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Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans

RESEARCH REPORT

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Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans

Findings from Interviews and Case Studies

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Preface

Beneficiaries who are dually enrolled in Medicare and Medicaid are less likely to be enrolled in Medicare Advantage (MA) plans that perform well in the MA Star Rating program than non-dually enrolled beneficiaries. Some plans with a high proportion of dually enrolled beneficiaries, however, perform well in the MA Star Rating program. The qualitative study documented in this report sought to identify the types of services that MA plans implement to meet the needs of dually enrolled and other high-cost, high-need beneficiaries, as well as the types of resources needed to implement these services.

The first phase of this project included an environmental scan and key informant interviews. The second phase of the study focused on identifying additional information via key informant interviews and in-depth case studies with high-performing MA plans serving a large proportion of dually enrolled beneficiaries and plans participating in the Medicare-Medicaid demonstration. This report presents results from the second phase and provides recommendations for policymakers and other stakeholders on strategies to support MA plans in their efforts to meet the needs of dually enrolled and other high-cost, high-need beneficiaries.

The findings will be of interest to operators of health plans and policymakers as they develop and implement approaches to meet the needs of dually enrolled and other high-cost, high-need beneficiaries.

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Summary

Dually enrolled beneficiaries are individuals who qualify for both Medicare and, because of poverty, Medicaid benefits. Medicare Advantage (MA) plans that serve relatively higher proportions of dually enrolled beneficiaries have lower ratings in the MA Star Rating program than plans that serve fewer dually enrolled beneficiaries. However, some MA plans that serve a high proportion of dually enrolled beneficiaries are high performers. Their high performance may be the result of successful strategies they have implemented to meet the complex health and social needs of their members. Addressing the social determinants of health (SDOH) is increasingly recognized as an important and key factor in determining overall health. Some high-performing MA plans have reported taking steps to address SDOH. These steps include identifying clinical and nonclinical needs to provide better care and referring and directly addressing needs for housing, food, and transportation. Centers for Medicare and Medicaid Services (CMS) policies can be informed by a better understanding of the services provided by these high-performing MA plans that serve a high proportion of dually enrolled beneficiaries. Additionally, other health plans can use such lessons to promote health and reduce disparities in care they provide.

The goals of this research, conducted in two phases, were to (1) characterize the needs of dually enrolled beneficiaries and the degree to which their needs overlap with other high-cost, high-need individuals more broadly; (2) identify the additional services that health plans provide to dually enrolled beneficiaries or other high-cost, high-need beneficiaries; (3) identify the range of added costs and resources needed to deliver these services and determine whether health plans found these services to be of value; and (4) assess the available evidence on whether such services were associated with better quality and outcomes. To address these goals, the first phase of this project included an environmental scan and key informant interviews (Sorbero et al., 2018). The second phase of the study—which focused on identifying additional information via key informant interviews with seven organizations and four in-depth case studies with high-performing MA plans serving a large proportion of dually enrolled beneficiaries—is presented in this report.

We found that the challenges identified for dually enrolled and high-need beneficiaries were consistent with our previous findings and included a mix of complex clinical issues and SDOH risk factors (Sorbero et al., 2018). Leading SDOH factors identified include low health literacy, poverty, lack of transportation, and food and housing insecurity, all of which frequently paired with inadequate services in the community to fully address all needs. Clinical issues include multiple morbidities and a high burden of mental health care needs.

Additionally, we found that a range of high-performing MA plans serving a large proportion of dually enrolled beneficiaries implement multipronged approaches to address the needs of their

complex member populations. Our findings are consistent with our previous work (Sorbero et al., 2018) that identified four broad categories of activities in which health plans engage: (1) identifying needs and data analytics to better target programs toward patients at high risk for hospitalization, readmission, and nursing home admission; (2) addressing clinical needs through care management and coordination; (3) meeting the social needs of dually enrolled beneficiaries by either referring them to existing programs that address housing, food security, and transportation needs or providing these services directly; and (4) undertaking administrative actions to better integrate Medicare and Medicaid. The high-performing MA plans that we reviewed reported engaging in activities that fall into most if not all of the four categories, demonstrating their organizational and leadership commitment to health equity and improving health outcomes for the vulnerable, dually enrolled population.

Examples of activities in each of the four categories suggest that plans are trying to engage and address patients' social needs in a systematic, comprehensive manner. Health risk assessments gathered in members' homes or via phone—which include items related to SDOH—are increasingly being used to identify the needs of specific individuals to better deliver services to them. Care management and efforts to coordinate care across providers and settings are universal among the plans we reviewed. Health plans continue to experiment with strategies to address SDOH; depending on the resources available in community, some plans may refer beneficiaries to local social services, while others in areas with fewer or less-reliable resources may opt to provide services themselves. The requirements of plans to coordinate the administrative activities of Medicare and Medicaid vary by the type of MA plan or demonstration. Some plans, however, provide additional services beyond their charge by implementing programs to assist dually enrolled beneficiaries as they navigate two insurers. Identifying strategies used by plans to address SDOH and sharing the most effective strategies with the broader community of MA plans can help to promote the health of dually enrolled beneficiaries.

The four case studies offer examples of the extent to which committed, high-performing MA plans engage in efforts to address the social and health needs of this vulnerable population and improve their health outcomes. Reported outcomes associated with these strategies included reductions of 20 to 33 percent in emergency department (ED) visits and hospitalizations through various pilots testing a care management program, an integrated care team approach, and a medically tailored meal-delivery program, as well as reductions in unplanned utilization estimated to result in a net savings of up to \$500 per participant through a pilot housing stability program. Innovative strategies and interventions described in the four case studies include the following:

HealthPartners, Minnesota (an integrated delivery system, operates a Fully Integrated Dual Eligible Special Needs Plan [FIDE SNP])

- The FIDE SNP reduced hospitalizations and ED visits of dually enrolled beneficiaries compared with dually enrolled beneficiaries not in the SNP.
- The enhanced care coordination program is the primary strategy for addressing needs of HealthPartners' dually enrolled beneficiaries.
- Examples of additional services include providing tablets preloaded with health education, engagement, and wellness applications to members; home delivery of meals following inpatient hospital stay; and a virtual online clinic available 24/7.

SCAN Health Plan, California (primarily serves dually enrolled beneficiaries via a FIDE SNP, chronic-condition SNP, and traditional MA plan)

- For SCAN, the key strategy to address needs of dually enrolled beneficiaries involves the use of well-trained care managers with customer-service experience to help members navigate their benefits. It was reported that a frail population on the FIDE SNP who received care management and long-term services and supports (LTSS) had 20-percent less acute utilization than a comparably complex population in the plan's membership that did not receive the care management and LTSS programs available to the FIDE SNP members.
- The plan launched "Provider to Home Pilot," a program to help physicians address SDOH by bringing a social worker and community health worker into the care team. This pilot reduced ED visits by 39 percent and hospitalizations by 27 percent.
- Other ongoing interventions include peer-to-peer motivational interviewing intervention to reduce social isolation and promote physical activity and in-home therapy from social workers to reduce depression.

UPMC *for You*, Pennsylvania (operates a Dual Eligible SNP [D-SNP])

- In partnership with community organizations, UPMC *for You* developed a program for homeless enrollees that paired stable housing with case management, which resulted in lower unplanned utilization such as ED visits and hospital readmission while increasing planned utilization of provider visits and medication use.
- UPMC *for You* is initiating a new program to use a less-restrictive homelessness requirement and instead focused on housing instability.
- There is an estimated net savings of approximately \$500 per participating beneficiary from reduced unplanned utilization.
- The health plan offers a variety of other interventions, including meal delivery after discharge from hospital or nursing home, transportation services, translation services, free fitness center membership, telephone-based care management, and virtual video visits.

Commonwealth Care Alliance®, Massachusetts (operates a D-SNP and a Medicare-Medicaid Plan [MMP] demonstration)

- In partnership with community-based organizations, meals are delivered to nutritionally at-risk patients; a study reported (Berkowitz et al., 2018) reductions in ED visits, admissions, and medical spending.
- Crisis support units provide respite care for members with behavioral health conditions; this reduced psychiatric hospitalizations.
- The Mobile Integrated Health program trained paramedics to assist members with acute and subacute issues in the home, leading to a high ED-diversion rate.

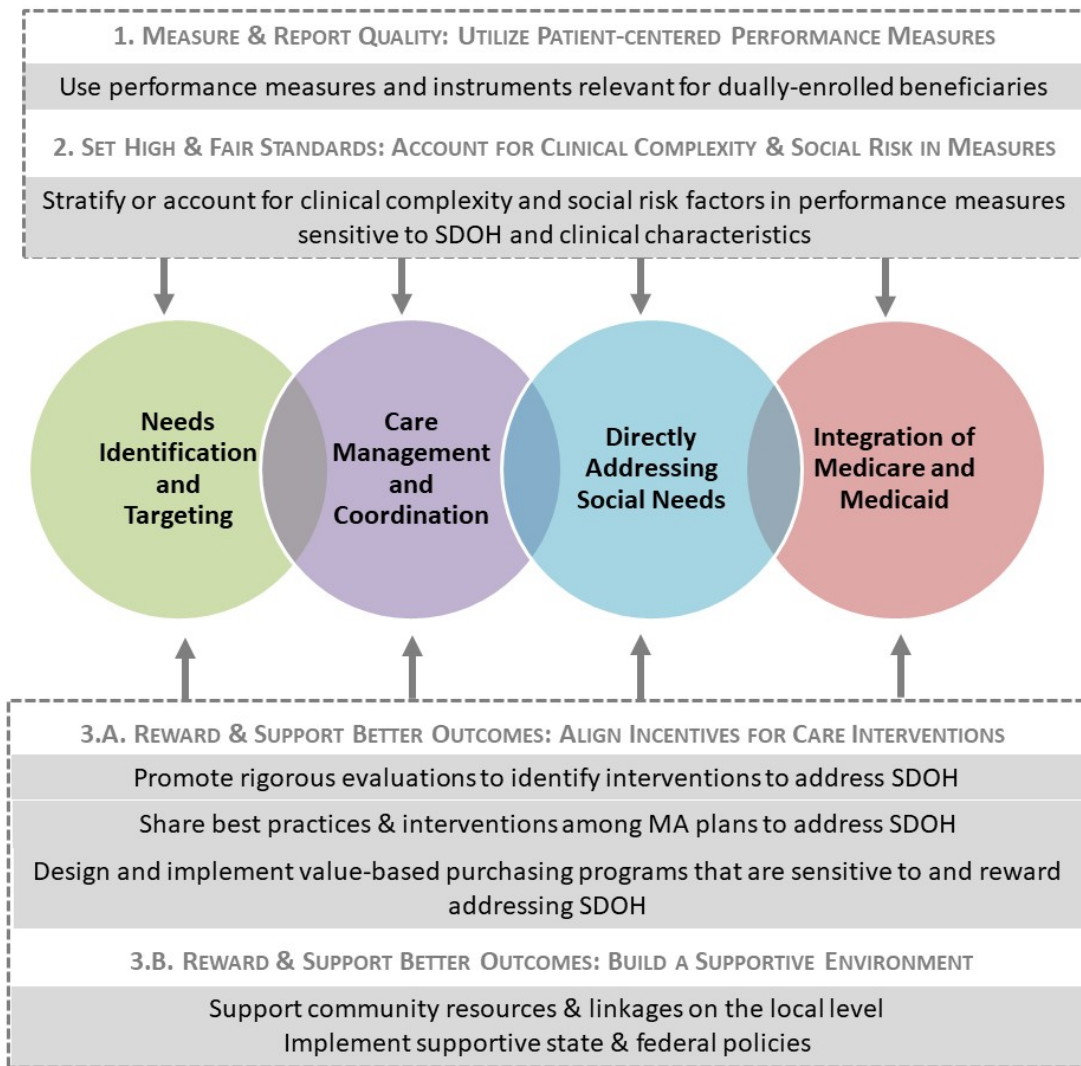
Approaches used by MA plans with high ratings in the MA Star Rating program to address the needs of dually enrolled beneficiaries were identified during the first phase of this study and refined following the interviews and case studies conducted for this report as illustrated by the intersecting circles in Figure S.1. Plans with high MA Star Ratings reported implementing multipronged approaches to address the needs of their complex member populations, including identifying and addressing clinical and social needs via health risk assessments, using care management and coordination to meet these needs, addressing social needs through referral or direct services, and taking administrative steps to better integrate Medicare and Medicaid.

There are a number of recommendations for policymakers and other stakeholders, informed by the interviews and case studies conducted for this report, to support organizations with MA contracts in their efforts to meet the needs of dually enrolled and other high cost, high-need beneficiaries. These recommendations fit within the framework developed in the Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) first report to Congress on accounting for social risk in Medicare's value-based purchasing programs (U.S. Department of Health and Human Services, 2016), which included three key approaches: (1) measure and report quality specifically for beneficiaries with social risk factors; (2) set high, fair quality standards for all beneficiaries and consider adjustment of measures for social risk factors based on empirical relationships and to improve adjustment for health status; (3) reward and support better outcomes through targeted financial incentives within value-based purchasing programs to reward achievement or improvement for beneficiaries with social risk factors. In Figure S.1, we organize these recommendations using ASPE's framework in gray boxes. These recommendations could help address the clinical and social needs of dually enrolled beneficiaries. These include the following recommended strategies:

1. Measure and report quality.
 - *Use patient-centered performance measures* and instruments that are relevant for dually enrolled beneficiaries for payment and public reporting programs.
2. Set high and fair quality standards.
 - *Account for clinical complexity and social risk in performance measures* by stratifying, adjusting, or otherwise accounting for clinical complexity and social needs of dually enrolled beneficiaries.

3. Reward and support better outcomes.
 - *Align incentives for care interventions* by building an evidence base through promoting rigorous evaluations to identify effective interventions, sharing best practices, and designing value-based purchasing programs that are sensitive to and reward the addressing of SDOH.
 - *Build a supportive environment* by supporting community resources and links at a local level and implementing supportive state and federal policies.

Figure S.1. Policy Recommendations for Addressing Social Needs of Dually Enrolled Beneficiaries in MA Plans



First Approach: Measure and Report Quality: Use Patient-Centered Performance Measures

Use performance measures and instruments relevant for dually enrolled beneficiaries in quality reporting and value-based payment programs. Existing instruments (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]) and performance measures included in the MA Star Rating program may not adequately account for improvements most important to dually enrolled beneficiaries (e.g., daily functioning, quality of life), improvements in intermediate outcomes for which dually enrolled beneficiaries have worse starting values than other beneficiaries, or measure plans' achievement of care coordination or patient-centered care. Measures currently used only for SNPs and MMPs could be implemented more broadly in the MA Star Rating program to bring more attention to the different needs of dually enrolled beneficiaries in all MA plans.

Second Approach: Set High and Fair Standards: Account for Complexity and Social Risk in Performance Measures

Stratify, adjust, or otherwise account for clinical complexity and social needs of dually enrolled beneficiaries in performance measures. Dually enrolled beneficiaries are more likely to be low-income and have a higher burden of disease than other Medicare beneficiaries. MA plans reported support for adjustment for socioeconomic status or other SDOH for clinical measures included in the MA Star Rating program and other value-based purchasing programs to address the aspects of care of outside the health plan's control and to account for the additional resources required to serve this population. CMS considers risk adjustment to be a component of the measure specification and, thus, the determination of need for risk adjustment is the responsibility of the measure developer. Another approach would be the stratified distribution of bonuses from the MA Star Ratings program based on the percentage of dually enrolled beneficiaries, an approach recommended by MedPAC, to prevent value-based purchasing programs from disadvantaging plans with large dually enrolled populations but retain incentives for quality improvement through reporting performance without adjustment beyond what is included in measure specifications.

Third Approach (Part A): Reward and Support Better Outcomes: Align Incentives for Care Interventions

Promote rigorous evaluations to identify interventions to address SDOH. MA plans reported addressing the SDOH of dually enrolled beneficiaries in a variety of ways, but few interventions and plan strategies had been rigorously evaluated. More support for rigorous evaluations of these plan strategies will help plans identify those that are effective and financially viable as well as identify for which members and subpopulations these strategies are most effective.

Share best practices and interventions among MA plans to address SDOH. Most strategies implemented by MA plans were developed or refined internally. For example, while all plans conducted health risk assessments, the approach for conducting these (e.g., in home, by phone) and the types of SDOH data collected varied. Mechanisms for MA plans to share their experiences developing and implementing interventions and strategies to meet the needs of dually enrolled beneficiaries and approaches to address barriers would facilitate the dissemination of best practices and more rapidly improve their care.

Design and implement value-based purchasing programs that are sensitive to and reward addressing SDOH. Dually enrolled beneficiaries are sicker and poorer on average than Medicare-only beneficiaries. Plans were concerned that the MA Star Rating program is not aligned with the needs of dually enrolled beneficiaries and were interested in seeing value-based purchasing programs that would reward the work plans do to address members' SDOH. Approaches could include use of performance measures relevant for dually enrolled beneficiaries, bonuses based on high performance among dually enrolled beneficiaries, and bonuses based on a lack of within-contract disparities when comparing dually enrolled with other beneficiaries.

Third Approach (Part B): Reward and Support Better Outcomes: Build a Supportive Environment

Support community resources and links at a local level. MA plans mentioned trying to fill gaps in community-based resources to meet the needs of their members. Federal support for developing community resources as a public good could enhance the ability of MA plans to partner with communities. Some economists and thought leaders have suggested ways for stakeholders to contribute toward those community resources, such as through a bidding-based contribution system or rethinking how public spending (medical care versus public health versus social services) may have the greatest impact on health outcomes.

Implement supportive state and federal policies. Many of the MA health plans included in the interviews and case studies supported the Chronic Care Act, which was enacted through the 2018 Bipartisan Budget Act and will allow greater flexibility for traditional MA plans to offer supplemental benefits to address health-related social needs of dually enrolled beneficiaries. We heard support from some plans for policies that provide even more flexibility in spending on these supplemental benefits and LTSS, including support from one plan for a recent bill, the Community-Based Independence for Seniors Act of 2017 (U.S. Congress, 2017), that would allow Medicare to pay for a limited set of home and community-based services and LTSS.

This report and these recommendations provide insight into the types of strategies that can support the needs of MA health plans in meeting the needs of dually enrolled and other high-cost, high-need beneficiaries. Dually enrolled beneficiaries have complex clinical and social needs, and MA plans are experimenting with different approaches to address SDOH. As described in this report, some MA plans that serve a high proportion of dually enrolled

beneficiaries perform well in the MA Star Rating program and have implemented innovative strategies to meet the needs of their members. Efforts are needed to support the sharing of these strategies that lead to improvements in quality of care and health. Questions remain about how to best measure care delivered to vulnerable beneficiaries and how to align value-based payment programs to encourage addressing SDOH. Addressing such questions could help improve the social and clinical outcomes of dually enrolled and other high-cost, high-need patients.

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Abbreviations

ACO	Accountable Care Organization
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCA	Commonwealth Care Alliance®
CHS	Community Human Services
CMS	Centers for Medicare and Medicaid Services
C-SNP	Chronic Conditions Special Needs Plan
CSU	crisis stabilization unit
D-SNP	Dual Eligible Special Needs Plan
ED	emergency department
FFS	fee-for-service
FIDE	Fully Integrated Dual Eligible
HCBS	home and community-based services
HEDIS	Healthcare Effectiveness Data and Information Set
HUD	U.S. Department of Housing and Urban Development
I-SNP	Institutional Special Needs Plan
LTSS	long-term services and supports
MA	Medicare Advantage
MIH	Mobile Integrated Health
MMP	Medicare-Medicaid Plan
SDOH	social determinants of health
SES	socioeconomic status
SNP	Special Needs Plan

1. Introduction

Background

Dually enrolled beneficiaries are individuals who qualify for both Medicare and Medicaid benefits because of poverty and age or poverty and long-term disability. This population has complex health needs, which often include acute care, long-term care, and behavioral health care, as well as complex social conditions, such as homelessness and food insecurity. A conceptual model developed by the National Academies of Sciences, Engineering, and Medicine (2017) illustrates how social risk factors, including socioeconomic status (SES), race or ethnicity, and community context, may affect access to care, utilization, and health outcomes. This framework is highly relevant for dually enrolled beneficiaries, who are more likely to be disabled, live in poverty, and report poorer health than Medicare-only beneficiaries (Medicare Payment Advisory Commission, 2015). Additionally, dually enrolled beneficiaries report two more chronic conditions on average (six chronic conditions) compared with beneficiaries who are not dually enrolled (four chronic conditions) (Burke et al., 2016). Sixty-three percent of dually enrolled beneficiaries have both chronic conditions and functional limitations (Alexih et al., 2010). Dually enrolled beneficiaries are some of the highest-cost beneficiaries across both Medicare and Medicaid (Medicare Payment Advisory Commission, 2012; Young et al., 2013). These costs are driven in part by hospitalizations and readmissions. For Medicare beneficiaries with social risk factors, a variety of factors are theorized to contribute to increased risk of readmission, including receipt of lower quality of care, measured and unmeasured medical risk, systematic bias, and availability of community resources (Office of the Assistant Secretary for Planning and Evaluation [ASPE], 2016).

All Medicare beneficiaries, including those who are dually enrolled, can choose to receive their Medicare benefits via Medicare Advantage (MA) private health plans instead of through the fee-for-service (FFS) system. However, concerns have been raised about the quality of care received by dually enrolled beneficiaries, including those enrolled in MA plans. As described in ASPE's 2016 report to Congress, MA plans that serve a high proportion of dually enrolled beneficiaries have lower ratings in the MA Star Rating program¹ than plans serving a lower proportion of these beneficiaries (ASPE, 2016). It has been hypothesized that differences in ratings across MA plans may in part be attributed to a lack of risk adjustment in the MA Star Rating program to account for the limited resources and other characteristics of low SES common among dually enrolled beneficiaries. While a topic of debate, those who support

¹ The MA Star Rating System consists of a mix of measures of process of care, intermediate outcomes, patient experience, and plan administrative measures.

adjustments for SES or other social risk factors argue that dually enrolled beneficiaries are more challenging to treat in ways that are beyond the providers' control, such as being more medically complex or having fewer resources to seek care or preventive services when needed (ASPE, 2016).

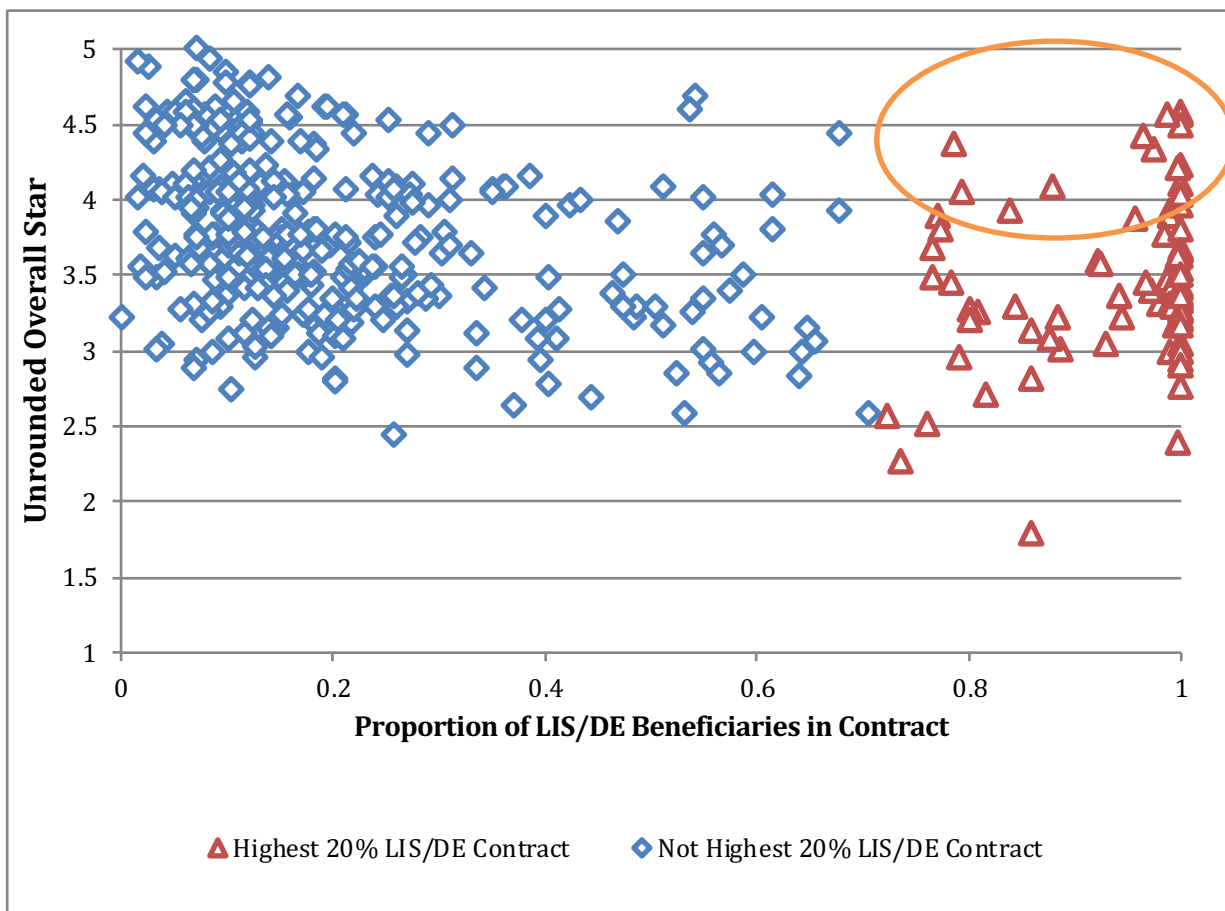
Despite the challenges related to treating dually enrolled beneficiaries, some MA plans that serve a high percentage of such beneficiaries still achieve high ratings in the MA Star Rating program. As illustrated in Figure 1.1, some plans in the highest quintile of beneficiaries who are dually enrolled or receive a Part D low-income subsidy perform very well (circled plans in Figure 1.1). Findings from interviews with key stakeholders, including representatives of MA plans that serve a high percentage of dually enrolled beneficiaries, suggest that MA plans may seek to improve quality by addressing the nonclinical needs of members, including food and housing insecurity, transportation issues, low health literacy, and language barriers (Sorbero et al., 2018). For example, these MA plans reported identifying clinical and nonclinical needs to better care for patients and referring (or directly providing services) to address patient needs for housing, food, and transportation (Sorbero et al., 2018).

Addressing social needs, referred to as *social determinants of health* (SDOH), is increasingly recognized as key factor in determining overall health. SDOH are broadly defined as “the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life” (World Health Organization, undated). These factors explain health inequalities and differential life expectancy (Chetty et al., 2016), and evidence is growing that addressing SDOH improves health (Taylor et al., 2016). Studies have demonstrated that greater government spending on SDOH, including education, cash assistance, and public safety, promotes health. Bradley et al. (2016) reported that states with a higher ratio of social service spending to total Medicare and Medicaid spending had better health outcomes for a variety of measures and reduced mortality from lung cancer. Additionally, McCullough and Leider (2016) found that counties with higher spending on social services—such as public health, public hospitals, fire protection, education, public safety, libraries, and housing—were found to have better health, as measured by county health rankings. This has also been demonstrated internationally by Rubin et al. (2016), who found that countries with higher spending on social services have better health outcomes.

Evidence is also growing about strategies to address SDOH and the impact of health plans that engage in them. Shan et al. (2018) linked data from the Meals on Wheels meal-delivery program with Medicare data and reported reductions in rates of institutionalization, hospitalization, and emergency department (ED) admissions after six months of enrollment in the meal-delivery program. Health Lead's long-running “help desk” program, which addresses members' basic social needs in addition to health care needs, led to improvements in quality of care and patient health (Onie et al., 2018). Aspects of this program have been adapted to serve diverse communities with high levels of social need. Additionally, a recent study examined the effect of home delivery of either medically tailored meals or nontailored meals on the use of

selected health care services and spending in a sample of dually enrolled beneficiaries (Berkowitz et al., 2018). Compared with matched beneficiaries not participating in the program, participants had fewer ED visits and lower medical spending overall. Participants in the medically tailored meal program also had fewer inpatient admissions.

Figure 1.1. Overall MA Star Ratings by Plan-Level Proportion of Dually Enrolled Beneficiaries



SOURCE: ASPE, 2016.

NOTES: DE = dually enrolled beneficiaries; LIS = Part D low-income subsidy. All DEs are eligible for LIS. Approximately 5 percent of MA beneficiaries are eligible for LIS and are not dually enrolled.

Additionally, the Commonwealth Care Alliance, which has two products focused on dually enrolled beneficiaries—a Medicare-Medicaid Plan (MMP) and a Dual Eligible Special Needs Plan (D-SNP) for older adults—reported conducting risk assessments to inform care planning, including the use of an interprofessional care team, the deployment of mobile health services, and the prevention of ED visits for dually enrolled beneficiaries with severe mental illness (Hill et al., 2017). Similarly, WellCare, which operates MA and Medicaid managed care plans, reported that addressing social needs (e.g., homelessness, transportation barriers, food insecurity) via a call-center referral program led to lower total health care expenditures (Pruitt et al., 2018). Furthermore, hospitals are trying to determine the best approaches for engaging complex and

diverse patients, including patient and family advisory programs for dually enrolled beneficiaries, which seek to bring together patients, family members, administrators, and clinicians to improve the delivery of health care (Grant, Jones, and Pilon, 2018). Recognizing the important role of SDOH, researchers are developing the business case for payers and providers to invest in strategies to address SDOH as a social good (Nichols and Taylor, 2018).

MA plans, which have some flexibility in how they allocate funds to promote patient health, are in a position to address the SDOH among dually enrolled beneficiaries. Addressing SDOH is a positive outcome for beneficiaries when it reduces barriers to obtaining necessary treatment and leads to improved health. Doing so benefits plans when lower barriers to obtaining care and improved patient health lead to improved performance and related bonus payments and rebates from the Centers for Medicare and Medicaid Services (CMS). Limited information is available regarding the strategies used by MA plans to effectively address the social and health needs of dually enrolled beneficiaries. MA plans that are high-performing and enroll a high percentage of dually enrolled beneficiaries represent an important learning opportunity, for administrators of the CMS and the MA plans, to understand successful strategies that can improve outcomes for vulnerable populations and reduce disparities in care. A deeper understanding of what types of services MA plans are deploying to dually enrolled beneficiaries and other similarly high-cost, high-need members can inform future quality-improvement efforts and inform the design of plans that focus on improving care for dually enrolled beneficiaries.

Purpose

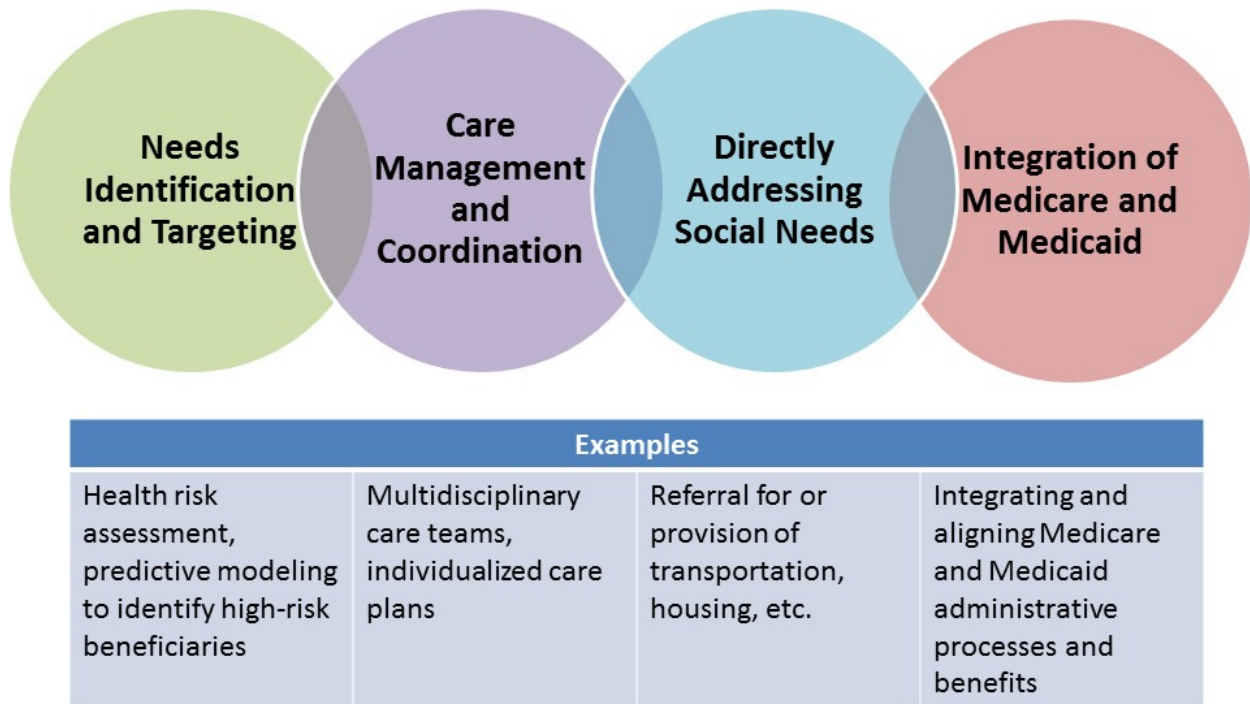
The goals of this research project, conducted in two phases, was to (1) characterize the needs of dually enrolled beneficiaries and the degree to which these needs overlap with other high-cost, high-need individuals more broadly; (2) identify the additional services that health plans provide to dually enrolled beneficiaries or other high-cost, high-need beneficiaries; (3) identify the range of added costs and resources needed to deliver these services and determine whether health plans found these services to be of value; and (4) assess the available evidence on whether such services were associated with better quality and outcomes. The first phase of this study included an environmental scan and key informant interviews to address these four objectives (Sorbero et al., 2018). This report presents results from the second phase of the study, which focused on identifying additional information via key informant interviews and in-depth case studies.

During the first phase of the project, researchers at the RAND Corporation determined that the activities conducted by health plans, providers, and their community partners to address the needs of dually enrolled and other high-cost, high-need beneficiaries could be grouped into the following categories (Figure 1.2):

- identification of needs and use of data analytics to better target programs toward patients at high risk for hospitalization, readmissions, and nursing home admission
- addressing clinical needs through care management and coordination

- meeting the social needs of dually enrolled beneficiaries by either referring dually enrolled beneficiaries to existing programs that address housing, food security, and transportation needs or providing these services directly
- undertaking administrative actions to better integrate Medicare and Medicaid.

Figure 1.2. Typology of Strategies Used by Medicare Plans to Improve Care for Dually Enrolled and Other High-Cost, High-Need Beneficiaries



While some studies have illustrated how these types of strategies may affect access to care, utilization, and health, this evidence base is still developing. Care management and coordination activities have the strongest evidence base, but long-term follow-up is still lacking, as many programs are new, and studies focus on a single program or setting. Little information was available about the resources or costs needed to implement and sustain these strategies.

Since the first report (Sorbero et al., 2018) was written, new evidence regarding the impact of additional SDOH services on dually enrolled and other high-cost, high-need beneficiaries has been published that shows that the services appear to be promising in reducing utilization, such as hospitalizations, readmissions, and institutionalization. These were described earlier and suggest that plans are approaching SDOH in a variety of ways to address the social needs of their complex and high-risk populations. As plans work toward addressing SDOH, other studies may

be underway and have yet to be published or disseminated. We therefore sought to find out directly from plans what interventions they were implementing and whether they were achieving success.

Building on findings from the first phase of the project, we conducted additional interviews and in-depth case studies to (1) identify additional strategies used by MA plans to address the needs of dually enrolled beneficiaries, (2) address outstanding questions from the first phase of the study (e.g., resources and costs associated with these activities), and (3) inquire about new policies and topics arising in the literature. In Chapter Two, we describe our approach to both the interviews and the case studies. We then describe our findings from the interviews and case studies, focusing on challenges faced by dually enrolled beneficiaries, services provided and strategies used by health plans to improve quality of care for dually enrolled beneficiaries and other high-cost beneficiaries, the role of community organizations and local government, and, lastly, the role of policies in supporting these strategies. We conclude by summarizing our findings and identifying future questions for researchers and policymakers.

2. Medicare Advantage Contract Structure

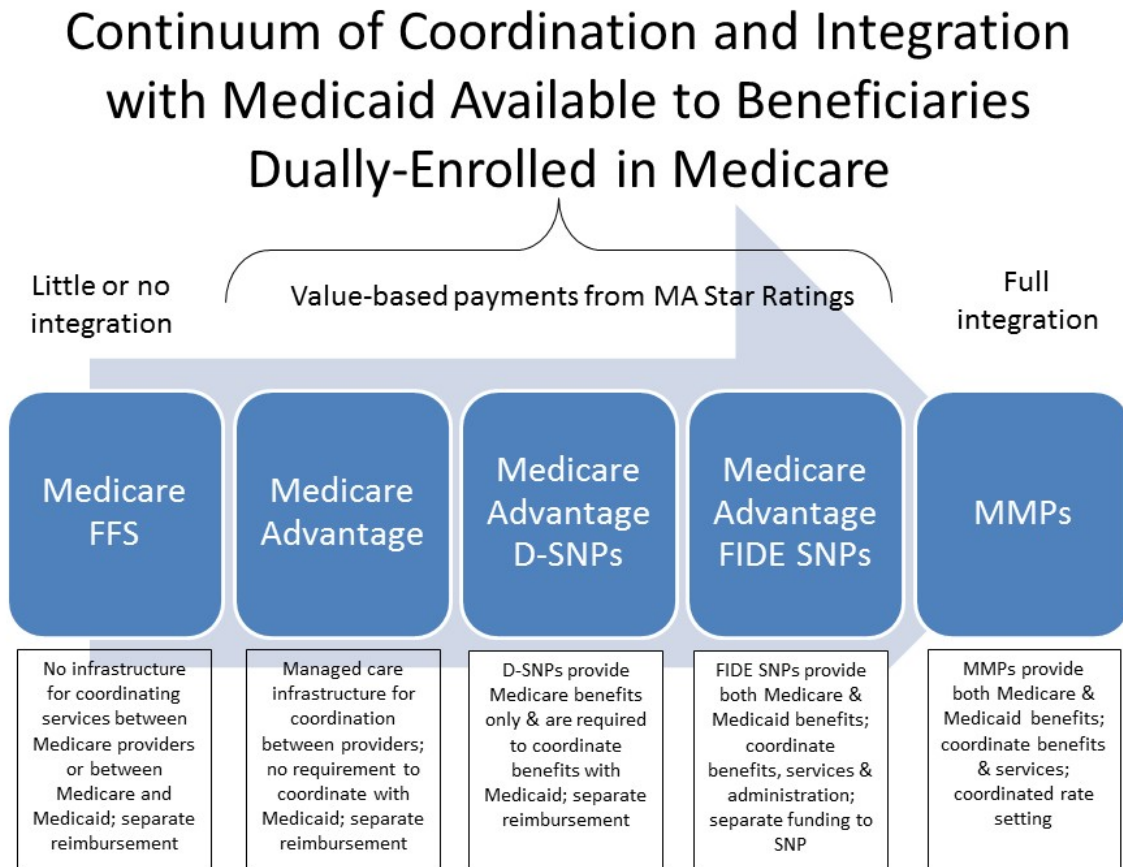
Description of MA Plans Serving Dually Enrolled Beneficiaries

Dually enrolled beneficiaries receive benefits from two separate payers: Medicare and Medicaid. The extent to which these programs are coordinated depends on the type of Medicare coverage in which beneficiaries are enrolled (Figure 2.1). FFS Medicare and Medicaid operate separately; FFS Medicare does not have an infrastructure that assigns responsibility for coordinating services to meet beneficiaries' needs. Thus, dually enrolled beneficiaries have to navigate both the separate clinical and administrative aspects of the two insurance programs. Traditional MA provides beneficiaries with coverage of benefits and services through managed care plans, which have the infrastructure to coordinate clinical care across providers, but no requirement to coordinate with Medicaid. Furthermore, the two programs are operationally separate. Thus, dually enrolled beneficiaries may have better clinical coordination in traditional MA plans (compared with FFS Medicare), but beneficiaries are still responsible for navigating the separate administrations of the two programs.

Recognizing the challenges experienced by dually enrolled and other high-cost, high-need beneficiaries, CMS developed a variety of specialized models of MA plans to enhance coordination of care and, for some models, administration of the two programs. Special Needs Plans (SNPs) were authorized by the Medicare Modernization Act of 2003 and are tailored to specific subgroups of Medicare beneficiaries. D-SNPs enroll dually enrolled beneficiaries, have contracts with both Medicare and state Medicaid agencies, and coordinate the benefits of the two programs, although D-SNPs are required only to include Medicare benefits in the benefit packages. The Affordable Care Act established Fully Integrated Dual Eligible (FIDE) SNPs to promote further coordination of care received by dually enrolled beneficiaries. FIDE SNPs are required to provide both Medicare and Medicaid benefits under a single managed care organization; coordinate covered Medicare and Medicaid services, including long-term services and supports (LTSS)²; and coordinate enrollment, member materials, communications, grievance and appeals, and quality improvement for both Medicare and Medicaid. Those D-SNPs and FIDE SNPs that are highly integrated may seek approval from CMS to provide benefits beyond what MA plans may offer in order to bridge the gap between services covered by Medicare and Medicaid (U.S. Government Accountability Office, 2014). As of July 2018, there were 412 D-SNPs and FIDE SNPs with over 2.3 million dually enrolled beneficiaries (CMS, 2018b).

² LTSS includes a range of services provided in the community or in facilities to assist with personal health care needs and activities of daily living. Use of LTSS, particularly home and community-based services (HCBS), is inversely related to receipt of institutional services (Minnesota Department of Human Services, 2015).

Figure 2.1. Integration and Coordination with Medicaid by Type of Medicare Coverage



NOTE: Intended to illustrate the range of integration across MA plans, which is why the Program of All-Inclusive Care for the Elderly (PACE) is not included. We include Medicare FFS in the figure because it is a typical comparison for beneficiaries with MA and most Medicare beneficiaries have FFS coverage.

CMS supports two other less-common SNP models that serve high-need beneficiaries but are not specific to dually enrolled beneficiaries (and therefore not listed in Figure 2.1). Chronic Condition Special Needs Plans (C-SNPs) are available for beneficiaries with one of 15 specific chronic conditions, including chronic heart failure, end-stage liver disease, and HIV/AIDS. The benefits packages of C-SNPs are required to include supplemental health benefits and specialized provider networks for the chronic condition on which the C-SNP is focused, as well as sufficient cost sharing involving chronic conditions and comorbidities for all Medicare-covered and supplemental benefits (CMS, 2016b). As of July 2018, 132 C-SNPs served approximately 360,000 Medicare beneficiaries (CMS, 2018b). Institutional Special Needs Plans (I-SNPs) are limited to MA-eligible individuals who, for a minimum of 90 days, have had, are expected to, or require the level of services provided in a long-term care skilled nursing facility, a long-term care nursing facility, a skilled nursing facility or nursing facility, an intermediate care facility for those with intellectual disabilities, or an inpatient psychiatric facility. I-SNPs may also enroll

MA-eligible individuals residing in the community who require an institutional level of care, with some restrictions (CMS, 2016c). I-SNPs are the least common of the models; there were 97 I-SNPs with approximately 77,000 enrollees in July 2018 (CMS, 2018b). Because C-SNPs and I-SNPs are not limited to dually enrolled beneficiaries, there are no requirements for how care should be coordinated across Medicare and Medicaid for dually enrolled beneficiaries.

SNP administrators have identified a variety of social risk factors faced by their enrollees through conducting health risk assessments. The top five include low health literacy, poverty or low income, lack of mental health services and support, living alone or with few social supports, and housing instability (SNP Alliance, 2017).

Demonstrations are underway to better integrate benefits and services for dually enrolled beneficiaries in different states. Between August 2012 and July 2015, CMS entered into a memorandum of understanding with 12 states to test two types of demonstration models. MMPs receive capitated payments similar to Medicaid managed care and MA. Under the capitated MMP model currently being implemented in nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas), CMS, the state, and the health plan have a three-way contract whereby the health plan receives a comprehensive capitated payment to provide services covered by both Medicare and Medicaid in a coordinated manner. Through a second managed FFS model being implemented in Colorado and Washington, the state implements initiatives to improve quality and reduce costs for both Medicare and Medicaid, and the state is eligible to benefit from subsequent savings. A 13th state, Minnesota, is integrating the administration, oversight, and other features of its D-SNPs. Minnesota's health plans are not MMPs because its integrated Medicare-Medicaid program—the Minnesota Senior Health Option (MSHO)—has been an option for dually enrolled beneficiaries statewide since 2005 (Anderson, Feng, and Long, 2016). MMPs are subject to quality-reporting requirements and have a portion of their capitated payments withheld subject to meeting certain performance benchmarks, but they currently do not participate in the MA Star Rating program, which is CMS's value-based purchasing program for MA contracts.

Growing Evidence on Impact of Integrated Plans

Evidence is growing about the relationship between participation in Medicare and Medicaid plans that are more integrated and the quality and cost of care. Kim et al. (2017) compared service use and quality of care for dually enrolled beneficiaries in Oregon across five coverage models, ranging from less to more integrated: (1) Medicare FFS and Medicaid FFS, (2) Medicare FFS and Medicaid managed care, (3) MA and Medicaid FFS, (4) nonaligned MA and Medicaid managed care, and (5) aligned MA and Medicaid managed care. Characteristics of beneficiaries varied across coverage models, with members having both FFS Medicare and Medicaid most likely to live in a nursing home. Differences in service use were minimal across coverage models. Members in the aligned MA and Medicaid managed care model, however, had the

lowest rates of ED visits and highest rate of primary care visits. MA and Medicaid FFS plans had worse quality of care than other coverage models in 2011, including having lower rates of diabetes A1c testing, LDL cholesterol screening, and medication monitoring, but quality improved over time. The aligned and nonaligned MA and Medicaid managed care plans had similar service use and quality in 2011, but aligned plans made greater improvements over time in reducing ED visits and increasing primary care visits, HbA1c testing, and LDL cholesterol screening. By 2014, quality of care was similar for most measures for most coverage models.

Furthermore, Zhang and Diana (2018) published a state-level study examining the effects of the penetration of D-SNPs at the state level on average beneficiary spending for Medicare, Medicaid, and total health care. During 2007–2011, higher enrollment in D-SNPs in a state was significantly associated with lower Medicare spending (a 1-percent increase in D-SNP enrollment was associated with a 0.2-percent reduction in Medicare cost per beneficiary) but did not affect Medicaid or total spending. During this time frame, D-SNPs were not required to coordinate between Medicare and Medicaid, which may explain the lack of impact on Medicaid costs. By 2013, D-SNPs were required to have contracts with state Medicaid agencies. Members, however, need to be engaged and aware of services available in order to benefit from them. Findings from focus groups of dually enrolled beneficiaries enrolled in California's federal dual-alignment demonstration indicate that passive enrollment led to confusion among members about services available and how their new plans differed from old plans (Graham et al., 2018).

Policy Landscape for MA Plans

In addition to CMS demonstration programs, Congress is responding to the growing evidence of the association between social needs, health, and health care spending and the need for greater flexibility in Medicare payments. Signed into law in 2018 as part of the Bipartisan Budget Act, the Chronic Care Act, which will take effect in 2020, holds promise with its increased flexibility to use supplemental benefits to pay for services thought to improve the overall health of beneficiaries with chronic conditions, but not directly related to a specific condition. Among other provisions, the Chronic Care Act permanently authorizes D-SNPs, C-SNPs, and I-SNPs and provides D-SNPs with three approaches for integrating Medicare and Medicaid LTSS and behavioral health services by 2021. Additionally, starting in 2020, the Chronic Care Act provides MA contracts with increased flexibility for targeting supplemental benefits to chronically ill enrollees, loosening the requirement that benefits be primarily health related to a reasonable expectation to improve or maintain health or function. Additionally, a bill introduced in the U.S. House of Representatives during the 115th Congress (2017–2018) aims to create a new SNP to give MA plans even more flexibility in spending. The Community-Based Independence for Seniors Act would create a demonstration program for a Community-Based Institutional SNP through which MA plans would receive additional funding, up to \$400 per member per month, to provide home and community-based LTSS to beneficiaries eligible for Medicare only and unable

to perform two or more activities of daily living (U.S. Congress, 2017). Community-based LTSS are costly and typically not covered by Medicare; they include home-delivered meals, transportation services, respite care, adult day care services, and some types of equipment. Low-income seniors may struggle to afford LTSS and, in the process, deplete their financial assets in order to gain Medicaid eligibility, which often covers these LTSS. The goal of this demonstration program is to help seniors get the LTSS they need without depleting their assets.

Given the evolving landscape of SNPs, integrated plans, and federal policies, this project sought to identify the current strategies being used and services provided by MA health plans to improve the quality of care for dually enrolled beneficiaries and other high-cost beneficiaries.

3. Approach

Overview

We conducted seven key informant interviews and four in-depth case studies with high-performing MA plans serving a large proportion of dually enrolled beneficiaries. The goals of these interviews and case studies were to expand the work of the first phase of the project by (1) identifying additional strategies used by MA plans to address the needs of dually enrolled beneficiaries, (2) addressing outstanding questions from the first phase of the study (e.g., resources and costs associated with these activities), and (3) inquiring about new policies and topics arising in the literature.

Key Informant Interviews

Project team members conducted seven semistructured interviews via telephone, lasting approximately one hour, with a convenience sample of 13 individuals at seven organizations identified through the environmental scan from the first phase of the project, suggestions from ASPE, and snowball sampling based on suggestions from other interviewees. The numbers of organizations and interviewees are summarized in Table 3.1 by type of organization. Interviewees were in administrative or clinical leadership positions and were familiar with MA, the MA Star Rating program, and working with dually enrolled beneficiaries. Organizations operating health plans were purposefully selected because they serve a high proportion of dually enrolled beneficiaries and had a high plan rating in the MA Star Rating program. While these organizations were identified based on their performance for a plan serving a high proportion of dually enrolled beneficiaries, interviewees were welcome to broadly discuss the services they provided to dually enrolled beneficiaries across multiple plans and contracts.

Interviews focused on the following topics:

- challenges faced by dually enrolled beneficiaries as they seek care
- additional services, interventions, supports, and resources MA health plans provide to dually enrolled beneficiaries
- estimated costs and resources needed to support these additional services
- impact of these services on quality of care and health outcomes, as well as how the impact is assessed
- examples of how health plans work with their provider networks and groups in the community, including social services or community providers, to support the needs of dually enrolled beneficiaries
- role of state and federal policies in supporting health plans in their efforts to meet the needs of socially at risk and high-need populations.

The full discussion guide is provided in Appendix A.

Table 3.1. Key Informant Interviews

Organization Type	Number of Organizations (Interviewees)
Organizations operating high-performing MA health plans that serve a high proportion of dually enrolled beneficiaries	5 (9)
Health plan association	1 (1)
Policy organization	1 (3)

Case Studies

The purpose of the case studies was to obtain in-depth information on the additional services, interventions, supports, and resources MA health plans are providing to dually enrolled beneficiaries. ASPE and interviewees from the first phase of the study provided suggestions regarding the types of staff within health plans to interview. We purposefully selected organizations operating MA health plans that primarily served dually enrolled beneficiaries, were high-performing on MA Star Ratings, and operated varying types of SNPs with a high percentage of dually enrolled beneficiaries to ensure variation. These organizations were also noted during the first phase of the study as being innovative in their efforts to address SDOH. The characteristics of organizations and interviewees are summarized in Table 3.2 by type of SNP.

Prior to conducting interviews, the research team prepared information briefs documenting information known about the additional services provided by health plans across these organizations to dually enrolled beneficiaries. This information came from the first phase of the project via interviews and the environmental scan and was updated using targeted internet searches. The information briefs enabled the research team to ask each case study interviewee targeted questions about known activities.

Project team members conducted semistructured interviews via telephone, approximately one hour in length, with nine individuals at four organizations operating MA health plans. Case study interviews covered topics similar to the stakeholder interviews but focused on gathering details about one or two specific services. Interviews covered the following topics:

- probing for details about services developed by the plan to address the needs of dually enrolled and other high-cost, high-need beneficiaries (e.g., what are the services, when were they developed)
- determining what challenges faced by dually enrolled beneficiaries the services are intended to address
- implementation challenges the plan faced when developing and deploying these services
- factors that facilitated developing and deploying these services
- estimated costs and resources need to support these additional services

- impact of these services on quality of care and health outcomes as well as how the impact is assessed.

The full discussion guide is provided in Appendix B. The final case studies summarize information from the information briefs, interviews, and materials provided by organizations operating the MA health plans. All organizations interviewed for case studies confirmed they wanted to be named in this report.

Table 3.2. Case Study Interviews with Organizations Operating MA Health Plans

Case Study	SNP Type(s)	2018 Overall MA Star Rating	Number of Organizations (Interviewees)
SCAN Health Plan, California	FIDE SNP, C-SNP, Traditional MA	4.5	1 (3)
Commonwealth Care Alliance®, Massachusetts	D-SNP, MMP	4	1 (1)
HealthPartners, Minnesota	FIDE SNP	4.5	1 (4)
UPMC <i>for You</i> , Pennsylvania	D-SNP	4	1 (1)

4. Interviews

We conducted seven interviews with 13 people representing seven types of organizations (described in Table 4.1) to identify challenges and strategies for addressing the complex needs of dually enrolled beneficiaries. In this chapter, we summarize the key findings and provide additional details below each respective section.

When asked about the challenges that dually enrolled beneficiaries encounter to accessing care, interviewees reported challenges similar to those reported in the initial phase of this project and in the SDOH literature (Sorbero et al., 2018). These include language barriers, housing issues, poor health literacy, cultural patterns, rurality, and food insecurity. During this phase of the research, plans we reviewed noted the complications arising from complex health disorders, mental and behavioral health challenges, and restrictive clinic hours designated for Medicaid beneficiaries. Notably, plans we reviewed stressed the fact that these challenges are synergistic, landing beneficiaries in a “constellation of needs that come at you like a swirling tsunami,” as described by one interviewee.

Table 4.1. Overview of Organizations Interviewed

Type of Organization	Location
Association	National
Policy organization	National
MMP, FIDE SNP, D-SNP	Ohio
FIDE SNP, D-SNP	Wisconsin
FIDE SNP, D-SNP, MA	New York
MMP	California
MA and a variety of SNPs	Multiple states

Strategies Used by Health Plans

The plans’ actions to address SDOH included (1) using multiple strategies to address the SDOH of their dually enrolled members, (2) conducting health risk assessments and employ staff to serve as care managers or care coordinators for dually enrolled members, (3) conducting outreach to community-based organizations (mentioned as important factors in providing care and addressing SDOH), and (4) tracking data on their dually enrolled members and seeking to tailor interventions based on variation at the subpopulation level (the degree to which plans have formalized this process varies).

All interviewed MA plan administrators expressed the need to take a collaborative and multipronged approach to addressing the clinical and social challenges facing their beneficiary

populations, recognizing that a health plan alone cannot resolve all issues, including those such as housing instability. The plan administrators recognized that promoting health and addressing SDOH requires a better understanding of how well members are able to meet their basic needs. All plans conducted risk assessments, and nearly all reported including in these assessment items related to SDOH, such as transportation limitations, food insecurity, and social isolation. Additionally, three plan administrators described how care managers and coordinators use this information to perform targeted outreach to those with the most pressing needs. One plan performed predictive modeling using these SDOH on their dually enrolled population, while others performed subgroup analyses to understand variation in social needs across their dually enrolled members. Multiple plans provided medical transportation to their members.

The plan administrators mentioned the need to employ care coordinators and care managers who could establish relationships with members and the community. One plan administrator emphasized the importance of retaining multilingual staff and having a community-engagement team to conduct member outreach. Multiple plans also sought to engage members by making their staff easily accessible to members. Two plan administrators spoke of the importance of choosing community engagement staff who were adept at establishing bonds within the community. One plan had member services in retail spaces in the community, as well as educational spaces, to facilitate outreach to members. And another underscored the utility of hiring additional staff to serve as outreach care managers. Specifically, the interviewee noted that these professionals were expected to conduct outreach to identify dually enrolled members and then engage them in care management. Finally, one plan used members, who successfully accessed social services, to work as peer-to-peer counselors to help other members who are new to accessing these services.

Plan administrators also mentioned using other strategies to address the needs of dually enrolled members. One plan involved using telemedicine platforms to link members with chronic conditions to nurses who can provide remote patient monitoring and intervene when acute issues arise. Another plan developed a 12-week program that occurs during the precarious time before a member is discharged from a nursing facility. This program is intended to help members overcome issues of social isolation and other issues that may arise as members return to independent living.

Building Community Resources: Partnerships with Community-Based Organizations

Plan administrators noted the importance of building partnerships with nonmedical and community-based organizations to best serve their dually enrolled members. The degree to which plans formalized relationships with these organizations varied and ranged from donations to referrals to contractual agreements. Most plan administrators mentioned that having an up-to-date database of available community services would be a useful tool for linking members to social services.

Interviewees noted that it was common for plans to engage with local organizations and vendors to augment services provided to members to promote their health and well-being. These organizations included, but were not limited to, housing shelters, religious organizations, and private foundations. Fostering relationships with community organizations was a key component of plans providing nonmedical care for members, and they mentioned varying levels of formality in partnerships between community-based organizations and their health plans. One plan formalized partnerships with community-based organizations through contracts, seeking to fully integrate care and remove fragmentation in care pathways for members. This health plan ensures that community-based organizations, ranging from the YMCA to food pantries, are written into contracts for their demonstrations. This plan administrator also described contractual relationships with dedicated mental health providers. Another health plan formalized its community involvement by drawing on community members in local governance, hospital systems, and other organizations not directly tied to the provision of health care, which helped foster and maintain trust with members and community partners alike. For example, the plan's community engagement team hosts local events, such as video game nights for the local youth population and back-to-school events, through its partnership with the New York Housing Authority.

Two plan administrators specifically mentioned the importance of these community partnerships for promoting housing stability of their members. One plan administrator described engaging in political advocacy to support local organizations that serve the state's homeless population. This plan also contracts with home health agencies to perform 30-day follow-ups on newly discharged members. Another plan works with housing developers to ensure that their members have access to affordable housing and space within assisted living facilities.

Because of the high social needs of dually enrolled beneficiaries, plan administrators noted that a tool or database, such as an online software application, could be useful for organizing and collating all available community resources. One plan is actively working to construct a database of community partners/social service agencies that includes information on the types of services provided, how the services are accessed, and how the agencies are networked within a community. The plan also provides technical assistance to smaller community partners to improve their data, reporting systems, and grant-writing capabilities, which the plans see as a win-win for the community partner, health plan, and member.

Health Plan and Provider Relationship

The plans that we reviewed reported variation in their formalized relationships with providers. Geography and member preference were mentioned as factors that can impact whether providers are included in-network, which plans did not always consider to be optimal. The plans that we reviewed mentioned the importance of gathering regular feedback from in-network providers.

Interviewees offered insights into the relationships between plans and providers, which varied based on whether a plan was part of an integrated system, had shared risk with providers, or operated in a capitated environment.

The administrator of one plan that operates in an integrated system mentioned using remote patient monitoring, which enables members to upload regular biometric data so that nurses can quickly intervene when needed. This is facilitated by the plan's integrated physician network, from whom the plan elicits regular feedback. While this plan provides arrangements for a long-term care waiver and a family care plan, the administrator also noted that the uptake of value-based agreements with providers has been slower than anticipated but did not provide additional reasoning for this.

Another plan administrator described the challenge of balancing performance measurement and patient satisfaction. This plan administrator mentioned the challenge of maintaining contracts with providers who do not pay close attention to quality metrics but are preferred by their dually enrolled members.

One plan administrator mentioned difficulty in obtaining visits for patients. This plan administrator reported that providers restrict the clinic hours offered to Medicaid patients. A different plan, however, is able to blind members' coverage status to their providers. Hence, some plans are able to find solutions, or "workarounds," to particular issues of access, but this is not universal.

Lastly, one plan emphasized the importance of "soft skills" for building provider relationships through regular in-person meetings with the ultimate aim that building trust and collaboration can have longer-term benefits, such as improved data sharing and interoperability.

Resources Required to Implement Strategies

The plan administrators noted significant resource allocation to implement the aforementioned strategies for their dually enrolled beneficiaries in terms of administrative, staffing, and care costs. Higher costs were mentioned for information technology to allow for tracking and follow-up of patients across care settings. Overall, most plans did not elaborate on actual operational costs to maintain these additional services.

The plans that we reviewed varied in the level of detail provided on the additional costs and resources required to conduct the dual demonstration. Only one plan that we reviewed provided actual dollar amounts for these additional services, stating it contributes \$1.5 million to a community-based social services program and additional project funding in the amount of \$500,000. Another plan that we reviewed noted that its programs are initiated out of reserve funding. It also indicated that an ongoing challenge to the sustainability of demonstration programs stems from Medicaid-related issues and not Medicare (because Medicare accounts for shared risk).

Other plans that we reviewed described the staffing and other resources needed to meet the clinical and social needs of dually enrolled beneficiaries. The plans that we reviewed reiterated that dually enrolled beneficiaries require additional time and resources in terms of outreach, particularly if members have frequent address and telephone number changes, requiring additional staff time and resources. In terms of the types of staffing required to meet the needs of their members, one plan that we reviewed reported having community health coordinators, community engagement team members, and staff members who work on clinical partnerships. The plan that we reviewed mentioned providing on-the-job training to these staff members. Another employing a dedicated program manager, an analytics team, and customer service support staff members.

Relatedly, in describing its “enhanced care model,” a plan administrator indicated that the following components were needed: provider training, interdisciplinary teams, high touch in the member’s home, more follow-up than usual, and a mechanism to prompt follow-up care. The plan that we reviewed noted that a major expense for the plan was for the technology related to the prompt for follow-up care (e.g., setting up the technology that allows for receipt of alerts when members are discharged or experience other care transitions). Another plan that we reviewed cited the additional expense of requiring information technology changes to account for tracking risk assessments in members’ homes and capturing adequate analytics on its members.

Challenges to Implementing Strategies or Achieving Success

The plan administrators mentioned that providing cost-effective care for dually enrolled members is challenging. Other common challenges reported included obtaining needed data, conducting analytics, and fragmented care. The plan administrators also mentioned challenges because of a lack of synthesis across Medicaid and Medicare policies and regulations within states, as well as among the federal and state policy landscapes.

Challenges for Plans

Across the board, the plans that we reviewed noted that their dually enrolled members have complex care needs, mental and behavioral health disorders, long-term health care needs, subsidized housing needs, and rehabilitation requirements. The plan administrators noted that these complex care needs require coordinated, comprehensive, and cross-sector care approaches, but some mentioned that it can be challenging to successfully implement these approaches. One plan administrator noted that being able to find up-to-date information on services across sectors is difficult. While plan administrators expressed awareness of the importance of SDOH, one noted that it is still an evolving concept and that current health insurance–coverage models need to evolve to better meet the social and clinical needs of vulnerable populations.

One plan administrator mentioned that some members refuse to participate in health risk assessments and that responses to sensitive questions (e.g., domestic violence) can be unreliable.

Insufficient personal rapport between the health plan coordinator and the member was often the reason for this failure to collect data.

Plans also faced challenges related to data, including obtaining up-to-date data and the ability to continuously track dually enrolled beneficiaries. All plan administrators noted the importance of data for care-coordination activities, and we learned that, for some plans, building this infrastructure remains an opportunity for their improvement. Several plan administrators mentioned that, in general, care coordination across the traditionally siloed Medicare and Medicaid worlds, particularly with the inclusion of community-based social services, requires extra efforts and recognition of ways to build more integration and interoperability. This coordination could improve data sharing and analytics and, in turn, could lead to more impactful, cost-effective approaches for this member base. One plan administrator described the difficulties of a “worst-case scenario”: when a member is covered through one health plan for Medicare and another for Medicaid.

An additional common challenge is the variation in Medicaid eligibility across states, which may result in gaps or lapses in care. Furthermore, multiple plan administrators described the additional efforts required to navigate the policy landscape across both state and federal levels as well as Medicare and Medicaid. One plan administrator additionally described the difficulties in Medicaid enrollment for certain members, noting that more guidance on proper documentation for enrollment would be useful.

Two plan administrators emphasized that the metrics and motives that drive policy do not necessarily align with what is important to members. Plan members may be less concerned with preventive screening tests (measured on quality metrics) than with their total personal health care costs. In addition, several plan administrators emphasized that there are no “one-size-fits-all” approaches to managing dually enrolled members. The young and disabled population will look very different from an older and institutionalized population, and the approaches, resources, and metrics employed to measure success should adjust for these differences.

Additional challenges mentioned by plan administrators included providing care and services to rural populations, ensuring stable at-home care for patients who are reluctant to allow care providers in their homes, and, at an organizational level, supporting supplemental programs for dually enrolled beneficiaries when plans may not be in a strong financial position.

Policy Factors

Commonly identified across plans was the need to adjust for SES in performance measures. Plan administrators indicated that alignment of state and federal Medicare and Medicaid policies would alleviate bureaucratic burden. Plan administrators expressed support for policies to reflect the unique needs of dually enrolled beneficiaries, as well as subgroups within this population, and allow for flexibility in delivery supplemental benefits.

In general, plan administrators reported actively providing comments to CMS and the U.S. Department of Health and Human Services’ Office of the Assistant Secretary for Planning and

Evaluation related to models of care for dually enrolled beneficiaries. Plans sought more flexibility in approaches to supplemental benefits for their dual demonstrations. One plan that we reviewed mentioned the expansion of supplemental benefits (e.g., transportation, wellness programs, weight management support systems) as an overall advantage. One plan furthermore advocated for Accountable Care Communities, as opposed to Accountable Care Organizations (ACOs), to better integrate care and interoperability.

Plans supported adjustments for SES in performance measures. In all interviews, we heard concern from interviewees that the lack of adjustment for SDOH in clinical measures disadvantages plans with large populations of dually enrolled beneficiaries and that even those measures that are risk-adjusted for other factors do not include all relevant social risk factors. Plan administrators noted that lack of adjustment for members' SES creates challenges in reaching targets. As one plan administrator noted, it can be difficult to reach the quality bonus in the MA Star Rating program, especially because there are no risk-adjustment mechanisms that are sensitive to the high needs of dually enrolled beneficiaries. Overall, plan administrators expressed a desire to be rated fairly vis-à-vis the complex populations that their plans are serving.

One plan administrator noted that performance on the MA Star Ratings can lose its evaluative power when measured in a special needs population. This relates to the issue of needing metrics that are representative and “meaningful” to this member population, something that was mentioned in several plans. Three plans we reviewed supported policies that allowed for subpopulation-focused strategies. This echoes the desire expressed by several plan administrators to tailor quality metrics that reflect the needs and pressing concerns of dually enrolled populations. One plan administrator specifically argued in favor of policies that are responsive to the needs of the dually enrolled member population that is under the age of 65, over 65, and over 85, for example.

Other criticisms of performance measures mentioned during interviews included the high similarity of some measures, whose slight differences can make it difficult to reach MA Star Ratings targets. Another plan noted sensitivity to the measures included in the MA Star Rating program in a given year, noting that its MA Star Rating can differ based on the measures included in the program in the specific year.

Lack of standardization of measures and reporting across Medicare and Medicaid was mentioned by several as a burden. As echoed in other plans we reviewed, one plan faced issues when particular long-term measures for its FIDE SNP did not align across state and federal requirements. Another plan administrator noted the issue resulting from a lack of consistency across states for Medicaid eligibility, which can lead to gaps in care and eligibility, as well as the “bureaucratic burden” resulting from points of divergence among state and federal Medicaid policies, which can result in conflicting information for members. One plan administrator suggested that streamlining and standardizing quality metrics would force better integration across Medicare and Medicaid.

Evidence of Success

Plans differ in their approaches to evaluation and measurement and used similar measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS] measures and other standardized outcomes) to monitor their goals.

Plan administrators reported using a range of metrics and approaches to track their plans' progress, including tracking member service calls, gathering feedback from community health coordinators and providers, conducting focus groups and surveys among members, and analyzing utilization data. Plans focused on commonly used metrics, such as HEDIS measures, to track overall quality, but it was less clear whether plans were using HEDIS scores when conducting evaluations of additional services and interventions. For example, one plan administrator reported tracking hospital admissions and readmissions, primary care visits, medication adherence, preventative measures (e.g., colonoscopies, mammograms), disease-specific outcomes (e.g., hypertension control, hemoglobin-A1C control), and member-experience surveys. While that plan performs well based on these measures, it is pushing for metrics that are more meaningful to its members. For example, an elderly member would be more concerned with having a stable living situation and overall costs than achieving a hemoglobin-A1C target. Furthermore, this plan stressed the importance of understanding not only how traditional metrics relate to cost, but also to quality-of-life improvements for members who can reduce hospitalization and nursing care institutionalization.

Other plans also tracked traditional metrics while emphasizing the importance of metrics that are meaningful to their members. For example, one plan determined that its SNP was able to show a 4-percent lower institutionalization rate than Medicaid FFS, resulting in a \$4 million reduction in cost to the state. The administrator of this plan added that this also conveys a quality-of-life benefit to members, who generally prefer not to be institutionalized.

Another plan administrator described conducting surveys, focus groups, and evaluations of utilization and claims data. This interviewee reported having “short-term feedback loops” that signal when the plan should scale up certain initiatives. This was echoed by another plan, which takes note of successes—such as fewer ED visits—and then seeks to scale up its programs accordingly.

To evaluate the impact of certain programs, one plan tracks quality metrics scores before and after funding hospital-based programs. However, another plan administrator described the difficulty in attributing changes in quality metrics to one specific program, noting that it would not be able to parse the added benefit of, for example, a telehealth platform or having additional care coordinators.

Plan administrators reported using these metrics for planning purposes with varying degrees of success. One plan administrator reported difficulty in using metrics to adequately strategize, while other plans performed sophisticated predictive modeling and implemented these findings into their broader care planning approach. Plan administrators mentioned that tracking progress

toward targets requires additional information technology and staffing resources, which one plan has contracted out to a third-party entity on an annual basis. However, this plan administrator added that it still faces issues in receiving reliable, up-to-date data from providers, as well as in calculating proper risk adjustments. In short, plan administrators described some commonalities in their approaches to evaluation (e.g. HEDIS scores), while noting some particular challenges to producing reliable, consistent data and reporting.

5. Case Study: SCAN Health Plan

This case study is focused on SCAN Health Plan, a nonprofit organization that has contracts to operate multiple SNPs and a traditional MA plan in California. A key feature of this health plan is its emphasis on enhanced care management services to members, both dually enrolled and other high-cost, high-need beneficiaries, which have demonstrated positive outcomes among members. In addition, the plan has implemented interventions addressing a variety of health needs among dually enrolled beneficiaries and other high-cost beneficiaries; these interventions are currently being evaluated.

Organizational Overview

SCAN Health Plan, founded in 1977, has a long history of serving the medical and social needs of seniors. Headquartered in Long Beach, California (SCAN Health Plan, 2017), SCAN operates health plans only in California.

SCAN offers several types of plans that serve dually enrolled beneficiaries, including a FIDE SNP, a C-SNP, and a traditional MA plan. The FIDE SNP serves approximately 13,000 dually enrolled beneficiaries in Los Angeles, Riverside, and San Bernardino counties. The health plan has contracts in place so that members have access to benefits from both Medicare and Medi-Cal (California's Medicaid program). The C-SNP serves both dually enrolled and Medicare-only beneficiaries but has a high proportion—around 25 percent—of dually enrolled beneficiaries. Dually enrolled beneficiaries enrolled in the C-SNP receive only Medicare benefits through the plan. Additionally, the plan's traditional MA plan serves around 16,000 beneficiaries and is targeted to dually enrolled beneficiaries. In this traditional MA plan, dually enrolled beneficiaries enroll in Medicare through SCAN and SCAN coordinates with Medi-Cal to address the needs of those beneficiaries who are dually enrolled for both Medicare and Medicaid benefits.

To gain a deeper understanding of services available for dually enrolled beneficiaries and other high-cost beneficiaries, we spoke with several representatives of the health plan, including the senior vice president of public, government and community affairs; the senior vice president of health care services; and the chief medical officer.

Services for Dually Enrolled Beneficiaries

Care Management Services

The health plan's model of care for dually enrolled beneficiaries, regardless of the type of MA contract, emphasizes care management, which includes helping members navigate their benefits and health care utilization. Upon enrollment, each dually enrolled member is assigned to

a care manager, also known as a *Personal Assistance Line* (PAL) (SCAN Health Plan, undated), who is bilingual (Spanish and English) with high school–level education or a bachelor’s degree. The PALs are well-trained in customer service and able to answer questions about Medicaid benefits. The health plan’s representatives noted that exemplary customer service experience was a key skill that enabled the PALs to effectively assist members.

SCAN began using PALs approximately 12–13 years ago to meet the needs of the dually enrolled population. The health plan observed that a large number of dually enrolled beneficiaries were contacting the customer service unit for assistance. Because of the extended amount of time it took for staff to respond to the calls, SCAN established a unit within the customer-service department specifically dedicated to the dually enrolled population. The unit housing the PALs was eventually moved from the customer-service department into the care coordination department so that they would have easier access to staff (e.g., nurses, social workers) who could support the clinical needs of the beneficiaries.

When a beneficiary newly enrolls in the plan, within the first 90 days of enrollment, the PAL welcomes the member via telephone, provides information about the plan, assists with any continuity-of-care concerns, and conducts a health risk assessment (SCAN Health Plan, 2018). This assessment uses a screening tool to identify an individual’s social and health care needs to inform the plan’s targeting of services. The health risk assessment also collects information related to functional status, cognitive status, mental health, physical health, chronic conditions, SDOH (e.g., whether the individual is living alone, food insecurity), and other domains. In 2018, the plan is launching an expanded health risk assessment that will collect more information related to SDOH, including education, race, and languages spoken. The health plan also uses a modeling approach to identify high-risk individuals for care management activities, which integrates pharmacy claims, ED utilization, and other relevant information. In addition to health risk assessments, members’ needs are also identified through a triggering event such as a hospitalization, members’ outreach to customer service or a PAL, physician referral, and self-referral.

Depending on need, as determined via the health risk assessment, members may be engaged in a complex care management program (SCAN Health Plan, 2015) or given an additional assessment to determine whether they meet state eligibility criteria for LTSS. Members eligible for the complex care management program are assigned a care manager—usually a nurse, social worker, or counselor—who conducts telephonic care management. Unlike a PAL, who is intended to help the member navigate the plan itself, including assisting with billing and Medicaid eligibility concerns (SCAN Health Plan, 2018), the care manager is intended to help the member navigate health care services and help promote the member’s health. This type of care management is available for both dually enrolled beneficiaries and Medicare-only beneficiaries.

SCAN’s objective in providing care management services has been to keep people living in the community, rather than in nursing homes. Representatives of SCAN emphasized that positive outcomes resulting from living in the community instead of nursing homes can include less-

expensive costs of living, better health outcomes, and reductions in hospitalizations and readmissions. SCAN contracts with a range of community-based organizations and corporate vendors to facilitate the provision of LTSS, including in-home personal care (e.g., assistance with bathing, dressing, housekeeping), adult day care, meal delivery, and transportation. Thus, SCAN coordinates LTSS, in addition to Medicare benefits and other Medicaid services, for members who are eligible to receive these additional benefits. The health plan also identifies resources (e.g., housing, food, transportation) that are available in the community through the website Aunt Bertha (2018) and refers members as needed.

Additional Strategies to Address the Needs of Dually Enrolled or Other High-Cost Beneficiaries

In addition to care management, SCAN is implementing a number of interventions to address the needs of dually enrolled or other high-cost beneficiaries:

- *Addressing clinical needs and SDOH:* In 2016, SCAN began a pilot program, called the Provider to Home Pilot, to support the needs of chronically ill, high-need patients. The primary aim of the pilot is to help physicians gain a full picture of a patient so that the physician can connect what they see in the office with the individual's life at home. The member's primary care physician is supported by a social worker and community health worker in order to address the patient's clinical needs, as well as SDOH. Based on knowledge gained, the physician develops a treatment plan that is tailored to an individual's needs.
- *Promoting medication adherence via telephone:* Through a telephonic program, bilingual care managers provide support to beneficiaries to reduce barriers to medication adherence.
- *Addressing isolation among the community-based elderly:* In partnership with the nonprofit organization Wider Circle, SCAN developed and deployed a pilot program to address issues of isolation and other health problems. The intervention is focused on engaging members through groups in the community and having them participate in physical activity together.
- *SCAN Buddy Program:* The health plan has trained seniors (who are also SCAN Health Plan members) in motivational interviewing, so that they can communicate peer-to-peer with individuals who are at high risk for geriatric conditions and areas of concern, including incontinence, mental health issues, and low physical activity. Through this outreach, the goal is to encourage individuals to be more engaged in their health and be open to discussing these topics with their physician.

Additionally, SCAN is pursuing the following in-home interventions:

- *Using social workers to address depression:* The health plan provides services to community-based seniors, many of whom are dually enrolled beneficiaries. SCAN uses culturally sensitive and linguistically appropriate licensed social workers to conduct cognitive behavioral therapy in members' homes to address depression.
- *Providing in-home palliative care:* The health plan has deployed an in-home palliative care model with an outside organization to address the palliative care needs of members.

Evidence of Impact of Services

Care Management Services

SCAN evaluates the impact of its care, including care management services, by conducting internal evaluations and comparing its members to state- and national-level benchmarks. Representatives from SCAN reported that an internal evaluation revealed a 20-percent reduction in the hospitalization rate among frail dually enrolled members receiving care management services compared with Medicare-only members not receiving care management services. This evaluation was used to make the business case for providing care management services and to inform organizational decisions. The health plan also evaluates its care management program every other year to inform organizational decisions. During our interview, representatives from SCAN indicated that this evaluation, which includes a pre/post comparison of hospitalizations, ED visits, and other outcomes, has consistently found positive effects from care management. Additionally, SCAN found that enrollment in the FIDE SNP reduced hospital readmission among dually enrolled members.

Other Evaluation Activities

SCAN compares its scores on HEDIS measures for each plan to scores from other California plans and national averages. From internal documents, we confirmed that SCAN's SNPs performed at or above the national average on measures related to blood pressure control for patients with hypertension, colorectal cancer screening, medication reconciliation postdischarge, and three measures related to care for older adults (assessment for pain, functional status, and medication reconciliation).

Interventions Addressing the Needs of Dually Enrolled or Other High-Cost Beneficiaries

SCAN has conducted a preliminary evaluation of the Provider to Home Pilot, which involves the collaboration of a primary care physician, social worker, and community health worker to support patient care. This pilot reduced emergency room visits and hospitalizations by 39 percent and 27 percent, respectively. Other metrics that are still being evaluated include patient and provider satisfaction, adherence to the physician's plan of care and treatment, and events or use that may have been avoided because of the intervention.

SCAN has also evaluated the use of in-home cognitive behavioral therapy provided by social workers to members with depression. This program led to improvements in depressive symptoms of members served as measured by the PHQ-9 (a depression screening tool).

Representatives from SCAN indicated that the other interventions mentioned are also being evaluated. The plan representatives noted that while they highly value conducting evaluations of their interventions, conducting rigorous evaluations was not always feasible because they do not have the research resources of an academic institution.

Costs of Services

SCAN budgets for care management services and other programs through its medical administrative expenses in its bidding process with Medicare. The health plan receives funding from the state of California for LTSS provided to eligible members and for associated administrative activities.

The plan's added cost of care management services helps support quality and compliance efforts. In particular, care management services and LTSS support the health plan's goal of achieving the triple aim of performance, which encompasses patient experience, health outcomes, and reduced cost of health care. In terms of compliance, the care management services allow the health plan to meet requirements set by Medicare and Medi-Cal.

Challenges and Opportunities for Addressing the Needs of Dually Enrolled Beneficiaries

The respondents discussed several challenges that the health plan has encountered in addressing the needs of dually enrolled beneficiaries. For one, the health plan operates its FIDE SNP in only three counties (Los Angeles, Riverside, and San Bernardino). This is because care is provided differently for dually enrolled beneficiaries in California based on each county's health system. For instance, in counties with County Organized Health Systems, all Medi-Cal beneficiaries receive their care through a single health plan. In other counties, beneficiaries can enroll in a plan of their choice. SCAN is interested in growing the FIDE SNP within its existing counties and expanding when the state is ready to expand the model.

A second challenge is a lack of adequate funding. SCAN is seeking to address this through a pilot program to encourage clinicians to invest in home- and community-based services. In this program, SCAN provides data to clinicians to illustrate the value of investing in helping their patients obtain home- and community-based services to reduce costs and prevent hospitalizations. Relatedly, SCAN mentioned encountering difficulty engaging provider partners in various efforts because of competing priorities.

A third barrier relates to SCAN's restrictions on paying for in-home caregivers. Caregivers who provide in-home care through SCAN's contract with providers of LTSS are required to work for an agency that is licensed and employs caregivers meeting state training requirements. Representatives for SCAN noted that members often preferred to hire family members to be their own in-home caregivers, yet these caregivers are not eligible for payment for LTSS from SCAN because of the employment restrictions placed on the funding, as the LTSS procured by SCAN are procured from caregiving agencies. As such, SCAN's restrictions present a challenge, but the health plan provides a variety of options for caregivers and helps members to find a caregiver they are comfortable with.

Finally, in attempting to engage members, SCAN has experienced challenges related to technology. In particular, members have struggled to use technology through different programs and services that have been offered, such as informational videos with case managers and physicians.

In terms of opportunities to address the needs of dually enrolled beneficiaries, SCAN supports the recently passed Chronic Care Act. The health plan also supports the Community-Based Independence for Seniors Act (U.S. Congress, 2017), a bill introduced in the U.S. House of Representatives, which would create a Community-Based Institutional SNP that provides a monthly Medicare benefit of \$400 per member for HCBS. The respondents felt that this bill could prevent those who are nearly dually enrolled from spending down their assets in order to become Medicaid-eligible and have LTSS covered. The representatives indicated that avoiding depleting financial assets would be a positive outcome for affected members.

Summary

SCAN Health Plan's care management effort has been successful in addressing the needs of dually enrolled beneficiaries. Internal evaluations of the program have been promising, demonstrating reduced hospitalizations and reduced ED visits. Other interventions targeting dually enrolled or other high-cost beneficiaries, including the Provider to Home Pilot and the use of social workers to deliver cognitive based therapy in-home, have also demonstrated positive outcomes. The health plan is supportive of the Community-Based Independence for Seniors Act because it could prevent people from becoming dually enrolled and allow them to live in their homes longer with the support of LTSS targeted for their specific needs.

6. Case Study: Commonwealth Care Alliance®

This case study is focused on Commonwealth Care Alliance® (CCA), a nonprofit community-based health care organization that operates an MMP demonstration and a D-SNP. CCA provides care to individuals who are dually enrolled for Medicaid and Medicare and have highly complex medical, behavioral health, and social needs. It uses a holistic, patient-centered, and team-based care model that is focused on enhanced primary care, care-coordination and management, and shared decisionmaking between individuals and health team members. CCA provides a broad range of additional services aimed at addressing SDOH. One example is a mobile integrated health (MIH) program, aimed at serving members where they are, thus addressing long-standing individual and community barriers to care. This intervention shows promising outcomes.

Organizational Overview

CCA was established by a group of organizations that promoted a holistic patient-centered care model. CCA operates only in Massachusetts as a managed care and health care delivery organization. A majority of its members are dually enrolled beneficiaries.

The organization operates two health plans that serve dually enrolled beneficiaries: D-SNP and an MMP. The D-SNP, Senior Care Options (SCO), is focused on approximately 9,800 individuals ages 65 and older who are dually enrolled in both Medicare and Medicaid or only Medicaid. The MMP, One Care, is a demonstration program with more than 18,000 dually enrolled beneficiaries aged 21 to 64. Both plans are comprehensive and provide all services covered under Medicare and Medicaid. Additional services are provided to members on a case-by-case basis to address social determinants of members' health, as deemed necessary by a multidisciplinary care team in conjunction with CCA's preferred provider network.

Overall, CCA has more than 25,000 providers in its network, four disability-competent primary care community care centers, and two community-based crisis stabilization units (CSUs).

To better understand the services available for dually enrolled and other high-cost, high-need beneficiaries, we spoke with CCA's vice president for medical affairs.

Services for Dually Enrolled Beneficiaries

Fully Integrated Care

CCA provides services and programs through a fully integrated care model that is flexible and patient-centered; entails care coordination and management; and shares decisionmaking with

its individual members. First, each member is comprehensively assessed to develop a care plan tailored to his or her needs. Through this multidisciplinary assessment, CCA acquires a minimum data set on the individual's medical, social, and behavioral health needs, as well as SDOH (e.g., housing, education, food insecurity, loneliness, family support).

As soon as a person is enrolled, he or she is assigned a care partner who becomes his or her first point of contact for all services: The care partner is responsible for helping him or her with all needs and reaches out to other team members when specialty services are required, such as behavioral health, wheelchair/seating assessments, or LTSS. Depending on the member's level of need and illness, the care partner may be a mobile care partner (i.e., provide home visits). For the sickest members, the care partner is typically a mobile nurse practitioner, a behavioral health worker, a licensed clinical social worker, or a licensed mental health clinician who is mobile and can meet the member in-person, at home, or in the community. For members who are more stable or have better community support, the care partner may manage them remotely via telephone. Each member is also assigned an individual team of health care practitioners who work collaboratively to meet the individual's needs, provide ongoing health management, early intervention, and response to episodic and urgent care. The care team involves the member and his or her family or guardian in all decisions.

Team-based medical care and support services are available 24 hours a day and seven days a week, wherever members need care: home, physician's office, hospital, or elsewhere in the community. Led by a nurse practitioner, a key feature of this team-based approach is the nurse practitioner's authority and flexibility to request medical tests, medications, durable medical equipment (such as wheelchairs), dental care, eyeglasses, or transportation.

Crisis Support Units

CCA opened CSUs in 2013 and 2014 after it recognized the high levels of behavioral health disorders among its members (age 21 to 64). It determined that it could provide a healthy environment of care for individuals with behavioral health disorders. CSUs provide respite care for members with acute behavioral health and/or substance use disorder needs as an alternative to psychiatric hospitalization. This care is offered at two locations: One is located in a community hospital, and the other is a house in Boston that was converted for this purpose. CCA has long-standing partnerships and collaborates with EDs across the state, such that if a CCA member is in the ED for a psychiatric reason, an ED representative will call CCA's behavioral health team to review level-of-care determination. CCA's behavioral health inpatient team coordinates this process during the day and staffs a behavioral health "on call" line in the evening. CCA can offer the member a place in a CSU, especially when the member does not require an inpatient level of psychiatric care. CCA's vice president for medical affairs noted that a key outcome of CCA's CSUs was a decrease in psychiatric hospitalization, and that 83 percent of members and patients admitted to its CSUs in 2017 were diverted from emergency rooms, inpatient hospitals, or

inpatient psychiatric institutions. This ensures continuity of care for CCA's members, as well as improved continuity with their outpatient team.

Food-Delivery Partnerships

CCA partners with many community-based organizations and food-delivery groups to deliver food to members determined to be at nutritional risk. One of their collaborations was described and evaluated in a recent peer-reviewed publication. Berkowitz et al. (2018) evaluated the impact of CCA's partnership with one meal-delivery service on ED visits, inpatient admissions, use of emergency transportation, and medical spending. The partnership described included daily delivery of five prepared lunches and dinners each week. Program members received either nutritionally tailored meals (e.g., tailored to a patient with diabetes) or nontailored meals. After six months of participation in the program, people who had received medically tailored meals had fewer ED visits than matched nonparticipants. Those who received nutritionally tailored meals also had fewer inpatient admissions. These findings suggest that there are benefits resulting from food-delivery programs for both patients and health systems, as meal-delivery programs could reduce the use of costly health care services, which in turn would decrease spending for vulnerable patients.

Mobile Integrated Health Program

CCA's MIH program was facilitated through a state regulatory waiver, since it was the first of its kind to exist in the state. MIH launched in 2015 after CCA frontline workers identified service gaps for certain subpopulations. To address these gaps, CCA partnered with an ambulance company and trained paramedics to assist members with acute and subacute issues. Central to this training was ensuring cultural competency of staff working with people with chronic medical and behavioral health issues. CCA recognized that many of its members have undergone significant life trauma, particularly within the health care system. As part of the training for the MIH program, CCA works to help engage with somebody who might react in an unexpected manner. Training is also provided on disability-specific care: for example, how to take care of someone with quadriplegia who cannot easily move around, how to respect their autonomy, as well as how to deal with intellectual disabilities, which is especially relevant for some of CCA's One Care members. Paramedics can take care of members at home, give intravenous hydration when needed, check on socially isolated enrollees, take care of minor to moderate illnesses that may arise, and ultimately decrease unnecessary ED utilization. CCA's vice president for medical affairs stated that the program has been extremely valuable; as of June 2018, an ED visit or hospital admission was avoided in 82 percent of visits by the program's mobile paramedics. Of those who went to the ED, most were admitted because they could not have been diverted by other interventions.

Complex Care Consultants Service for Providers

CCA started this service in 2018 to focus on training providers to deliver more patient-centered care to the plan's complex hospitalized patients. For example, CCA may provide cultural competency training to providers, such as focusing on how to look after someone with schizophrenia and behavioral issues or how to care for someone who is quadriplegic and is in need of an air mattress, explaining why a patient may have very specific needs when they are in the hospital. This service includes patient oversight, broad provider training, and consultations with providers on specific patient cases. The plan's overall goal for this intervention is to better use the specialized services of the hospital to deliver more patient-centered care, to improve communication between the inpatient and outpatient teams, to ensure that hospital stays are appropriate lengths, to decrease readmissions, and to improve and facilitate adherence to care plans by patients.

Evidence of Impact of Services

CCA attempts to collect data and measure the impact of many of these interventions. We heard from CCA's representative that 83 percent of members and patients admitted to the organization's CSUs in 2017 were diverted from emergency rooms, inpatient hospitals, or inpatient psychiatric institutions.

Regarding MIH, CCA records variables such as the number of ED visits, the reason for the visit, whether the member was taken to ED, total medical expenses, costs, and patient satisfaction. CCA uses both clinical and business data to make the case for sustaining its programs in general. In both 2016 and 2017, CCA's One Care plan was measured by CMS using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) instrument and received a top rating for satisfaction with care.

Challenges and Opportunities for Addressing the Needs of Dually Enrolled Beneficiaries

Challenges

CCA's vice president for medical affairs discussed several challenges that CCA has encountered in addressing the needs of dually enrolled and high-cost, high-need populations. A few challenges relate to individual-level barriers, including language. Some are broader, system-level problems, such as housing, lack of community resources, and transportation infrastructure. As the organization grows, it is focused on appropriately scaling its services for its members.

Language

In its SCO population (65 years and older), more than half speak English as a second language. These members need help navigating the health and social system both linguistically and culturally. To address this challenge, CCA has hired a diverse workforce and uses culturally competent interpreter services.

Housing

Housing is a dominant issue for the plan's members, some of whom are homeless and some of whom are housing insecure. To address this challenge, CCA hired a group of health outreach workers who can help members fill out applications for subsidized housing or accompany members to eviction court proceedings. These outreach workers are versatile and can easily assist members with accessing other services, such as nonemergency transportation, to enable members to maintain independence (e.g., attending Alcoholics Anonymous meetings, addiction and sobriety services).

Lack of Resources Among Community Partners

CCA's vice president for medical affairs noted that many small, community-based organizations do a great amount of work for very little money and are too stretched to take on additional tasks. To address this, CCA attempts to provide some resources for a site or service and then invites community organizations to partner with them. CCA partners with community-based organizations both in mental health and LTSS. Because the state health care market is dense, there is a shared understanding among stakeholders that CCA wants to fill needs where there are gaps and complement services that already exist.

Opportunities

CCA's vice president for medical affairs highlighted CCA's ability to harness innovative technology as a key opportunity that the organization is currently exploring.

Technology

By leveraging its proven care model, CCA is uniquely positioned to pilot emerging technologies to create a connected home environment—with remote monitoring, voice-first caregiving, and devices such as medication adherence tools. CCA's goal is to augment the care its clinical teams provide to members to achieve the best possible outcomes. Contrary to general assumptions, the organization has found that the member populations it serves are quite adept at technology use and excited about the role it may play as they partner with CCA to achieve better health. While many members are highly engaged and receptive to new technologies, barriers exist regarding how these devices are designed, manufactured, and marketed—often limiting adoption and use by dually enrolled populations, which includes individuals with physical and intellectual disability. A cutting-edge connected home offers significant potential to build on the

robust care model already deployed and can be adapted, when necessary, to serve CCA's members. In addition, the ability to share and transmit health data such as electrocardiograms (EKGs) over the phone, to insert clinically relevant pictures in the medical record, and to use emerging telemedicine solutions can improve efficiency and allow for clinical model scale. CCA is dedicated to shaping and implementing the latest in medical technology to assure best-in-class care for its members.

Summary

CCA's comprehensive, patient-centered care model has been central to its effort to provide tailored, coordinated, and continued care services to a highly complex and vulnerable member population. Evaluations of some of the organization's programs, such as food-delivery partnerships, have been promising, demonstrating reduced ED visits and high patient satisfaction with care. Other services, such as the CSUs and the MIH program, have leveraged community partners and training and have also demonstrated positive outcomes. Moving forward, CCA is responsive to feedback provided by its frontline staff, and the organization continues to refine its programs accordingly, as illustrated by its Complex Care Consultants Service that was launched in 2018.

7. Case Study: HealthPartners

This case study is focused on HealthPartners, which operates a FIDE SNP in Minnesota. A key feature of this FIDE SNP is HealthPartners' provision of enhanced care coordination to dually enrolled beneficiaries. HealthPartners also provides additional benefits and services to meet the clinical and social needs of its members.

Organizational Overview

HealthPartners is an integrated nonprofit health care provider and health plan in Minnesota. It previously participated in CMS's social health maintenance organization (S/HMO) demonstration project and has a long history of working to support the complex health needs of seniors. It offers two Medicare products in Minnesota, a traditional MA plan (as of January 2018) and a FIDE SNP. The FIDE SNP is referred to as the Minnesota Senior Health Option (MSHO). MSHO is a collaborative effort that was developed with health plans, state leadership, and CMS. Other health plans can and do offer MSHO plans. To gain a deeper understanding of the additional services delivered to dually enrolled beneficiaries served by HealthPartners, we spoke with several representatives of the health plan: care coordination director, care coordination manager, medical director, Medicaid manager, and senior director of government programs.

Services for Dually Enrolled Beneficiaries

Enhanced Care Coordination

HealthPartners' enhanced care coordination program has been implemented since 2005. It is an organizational priority, as the plan has prioritized care coordination for members considered to be at high risk of poor outcomes across all of its insured populations (i.e., Medicaid, traditional MA, and commercial). Every member is assigned an individual care coordinator who provides one-on-one attention and has ongoing interactions with members. Care coordinators serve as members' primary contact at the health plan for all matters, including questions about health, pharmacy, social services, and other health plan resources. Care coordinators have clinical backgrounds and are often trained as registered nurses, nurse practitioners, or licensed clinical social workers. The plan representatives emphasized that the trust established between the coordinator and the member is an important component of the success of this program, and coordinators are encouraged to cultivate relationships with members. The health plan works to provide culturally sensitive care coordination services. HealthPartners seeks to hire coordinators from a variety of cultures and who speak multiple languages in order to meet the needs of its

diverse and often non-English-speaking members. In cases where members and coordinators do not speak the same language, coordinators will work with translators and/or family of the members to ensure the member's needs are met and a relationship between the member and care coordinator exists.

Care coordinators cultivate relationships as soon as the member enrolls in the health plan. Upon a member's enrollment, care coordinators conduct a health risk assessment, which includes an assessment of clinical needs, safety needs, and social needs. The risk assessment is intended to be conducted in the member's home to allow the coordinator to visually assess safety risks, confirm medications, and assess food security and other social needs. Representatives from HealthPartners indicated that nearly all of its dually enrolled beneficiaries agree to in-home health risk assessments. Health risk assessments are also conducted annually and when there is a change in the member's health. Following the assessment, the care coordinator puts together a care plan with input from the member and the member's clinical care team. The care plan is developed using a person-centered approach that values the needs and desires of the member.

The care coordinator remains actively involved in the member's care, ensuring that transfers, discharges, and movements to and from different settings occur smoothly. HealthPartners receives alerts from local hospitals when members are admitted—information that is passed directly to care coordinators. Additionally, because HealthPartners is an integrated health care provider and health plan, the care coordinators are able to have real-time access to the electronic medical records of nearly all of their patients. This allows the care coordinator to monitor where a member is and also add notes for the clinical care team to review.

Care coordinators develop close relationships with departments throughout the health plan, which facilitate the coordination of additional services for members, such as transportation to and from appointments. Coordinators also have strong relationships with the plan's palliative care providers. Care coordinators encourage members to meet with palliative care providers, who also do home visits, to discuss end-of-life planning and develop health care directives.

Through all of these activities, the overall goal of the enhanced care coordination program is to elevate the level of the care coordinator to be a partner of the member's clinician.

Health Engagement Tablets

For the past 1.5 years, HealthPartners has provided health engagement tablets to MSHO members with diabetes, heart disease, or depression. These tablets are preloaded with health education, engagement, and wellness applications relevant to the member's conditions. The HealthPartners application, also preloaded onto the tablet, enables transmission of health information (e.g., glucose, blood pressure weight) to the care team that may lead to action from the member's physician or other care team member. The plan offers in-person assistance to help members learn how to use the tablets. Beginning in 2019, members with cognitive impairment will be eligible to receive tablets.

Additional Strategies to Address the Needs of Dually Enrolled or Other High-Cost, High-Need Beneficiaries

In addition to enhanced care coordination, HealthPartners provides additional services to address the needs of dually enrolled beneficiaries:

- a virtual online clinic to members 24 hours a day, 7 days a week
- delivery of meals to members at home after an inpatient hospital stay or surgery
- home-based care to members who cannot or will not visit medical offices; care coordinators are key to identifying members who need this service
- purposeful maintenance of a narrow network of providers for members in the FIDE SNP to foster relationships with providers and ensure that members receive high-quality care
- transfer of the care-coordinator role to a nurse practitioner in a nursing home when a member is permanently placed in nursing home care; in-person care coordination was found to be more effective than telephone coordination
- enabling care coordinators to recommend shared visits for members following hospital discharge; in such visits, the member meets with a nurse before and after meeting with the physician to address any questions or concerns
- additional supplemental benefits offered in 2018 include exercise programs, fall prevention kits, healthy eating classes, and electronic toothbrushes.

Evidence of Impact of Services

Representatives from HealthPartners mentioned that it is challenging to evaluate the impact of its enhanced care-coordination program. Because all dually enrolled beneficiaries have been engaged in this program since 2005, there is not an easily defined control group. Additionally, because the plan is committed to delivering patient-centered care, the representatives indicated that the true value of the program and how it improves quality of life is difficult to measure. Broadly, HealthPartners measures the impact of its services by monitoring its rating in the MA Star Rating program. It also tracks utilization, including hospital visits, readmissions, and ED visits. The plan also conducts member-satisfaction surveys for its care-coordination program and told us that members report extremely high rates of satisfaction.

HealthPartners also mentioned the positive findings from a recent evaluation of MSHO. A report from RTI International and the Urban Institute, published by ASPE in 2016, compared outcomes for dually enrolled beneficiaries in MSHO with outcomes for dually enrolled beneficiaries in a Medicaid-only Managed Care Organization (MCO) (Anderson et al., 2016). Compared with the Medicaid-only MCO, dually enrolled beneficiaries in the integrated MSHO were 48 percent less likely to be hospitalized and 6 percent less likely to have an ED visit. Additionally, MSHO enrollees were 2.7 times more likely than Medicaid-only enrollees to have a primary care visit, yet they had fewer visits overall on average. Multiple health plans in Minnesota offer MSHO plans, thus the results from this report include, but are not limited to, HealthPartners' dually enrolled beneficiaries.

Costs of Services

HealthPartners' representatives indicated that they perform ongoing financial analyses because they receive capitated payments and need to ensure their services are allowing them to achieve the triple aim. They also mentioned several resources key to their high MA Star Rating and the success of their enhanced care coordination program. The inputs for the enhanced care coordination program are critical and require the largest investments. Having a sufficient number of support staff, particularly care coordinators, was mentioned as being important. The plan's representatives indicated that assigning fewer dually enrolled members per care coordinator allows care coordinators to effectively meet the complex needs of these members. Additionally, health information technology and data analytics capabilities were also mentioned as key inputs. Plans need technology to allow receipt of real-time information about hospital admissions to best coordinate member care. Data analytics capabilities are needed for utilization management, which has important financial impacts because plans receive a capitated per member–per month payment.

Challenges and Opportunities for Addressing the Needs of Dually Enrolled Beneficiaries

As discussed, HealthPartners is engaging in a wide variety of activities to address the clinical and social needs of its members. In addition, HealthPartners has both contractual and informal relationships with a variety of community-based organizations to address SDOH, including county agencies and organizations that provide meals, housing, adult day care, meals, and other support services. Lack of community-based organizations to address SDOH is not an issue. However, the representatives from HealthPartners noted that few community-based organizations, if any, were large enough to serve as a principal referral site for HealthPartners. Rather, the care coordinator focuses on finding the right organization to meet the member's needs at the right time. Additionally, the plan mentioned that some of the additional needs of members are LTSS that can be covered by Medicaid, thus the plan works to obtain Medicaid waivers for LTSS for eligible members.

In terms of challenges, the representatives from HealthPartners expressed concern that the MA Star Rating program does not adjust for members' SES. They mentioned that the MA Star Rating program disadvantages plans that serve a high proportion of low-SES patients, new immigrants, and non-English speakers—all of which require more effort than an average patient. Additionally, administrative burden was mentioned as an ongoing challenge in operating the FIDE SNP. This related to the many reports, administrative requirements, and regulatory requirements of both Medicare and Medicaid. HealthPartners suggested that as the benefits from these plans are being more integrated, so could the reporting requirements. The representatives also mentioned that compliance and regulatory requirements specific to the care coordination

team were becoming “overwhelming.” They expressed concern that care coordinators were spending more time on paperwork than with patients. They acknowledged the value of these requirements for ensuring that all patients in all plans received high-quality care, but suggested that some of these administrative burdens could be eased for plans that continually obtain high ratings in the MA Star Rating program. Finally, the plan we reviewed mentioned that it was a “huge administration burden” to fulfill the CMS requirement to train their entire network of physicians on the FIDE SNP model. The intention of this requirement is to encourage physician cooperation with care coordination. However, HealthPartners found that this approach was impersonal and not a successful way to engage physicians. It has achieved more success by engaging individual providers to address individual member needs.

Summary

HealthPartners’ enhanced care coordination program has been the plan’s primary strategy for addressing the needs of its dually enrolled beneficiaries. This program emphasizes the important role of the coordinator on the clinical team and fosters a personal connection between the member and the care coordinator. A statewide evaluation of MSHO, a FIDE SNP, reported reductions in hospitalizations and ED visits. Moving forward, the health plan supports inclusion of SES-adjustment in the MA Star Rating program to more accurately account for the challenges faced by plans serving patients with lower SES and other SDOH.

8. Case Study: UPMC *for You*

This case study is focused on UPMC *for You*, a nonprofit subsidiary of UPMC Insurance Services Division, which operates a D-SNP. UPMC *for You* partners with Community Human Services Corporation, a nonprofit based in Pittsburgh, Pennsylvania, on a housing program that is supported in part by a grant from the U.S. Department of Housing and Urban Development (HUD).

Organizational Overview

UPMC Insurance Services Division has eight regulated insurance companies within it, including UPMC *for You*, which focuses on its Medicaid products. UPMC *for You* has three lines of business: a D-SNP (UPMC for Life Dual), Community Health Choices (LTSS, Medicaid), and a physical health Medicaid program called HealthChoices. UPMC for Life Dual is the only Medicare product in the business unit; UPMC's other MA plans, including an I-SNP, are housed in a separate business unit of the Insurance Services Division. UPMC for Life Dual enrolls approximately 26,000 dually enrolled beneficiaries. The D-SNP is maintained as a separate MA contract and, as such, is rated separately in the MA Star Rating program. This is in part because of the recognition of the challenges of performing well in the dually enrolled population. UPMC's Health Services Division includes more than 30 hospitals, 500 outpatient locations, and approximately 5,700 physicians. To better understand the services available for dually enrolled and other high-cost, high-need beneficiaries, we spoke with the president of UPMC *for You*.

Services for Dually Enrolled Beneficiaries

Permanent Supported Housing

Cultivating Health for Success is a program that was started in 2009 to provide stable housing paired with an assigned medical home and care management to eligible members who meet the HUD criteria for homelessness through a partnership between UPMC, the Pennsylvania HUD, and community service providers, including Community Human Services, Inc. (CHS; a HUD vendor) and Metro Community Health Center. The definition of *homelessness* encompasses four categories: (1) literally homeless, (2) imminent risk of homelessness, (3) homeless under other federal statutes; and (4) fleeing/attempting to flee domestic violence. The program is open to eligible Medicaid enrollees, with almost two-thirds of the program participants being dually enrolled beneficiaries. Additional eligibility requirements for the program include having high health expenditures for at least a year, a willingness to work with care managers to develop a health plan, and the ability to live independently. The goals of the

program are to reduce unplanned health care services, which tend to take the form of expensive ED use and unscheduled hospital admissions and readmissions, and to increase planned services such as visits to primary care physicians, compliance with care plans for chronic diseases management, and preventive screenings. The program can accommodate 25 enrollees at a time, which plan administrators find is adequate capacity in terms of people who meet the strict HUD definition.

Program participants are placed in permanent housing in locations throughout the city and have a team of two care managers—one from the health plan and one from CHS. These care managers are the primary contacts for program participants and talk to the participants at least once a month but as frequently as daily. CHS helps identify places that meet the needs and preferences of participants, provide ongoing rental and other housing supports, and provide landlord mediation as necessary. UPMC provides a mobile clinical care manager—a nurse who works with program participants on care management and medication management as well as providing referrals to specialty care and conducts some limited testing. UPMC also provides community health workers who provide connections to appointments and links to community resources. In addition, CHS staff and UPMC care managers meet biweekly for case coordination and daily check-in calls with monthly case management meetings with a broader group of staff for more in-depth discussion. CHS receives alerts if a program participant goes to the ED or is admitted.

There is no limit to how long participants can stay in the program. The representative from UPMC said some people stabilize quickly, do not need the program's support, and can switch out of the program and receive a Section 8 voucher for housing support instead. In general, it is uncommon for people to drop out of the program, but this can occur if they have sustained substance use that makes it difficult for them to engage with the care management team or the they decide they do not want to talk to people. The program adopts a harm-reduction model, meaning that the participants do not have to be on good behavior all the time, but they do have to be willing to engage with the care managers.

UPMC also provides respite housing, which is typically time limited until the person's health is stabilized (typically a few weeks), but there is no time limit on use of the beds.

Many people with housing instability who need support do not meet the HUD homelessness criteria. The UPMC representative estimated that five to ten enrollees at any moment face housing instability problems. Housing instability can include people who move frequently, temporarily sleep on the couch (or guest bed) of friends or family (couch surf), and even those with stable but unsafe housing. UPMC wants to focus on this broader group of enrollees because of the relationship it observes between housing instability and inappropriate health care use. Based on the success of Cultivating Health for Success, UPMC has plans to implement a new program starting in January 2019 that focuses on individuals with housing instability, which it is striving to define for the purposes of the program, rather than using the HUD definition of

homelessness. This program will use different resources and aims to serve 200 people over three years.

Additional Strategies to Address the Needs of Dually Enrolled or Other High-Cost, High-Need Beneficiaries

In addition to the housing program, UPMC *for You* provides additional services to address the needs of dually enrolled beneficiaries:

- virtual online provider video visits accessible via a tablet, smartphone, or computer 24 hours a day, 7 days a week
- meals deliveries to members at home following discharge from an inpatient hospital stay or nursing home stay
- support for free membership at participating fitness facilities
- translation services in 15 languages
- up to 50 transportation services for provider and physical therapy visits as well as to obtain blood work
- free bathroom safety modification products.
- phone access to a registered nurse for general health information or to address questions about a specific problem 24 hours a day, 7 days a week
- telephone-based case management for enrollees with complex medical or behavioral health conditions (case managers work with enrollees, their caregivers, and providers to develop a care plan)
- annual comprehensive risk assessment when people enroll and when there is a change of condition, such as a hospitalization. The risk assessment focuses on medical and behavioral health, social circumstances, and social determinants, including housing and food insecurity. Risk assessments are often conducted by phone but are frequently performed in person by a social worker or community health worker who does in-person work in the community. Enrollees can also complete the risk assessment through UPMC's patient portal.

Evidence of Impact of Services

UPMC conducted an internal two-year evaluation of Cultivating Health for Success. Eighty-five percent of eligible participants were successfully placed in housing. Comparisons of 32 participants to a comparison group of homeless members showed that participants' use of care shifted from unplanned health care such as ED visits and hospitalizations to planned physician appointments and improved medication adherence. Participants had 59 percent more routine office visits, 57 percent more specialist visits, and 72 percent more pharmacy spending than controls. CHS participants had statistically significantly lower costs associated with unplanned care and significantly higher pharmacy costs.

Because of the small numbers of beneficiaries participating in the program, it is difficult to demonstrate improvements in health outcomes or life expectancy. The plan anticipates that it will be easier to identify improvements as the number of participants increases.

Costs of Services

UPMC's representative mentioned that the plan pays CHS about \$100,000 per year for care management, in addition to its own staff costs. The representative estimated that the gross medical savings of unplanned medical care are approximately \$8,500 per person per year. The program costs \$6,000 per person per year. There is also an increase of about \$2,000 per year per participating enrollment in medication adherence costs. Thus, the estimated net savings are about \$500 per person per year. The UPMC representative stated that the plan is not only interested in short-term savings. Many of the dually enrolled beneficiaries are in their mid-40s to mid-50s. If the plan can slow the progression of disease among this group with the programs, the representative anticipates that net savings will grow over time.

Challenges and Opportunities for Addressing the Needs of Dually Enrolled Beneficiaries

The UPMC representative identified multiple challenges in the development and implementation of its housing program. First, building relationships with community organizations is necessary to identify ways to address the SDOH. This process can take time, as each organization has its own set of processes and standards, and they need to learn to communicate and cooperate around a common goal. It also can take time to identify an appropriate opportunity to partner with another organization.

Second, UPMC's representative emphasized that identifying members who meet all of the inclusion criteria for the program can be difficult. The necessary information comes from different data sources, which are then combined. Specifically, members with at least one year of high unplanned health care costs are identified through claims or encounter data. Homelessness is identified through the risk-assessment materials and, to a lesser extent, through diagnoses on claims or encounter data, which can be difficult. There is no systematic way to know who is stably housed. There are some ICD-10 (International Statistical Classification) codes, but they are not very definitive and are underused. Identification most likely does not result in many false positives but likely results in false negatives. This, paired with the needs to adhere to the HUD definition of homelessness, creates a situation where it is burdensome to identify participants.

Another challenge shared by the representative is that some of the beneficiaries do not want to engage with case managers from UPMC. They are highly suspicious of anyone associated with the health plan and prefer to be left on their own.

Lastly, UPMC's representative mentioned that it frequently is not effective to identify a resource and refer people to it. While that might be all that some people need, others need more support and assistance navigating the system. For example, approximately 80 percent of housing choice vouchers distributed do not get used because people do not know where to look, how to navigate the process, or are discouraged by the lack of housing availability.

Summary

The UPMC Cultivating Health for Success housing program is small in scale but has demonstrated its effectiveness in terms of reduced unplanned utilization while supporting obtaining planned care. The plan estimates that it saves approximately \$500 per participating beneficiary. In the program, participants are required to meet the HUD definition of homelessness. The plan expects to start a new housing program in 2019 that focuses on housing instability more broadly. The plan also offers a variety of services to meet the SDOH needs of dually enrolled beneficiaries, including a food-delivery program after hospital discharge and transportation services.

9. Summary and Conclusions

Summary

It is widely recognized that dually enrolled and other high-cost, high-need Medicare beneficiaries experience challenges in obtaining high-quality care. MA plans that serve a high proportion of beneficiaries who are dually enrolled in both Medicare and Medicaid—a marker for living in poverty—have lower performance and lower MA Star Ratings on average than plans serving a lower proportion of these beneficiaries. However, some MA plans that care for a high portion of dually enrolled beneficiaries or other high-cost, high-need beneficiaries are high performers. These findings suggest that some plans that focus on dually enrolled beneficiaries have identified effective ways to meet the needs of their beneficiaries.

This project consisted of high-level semistructured interviews with health plans that serve a high portion of dually enrolled or other high-need beneficiaries and other stakeholders. We also conducted more-detailed case studies of a small number of health plans. We focused on plans identified through our previous work as having innovative programs to meet the needs of their dual and high-need populations as well as those that generally performed well in the MA Star Rating program.

We found that the challenges identified for dually enrolled and high-need beneficiaries were consistent with our previous findings and included a mix of complex clinical issues and SDOH risk factors (Sorbero et al., 2018). If anything, awareness of the role of SDOH in creating challenges for dually enrolled beneficiaries as they navigate the complex health care system has increased since the first phase of our project. Leading SDOH factors identified by interviewees include low health literacy, poverty, and food and housing insecurity, frequently with inadequate services in the community to fully address all needs. Clinical issues include multiple morbidities and a high burden of mental health care needs.

MA health plans implement multipronged approaches to address the needs of their complex member populations. Our findings are consistent with our previous work that identified four broad categories of activities in which health plans engage. Specifically, the plans with high MA Star Ratings included in the interviews and case studies in this report implement multipronged approaches to address the needs of their complex member populations, including (1) identifying needs and data analytics to better target programs toward patients at high risk for hospitalization, readmission, and nursing home admission; (2) addressing clinical needs through care management and coordination; (3) meeting the social needs of dually enrolled beneficiaries by either referring dually enrolled beneficiaries to existing programs that address housing, food security, and transportation needs or providing these services directly; and (4) undertaking administrative actions to better integrate Medicare and Medicaid. High-performing plans are

likely to engage in activities that fall into many of the four categories, or all four. Specific types of services provided by MA plans that we learned about from the interviews and case studies are summarized in Table 9.1 and listed in detail in Appendix C.

Table 9.1. Types of Additional Services Provided by MA Plans to Address SDOH

Conduct health risk assessments that include items related to SDOH.
Conduct assessments in home.
Conduct ongoing assessments, not only at enrollment.
Facilitate access to medical care.
Employ care managers or care coordinators.
Offer an online virtual clinic or phone assistance 24 hours a day, 7 days a week.
Offer in home services.
Deliver meals.
Have social workers make home visits to address depression.
Provide resources to meet SDOH.
Provide transportation to Alcoholics Anonymous meetings and other addiction or sobriety services.
Work with local organizations to find stable housing for members.
Help providers meet the needs of members.
Help physician develop a treatment plan that is responsive to members' SDOH.
Train paramedics to assist members with acute issues.
Track outcomes.
Use health information technology for tracking members across care settings.
Collect patient-centered outcomes measures (e.g., quality of life).
Community engagement
Hire staff to work engage with the community, coordinate care, work on clinical partnerships.
Host events at community organizations to combat social isolation among the community-based elderly.

Health risk assessments are increasingly used to identify the needs of specific individuals to better target their services. Often, these risk assessments are included in questions related to SDOH in addition to clinical needs. Care management and efforts to coordinate care across providers and settings are universal among the plans we interviewed. Efforts to address SDOH are something health plans continue to experiment with, and successful approaches will need to be tailored to particular communities and the services available in the local area. Plans are frequently trying to address the following SDOH: language issues, low health literacy, poverty, and food and housing insecurity. The importance of maintaining good relationships with community resources was emphasized. Depending on the resources available in a community, some plans may refer beneficiaries to local social services, while others in areas with fewer resources may opt to provide services themselves or even to support building community infrastructure. The requirements of plans to coordinate the administrative activities of Medicare

and Medicaid vary by the type of MA plan or demonstration. Some plans, however, go above and beyond by implementing a program to assist dually enrolled beneficiaries as they navigate the two insurers.

The plan administrators reported typically performing some form of evaluation of their interventions to verify their benefit to health plan leadership. Some concerns were raised by health plans about the rigor behind these evaluations. None of the plans reported conducting a return-on-investment calculation as part of efforts to verify the value of programs, although UPMC reported an estimated net savings of up to \$500 per participating beneficiary based on its housing program. To assist plans in both the planning for and evaluation of activities to address social risk factors, the Commonwealth Fund released a return-on-investment calculator in May 2018 for partnerships to address SDOH (The Commonwealth Fund, undated). Users select the types of social services offered and medical utilization affected, then enter information on baseline utilization and costs, the need for services in their population, and the cost of providing these services. The tool then provides information on the expected number of beneficiaries served, expected cost per recipient, and expected cost per beneficiary. Still in its beta phase, use has been limited to fairly sophisticated health plans. As documentation for the tool is established, it has the potential to aid plans in their efforts to justify their services to address SDOH.

Although the plans reviewed for this project perform well in the MA Star Rating program, the interview participants were concerned that the MA Star Rating program is not aligned with the needs of dually enrolled beneficiaries. There are concerns that the lack of adjustment for socioeconomic factors for most clinical measures disadvantages plans that serve a large portion of dually enrolled beneficiaries. A recent analysis assessed the impact of risk adjusting for sex, race or ethnicity, dual eligibility, disability, rurality, and neighborhood disadvantage on MA contract rankings for three measures included in the MA Star Rating program: blood pressure control, diabetes control, and cholesterol control (Durfey et al., 2018). The percentage of plans that improved plan rankings by at least one quintile on the three measures was 11.4 percent, 20.3 percent, and 19.5 percent, respectively. Contracts with improved rankings after risk adjustment had a larger proportion of socioeconomically disadvantaged enrollees than either contracts that did not change quintiles or contracts with rankings that declined. The actual effect of risk adjustment in the MA Star Rating program could be different, however, because of the algorithms used to assign stars and the potential for the effect of risk adjustment to vary across measures. Risk adjustment is considered part of the measure specification by CMS, rather than a policy decision to be made about the MA Star Rating program broadly (CMS, 2016a). CMS has requested that measure developers consider whether individual measures should be adjusted for SDOH.

The plan administrators felt the Chronic Care Act, which was implemented in the Bipartisan Budget Act, holds promise with its increased flexibility to use supplemental benefits to pay for services thought to improve the overall health of beneficiaries with chronic conditions, but do not have to be directly related to a specific condition. We also heard support for a bill that would

provide even greater resources to vulnerable Medicare beneficiaries. Introduced in the U.S. House of Representatives during the 115th Congress (2017–2018), the Community-Based Independence for Seniors Act of 2017 would create a demonstration program for a community-based institutional SNP through which MA plans would receive additional funding of up to \$400 per member per month to provide home and community-based LTSS to beneficiaries eligible for Medicare only and unable to perform two or more activities of daily living (U.S. Congress, 2017). Community-based LTSS are costly and typically not covered by Medicare. The bill provides examples of LTSS that could be covered by the community-based institutional SNP: home delivered meals; transportation services; respite care; adult day care services; and safety and other equipment that is not covered by Medicare.

Recommendations

The intersecting circles in Figure 9.1 illustrate the approaches used by MA plans with high MA Star Ratings to address the needs of dually enrolled beneficiaries as identified via an environmental scan and key informant interviews (Sorbero et al., 2018) and confirmed via case studies and interviews described in this report. Plans with high MA Star Ratings report implementing multipronged approaches to address the needs of their complex member populations, including identifying and targeting services for clinical and social needs via health risk assessments, using care management and coordination to meet these needs, addressing social needs through referral or direct services, and taking administrative steps to better integrate Medicare and Medicaid or help enrollees navigate the two programs.

Based on findings from our interviews and case studies, we recommend a number of strategies that policymakers and other stakeholders could pursue to support organizations with MA contracts in their efforts to meet the needs of dually enrolled and other high-cost, high-need beneficiaries. These recommendations are listed in gray boxes in Figure 9.1 and can be categorized into three main approaches that were presented in ASPE’s first report to Congress on accounting for social risk in Medicare’s value-based purchasing programs (ASPE, 2016):

1. Measure and report quality.
 - *Use patient-centered performance measures* and instruments that are relevant for dually enrolled beneficiaries for payment and public reporting programs.
2. Set high and fair quality standards.
 - *Account for clinical complexity and social risk in performance measures* by stratifying, adjusting, or otherwise accounting for clinical complexity and social needs of dually enrolled beneficiaries.
3. Reward and support better outcomes.
 - *Align incentives for care interventions* by building an evidence base through promoting rigorous evaluations to identify effective interventions, sharing best practices, and

designing value-based purchasing programs that are sensitive to and reward the addressing of SDOH.

- *Build a supportive environment* by supporting community resources and links at a local level and implementing supportive state and federal policies.

Figure 9.1. Policy Recommendations for Addressing Social Needs of Dually Enrolled Beneficiaries in MA Plans



First Approach: Measure and Report Quality: Use Patient-Centered Performance Measures

Use Performance Measures and Instruments Relevant for Dually Enrolled Beneficiaries for Payment Programs

Several interview participants mentioned the need for survey instruments and the methods for administering those surveys to be better tailored to the needs of dually enrolled beneficiaries. Better tailoring of the instruments and administration methods could encourage more widespread use of surveys and survey findings for quality improvement purposes in this population. This population is characterized by having low education and health literacy, as well as having barriers to accessing modern communication platforms. Thus, to meet the communications needs of this population, interview participants suggested that survey instruments be developed for lower grade levels (e.g., third grade), be brief, be easy to understand and administer, and be easy to translate into other languages. Equally important is the opportunity to supplement instruments focused on consumer experience (such as CAHPS) with tailored consumer-reported outcomes measures that capture general or condition-specific health status and quality of life. Results from these surveys can further inform health plans' quality-improvement efforts with a view to improving not just health utilization, but also health-related quality of life. For example, beneficiaries who suffer from multiple chronic conditions are most likely to experience symptoms (e.g., pain, fatigue) that may interfere with their daily functioning and diminish their quality of life. Condition-specific instruments can capture important patient-reported information about why and how such symptoms affect the patient, and even point out possible remedial interventions.

Functional outcomes and quality-of-life measures relevant to dually enrolled beneficiaries are needed. Additionally, existing performance measures included in the MA Star Rating program may not adequately account for improvements most important to dually enrolled beneficiaries (e.g., daily functioning, quality of life) or measure plans' achievement of care coordination or patient-centered care. Measures currently used only for SNPs and MMPs (Table 9.2) could be implemented more broadly in the MA Star Rating program to bring more attention to the needs of dually enrolled beneficiaries in all MA plans.

Table 9.2. Performance Measures for SNPs and MMPs That Could Be Expanded to All MA Plans

Performance Measures	Currently Used Only for SNPs (CMS, 2018a)	Currently Used Only for MMPs (CMS, 2017)
SNP care management	X	
Care for older adults (medication review)	X	
Care for older adults (functional status assessment)	X	
Care for older adults (pain assessment)	X	
Comprehensive health risk assessment		X
Care plan completion		X
Satisfaction with care coordination		X
Access to personal care		X

Second Approach: Set High and Fair Standards: Account for Clinical Complexity and Social Risk in Performance Measures

Stratify, Adjust, or Otherwise Account for Clinical Complexity and Social Needs of Dually Enrolled Beneficiaries in Performance Measures

Dually enrolled beneficiaries have a higher burden of disease and more functional impairments than other Medicare beneficiaries. Adjustment for SDOH of clinical measures included in MA Star Ratings and other value-based purchasing programs has been suggested to address the aspects of care of outside the health plan’s control and the additional resources required to serve this population. CMS considers risk adjustment to be a component of the measure specification, and, thus, the determination of need for risk adjustment is the responsibility of the measure developer. Stratified distribution of bonuses based on the percentage of dually enrolled beneficiaries— an approach recommended by MedPAC—prevents value-based purchasing programs from disadvantaging plans with large dually enrolled populations but retains incentives for quality improvement through reporting performance without adjustment beyond what is included in measure specifications.

Third Approach (Part A): Reward and Support Better Outcomes: Align Incentives for Care Interventions

Promote Rigorous Evaluations to Identify Interventions to Address SDOH

Throughout interviews with health plan administrators, we learned about a variety of strategies and additional services provided by plans to promote the overall health and well-being of dually enrolled beneficiaries. Plan administrators generally described developing these interventions in response to the needs of their members, rather than using a known successful

intervention. This is likely because of the limited information that exists in the peer-reviewed and gray literature about the effectiveness of interventions addressing SDOH among dually enrolled beneficiaries (Sorbero et al., 2018). While some evaluations are published in the peer-reviewed literature (Berkowitz et al., 2018), this is not the norm. Organizations such as the Center for Health Care Strategies (Center for Health Care Strategies, undated) and the Institute for Healthcare Improvement, via the Better Care Playbook (2018), are working to compile and share best practices to improve care for dually enrolled beneficiaries and the broader population of patients with complex health and social needs. However, resources from these organizations and findings from our interviews suggest that while plans do evaluate the effect of their interventions, these evaluations often lack rigor or are primarily done for internal decisionmaking purposes. Additionally, while plan administrators were cognizant of cost, they infrequently mentioned evaluating cost of the interventions in these evaluations. Greater support for rigorous evaluations of these interventions from CMS, other government agencies that support evaluation, and nongovernmental funding organizations would build the evidence base and could help plans that serve a high proportion of dually enrolled beneficiaries identify the best approaches to promoting the health of their members. Moreover, this support could help to identify those strategies that are effective and financially viable

Share Best Practices and Interventions Among MA Plans to Address SDOH

Currently, there is substantial experimentation occurring among D-SNPs and other types of MA plans in their efforts to identify and meet the needs of dually enrolled and other high-cost, high-need beneficiaries. Even when plans are engaged in similar activities, such as performing health risk assessments, there is variability in the types of SDOH characteristics included. Other interventions to meet the needs of this population are even more variable and evolve as plans gain experience and develop new relationships in their communities.

The dissemination of best practices and rapid improvement of care would be facilitated by mechanisms through which MA plans can share their experiences in developing and implementing interventions and strategies to meet the needs of dually enrolled beneficiaries and approaches to address barriers. Some plans may be reluctant to share information because of competition among plans. Membership-based organizations such as the SNP Alliance provide one mechanism through which to build trust and encourage information sharing. Opportunities on a larger scale with CMS or another central body acting as a convener, however, could strengthen the spread of information.

Design and Implement Value-Based Purchasing Programs That Are Sensitive to and Reward Addressing SDOH

Dually enrolled beneficiaries are sicker and poorer on average than Medicare-only beneficiaries. The interview participants were concerned that the MA Star Rating program is not aligned with the needs of dually enrolled beneficiaries and were interested in seeing value-based

purchasing programs that would reward the work they do to address members' SDOH. Approaches to address this concern could include the use of performance measures relevant for dually enrolled beneficiaries, bonuses based on high performance among dually enrolled beneficiaries, and bonuses based on a lack of within-contract disparities when comparing dually enrolled and other high-cost, high-need beneficiaries. Simulations based on data from previous years of the MA Star Rating program could inform whether policy alternatives would function as expected and affect plans in the desired manner.

Third Approach (Part B): Reward and Support Better Outcomes: Build a Supportive Environment

Support Community Resources and Linkages at a Local Level

MA plan administrators mentioned that they are trying to fill gaps in community-based resources to meet the needs of their members. Federal support for developing community resources as a public good could enhance the ability of MA plans to partner with communities. Studies have demonstrated that greater government spending on SDOH, including education, cash assistance, and public safety, promotes health (Bradley et al., 2016; McCullough and Leider, 2016; Rubin et al., 2016). Recognizing the important role of SDOH, researchers are developing the business case for payers and providers to invest in strategies to address SDOH as a social good (Nichols and Taylor, 2018). Some economists and thought leaders have suggested ways for stakeholders to contribute toward those community resources, such as through a bidding-based contribution system or rethinking how public resources spending (medical care versus public health versus social services) may have the greatest impact on health outcomes.

Implement Supportive State and Federal Policies

Many MA health plans included in the interviews and case studies supported the Chronic Care Act, which was enacted through the 2018 Bipartisan Budget Act and will allow greater flexibility for traditional MA plans to offer supplemental benefits to address health-related social needs of dually enrolled beneficiaries. We heard support from some plan administrators for policies that provide even more flexibility in spending on these supplemental benefits and LTSS, including support from one plan for a recent bill, Community-Based Independence for Seniors Act of 2017, that would allow Medicare to pay for a limited set of HCBS and LTSS. MA health plans supported policies that allow for payment for the additional services from which dually enrolled beneficiaries benefit and reduce administrative burden across Medicare and Medicaid services.

Conclusions

Plans are still experimenting with different approaches to address SDOH, and the literature to support these interventions is slowly growing. Some MA plans that serve a high proportion of

dually enrolled beneficiaries perform well in the MA Star Rating program and have implemented innovative strategies to meet the needs of their members. Plans shared limited information about resources or costs required to implement and sustain these strategies, and the extent to which resources and costs are tracked internally is unclear.

Questions remain about the most effective strategies to meet the needs of dually enrolled and other high-cost, high-need beneficiaries, how to best measure care delivered to these vulnerable beneficiaries, and how to align value-based payment programs to encourage addressing SDOH. Continuing to track the strategies that plans implement and their costs will inform the resources needed as plans develop strategies to address the needs of dually enrolled and other high-cost, high-need beneficiaries. Efforts are needed to support rigorous evaluations to identify the most-effective approaches and support the sharing of strategies that lead to improvements in quality of care and the health of dually enrolled beneficiaries. Taking this population into consideration in the design and implementation of value-based purchasing programs will reduce the potential for negative impacts on an already-vulnerable group of Medicare beneficiaries. Jointly, these strategies could help improve the social and clinical outcomes of dually enrolled and other high-cost, high-need patients.

Appendix A. Interview Discussion Guide

Medicare Advantage (MA) plans that serve a high proportion of Medicare and Medicaid dual eligible beneficiaries or other socially at-risk beneficiaries have lower performance and lower Star Ratings on average than plans serving a lower proportion of socially at-risk beneficiaries. Some MA plans with a high percentage of dual eligible beneficiaries are high performing, but little is known about how these plans and their contracted providers achieve better performance or about the types of resources required to do so and the associated costs.

The Office for the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services has contracted with RAND to explore whether and to what extent high-performing high-dual MA plans focus efforts and target resources to meet the needs of dual beneficiaries, identify any additional services health plans provide to care for dually eligible Medicare beneficiaries, determine the range of additional costs and resources used to deliver these services, and determine if health plans have found these services to be of value. We will also explore whether plans partner with community organizations and what types of resources might be available in communities.

The goal of this stage of the project is to identify the range of services MA plans and their partners offer to dual-eligible beneficiaries to support the receipt of high-quality care and improve patient outcomes, identify MA plans that might be appropriate for case studies to further understand their activities, identify the types of people within MA plans and in the community that we should talk to as part of our case studies, and explore the types of questions we should ask to gather comprehensive information on activities and their costs. We are interested in speaking with you because [TAILOR TO SPECIFIC PARTICIPANT].

RAND will use the information you provide for research purposes only, and we will limit this interview to an hour. You do not have to participate in the interview, and we can stop at any time for any reason. Your participation or nonparticipation will not be reported to anyone. You should feel free to decline to discuss any topic that we raise.

- Do you have any questions about the study?
 - Do you agree to participate in this interview?
 - We would like to record our conversation so that we can refer to it while summarizing our interview notes. This recording be used only for the purpose of ensuring the accuracy of notes and will be destroyed once the summary is finalized. Tape recording is not necessary. Do you agree to have the conversation recorded?
 - Are you willing to have your name included in a list of individuals spoken with as part of this project?
1. What types of challenges face dual eligible Medicare beneficiaries as they seek care?

- Probes: cost of care, transportation issues, lack of someone to go to appointment with them, lack of understanding of care needs, complexity of treatment/medication regimens, provider offices not physically accessible or exceedingly difficult [specific to disabled], co-morbidities.
 - Please describe subgroups of dual eligible that may experience greater challenges.
 - What role do health plans play in addressing these challenges?
 - How are the challenges faced by other socially at-risk or high-need Medicare beneficiaries similar or different?
2. What additional services, interventions, supports, and resources do health plans/contracts provide to dual beneficiaries?
 - Are these services targeted to duals, or are they available to any individual with particular needs?
 - How are these services targeted?
 - What services, interventions, supports and resources are most effective in meeting the needs of duals?
 - Which are least effective?
 - What factors motivate health plans to focus on duals?
 - Can health plans improve their performance in the Star Ratings program with strategies to address the needs of dual eligibles?
 - What role does leadership/management play in implementing additional services for dual beneficiaries?
 - How do health plans identify services or interventions to provide to dually eligible beneficiaries?
 - Which additional resources would health plans need to best provide care for dual beneficiaries?
 - How do services vary by MA plan type (i.e., size, SNP status, portion of duals)?
 - How do high-dual contracts interact with state Medicaid programs or community-based organizations to provide services?
 - Who within a health plan could answer questions about what services are designed to support duals?
 3. Are estimates available about how much services to support duals cost health plans?
 - What types of resources (both in terms of people and other resources) are necessary to provide additional services to dual beneficiaries?
 - How do plans budget and account for these approaches, services, or extra resources?
 - Who within a health plan could answer questions about the costs of services or resources required to provide them?
 4. What is known about the impact of these services on patient care and outcomes?
 - How do health plans assess the impact of services to support duals?
 - Are evaluations performed or the return on investment assessed to justify the continued provision of services?
 - What are the metrics used to measure impact?

5. How do health plans work with their provider networks to support the needs of dual eligibles?
 - Probe: Are they taking advantage of the infrastructure developed by ACOs?
6. How do health plans work with other groups in the community, including social or community providers, to support the needs of dual eligible?
 - What types of organizations do health plans work with?
 - Even if health plans don't work directly with other organizations, what types of resources are available in the community to support dual eligible beneficiaries in the receipt of care?
 - Probes: Social services, church organizations, patient advocacy groups
 - What types of services or supports do they provide?
 - What other resources in the community are missing but would be helpful in supporting the needs of dual beneficiaries?
 - If resources are lacking in the community, how can health plans initiate or support the development of needed resources?
7. What implementation or other challenges do health plans experience when trying to address the needs of dual eligible?
 - Are there particular services, interventions, supports that are the most challenging to implement?
 - How are these challenges addressed?
8. **For health plan organizations:** How can state and federal policies provide support for health plans in their efforts to meet the needs of socially at-risk and high-need populations?
 - Are there opportunities for policy changes?
 - The Chronic Care Act of 2018 provides MA plans starting in 2020 with greater flexibility to cover supplemental nonmedical benefits for chronically ill enrollees as long as there is a "reasonable expectation of improving or maintaining the health or overall function" of the enrollee, with chronically ill enrollees defined as having one or more comorbid and medically complex conditions, has a high risk of hospitalization or other adverse health outcomes, or requires intensive care coordination. How do you anticipate using this flexibility to meet the needs of dual eligible and other high-need beneficiaries?
 - CMS reinterpretation of current regulations allows some flexibility starting in 2019. How do you anticipate using this flexibility?
9. Is there anything else that you would like to add? Do you have any suggestions for the federal government?
10. If we have clarifying questions as we are preparing our summary, may we contact you again?

Appendix B. Case Study Discussion Guide

Medicare Advantage (MA) plans that serve a high proportion of Medicare and Medicaid dual-eligible beneficiaries or other socially at-risk beneficiaries have lower performance and lower Star Ratings on average than plans serving a lower proportion of socially at-risk beneficiaries. Some MA plans with a high percentage of dual-eligible beneficiaries are high performing, but little is known about how these plans and their contracted providers achieve better performance or about the types of resources required to do so and the associated costs.

The Office for the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services has contracted with RAND to explore approaches high-performing high-dual MA plans use to meet the needs of dual beneficiaries, explore the additional costs and resources used to deliver these services, and determine if health plans have found these services to be of value. We will also explore whether plans partner with community organizations and what types of resources might be available in communities.

We are interested in speaking with you because your health plan has been identified as using innovative approaches to meet the needs of dual eligible and other high need beneficiaries.

RAND will use the information you provide for research purposes only and we will make every effort to limit this interview to an hour. You do not have to participate in the interview, and we can stop at any time for any reason. Your participation or nonparticipation will not be reported to anyone. You should feel free to decline to discuss any topic that we raise. If we raise topics that you are unable to address, please feel free to suggest others within your organization that we could talk to as part of this project.

- Do you have any questions about the study?
- Do you agree to participate in this interview?
- We would like to record our conversation so that we can refer to it while summarizing our interview notes. This recording be used only for the purpose of ensuring the accuracy of notes and will be destroyed once the summary is finalized. Tape recording is not necessary. Do you agree to have the conversation recorded?
- Are you willing to have your name included in a list of individuals spoken with as part of this project?

Thank you.

First, we would like to verify information that we have gathered. If you are unable to address any of the questions, please suggest someone we may contact.

Interviewer reviews services/interventions on which we have gathered information and verifies type of health plan (D-SNP, MMP, etc). Ask following questions if we don't already have the information.

1. Is this an accurate description of services you have developed for duals or other high cost beneficiaries?
 - If not, please describe.
 - Approximately when were these services started?
2. What types of challenges experienced by duals and other high cost beneficiaries is the intervention designed to address?
 - Probes: cost of care, transportation issues, lack of someone to go to appointment with them, lack of understanding of care needs, complexity of treatment/medication regimens, provider offices not physically accessible or exceedingly difficult [specific to disabled], co-morbidities.
3. How were the interventions/services developed?
4. How did the health plan partner with community organization including social services? How do you address a lack of community resources, or if your plans have not yet developed partnerships with existing community resources?
 - Probe on specific organization types: Social services, church organizations, patient advocacy groups
 - Please describe the partnerships.
5. How were providers involved in the development of the services? How are they involved in the implementation? Does the health plan partner with provider organizations such as ACOs or safety-net providers in the development and implementation of services to meet the needs of duals and other high cost beneficiaries?
6. Are these services targeted to duals, or are they available to any individual with particular needs?
 - How are these services targeted?
 - Probe on specific approaches: risk-stratification algorithms (ask what is included in them); data collected on social determinants of health (ask specific characteristics).
7. What implementation or other challenges do health plans experience when trying to address the needs of dual eligible?
 - Probes: lack of community partnerships; resources missing in the community; lack of resources; tensions between health plan and providers; state and federal policies?
 - How are these challenges addressed?
 - The Chronic Care Act of 2018 provides MA plans starting in 2020 with greater flexibility to cover supplemental non-medical benefits for chronically ill enrollees as long as there is a “reasonable expectation of improving or maintaining the health or overall function” of the enrollee with chronically ill enrollees defined as having one or more comorbid and medically complex conditions, has a high risk of hospitalization or other adverse health outcomes, or requires intensive care coordination. How will this flexibility reduce barriers to meeting the needs of dual eligible and other high-need beneficiaries?
8. Did anything in particular function as a facilitator for the intervention/services?
9. What additional resources would be required for delivering the services/intervention?
 - How did the plans budget and account for these approaches, services or extra resources?

10. What is known about the impact of these services on patient care and outcomes?
 - Has an evaluation been performed?
 - How do you make the case to health plan leadership that a pilot or program should be continued? What types of information do you provide or use to assess the return on investment to justify the continued provision of services?
 - Please describe any evaluations. Can you provide any evaluation reports or summaries?
 - What are the metrics used to measure impact?
11. What other types of interventions or services has your health plan developed to meet the needs of duals or other high cost beneficiaries? *Interviewer reviews above questions for newly identified services as necessary.*
12. Have there been previous attempts to meet the needs of dual eligible and other high-cost beneficiaries that were unsuccessful?
 - Please describe
13. Is there anything else that you would like to add? Do you have any suggestions for the federal government?
14. If we have clarifying questions as we are preparing our summary, may we contact you again?

Thank you for your time today.

Appendix C. Types of Additional Services Provided by MA Plans to Address SDOH

Table C.1 describes in detail what we learned during interviews and case studies regarding strategies implemented by MA health plans to address the clinical and social needs of dually enrolled beneficiaries. Items listed in the table were reported by one or more organizations interviewed.

Table C.1. Types of Additional Services Provided by MA Plans to Address SDOH

Approaches to Identify Clinical and Social Needs

- Conduct health risk assessments.
- Include items related to SDOH.
- Conduct ongoing assessments, not only at enrollment.
- Conduct in-home assessments.
- Perform predictive modeling using SDOH to identify high-need patients.

Strategies to Address Patient Needs Related to SDOH

- Facilitate access to medical care.*
 - Employ care managers/care coordinators.
 - Use peer-to-peer counseling.
 - Offer online virtual clinic, 24 hours a day, seven days a week.
 - Offer phone access to a registered nurse, 24 hours a day, seven days a week.
 - Use telemedicine for remote patient monitoring.
 - Promote medication adherence via telephone.
 - Provide tablets preloaded with health education, engagement and wellness applications.
 - Maintain member services in retail spaces in the community.
 - Provide transportation to medical appointments.
- Offer in-home services.*
 - Deliver meals.
 - Provide in-home palliative care.
 - Perform in-home follow-ups 30-days post-discharge.
 - Have social workers make home visits to address depression.
 - Provide free bathroom safety modification products.
- Provide resources to meet SDOH.*
 - Hire multilingual staff members.
 - Maintain database of available community services.
 - Provide transportation to Alcoholics Anonymous meetings and other addiction or sobriety services.
 - Work with local organizations to find stable housing for members.
 - Help members fill out applications for subsidized housing, accompany members to eviction court proceedings, and other similar tasks.
- Help providers meet the needs of members.*
 - Help physician develop a treatment plan that is responsive to members' SDOH.
 - Train providers to deliver patient-centered care.
 - Enables care coordinators to recommend “shared visits,” where the member meets with a

nurse before and after they meet with the physician to address questions.
Train paramedics to assist members with acute and subacute issues.
Offer respite care for members who have behavioral health challenges.

Track outcomes.

Use of health information technology for tracking members across care settings.
Use data to perform targeted outreach to high-need members.
Collect patient-centered outcomes measures (e.g., quality of life).
Measure outcomes via focus groups, surveys, member services calls, utilization data, etc.

Community engagement.

Engage in formal and informal partnerships with local organizations to address clinical and social needs.
Hire staff to work engage with the community, coordinate care, work on clinical partnerships.
Host events at community organizations to combat social isolation among the community-based elderly.
Hosts local events, such as video game nights, for the local youth.
Provide technical assistance to community partners to improve their data and reporting systems and grant-writing capabilities.
Offer free membership at participating fitness facilities.

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