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Health Issue Brief

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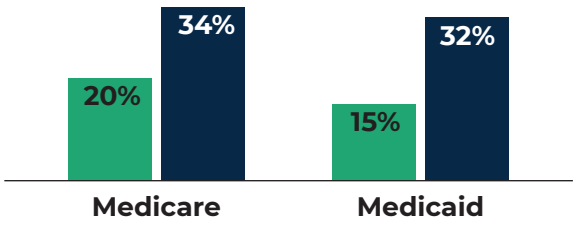
Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans

To reduce costs and improve care outcomes for people who are eligible for both Medicare and Medicaid, federal and state agencies have developed a variety of integrated care models to better coordinate services across the two programs. The model with the largest number of enrollees is a Medicare Advantage plan that limits enrollment to dually eligible beneficiaries and is required to coordinate their Medicaid benefits, known as a Dual Eligible Special Needs Plan (D-SNP). Despite rapid growth in the number of beneficiaries in D-SNPs, and more of these plans becoming available in 2021, voluntary disenrollment rates among this population are higher than those among Medicare-only enrollees. To understand the reasons dually eligible individuals leave these plans, Mathematica conducted a study supported by Arnold Ventures, which looked specifically at disenrollment patterns in Medicare Advantage plans with a majority of D-SNP members that varied in the range of Medicaid benefits covered. We tested the association of quality and member experience scores, and level of Medicaid integration, with disenrollment rates. We also interviewed key stakeholders to explore the influence of other factors on disenrollment patterns. This brief summarizes key findings from the study and draws implications for federal and state policymakers seeking to increase enrollment and retention in integrated care plans. For more background and detailed results, see the full report.

Background

Who are dually eligible beneficiaries? In 2019, about 12.2 million people in the United States were dually eligible for and enrolled in Medicare and Medicaid. Those who qualify for coverage under both programs are low-income and either age 65 and older, or under 65 and have long-term disabilities. Due to their advanced 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 care services and LTSS than people who are eligible only for Medicare, total spending for dually eligible individuals was almost twice that for

Figure 1. Dually eligible beneficiaries as a share of all Medicare and Medicaid beneficiaries and spending, by program, 2013



Source: MACPAC and MedPAC 2018.

Medicare-only beneficiaries. Consequently, dually eligible beneficiaries account for about 33 percent of total Medicare and Medicaid spending, even though they comprise 20 percent and 15 percent of all enrollees in each program, respectively (Figure 1). To reduce costs and improve care outcomes for dually eligible beneficiaries, the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies have developed a variety of integrated care models to better coordinate services across the two programs.

Medicare Advantage (MA) Dual-eligible Special Needs Plans (D-SNPs). Among several types of integrated care models, the one with the largest enrollment is D-SNPs, a type of MA managed care plan that only enrolls dually eligible beneficiaries. Total D-SNP enrollment has grown rapidly, more than doubling from 850,000 in 2008 to 2.18 million in 2018 and exceeded 3 million at the end of 2020. Although all D-SNPs must contract with state Medicaid agencies and coordinate Medicare and Medicaid services to some extent, D-SNPs vary in the range of Medicaid benefits covered, from none to all. In 2019, about 14 percent of D-SNP enrollees were enrolled in plans that were fully integrated with Medicaid benefits, which gives them the ability to directly manage and coordinate all of the services needed by each member.

Importance of disenrollment from D-SNPs. Because integrated care has the potential to improve care outcomes and reduce costs, federal and state officials are 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 beneficiaries are more likely than Medicare-only beneficiaries to disenroll from MA plans and are more likely to disenroll from MA contracts with lower quality and member experience of care 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 D-SNP disenrollment rates are affected by local market competition with other MA plans, or how other factors influence disenrollment from D-SNPs. The purpose of this study was to examine rates of voluntary disenrollment, and factors affecting those rates, among dually eligible beneficiaries in MA contracts whose members are all or mostly D-SNP enrollees.

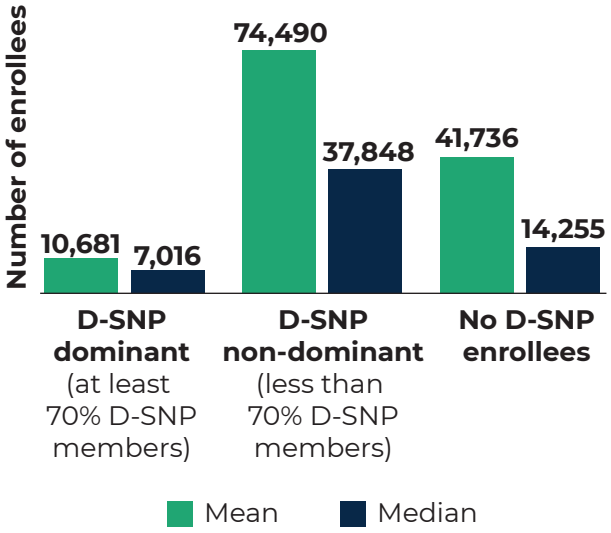
D-SNP dominant MA contracts. CMS reports VDRs at the MA contract level, which can be comprised of several plans including D-SNPs, other types of SNPs, and regular (non-SNP) MA plans. This makes it difficult to determine differences in VDRs for D-SNPs alone. VDRs also conflate dual and non-dual enrollees, and in some cases combine rates for contracts that operate in multiple states. By restricting this study to MA contracts in which at least 70 percent of all members were D-SNP enrollees, we were able to examine the factors driving disenrollment among dually eligible beneficiaries in this particular type of integrated care plan.

How D-SNP dominant MA contracts compare to other types of MA contracts

D-SNP dominant contracts were much smaller, on average, than the other two MA contract types. Over the four-year study period, 2015-2018, average enrollment in D-SNP dominant MA contracts was about 10,681, substantially smaller than for MA contracts with less than 70 percent D-SNP members (74,490), and those with no D-SNP enrollees (41,736) (Figure 2). Median enrollment was lower than average enrollment for all three contract types, because a small subset of contracts with very large enrollment skewed the mean higher.

Median VDR for D-SNP dominant MA contracts (10.0) fell between that for non-D-SNP MA contracts (8.0) and D-SNP non-dominant MA contracts (12.0) in all four study years. Higher VDRs for both types of MA contracts with any D-SNP enrollees, compared

Figure 2. Enrollment in Medicare Advantage plans by type, 2015-2018

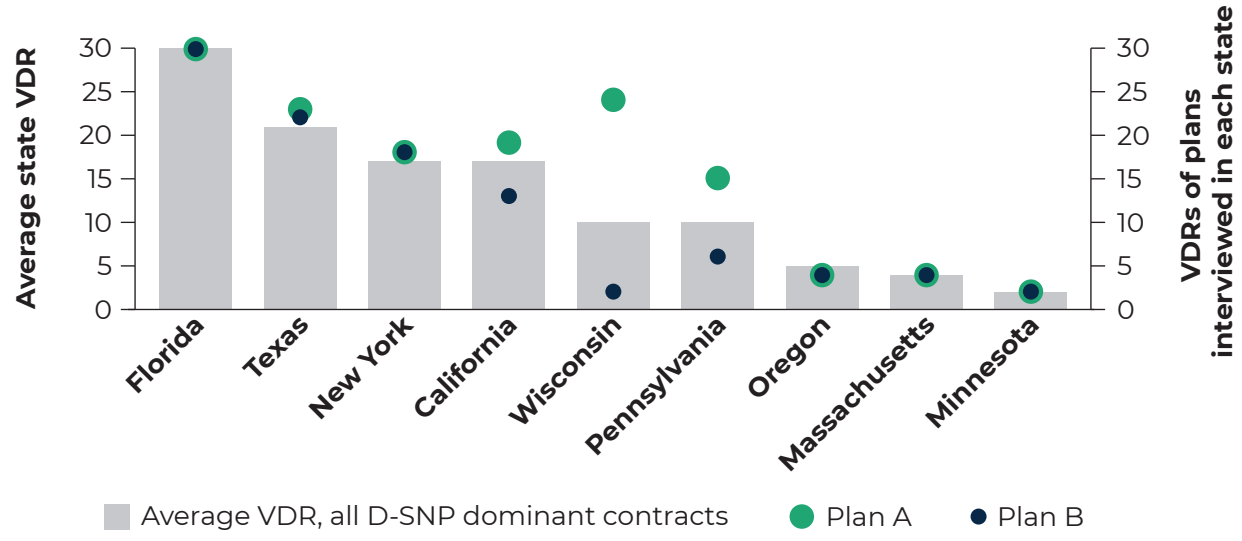


Source: Mathematica analysis of 2015-2018 MA Star Ratings and D-SNP enrollment data, CMS Monthly Enrollment by Plan Reports, SNP Comprehensive Reports, and Medicare Advantage Plan Directories.

to those with no D-SNP enrollees, could be due in part to the fact that unlike Medicare-only beneficiaries who could only change plans once a year (with some exceptions), dually eligible beneficiaries could change plans monthly during the study period. (As of 2019, dually eligible beneficiaries can change plans once per quarter, except in the last quarter of the calendar year.) Average VDR among D-SNP dominant MA contracts rose over the period, from 10.7 in 2015 to 12.2 in 2018.

VDR varied substantially by state. Average VDR rates in D-SNP dominant contracts over the four-year study period were highest in Florida (30.4 percent) and Texas (20.9 percent), and lowest in Minnesota (2.3 percent), Massachusetts (4.4 percent), and Oregon (5.0 percent). To understand the factors that differentiate plans with varying VDR patterns, we interviewed state officials and/or health plan representatives in these states, as well as two plans with different VDR patterns in four other states with average state VDRs between the two extremes: California, New York, Pennsylvania, and Wisconsin (Figure 3).

Figure 3. Voluntary disenrollment rates of D-SNP dominant Medicare Advantage contracts discussed in interviews (2015-2018)



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

Key Findings

We used a mixed methods study design (see Data and Methods section at the end of this brief) to answer three questions about the drivers of voluntary disenrollment from D-SNP dominant MA contracts. Below, we summarize key findings for each question.

Are quality and member experience measures in MA Star Ratings associated with VDRs?

Among the D-SNP dominant MA contracts examined in this study, three of nine MA Star Ratings quality and member experience measures had statistically significant associations with VDR in the expected direction (shaded in green in Table 1). 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. One measure was associated with VDR, but in the opposite of what one would expect: better performance on Breast Cancer Screening was associated with higher disenrollment rates (shaded in pink in Table 1). The other five measures were not associated with VDR.

Table 1. Medicare Advantage Star Ratings Quality and Member Experience Measures: Statistically Significant Associations with Voluntary Disenrollment Rate

Domain	Measures	Results
Staying Healthy: Screenings, tests and vaccines	1. Breast Cancer Screening	Better performance associated with *higher* VDR
	2. Annual Flu Vaccine	Better performance associated with lower VDR
Managing Chronic Conditions	3. Care for Older Adults – Functional Status Assessment	Not associated with VDR
	4. Diabetes Care – Blood Sugar Controlled	Not associated with VDR
	5. Plan All-Cause Readmissions	Not associated with VDR
Member Experience with Health Plan	6. Rating of Health Plan	Better performance associated with lower VDR
Member Complaints	7. Complaints about the Health Plan	Lower performance associated with higher VDR
Drug Plan Customer Service	8. Appeals Auto-Forward—Drug plan fails to make timely decisions about appeals	Not associated with VDR
Drug Safety	9. Medication Therapy Management Program Completion Rate for Comprehensive Medication Review	Not associated with VDR

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 Medicare Advantage Plan Directories.

Note: Measures shaded in green were statistically significant in the expected direction. Measures shaded in red were statistically significant in the unexpected direction. Measures not shaded did not have statistically significant results.

To standardize the impacts across the three measures that were associated with VDR in the expected direction, we calculated the percentage point change in the voluntary disenrollment rate associated with a 10 percent improvement in the measure rate (Table 2). For example, for higher flu vaccination rates which were associated with lower VDRs, a 10 percent improvement in the mean rate on Annual Flu Vaccine corresponds to a 7.0 percentage point *increase*, from a mean of 69.5 percent to 76.5 percent. In the midst of the coronavirus pandemic, whose resolution depends in part on people getting vaccinated, this particular result is encouraging.

Table 2. Estimated change in voluntary disenrollment rate associated with a 10 percent change in selected quality and experience measure rates

Measure	Mean, percentage	Change in measure performance if contract were to improve by 10 percent on this measure, percentage points	Estimated change in voluntary disenrollment rate associated with 10 percent improvement in measure performance, percentage points
Annual Flu Vaccine	69.5	7.0	-1.2*
Member Rating of Health Plan	86.6	8.7	-6.6***
Complaints about the Health Plan at or above the 75th percentile[a]	23.2	N/A[a]	N/A[a]

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 Medicare Advantage Plan Directories.

[a] 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. Being at or above the 75th percentile on this measure was associated with a 4.5 percentage point increase in the voluntary disenrollment rate.

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

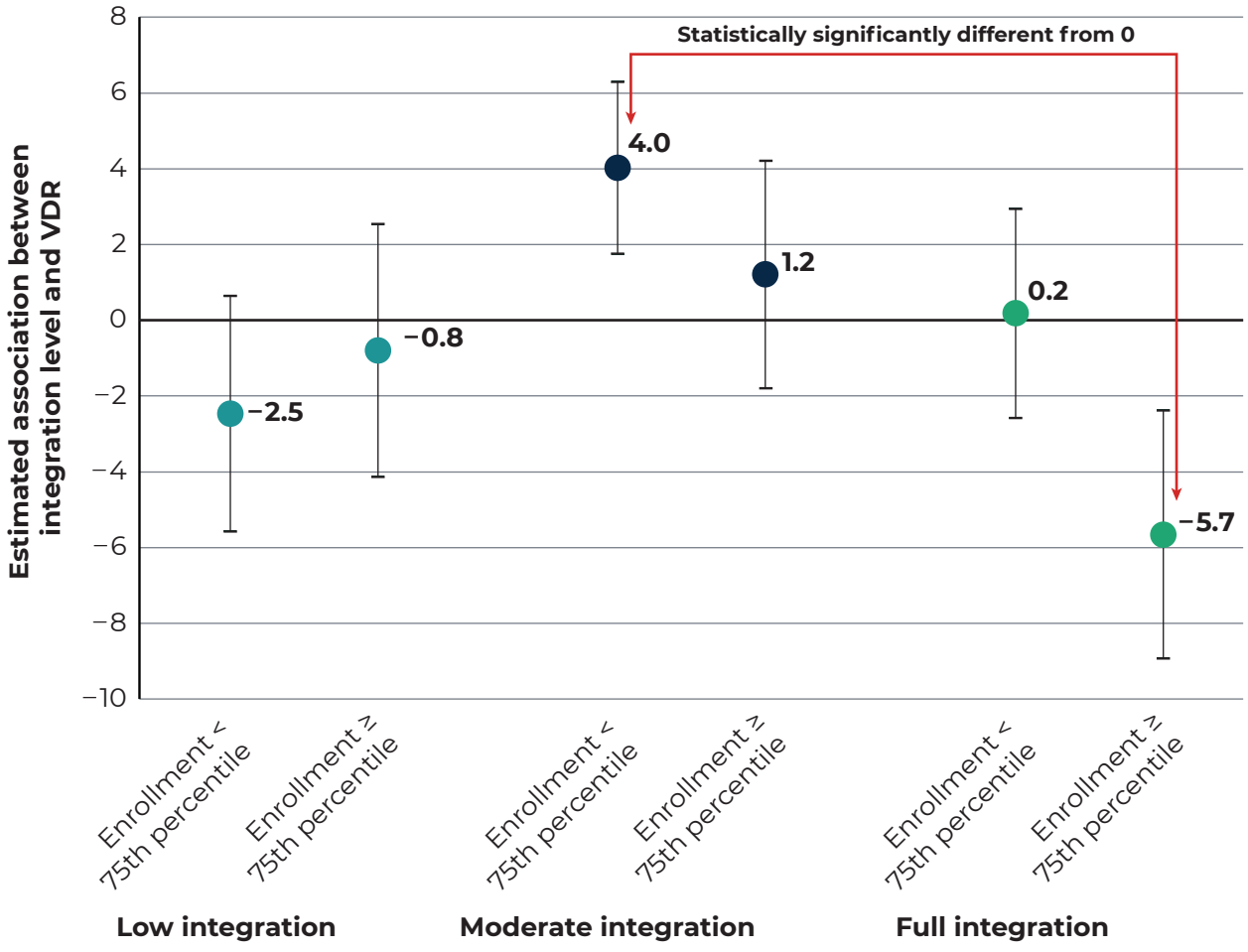
*** Significantly different from zero at the .01 level, two-tailed test.

N/A = not applicable to this measure

Is D-SNP level of integration with Medicaid benefits associated with VDRs?

Level of integration with Medicaid was not associated with VDRs. When separated by level of integration and size, however, 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 divided by size and level of integration, we found (a) full integration was associated with *lower* VDR among the largest contracts above the 75th percentile of enrollment, and (b) moderate integration was associated with *higher* VDR among D-SNP dominant contracts below the 75th percentile (Figure 4) . The difference in the direction of the effect on VDR suggests that one or both associations might be due to something in addition to (or other than) the level of Medicaid integration.

Figure 4. Association of D-SNP dominant MA contract Medicaid integration with voluntary disenrollment rate, by size and integration level



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 Medicare Advantage Plan Directories.

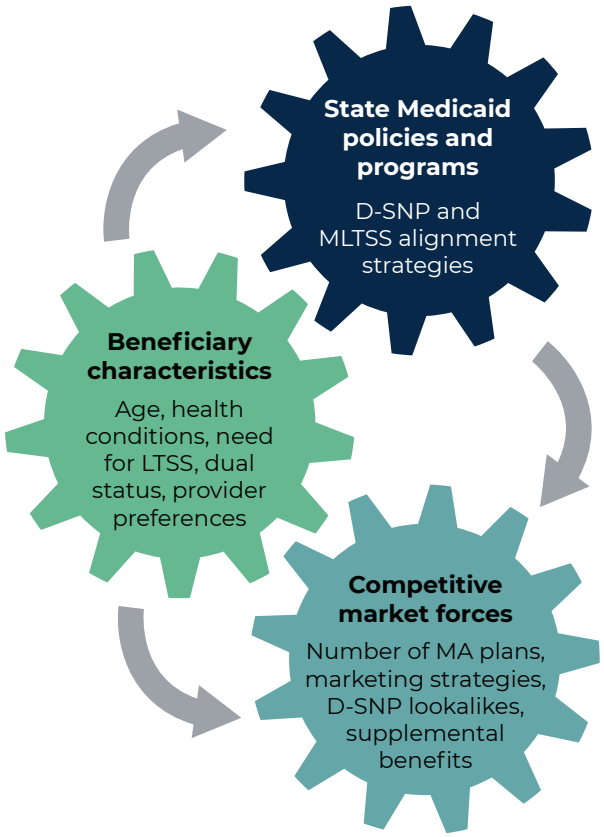
Note: This exhibit shows the estimated average change in VDR for contract-year observations with a certain level of integration relative to those with no integration. The green lines show the 95 percent confidence interval; associations where the confidence interval does not include 0 were statistically 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.

Although level of Medicaid integration was not associated with VDRs, results from the qualitative analysis indicated broad consensus that the ability to coordinate care across Medicare and Medicaid benefits contributes to retention. The apparent inconsistency in these findings might be explained by several factors.

- **Covering a full range of Medicaid benefits may be necessary but not sufficient.** That is, fully or moderately integrated plans may be a prerequisite to care coordination, but the effectiveness of health plan care coordination may vary. If done well, care coordination may increase retention.
- **The Medicaid integration levels developed for this study do not necessarily indicate how well health plans provide person-centered care coordination.** The four integration levels are distinguished by which benefits are covered in D-SNP Medicaid contracts, and the extent of aligned enrollment. But some plans with lower levels of Medicaid integration may 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.
- **The effect of full integration and aligned enrollment on retention may be limited to, or perhaps more pronounced, for a subgroup of members.** Interview respondents reported that the benefits of full integration are greatest for members enrolled long enough to experience the benefit of care coordination and those with greater need for LTSS and/or behavioral health services, which are covered in fully integrated plans. Members with greater needs were less likely to switch plans once they have already established relationships with all of their providers in their current plan.

What other factors influence differences in VDR patterns in D-SNPs operating within and across states?

Three inter-related sets of factors 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 beneficiary 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: (a) state contracts with Fully Integrated Dual Eligible SNPs, some of which began in states with long-standing CMS integrated care demonstrations and provide care coordination to enrollees; (b) 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; (c) state Medicaid policies that automatically assign dually eligible beneficiaries into aligned plans; and (d) clear and direct state Medicaid communications with beneficiaries about their coverage options. The degree of influence of these state Medicaid policies and programs varies considerably across states and can be mediated by market competition and beneficiary characteristics. Table 3 summarizes these policies and programs and illustrates how they can increase or decrease VDRs.

> **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*

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 may contribute to higher VDRs, whereas areas with few MA plans may 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 beneficiary choices to enroll and disenroll.

Beneficiary characteristics can influence decisions to disenroll from D-SNPs. Beneficiaries' health conditions and need for long-term services and supports, their age, whether they qualify as full- or partial-benefit dually eligible, and relationships with or preferences for providers influence retention or disenrollment. Changes in health or functional ability, changes in health plans' provider networks, and changes in dual status can prompt beneficiaries to switch plans.

> **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 Manager*

Table 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 Medicare-Medicaid Plans 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 policy or program options for dually eligible beneficiaries	State examples	Potential to decrease voluntary disenrollment	Potential to increase voluntary disenrollment
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
State automatic enrollment policies into aligned plans (see note)	Varies by state	Offers continuous coverage within plans that members are already familiar with. Particularly successful when states allowed plans to reach out to member prior to enrollment	When states did not allow plans to communicate with members prior to 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 around 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 (previously called seamless conversion); 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.

Policy Implications

Federal and state policymakers are considering policies and strategies to increase enrollment of dually eligible beneficiaries in integrated care models. To achieve this goal, policies 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 the most integrated care plans.

Policy changes that would help increase retention in D-SNPs

Policy	Rationale
 **Report VDRs at the MA plan level, disaggregate VDR rates by full- vs. partial-benefit dual status, 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 also 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 VDRs 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 dually eligible beneficiaries. 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 dually eligible beneficiaries 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 last few years—an indication of members' satisfaction with the plan—as well as other quality of care 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.

Conclusion

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, they must understand and address the reasons beneficiaries decide to leave these plans. Previous research has primarily focused on the influence of Medicare quality ratings on voluntary disenrollment rates. However, this study finds myriad factors, other than MA quality and member experience ratings affect disenrollment, including state Medicaid policies and programs and local market competitive forces. And because dually eligible beneficiaries are a diverse group, the factors driving their decisions to disenroll vary by their characteristics including health conditions, need for LTSS, and full- or partial-benefit dual status.

Although this study focused on disenrollment, the implications are relevant to enrollment policies broadly, since the factors that promote retention of dually eligible beneficiaries in integrated care plans 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.

Data and Methods

Quantitative and qualitative data for this study came from several sources. For the quantitative analysis we used publicly reported CMS data on MA enrollment by contract number, plan type and state and county during the 2015-2018 period. We also 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 experience of care measure scores. Because the most recent MA Star Ratings scores available for this analysis, in the CMS spring 2020 release, were for the 2018 measurement year, we used 2015-2018 MA contract enrollment data for the analyses. We 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, based on the type of Medicaid benefits covered by each D-SNP dominant contract, and the share of beneficiaries in exclusively aligned arrangements, that is, those who receive Medicare and Medicaid benefits from plans operated by the same parent organization. Information about Medicaid managed care plan types and benefits came from: (1) CMS Medicaid managed care enrollment reports 2016, 2017 and 2018; (2) state Medicaid agency D-SNP contracts; and (3) state Medicaid agency websites and other publicly available resources about Medicaid managed care and integrated care programs. For the qualitative analysis, we conducted interviews with 15 groups of state Medicaid officials, beneficiary counselors, and senior executives of D-SNP health plans between July and September 2020.

We developed a linear regression model to test the association of MA quality and experience of care measures, and the level of integration with Medicaid, with VDRs at the MA contract level, and conducted several sensitivity tests. After coding interview notes, we identified major themes across respondents about the role of other factors that explain differences in VDRs across D-SNP dominant MA contracts. For more detail about the regression model, sensitivity analyses, and interview respondents, see the full report and appendix.

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Disclaimer

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