect.

C. Key findings: State Medicaid policies and programs for dually eligible beneficiaries

Interview respondents identified five types of state Medicaid policies and programs that can affect VDRs in D-SNP dominant MA contracts: (1) state programs that operate long-standing fully integrated programs under federal demonstration authority, (2) state participation in newer federal demonstrations that offer fully integrated Medicare-Medicaid Plans (MMPs) to dually eligible beneficiaries, (3) state D-SNP and Medicaid contracting policies that require D-SNPs to operate an affiliated Medicaid MLTSS plan or vice versa, (4) policies allowing automatic enrollment of dually eligible beneficiaries into aligned plans, and (5) state communication with beneficiaries about their Medicaid and Medicare coverage options. Exhibit IV.3 summarizes these policies and programs and illustrates how they can increase or decrease VDRs.

As noted earlier, the influence of Medicaid policies and programs on disenrollment varies by state and by beneficiaries' characteristics. For example, some states limit D-SNP enrollment to full-benefit dually eligible individuals (FBDEs). In these states, if an FBDE loses eligibility for Medicaid, or a change in income causes the person to switch to partial dual status, the individual would have to disenroll from the D-SNP.[12] In addition, some states mandate enrollment in MLTSS plans for dually eligible beneficiaries who qualify for a certain level of LTSS. If a beneficiary in a non-integrated D-SNP becomes eligible for that level of LTSS, triggering enrollment into an MLTSS plan, that person might have to disenroll from the D-SNP to switch to an aligned D-SNP-MLTSS plan.

1. In states with long-standing CMS integrated care demonstrations in which D-SNPs now qualify as FIDE SNPs, respondents attributed low VDRs to the benefits of coordinated care.

Legacy Medicare-Medicaid demonstrations: the first FIDE SNPs

- Massachusetts Senior Care Options began in 2004.
- Minnesota Senior Health Options began in 1997.
- Wisconsin Family Care Partnership began in 1996.
- All legacy Medicare-Medicaid plans converted to D-SNPs in 2006.

All D-SNP dominant MA contracts in Massachusetts and Minnesota during the study period (with one exception in 2017 and 2018) and two parent companies in Wisconsin that operate D-SNP dominant MA contracts qualify as FIDE SNPs.[13] Like other D-SNPs, FIDE SNPs must have a contract with each state in which they operate, but these types of plans must also cover all or most state Medicaid benefits, including LTSS and behavioral health services. FIDE SNPs must also coordinate Medicare and Medicaid services, enrollment processes, member communications, and grievance and appeal systems. FIDE SNPs are eligible to receive an extra amount for each enrollee if their members' risk scores indicate a similar average level of frailty as PACE program participants.

[12] Although loss of Medicaid eligibility does not affect the VDR measure, respondents informed us members sometimes disenroll before the change takes effect, which would affect the VDR measure.

[13] FIDE D-SNPs were authorized by the 2010 Affordable Care Act, Section 3205, and the D-SNPs in the legacy Medicare-Medicaid demonstrations in Massachusetts, Minnesota, and Wisconsin were all classified as FIDE SNPs after that.

Exhibit IV.3. Potential effects of state Medicaid policies and programs on D-SNP voluntary disenrollment rates

State policy or program options for dually eligible beneficiaries	State examples	Potential to decrease voluntary disenrollment	Potential to increase voluntary disenrollment
Long-standing Medicare-Medicaid integrated care programs operating under federal demonstration authority	Massachusetts, Minnesota, Wisconsin	Plan covers all (or almost all) Medicare and Medicaid services under one plan, which increases care coordination and member satisfaction	No reported effects.
State contracts with MMPs operating under FAI demonstration authority: companies that operate MMPs also may have D-SNPs	California, New York, Texas	No reported effects	Plans that operate both D-SNPs and MMPs may encourage members to disenroll from the D-SNP to enroll in a more integrated product.
State D-SNP contracts require D-SNPs to operate affiliated Medicaid managed care plans or vice versa	Arizona, New Jersey, Pennsylvania, Texas	Promotes aligned enrollment, which increases opportunity for care coordination and member satisfaction	In exclusively aligned enrollment arrangements, members who switch Medicaid plans or lose Medicaid eligibility will also have to disenroll from the D-SNP. If a plan loses a contract in a Medicaid reprocurement, members become unaligned and may disenroll from a D-SNP to switch to an aligned Medicaid plan operated by another company.
State automatic enrollment policies into aligned plans	Varies by state	Offers continuous coverage within plans that members are already familiar with; particularly successful when states allowed plans to reach out to members before enrollment	When states did not allow plans to communicate with members before automatic enrollment, members were unaware and might not have understood their benefits and their new plan.
State communication with beneficiaries	California, Minnesota, New York	Coordination with SHIP to contact members who notify D-SNPs of their intention to disenroll and explain the pros and cons of coverage options. States and SHIP counselors encourage members to stay enrolled in integrated products	It is confusing and difficult to understand letters and language about enrollment criteria in various Medicaid programs, and notices generally do not explain the benefits of integrated care.

Source: Mathematica's analysis of interview responses.

Note: Boxes shaded in green indicate retention in, or switches to, more integrated care plans; boxes shaded in red indicate disenrollment to less integrated care plans. Automatic enrollment into a D-SNP or an MMC plan owned by the same company can take several forms: on the Medicare side, this could include default enrollment (called seamless conversion until 2016); on the Medicaid side, this could be either passive or default Medicaid plan auto-assignment.

D-SNP = Dual Eligible Special Needs Plan; FAI = Financial Alignment Initiative; MMC = Medicaid Managed Care; MMP = Medicare-Medicaid Plan; SHIP = State Health Insurance Program.

The FIDE SNPs in these three states began many years ago as the first type of Medicare-Medicaid integrated plans. They are jointly overseen by CMS and states and operate under special federal waiver authority. Sometimes called legacy Medi-Medi demonstrations because they preceded the more recent

FAI demonstrations, these programs are limited to FBDE enrollees. Enrollment is voluntary and individuals retain the ability to choose Medicare benefits from traditional FFS or a different MA plan.[14] In Minnesota and Wisconsin, dually eligible beneficiaries who do not choose to enroll in one of the FIDE SNPs must enroll in a Medicaid managed care plan to receive LTSS.

The ability to receive both Medicare and Medicaid benefits from one plan can make the FIDE SNP attractive to beneficiaries, according to interview respondents. State officials in Minnesota and plan representatives in Wisconsin believed this was a key factor in retaining members, particularly after beneficiaries had first-hand experience with care coordination. One respondent from Wisconsin reported, "Members [in the integrated plan] don't seem to switch." In comparison, D-SNP dominant MA contracts in Wisconsin that were not a FIDE SNP and did not offer an integrated product had higher VDRs. Some respondents speculated this was because members who enrolled in non-integrated plans did not experience the same level of care coordination of Medicare and Medicaid benefits.

2. State participation in the federal FAI demonstrations, which offer fully integrated plans to dually eligible beneficiaries through MMPs, can in some circumstances lead to increased disenrollment from D-SNPs offered by the same companies.

Since 2014, 10 states have participated in the federal FAI capitated model in which FBDE beneficiaries can elect to enroll in MMPs. MMPs are fully integrated plans that provide and coordinate all Medicare and Medicaid benefits. States can restrict eligibility based on age, regions within the state, and other criteria, and enrollees can enroll in, disenroll from, or change plans at any time (Lipson et al. 2018).

According to interview respondents involved in FAI demonstrations in California, New York, and Texas, health plans that offered both D-SNP and MMP products often had high VDRs from the D-SNP.[15] In one case, a high VDR reflected the plan's response to state policy. California's policy prohibited D-SNPs located in counties where MMPs were available to enroll MMP-eligible beneficiaries into the D-SNP. This policy gave D-SNPs that operated an MMP an incentive to encourage FAI-eligible members in the D-SNP to switch to the MMP to better coordinate their Medicare and Medicaid services. As a result, the high VDR for the California D-SNP we interviewed represented a positive outcome: rather than disenrolling due to dissatisfaction with the plan, members left to enroll in a more integrated model. This suggests in states that operate FAI demonstrations, disenrollment rates from D-SNPs operated by the same companies as those that operate MMPs should be examined on a case-by-case basis to determine if they indicate switches toward more integrated arrangements.[16]

[14] Massachusetts began operating a separate integrated care program for dually eligible beneficiaries younger than 65 as a federal FAI demonstration in 2014. Minnesota operates a separate program for dually eligible beneficiaries younger than 65 called Special Needs Basic Care; some of these plans integrate Medicaid and Medicare benefits for these members.

[15] VDRs do not count D-SNP enrollees who were passively enrolled into an MMP, but the VDR measure did count D-SNP members who voluntarily chose to switch from a D-SNP to an MMP.

[16] Massachusetts also operated an FAI demonstration during the study period, but it was limited to dually eligible beneficiaries younger than 65, whereas its D-SNPs primarily enroll those who are 65 and older. This made it less likely that plans would try to switch members from D-SNPs into MMPs.

3. State D-SNP and Medicaid contract requirements that promote aligned enrollment with Medicaid managed care and managed LTSS plans increase the opportunity for care coordination that can *reduce* voluntary disenrollment.

> *Aligned enrollment is a particularly important driver. If a member is enrolled in an aligned arrangement, the voluntary disenrollment rate is a trickle … due to care coordination, access to providers, extra benefits. Where we offer a Medicaid managed care product in the same location as a D-SNP, the ability to align them with a Medicare D-SNP helps to keep VDRs low.*
>
> D-SNP plan manager

Since 2013, federal law has required D-SNPs to contract with state Medicaid agencies and provides states flexibility to decide which Medicaid benefits are covered under the contract and specify other terms and conditions.[17] States have a number of levers to promote aligned enrollment, which occurs when dually eligible beneficiaries receive Medicare and Medicaid benefits from the same company. When dually eligible beneficiaries enroll in the same plan to provide Medicare benefits through the D-SNP and Medicaid benefits, it increases the opportunity for plans to integrate and coordinate services across the two programs and might improve member retention according to respondents.

State Medicaid policies and programs can promote aligned enrollment in several ways. States can require D-SNPs to operate an affiliated Medicaid MLTSS plan to give enrollees the option of receiving Medicaid benefits from the same plan offered in the same service area. In states that require dually eligible beneficiaries to enroll in Medicaid MLTSS plans to receive LTSS benefits, and require or encourage Medicaid plans to have affiliated D-SNPs, states can limit enrollment in D-SNPs to beneficiaries who are enrolled in the affiliated Medicaid managed care plan offered by the same parent company, referred to as exclusively aligned enrollment. Exhibit IV.4 illustrates policies that promote aligned enrollment in selected states.

Respondents from states with policies that promoted aligned enrollment said these policies helped to retain members in D-SNPs. They attributed high retention rates in these plans to the plans' ability to coordinate care, simplify enrollment processes, and link provider network contracts, which they believed appealed to members. For example, after Pennsylvania began its MLTSS program in 2018, the D-SNP VDR declined in the first year that plan offered an affiliated MLTSS plan, which respondents attributed to their ability to better coordinate care for members with aligned enrollment. "Beneficiaries had one ID card, one network of providers, and one care coordinator, which helped to decrease voluntary disenrollment," according to a plan manager.

[17] Medicare Improvements for Patients and Providers Act of 2008, section 164 and regulations clarifying these requirements at 42 CFR § 422.107.

Exhibit IV.4. Examples of state Medicaid policies and programs that promote aligned enrollment, as of 2020

State	D-SNPs must operate an MMC or MLTSS plan (or vice versa)	D-SNPs can enroll members only in affiliated MMC or MLTSS plans[a]	Duals must enroll in MLTSS plans to receive LTSS benefits
Arizona	X	FIDE only (*with some exceptions*)	X
California		X (only select plans)	In some areas
Florida			X
Massachusetts	X	X	
Minnesota	X	X	X
New Jersey	X	X	X
New York		FIDE SNP only	X
Oregon			
Pennsylvania	X (eff. 2018, only select plans)		X
Tennessee	X[b]		
Texas	X[c]		X
Wisconsin		FIDE SNP only	X

Sources: Verdier and Chelminsky 2017; Integrated Care Resource Center July 2019 webinar; state contracts or information obtained directly from states.

[a] Also known as exclusively aligned enrollment.
[b] D-SNPs that operated in Tennessee before the state's FIDE SNP requirement do not have to offer affiliated MLTSS plans.
[c] Plans in Texas must offer both a D-SNP and MLTSS only in select service areas.

D-SNP = Dual Eligible Special Needs Plan; FIDE = Fully Integrated Dual Eligible; LTSS = long-term services and supports; MLTSS = managed long-term services and supports; MMC = Medicaid Managed Care.

Respondents offered examples of specific care coordination activities that encourage member loyalty. These included care coordinators conducting face-to-face or in-home meetings with new members, maintaining regular contact with members, ensuring members can identify their care coordinator, and ongoing training to improve care coordinators' skills in providing person-centered care. A national plan said it has had success retaining members by ensuring care coordinators make house calls within the first 90 days of enrollment. Another plan said after beneficiaries are enrolled in an integrated program for a while, they understand and appreciate the benefits of care coordination: "Once people get into the [integrated] program, they see how it helps them navigate plan benefits and services, so it becomes valuable to them."

In a few cases, respondents reported state requirements for Medicaid beneficiaries to enroll in a D-SNP offered by the same plan that covers their Medicaid MLTSS benefits can unintentionally increase the D-SNP VDR. For example, if a state requires beneficiaries to enroll in such exclusively aligned arrangements, a beneficiary who disenrolls from his or her Medicaid managed care plan would also have to disenroll from the aligned D-SNP. Or, if a D-SNP loses its Medicaid contract as the result of a reprocurement, Medicaid members would have to disenroll from the affiliated D-SNP. Respondents told us when members are notified of these changes, many disenroll before the date such changes take effect, which is counted in the VDR. For example, one company that lost a Medicaid MLTSS contract in a region of the state in 2018 said: "Because D-SNP members in that area knew their Medicaid plan was terminating, they disenrolled from our D-SNP prior to its actual termination." Another plan that lost a

Medicaid managed care contract said negative press coverage led members to disenroll from the affiliated D-SNP before it ended. Because these types of changes on the Medicaid side can influence disenrollment from D-SNPs, it is important to consider their effect on D-SNP VDRs on a case-by-case basis.

4. State Medicaid policies allowing automatic enrollment into aligned plans can increase retention.

If approved by CMS, D-SNPs can automatically enroll individuals who are members in their affiliated Medicaid managed care plan into their D-SNP when they become eligible for Medicare—for example, when they turn 65 or due to a disabling condition—as long as they remain enrolled in the Medicaid managed care plan. Previously called seamless conversion, and since 2019 default enrollment, states decide which D-SNPs can use this option (Stringer and Kruse 2019). Medicaid agencies can automatically assign Medicaid enrollees to a Medicaid plan owned by the same parent company as the D-SNP.

Several respondents from health plans said automatic enrollment contributes to D-SNP retention by ensuring continuity of coverage for members.[18] One plan told us, "If members are already enrolled in a Medicaid managed care plan before becoming Medicare eligible, and they are already comfortable or familiar with the plan, they will likely just stay in [the D-SNP]." Several plan respondents said many of their new D-SNP enrollees were formerly members of their Medicaid managed care plans, and that if those members enroll in an aligned Medicare-Medicaid arrangement when they first become dually eligible, they are more likely to stay. For this reason, one plan noted its ability to use automatic enrollment was a major advantage over other D-SNPs that did not operate a Medicaid plan.

5. Clear and direct state Medicaid communications with beneficiaries about their coverage options can help to increase retention in integrated plans.

Clear communication with Medicaid beneficiaries about their coverage options is always important, but particularly so when they are default enrolled into a Medicare plan. Respondents said members who enrolled in a D-SNP through default enrollment were more likely to stay if the state allowed the plans to communicate with members before it took place. In states that did not allow such prior communication, respondents said members were more apt to disenroll from the D-SNP right after enrollment because the change took them by surprise, or they were concerned about its effect on their Medicaid coverage.

One-to-one communication with beneficiaries can also help them understand the consequences of switching from an integrated plan to a non-integrated plan. For example, a State Health Insurance Program (SHIP) representative in one state said counselors explain the benefits of integrated care programs when Medicaid beneficiaries first become dually eligible, or when consumers call to ask about coverage options. Officials in a state that operates FIDE SNPs in partnership with CMS receives real-time disenrollment files from CMS that they share with the SHIP, which then contacts D-SNP members who wish to disenroll to understand why and, if possible, mitigate problems that prompted them to disenroll. SHIP counselors also use this opportunity to explain the benefits of having one plan coordinate care across the two programs.

[18] In some instances, it was unclear whether interviewees were referring to seamless conversion during the study period (2015–2018), to default enrollment after January 2019, or to automatic assignment of Medicaid beneficiaries to a plan when they do not choose one within a specified period.

In contrast, several states and plans attributed high disenrollment rates to confusing communications with beneficiaries about Medicare and Medicaid program changes. For example, when California and New York first implemented their FAI demonstrations in 2015, respondents from those states blamed poor beneficiary education about passive enrollment into MMPs for high opt-out rates and for creating a more confusing MA marketplace. Another plan said CMS sent letters to beneficiaries about MMPs and D-SNP plan terminations at the same time, which caused confusion and led to more switching among products and plans.

D. Key findings: Local market features and competitive forces

Respondents identified five types of MA market features and competitive forces that can affect VDRs in D-SNP dominant MA contracts: (1) degree of overall competition among MA plans in the market; (2) competition over supplemental benefits; (3) competition over member cost-sharing requirements; and (4) breadth and composition of, and changes to, provider networks. Next, we describe how these factors can affect disenrollment and the circumstances that lead to higher or lower VDRs.

1. Degree of local MA market competition can influence beneficiaries' decisions to disenroll.

According to many interview respondents, the degree of competition among MA plans in each state or local market influences VDR patterns across D-SNP dominant MA contracts. Fewer plans and less competition can contribute to low VDRs, whereas more plans and more competitive behavior can contribute to high VDRs. More plan choices can lead to more plan changes. Several respondents also reported MA plan entry and exit can contribute to enrollment churn. For example, two health plan representatives noticed conspicuous increases in voluntary disenrollment after new plans entered the market. And when a plan decides to exit a market, voluntary disenrollment from that plan can increase because members who are notified that their plan will cease to operate choose to disenroll before it closes. Respondents reported enrollment churn in highly competitive markets could also be due to aggressive marketing strategies. For example, one respondent reported a competitor stationed sales teams outside clinics and emergency rooms to approach consumers going to medical appointments. In addition, respondents discussed the effect on disenrollment of market competition from three types of plans:

- **Large national plans.** Many plan respondents reported competition from large national brands contributed to high disenrollment rates. They explained that national plans often had stronger provider networks, larger sales teams, and more robust supplemental benefit packages. Another plan representative said, "National brands focus on attracting members from smaller competitors to avoid competing directly with other large national plans." Another respondent said large plans have better brand recognition, making it easier for them to attract and retain members. Large companies have more resources to hire staff who can speak languages other than English. However, one state representative noted when a national company acquired a local plan, "There was major backlash from providers, beneficiaries, and the community because they did not like a national brand taking over a local organization." That MA contract had a small increase in the VDR in the year after the acquisition, indicating large national companies might not have an advantage in all markets. Supporting that view, other respondents noted small, locally owned plans that have been in operation for a long time have local name recognition and strong connections to the community, which engender member loyalty.
- **D-SNP look-alike plans.** D-SNP look-alike plans are regular MA plans that target their marketing to dually eligible beneficiaries through reduced cost sharing and supplemental benefits (MedPAC 2019;

MACPAC 2020b). Even though most of their members are dually eligible beneficiaries, these plans do not hold a contract with the State Medicaid Agency and are therefore not obligated to satisfy D-SNP requirements imposed by the state and the federal government. One plan representative noted one of its main competitors in the MA market operated a D-SNP look-alike plan and offered well-paid commissions to independent agents and brokers (see box), which it believed contributed to higher VDRs in its D-SNP. A state official credited the Medicaid agency's close monitoring of D-SNP look-alike activity in the market and reporting incidents to CMS for potential investigation, which it believed helped to reduce VDRs for D-SNPs in the market.

Role of insurance agents and brokers

Insurance agents and brokers often play a role in beneficiaries' decisions to enroll and disenroll from plans. Brokers target dually eligible individuals because, unlike nondual Medicare beneficiaries, dually eligible beneficiaries can make enrollment changes more frequently. Many respondents said brokers generally steer consumers toward plans with broad provider networks, robust supplemental benefit packages, brand recognition and high MA Star Ratings. But several respondents noted brokers encourage dually eligible individuals to switch from current plans to those that offer brokers the highest commission rates. In one state, after a change in state policy that allowed brokers to receive commissions for members who enrolled in MMPs, brokers had an incentive to disenroll members from D-SNPs to enroll them in MMPs. A health plan representative noted brokers preferred to enroll dually eligible beneficiaries in plans that accept both full- and partial-benefit dually eligible individuals to avoid rejection if the state limits D-SNP enrollment to full-benefit dually eligible beneficiaries.

- **Multiple MA product lines offered by the same carrier.** Insurance companies that operate MA plans often have multiple products within the same parent company, including regular MA plans. D-SNP look-alike plans, MMPs, or FIDE SNPs. One plan respondent said a major advertising and grassroots marketing campaign by its parent company for the regular MA product could have affected its D-SNP disenrollment rates in certain years. Another plan representative said its company had made a business decision to invest in its FIDE SNP product because it believed in the value of integrated care and wanted to continue offering an integrated product, particularly as enrollment in its MMP product dwindled. As a consequence, the company decided to discontinue its non-integrated D-SNPs (one for fully eligible and one for partially eligible duals); the high VDR during the year when it made this decision might have reflected large numbers of members who voluntarily disenrolled before the plan's actual termination.

2. MA plans, including D-SNP dominant plans, compete with one another based on generosity and type of supplemental benefits offered.

One of the major attractions to consumers to enroll in MA plans rather than traditional Medicare FFS is the ability to benefit from lower cost sharing and extra benefits not covered by Medicare. MA plans offer a wide range of supplemental benefits to enrollees such as reductions in premiums, deductibles, coinsurance, and other cost-sharing for Medicare-covered services, as well as health-related benefits, such as dental and vision services and over-the-counter (OTC) pharmacy items. Plans cover the cost of these supplemental benefits by charging extra premiums to beneficiaries, or more commonly, through rebates (see box). Each plan decides whether and how to allocate rebate dollars toward the mix of supplemental benefits based on many factors. These include "competitor offerings, current and prospective enrollee needs or expected demand, and the anticipated impact of various supplemental benefit offerings on total cost of care and enrollee satisfaction" (Ipakchi et al. 2020).

Relationship of MA rebates and MA Star Ratings to supplemental benefits

MA plans finance supplemental benefits through rebate dollars, which are calculated based on the difference between the capitation rates that each MA plan bids and the average Medicare FFS benchmark rate in the county in which a plan is offered. Plans that bid below the county benchmark receive rebates, pegged to a percentage difference between the plan's bid and the risk-adjusted benchmark.

MA plans also receive bonuses that are directly proportional to the MA plan's overall Star Rating, which is based on its performance on quality and experience-of-care measures. Plans with an overall Star Rating of 4 or more receive additional rebate dollars to apply toward supplemental benefits. Consequently, MA contracts with higher Star Ratings have more funds to provide desirable supplemental benefits than plans with lower Star Ratings.

Numerous respondents said D-SNPs, like other MA plans, compete for enrollees based on the supplemental benefits they believe will attract enrollees. Several plan respondents stressed that members often disenroll from D-SNPs when competing plans offer more attractive supplemental benefits, especially dental, vision, transportation, and OTC medications. Many respondents also noted the importance of cost-sharing subsidies on plans' ability to attract and retain enrollees. They cited plans in highly competitive markets that offer more generous cost-sharing savings as having a strong influence on beneficiaries' decisions to disenroll from their current plan to take advantage of the financial savings.

> *When you have more competitors in the D-SNP space that are aggressive and out to get market share, supplemental benefits become a 'spreadsheet' exercise. Beneficiaries are comparing which plans have more hours in one benefit or higher allowances in another.*
>
> *– D-SNP plan*

One representative from a plan that operated both a standalone D-SNP and an integrated FIDE SNP under the same MA contract noted members who had voluntarily disenrolled from either plan often moved to plans that offered more attractive benefits. However, this respondent reported supplemental benefit packages were more likely to influence members enrolled in the standalone D-SNP product than members in the FIDE SNP. Another representative from a plan with low VDRs stated that although historically it offered generous supplemental benefits, competition from large national plans led it to diversify the supplemental benefits it offered in recent years. Other health plan respondents talked about competing with other plans to offer the highest OTC allowance or the greatest number of transportation trips. Although one respondent believed this competition drove better supplemental benefits for members, some

plan representatives said the competition can lead some enrollees to "plan hop" by enrolling in a new plan to reset allowance amounts for benefits, such as opioid medications, when they reach their limit.

3. The breadth and composition of managed care plan provider networks, and changes in provider networks, can influence beneficiaries' choices to enroll and disenroll.

According to respondents, dually eligible beneficiaries are very attuned to provider network participation in MA plans. Because they are more likely to have chronic health conditions than Medicare-only beneficiaries, and dually eligible beneficiaries often have long-standing relationships with health care providers. Many respondents specifically cited the importance of including certain hospitals, primary care doctors, and specialty physicians in plan networks, and some said the participation of community health clinics, home health aides, behavioral health professionals, and other types of providers often mattered to members. Plan respondents highlighted the need to include providers who can serve people with complex needs to attract and retain dually eligible beneficiaries. They also tried to create a broad network to attract and keep members who prefer providers located near their homes. Problems accessing providers was the second highest reason for disenrollment in CMS disenrollment reasons surveys among the plans we interviewed for which survey data were available.

For example, respondents reported plans that did not contract with large regional health systems were less attractive to beneficiaries who preferred to go to hospitals that are part of large systems. Plans with smaller numbers of members do not have as much leverage as larger plans to offer dominant provider groups attractive reimbursement rates or shared savings arrangements. Large plans with thousands of members can also afford to contract with numerous providers, enabling them to offer beneficiaries more choice. In addition, D-SNPs that have strong connections to Medicaid providers, such as federally qualified health centers and rural health clinics, are attractive to people who were Medicaid eligible before they become Medicare eligible because they can remain with the same providers when they become dually eligible. Conversely, respondents said if people who were Medicare eligible before they became dually eligible find that some of their previous providers do not accept Medicaid, they are attracted to D-SNPs that contract with providers who do participate in Medicaid.

Results from CMS surveys of MA members leaving plans show that problems accessing providers is the second most common reason for disenrollment. Interview respondents explained how providers' participation in plan networks can influence members' decisions to disenroll in different situations.

- **Changes in provider participation in plan networks.** Respondents cited several examples of changes in provider networks that led beneficiaries to switch plans—for instance, when a provider terminates a contract with a plan, or vice versa. "Members leave to follow their providers," said one health plan representative. In another case, after a major multi-physician group and an academic health center terminated contracts with a plan, it led to a high disenrollment rate the following year.
- **Providers induce beneficiaries to switch plans.** Several plan representatives cited providers' influence on beneficiaries' decisions to disenroll and switch coverage. They cited instances in which major hospital systems and individual providers steered patients away from certain plans that paid them lower rates than they could obtain from Medicare FFS or another plan. In other cases, providers steered patients toward certain plans if they sought to increase their leverage with those plans, or to simplify billing and administrative functions. Provider-owned plans also influence beneficiaries' choices. According to one plan executive, "Hospitals affiliated with, or owned by, a particular plan encouraged our members to switch to their affiliated plan."

- **Change in a beneficiary's residence or health status.** In some situations, beneficiaries' characteristics determine the importance of provider networks in their choice to disenroll or switch plans. For example, in MA contracts with disenrollment rates above the median rate in 2014, beneficiaries in poor health were more likely to disenroll compared to beneficiaries in better health, and they tended to report leaving for reasons related to preferred providers (GAO 2017). Interview respondents affirmed this finding, noting when beneficiaries' health conditions worsen, they are more likely to make a change in health coverage to be able to see certain providers. According to one plan representative, as beneficiaries age or experience a change in health status, "They start to place greater value on having a choice of doctors." Another plan executive said that as members' health care needs change, the more likely it is they will switch plans because they need more care from a variety of providers, "not necessarily because their satisfaction with the plan has changed." Conversely, a few respondents said members with stable health and long-term care needs were less likely to switch plans to preserve continuity of care with care coordinators, home health aides, and health care providers.

4. Medicare cost-sharing requirements contribute to voluntary disenrollment for some beneficiaries, especially partial duals and those who live in highly competitive markets.

Dually eligible beneficiaries generally have no, or lower, Medicare cost-sharing requirements relative to Medicare-only beneficiaries, because Medicaid covers most of their cost sharing. However, cost-sharing obligations vary considerably by dual status (full- or partial-benefit eligible), by plan, and by state (see box). Interview respondents said because partial-benefit duals incur higher cost sharing, they are sensitive to even small increases in monthly premiums or copays, which can lead them to switch to plans that offer lower cost sharing. This is consistent with CMS disenrollment reasons surveys of MA beneficiaries, which show financial reasons to be among the top causes of disenrollment from MA plans.

In addition, respondents reported widespread confusion among providers and beneficiaries about cost-sharing obligations for different types of dually eligible beneficiaries, contributing to decisions to disenroll or switch plans. For example, one health plan respondent said full-benefit dually eligible beneficiaries disenrolled from its plan because providers improperly billed the members for the balance of charges not covered by Medicaid. Although the plan educates beneficiaries and providers about the federal prohibition on balance billing for most dually eligible enrollees, the existence of multiple dual categories makes billing very difficult.

Cost sharing for full- versus partial-benefit dual eligible beneficiaries

The amount of dually eligible beneficiaries' Medicare cost-sharing obligations varies by dual status.

- About 71 percent of all duals are FBDEs who qualify for Medicaid coverage of all Medicare cost-sharing obligations, as well as other state Medicaid plan benefits.
- The remaining 29 percent are partial-benefit dual eligible beneficiaries who qualify for Medicare Savings Programs in which the state Medicaid program covers some Medicare cost-sharing obligations (premiums, deductibles, and copays for Medicare Parts A, B, and D), which vary depending on the person's income and assets.
- For all dually eligible beneficiaries, both full and partial, state Medicaid agencies can limit the amount of Medicare Part A and B cost sharing Medicaid will pay to an amount based on the lesser of (1) the Medicare rate or (2) the Medicaid rate, and most states choose the latter. Providers paid at the lower Medicaid rates cannot bill most dually eligible beneficiaries for the difference between the Medicare and Medicaid rate, known as balance billing.

Another source of instability comes from the federal requirement that states redetermine the eligibility of people who receive Medicaid coverage, including Medicare Savings Programs that cover partial duals, at least once every 12 months. About 16 percent of dually eligible beneficiaries with full benefits, and 23

percent of those with partial benefits, lost Medicaid coverage at least once over a three-year period (Riley et al. 2014). Some interview respondents said the loss of Medicaid eligibility can lead to disenrollment from a D-SNP when loss of dual status means they cannot remain enrolled in such plans. Although loss of Medicaid eligibility is not counted as a reason for voluntary disenrollment, respondents said beneficiaries sometimes switch plans before their termination date, which counts in the calculation of VDRs. Even if these individuals are redetermined to be Medicaid eligible, the notice informing them that they will be subject to higher cost sharing if they lose eligibility can prompt them to switch to a plan that has lower cost sharing.

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V. Conclusions and Policy Implications

In this last section, we compare and contrast results from both quantitative and qualitive analyses and draw overall conclusions to the study research questions. Based on these results, we identify six changes in federal and state policy and reporting practices that could help to increase retention in integrated care plans.

A. Are voluntary disenrollment rates (VDRs) among D-SNP dominant MA contracts associated with MA quality and experience-of-care measures and/or the level of Medicaid integration?

- **Three of the nine of the MA quality and experience-of-care measures examined in this study were associated with VDRs in the expected direction.** More member complaints—a direct expression of consumer dissatisfaction—was associated with *higher* VDRs. Better member ratings of the health plan, and higher flu vaccination rates, were associated with *lower* VDRs. In the midst of the coronavirus pandemic, whose resolution depends in part on developing a safe and effective vaccine, this particular result is encouraging. If there is an association between other MA quality and experience-of-care measure scores and VDRs among this group of contracts, results from the interviews suggest the relationship might be to some extent indirect. That is, higher MA Star Ratings generate bonuses that the plans use to gain market advantage by offering generous supplemental benefits and reduced member cost sharing, which in turn drives disenrollment from competing plans.
- **Level of integration with Medicaid was not associated with VDRs overall, but when divided by size and level of integration, two subgroups of contracts were associated with VDRs.** Results from the quantitative analysis found no statistically significant associations between level of Medicaid integration and VDRs. However, it found full integration was associated with lower VDRs among the largest D-SNP dominant MA contracts and moderate integration was associated to higher VDR among smaller contracts. Although it is unclear why this association holds for very large contracts but not for those of medium and small size, it might be the parent companies have more resources to invest in person-centered care coordination, offer richer supplemental benefits, create broad provider networks, and provide other services that increase members' satisfaction. However, the difference in the direction of the effect on VDRs suggests one or both of the associations might be due to something in addition to (or other than) the level of Medicaid integration. Results from the qualitative analysis also suggest state Medicaid policies and programs that promote aligned enrollment across D-SNPs and Medicaid managed care plans could help to increase retention in the most integrated care plans.
- **Care coordination across Medicare and Medicaid can improve member retention.** There was broad consensus among virtually all respondents that the ability to coordinate care across Medicare and Medicaid benefits contributes to member retention. This finding seems to be at odds with the lack of association between the level of Medicaid integration and VDRs, because integration is often a precursor to care coordination. Several factors could explain the apparent inconsistency. First, covering a full range of Medicaid benefits might be necessary but not sufficient. That is, fully or moderately integrated plans might be a prerequisite to care coordination, but the effectiveness of health plan care coordination can vary. If done well, care coordination might increase retention. Second, the Medicaid integration levels developed for this study do not necessarily indicate how well health plans provide person-centered care coordination. The benefits covered in D-SNP Medicaid

contracts and the extent of aligned enrollment distinguish the four integration levels. But some plans with lower levels of Medicaid integration could coordinate care well, especially if the D-SNP contract contains specific provisions to achieve this or if the plan deploys effective care coordination systems and procedures. Third, the effect of full integration and aligned enrollment on retention might be limited to, or perhaps more pronounced, for members who have been enrolled long enough to experience the benefit of care coordination and those with greater need for LTSS and/or behavioral health services, which fully integrated plans cover. This explanation could be tested with beneficiary-level data on these characteristics for all members who leave or remain in these plans.

B. What other factors influence differences in VDR patterns in D-SNP dominant MA contracts within and across states?

Themes from interviews with state officials and health plan representatives indicate three sets of interrelated factors influence D-SNP dominant MA contract VDR patterns within and across states.

1. **State Medicaid policies and programs.** Because they are dually eligible for both Medicaid and Medicare, state Medicaid policies and programs determine the types of Medicaid coverage options available, and the incentives (or requirements) for these individuals to enroll and remain in certain types of arrangements to receive Medicaid benefits. Depending on the state in which they live and the types of options available, beneficiaries can enroll in arrangements that might be more or less integrated with Medicare. State policies that steer beneficiaries toward the most integrated models can help to promote retention. In states with multiple Medicaid-Medicare arrangements, high VDRs in D-SNPs could be a positive sign beneficiaries are switching from a less integrated to a more integrated model, such as a FIDE SNP, an MMP, or a D-SNP with an aligned Medicaid contract.
2. **Local market competitive forces.** Results from the qualitative analysis indicate VDR patterns reflect the degree of local market competition among MA plans. Respondents reported that highly competitive markets with numerous MA plans contribute to higher VDRs among D-SNP dominant MA contracts, whereas those with few MA plans generally had lower VDRs. MA plans compete on type and generosity of supplemental benefits and cost sharing, the breadth and composition of provider networks, and in other ways. Respondents also discussed the destabilizing effect of D-SNP look-alike plan marketing. We found no statistically significant association between market concentration, measured by HHI, and VDRs at the D-SNP dominant MA contract level; however, HHI does not necessarily measure the nature or degree of market *competition* on the ground.
3. **Beneficiary characteristics and needs.** The extent to which state Medicaid policies and programs and local market competition influence dually eligible beneficiaries' decisions to disenroll from a D-SNP appear to vary based on beneficiaries' characteristics, including their dual eligible status, and their health or functional ability, as well as their relationships with and preferences for certain providers. For example, a dually eligible beneficiary who loses Medicaid eligibility might disenroll from a D-SNP before the grace period, or someone whose health or LTSS needs change might switch from a standalone D-SNP to a more integrated D-SNP. In addition, beneficiaries might disenroll from a D-SNP if their preferred provider leaves the plan's network, or if their provider encourages the beneficiary to disenroll.

C. Implications for federal and state policy

MedPAC and MACPAC have conducted research and deliberated about the merits of various policies that can help increase enrollment of dually eligible beneficiaries in integrated Medicare-Medicaid care models to improve the coordination of benefits and to align financing and beneficiary protections (MedPAC 2019; MACPAC 2020b). The MMCO in CMS similarly strives to align and coordinate benefits between the two programs by partnering with states to develop new care models for dually eligible individuals (MMCO 2019; CMS 2019). Many other groups have also proposed to remove federal policy barriers that hinder states' ability or willingness to integrate or align Medicare and Medicaid benefits (Bipartisan Policy Center 2020; Archibald et al. 2019).

The results of this study have several implications for federal and state policymakers seeking to increase enrollment of dually eligible individuals in integrated care models while preserving their choice of Medicare coverage. To increase overall enrollment, policies designed to attract new beneficiaries to enroll in such models are as important as those designed to retain existing enrollees. In addition, it costs more to recruit and enroll new members than to retain existing members. High rates of turnover are therefore costly to health plans, federal and state governments, and taxpayers who pay these costs for Medicare and Medicaid beneficiaries.

Based on previous studies, it is widely believed that consumers who choose to voluntarily leave MA plans are dissatisfied with the plan's performance and, specifically, with the quality of care they receive through the plan (Meyers et al. 2019; DuGoff and Chao 2019; Cohen et al. 2019). VDRs are an important measure of D-SNP performance that warrants more attention and weight. However, the results of this study show that VDRs are not by themselves a definitive measure of quality and performance. In addition, myriad other factors affect voluntary disenrollment rates from D-SNPs.

Although this study focused on disenrollment, the implications are relevant to enrollment policies broadly, because the factors that promote retention often mirror those that attract beneficiaries to certain types of plans or coverage models in the first place. Indeed, a lesson that emerges from this study is that one of the best ways to retain members is to ensure they enroll in highly integrated, high quality, member-centric plans from the start. Based on the study results, the following policy changes could help to increase retention in integrated care plans.

1. Report VDRs at the MA plan level, disaggregate VDR rates by full- versus partial-benefit dual status, and share this information with state Medicaid agencies.

When reported at the MA contract level, VDRs obscure differences that might exist for (1) multiple plans within the contract; (2) plans operating in different states; (3) plans serving both dual versus non-dual beneficiaries; and (4) plans that enroll full-benefit duals only, or both full- and partial-benefit duals. Disaggregating VDRs and quality scores by MA plan type and members' dual status would enable these data to be more useful to federal and state officials for overseeing the performance of D-SNPs and other integrated care plans by giving them the ability to monitor VDRs for each D-SNP. Although others have recommended that CMS report VDRs at the plan level (MedPAC 2019; DuGoff and Chao 2019), this study goes further by highlighting the importance of reporting VDRs at the MA plan level and by dual status: dual versus nondual, and full- versus partial-benefit dual status. CMS currently distinguishes

between dual and non-dual beneficiaries, as well as full- and partial-dual enrollees, for purposes of adjusting capitation payment rates, so doing the same for VDRs should be feasible.[19]

In the course of this study, we learned that some state officials do not monitor contract-level MA D-SNP VDRs or have little insight into what might explain differences in MA contract-level VDRs. That is likely because when these rates are reported at the MA contract level, state Medicaid managers cannot distinguish performance for dual and nondual enrollees, for plans that operate in multiple states, or different types of dual enrollees (full versus partial) enrolled in each D-SNP with which they contract.

Disaggregating and reporting VDRs by plan and dual status would also give state officials the ability to compare VDRs for D-SNPs by their level of integration with Medicaid, which would enable them to determine the value of such integration to beneficiaries or identify areas of concern. For example, if states see lower VDRs among contracts that are fully integrated D-SNPs than in contracts with less integration, it could strengthen the case for strengthening D-SNP integration requirements. States could also use VDR rates to inform decisions about whether to allow D-SNPs to use default enrollment (discussed later).

2. Provide real-time data to states about dually eligible beneficiaries who disenroll from D-SNPs.

CMS now reports VDRs publicly twice each year in conjunction with release of MA Star Ratings measure scores (early release in the fall and final release in the spring), but with a two-year lag. The VDRs reported in 2020, for example, reflect plan experience in 2018. Although such information might be useful for general oversight and comparison of plan performance, it is not very helpful to state officials who want to monitor disenrollment from D-SNPs on an ongoing basis, or in real time, to identify the potential reasons for disenrollment and try to address them. To promote timely monitoring and evaluation of this data, CMS may want to consider publishing VDRs monthly along with other enrollment files instead of waiting to publish them in the Star Ratings. Additionally, states can monitor D-SNP VDRs by extracting data on Medicare plan enrollment from files that they exchange with CMS at least monthly. [20]

In addition, CMS could share pending disenrollment files with states to facilitate beneficiary outreach. For example, Minnesota accesses files on a daily basis that contain lists of enrollees who have notified their Minnesota Senior Health Options (MSHO) FIDE SNP that they wish to disenroll. In some cases, state officials contact the enrollees to determine if their disenrollment was due to a breakdown in coordination or communication, try to resolve the problems, and advise them on the procedures to maintain coverage during the enrollment transition. Although Minnesota is unusual because it assumed the enrollment intermediary role and high-touch, one-to-one counseling may not be feasible in all states with high D-SNP VDRs, it illustrates the value to state Medicaid agencies of receiving timely data on D-SNP disenrollment from CMS and states' potential to mitigate unintended harm that may be caused by disenrollment.

[19] Before 2017, MA plans received excessive risk-adjusted Medicare capitation rates for dually eligible members because the CMS risk-adjustment model overpredicted spending for partial dually eligible beneficiaries, which inflated overall risk scores for all dual members (MedPAC 2019). CMS revised the risk-adjustment model in 2017 by distinguishing community-dwelling beneficiaries who are Medicare-only versus dual. Within the dual beneficiary group, the model distinguishes between those who are full or partial dual, and those who qualify for Medicare on the basis of age (65 and older) or disability (CMS 2016).

[20] Medicare plan enrollment information is available in Medicare Modernization Act files that states and CMS exchange at least monthly. For more information, see the Medicare Advantage Prescription Drug State User Guide: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/MAPD-State-User-Guide.

3. Reduce the impact of beneficiary cost sharing on disenrollment among full duals through stronger enforcement of and education about the federal prohibition on balance billing.

CMS surveys of MA beneficiaries consistently show financial reasons to be among the top reasons for disenrollment from MA plans and the most frequent reason for disenrollment in MA contracts without health-biased disenrollment, defined as plans in which beneficiaries in poor health are more likely to disenroll than those in better health (GAO 2017). The out-of-pocket costs associated with Medicare deductibles, coinsurance, and copayments are particularly important to dually eligible beneficiaries, who because of their low incomes, can be very sensitive to differences across plans in Medicare cost sharing and more apt to shop around to find the best deals.

Full-benefit dually eligible beneficiaries, however, are typically exempt from most Medicare cost sharing[21], except for nominal copayments for Part D drugs.[22] States do have the option of limiting the amount of Medicare Part A and B cost sharing covered under the state plan to amounts based on the lesser of the Medicare or Medicaid rate, and most states do so (MACPAC 2018; Roberts et al. 2020). In states where providers are paid at the lower Medicaid rates, however, they are prohibited from billing duals classified as Qualified Medicare Beneficiaries (QMBs) for the difference.[23] The distinctions between QMBs and other types of dual eligibility categories are very complicated and interview respondents reported widespread confusion about members' dual status. This confusion led to improper balance billing by providers to full-benefit dually eligible beneficiaries who qualify as QMBs and contributed to their decisions to disenroll and switch to a plan with lower cost sharing.

To protect full-benefit dually eligible D-SNP members from balance billing, MMCO is helping Medicare providers identify QMBs before they submit claims, notifying providers not to bill the beneficiary, giving beneficiaries more information about their cost-sharing liability, and building capacity to track incidences of inappropriate billing reported to CMS (MMCO 2019). States and plans also could do more to enforce the ban on QMB balance billing and educate providers and consumers about this ban. For example, plans could add a "no cost-sharing" flag to members' cards if they are exempt from balance billing. Such efforts could help to prevent members from disenrolling due to confusion about cost-sharing liability and instead help keep the focus of competition among MA plans (including D-SNPs) on the value of traditional supplemental benefits, such as dental, vision, and OTC coverage, as well as in-home personal assistance, home-delivered meals, adult day care, and caregiver support services, which state Medicaid programs cap or do not cover at all.

4. Decide whether to allow D-SNPs to use default enrollment based on retention rates and performance on other MA quality measures and care coordination.

D-SNPs that receive approval from CMS and the state can offer automatic (default) enrollment into their D-SNP for newly Medicare-eligible beneficiaries if those individuals are already enrolled in their

[21] QMBs constitute the majority of full-benefit dually eligible beneficiaries. Most of the remaining full-benefit dually eligible individuals were classified as "other" full-benefit duals, meaning they qualified for full Medicaid benefits in their state, but were not eligible for Medicaid coverage of Medicare cost-sharing obligations. Depending on the state, these individuals might have to pay Part A and/or B cost sharing for services covered by Medicare, but not Medicaid because the service or provider is not covered under the state plan.

[22] Full-benefit Medicaid dually eligible individuals who are institutionalized or receive Medicaid home and community-based services might not be charged any cost sharing for Part D drugs (Social Security Act,§1860D-14).

[23] For an explanation of dual eligibility categories and balance billing, see an Integrated Care Resource Center issue brief at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Prevent_Improper_Billing.pdf.

affiliated Medicaid managed care plan and will remain enrolled in that Medicaid plan after they become dually eligible. States have the power to determine whether and which D-SNPs in their state can use this option (Stringer and Kruse 2019). Enrollment into an integrated D-SNP as soon as one becomes dually eligible has several advantages, including greater ability of the plan to integrate and coordinate services covered by each program and increasing members' continuity of care with providers.

Perhaps because of these benefits, several interview respondents said automatic enrollment (including default enrollment) seems to contribute to greater member retention in D-SNPs. That makes it even more important for CMS and states to carefully choose which plans are eligible to use automatic enrollment. Criteria for approving these policies could include the plan's performance on (1) VDR in the D-SNP in the past few years, an indication of members' satisfaction with the plan; (2) quality of care measures relevant to Medicare and Medicaid covered benefits; and (3) indicators of effective coordination of care across both sets of benefits, such as use of person-centered, comprehensive assessment and care planning processes,[24] greater use of preventive and primary care services, and reductions in avoidable hospital, nursing home, and other institutional care stays. Using VDR for this purpose requires plan-level reporting of these rates.

5. Award higher MA Star Ratings or bonus payments based on plan-level performance on retention and measures that directly reflect members' satisfaction.

MA plans that receive an overall Star Rating of 4 or more earn bonuses, which they use to offer richer supplemental benefits and lower cost sharing for members. Bonus payments constitute an estimated 2.5 to 3.0 percent of aggregate payments to MA plans, or about $6 billion a year in additional program costs (MedPAC 2019). As many interview respondents explained, this drives competition and can induce price-sensitive dually eligible beneficiaries to switch plans even for small gains. However, the VDR is currently just 1 of about 45 measures used to calculate MA Star Ratings, diluting its importance. It also has less weight in calculating MA Star Ratings than quality improvement and outcome measures.[25]

Because retention and measures of patient experience are key indicators of plan performance, CMS signaled its intent to assign greater weight to the VDR and other measures that directly reflect members' satisfaction in the MA Star Ratings, starting with the 2023 Star Ratings (2021 measurement year).[26] This change would give plans more incentive to address the major reasons for disenrollment and the issues that trigger member complaints. Such changes would be more effective if VDRs (and potentially other quality measures) are calculated at the plan level to avoid the incentive for MA plans to consolidate contracts to increase their Star Ratings and earn unwarranted bonus payments.[27] Although changes in federal law that

[24] For example, measures of person-centered comprehensive assessments and care planning for MLTSS plans, developed by Mathematica for CMS and included in HEDIS as of 2019, are described here.

[25] Weights of individual performance measures in the calculation of 2021 summary and overall MA Star Ratings are available in the CMS Medicare 2021 Part C & D Star Ratings Technical Notes, Appendix F, available at https://www.cms.gov/files/document/2021technotes20201001.pdf-0.

[26] CMS. Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program. Final Rule. Federal Register, June 2, 2020. https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf.

[27] According to MedPAC (2019), "At the end of 2018, about 550,000 beneficiaries were moved from non-bonus plans to bonus-level plans through contract consolidations, and the sponsors will receive unwarranted bonus payments for those enrollees." Starting in 2019, the Balanced Budget Act of 2018 requires MA Star Ratings for contracts that have been consolidated to be based on an enrollment weighted average of the quality results of each contract that is merged. The averaging method might reduce the potential for plans to earn unwarranted bonuses, but it will not eliminate the problem because plans can still select which plans to include in the consolidated contract.

took effect in 2019 have reduced the potential for plans to earn unwarranted bonuses, calculating VDRs and other quality measures at the MA plan level could further reduce that potential.

6. Limit enrollment of full-benefit dually eligible individuals to D-SNPs, MMPs, or PACE in areas where multiple integrated plans operate, retaining traditional Medicare FFS as an alternative.

According to several interview respondents, aggressive marketing by multiple types of MA plans can make it more difficult for D-SNPs to retain members. For example, D-SNP look-alikes have drawn beneficiaries away from plans that are real D-SNPs. Interview respondents also reported independent insurance agents target dually eligible beneficiaries throughout the year, because they can switch plans more frequently than Medicare-only beneficiaries and steer these consumers toward plans that pay agents higher commissions, regardless of whether they are integrated or not.

To reduce the influence of misleading marketing by regular MA plans on disenrollment from D-SNPs, CMS could consider (1) restricting regular MA plans from enrolling FBDEs in regions where multiple integrated plan options exist, including D-SNPs, MMPs, or PACE; and/or (2) limiting FBDE beneficiaries' Medicare enrollment choices to D-SNPs, MMPs, PACE, or traditional Medicare FFS. This would help to increase enrollment of FDBEs in MA plans that can coordinate Medicare and Medicaid services, while preserving beneficiaries' choice to receive traditional Medicare FFS. This policy would apply only to FDBEs who are eligible for state Medicaid LTSS and behavioral health services because they stand to benefit more from plans' ability to coordinate Medicare and Medicaid services. Partial-benefit dually eligible beneficiaries, on the other hand, are not eligible for state Medicaid benefits, except for subsidies for Medicare cost sharing, and would therefore be more likely to benefit from regular MA plans that offer attractive supplemental benefit packages and cost-sharing reductions. Although there are some drawbacks to such a change in policy, as discussed by MACPAC (2020b), it has potential to reduce the influence of misleading marketing by non-D-SNP MA plans on disenrollment from D-SNPs.

The number of D-SNPs has grown by 60 percent from 373 in 2017, to nearly 600 in 2021, indicating increasing availability of these plans (Fugelsten Biniek et al. 2020). However, because D-SNPs, MMPs, and PACE programs are not available throughout the country, limiting the enrollment of FDBEs into these types of plans should be restricted to areas where at least two or more D-SNPs or MMPs are available to ensure FBDEs have a choice of plans. For example, in a region with six integrated D-SNPs to choose from, along with FFS Medicare, the vast majority of FBDEs would likely be less well served by a regular MA plan. Moreover, those individuals would still have a reasonable number of plan options to choose from, and the number of integrated plans should still encourage competition in supplemental benefits, care management strategies, and other benefits of importance to members. This would also enable D-SNPs and other integrated plans to spend less on marketing and devote more resources to developing robust models of care, provider networks, and care coordination systems for their full-benefit dually eligible members.

To determine the number of FDBE beneficiaries in each state and county who might have to switch to a D-SNP or other integrated care plan if enough are available in their area, it would be important to compare the number of FDBEs now enrolled in regular MA plans to the number of D-SNPs or MMPs in each area. The analysis could also consider the availability of PACE programs, in which about 50,000 mostly fully dual beneficiaries are now enrolled. However, because these programs are typically small, and most cannot rapidly expand their capacity to accommodate large enrollment increases, PACE programs might be excluded from the number of plans available to FDBEs in each area.

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References

Adrion, E.R. "Competition and Health Plan Quality in the Medicare Advantage Market." *Health Services Research,* vol. 54, 2019, pp. 1126–1136. Available at https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13196.

Archibald, N., M. Soper, L. Smith, A. Kruse, and J. Wiener. "Integrating Care Through Dual Eligible Special Needs Plans: Opportunities and Challenges." Prepared for DHHS, Assistant Secretary for Planning and Evaluation (ASPE). April 8, 2019. Available at https://aspe.hhs.gov/basic-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges. Accessed November 12, 2020.

Bipartisan Policy Center. "A Pathway to Full Integration of Care for Medicare Medicaid Beneficiaries." July 2020. Available at https://bipartisanpolicy.org/wp-content/uploads/2020/07/BPC_Health_Integration_of_Care_V3.pdf. Accessed November 12, 2020.

Centers for Medicare & Medicaid Services. "Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare." State Medicaid Director Letter #19-002. April 24, 2019. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf. Accessed November 12, 2020.

Centers for Medicare & Medicaid Services. "SNP Comprehensive Report, March 2018." Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

Centers for Medicare & Medicaid Services. "Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter." April 4, 2016. Available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2017.pdf. Accessed November 12, 2020.

Cohen, M.A., L. Sharma, and A. Hwang. "The Rational Consumer: High Disenrollment Associated with Poor Quality Performance Among Medicare Special Needs Plans." *Health Affairs Blog,* March 12, 2019. Available at https://www.healthaffairs.org/do/10.1377/hblog20190306.306555/full/

DuGoff, E., and S. Chao. "What's Driving High Disenrollment in Medicare Advantage?" *Inquiry: The Journal of Health Care Organization, Provision, and Financing*, vol. 56, 2019, pp. 1–7. Available at https://journals.sagepub.com/doi/10.1177/0046958019841506#.

Fuglesten Biniek, J., M. Freed, A. Damico, and T. Neuman. "Medicare Advantage 2021 Spotlight: First Look." Kaiser Family Foundation, Data Note, October 29, 2020. Available at https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look/. Accessed November 12, 2020.

Ipakchi, N., J. Blum, E. Hammelman, and M. Hseih. "Medicare Advantage Supplemental Benefit Flexibilities: Adoption of and Access to Newly Expanded Supplemental Benefits in 2020." Health Management Associates, May 2020. Available at https://www.healthmanagement.com/wp-content/uploads/Medicare_Advantage_Supplemental_Benefit_Flexibilities_Issue_Brief_2-27-20_HMA.pdf. Accessed October 26, 2020.

Lipson, D., E. Weir Lakhmani, A. Tourtellotte, and D. Chelminsky. "The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries." Washington, DC: Mathematica Policy Research, December 2018. Available at https://www.macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf. Accessed November 8, 2020.

Medicaid and CHIP Payment and Access Commission. "Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps." Issue Brief, August 2020a. Available at https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf. Accessed November 17, 2020.

Medicaid and CHIP Payment and Access Commission. "Report to Congress on Medicaid and CHIP." June 2020b. Available at https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf. Accessed October 26, 2020.

Medicaid and CHIP Payment and Access Commission. "State Medicaid Payment Policies for Medicare Cost Sharing." September 2018. Available at https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/ Accessed November 12, 2020.

Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission. "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." Washington, DC: MACPAC and MedPAC, 2018. Available at https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/. Accessed November 28, 2020.

Medicare Payment Advisory Commission. "Medicare Advantage Program Payment System." October 2020. Available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_ma_final_sec.pdf?sfvrsn=0. Accessed October 29, 2020.

Medicare Payment Advisory Commission. "Report to Congress: Promoting Integration in Dual-Eligible Special Needs Plans." Chapter 12. June 2019. Available at http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0. Accessed October 26, 2020.

Medicare Medicaid Coordination Office. "Report to Congress FY 2019." Available at https://www.cms.gov/files/document/mmco-report-congress.pdf (Accessed November 12, 2020)

Meyers, D.J., E. Belanger, N. Joyce, J. McHugh, M. Rahman, and V. Mor. "Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries." *JAMA Internal Medicine,* vol. 179, no. 4, 2019, pp. 524–532.

Patton, M.Q. *Qualitative Research and Evaluation Methods.* 4th edition. Thousand Oaks, CA: Sage Publications, 2015.

Riley, G.F., L. Zhao, and N. Tilahun. "Understanding Factors Associated with Loss of Medicaid Coverage Among Dual Eligibles Can Help Identify Vulnerable Enrollees." *Health Affairs,* vol. 33, no. 1,2014, pp. 147–152.

Roberts, E.T, A. Nimgaonkar, J. Aarons, et al. "New Evidence of State Variation in Medicaid Payment Policies for Dual Medicare-Medicaid Enrollees." *Health Services Research,* vol. 55, 2020, pp. 701–709. Available at https://doi.org/10.1111/1475-6773.13545.

Stringer, R., and A. Kruse. "Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries." July 2019. Available at https://www.integratedcareresourcecenter.com/sites/default/files/Default_Enrollment.pdf. Accessed October 26, 2020.

U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. "Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors and Implications." May 2019. Available at https://aspe.hhs.gov/system/files/pdf/261716/DualLoss.pdf. Accessed October 26, 2020.

U.S. Department of Justice. "Herfindahl-Hirschman Index." Washington, DC: U.S. Department of Justice, 2018. Available at https://www.justice.gov/atr/herfindahl-hirschman-index.

U.S. Government Accountability Office. "Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight." April 2017. Available at https://www.gao.gov/assets/690/684386.pdf. Accessed October 26, 2020.

Verdier, J., and D. Chelminsky. "State and Health Plan Strategies to Grow Enrollment in Integrated Managed Care Plans for Dually Eligible Beneficiaries." June 2017. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf. Accessed November 24, 2020.

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Appendix A:

Technical appendix for quantitative analyses

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