



**U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation  
Office of Health Policy**

# **Types and Costs of Services for Dual Beneficiaries by Medicare Advantage Health Plans**

## **RESEARCH REPORT**

**2018**

# Types and Costs of Services for Dual Beneficiaries by Medicare Advantage Health Plans

## An Environmental Scan

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## Preface

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This qualitative study sought to identify the types of services that Medicare Advantage 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. We conducted an environmental scan of the literature and key informant interviews with the goal of developing a typology of the services that Medicare Advantage plans implement. This qualitative study is divided into two phases; the second phase with in-depth case studies. The results 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.

This research was sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, and conducted within RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at [www.rand.org/health](http://www.rand.org/health).

# Table of Contents

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Preface.....	iii
Figures.....	vi
Tables.....	vii
Summary.....	viii
Acknowledgments.....	xi
Abbreviations.....	xii
1. Introduction.....	1
Background.....	1
Purpose.....	3
Outline of the Report.....	4
2. Approach.....	5
Environmental Scan.....	5
Key Informant Interviews.....	5
3. Medicare Advantage Contract Structure.....	7
4. Dually Enrolled Beneficiaries and Challenges to Obtaining Care.....	10
Types of Dually Enrolled Beneficiaries.....	10
Key Challenges Faced by Dual Beneficiaries.....	11
5. Strategies Used by Health Plans, Providers, and Community Partners.....	13
Identifying and Targeting Needs.....	14
Managing and Coordinating Care.....	16
Directly Addressing Social Needs Through Targeted Interventions.....	18
Integrating Medicare and Medicaid Benefits and Processes.....	21
6. Resources Required to Implement Strategies.....	22
Resources to Support Care Management and Coordination.....	22
Resources to Support Identification and Targeting of Services.....	22
Resources to Provide Services That Directly Address Social Needs.....	23
Resources to Support Integration.....	23
7. Evidence of Success.....	25
Studies Focused on Dually Enrolled Beneficiaries.....	25
Care Coordination Literature.....	30
Literature on High-Cost, High-Need Patients.....	32
8. Unanswered Questions and Next Steps.....	33
Prevalence of Identified Services.....	33
Costs of Identified Services.....	34
Role of Community, Medicaid State Agencies, and State Environment.....	34
Future Research.....	35
9. Summary and Conclusions.....	36

Appendix A. Discussion Guide.....	37
Appendix B. Financial Alignment Demonstrations.....	40
Appendix C. Examples of Risk Stratification Used by Medicare-Medicaid Plans .....	41
Appendix D. Potential Targets for Case Studies Identified Through Environmental Scan and Interviews.....	42
Appendix E. Literature Cited in Chapter Seven, “Evidence of Success” .....	43
References.....	46

# Figures

---

Figure S.1. Typology of Strategies Used by Medicare Plans to Improve Care for Dually Enrolled and Other High-Cost, High-Need Beneficiaries .....	ix
Figure 1.1. Overall Star Ratings by Plan-Level Proportion of Dually Enrolled Beneficiaries.....	2
Figure 3.1. Integration and Coordination with Medicaid, by Type of Medicare Coverage .....	8
Figure 4.1. Characteristics of High-Cost, High-Need Patients.....	11
Figure 5.1. Typology of Strategies Used by Medicare Plans to Improve Care for Dually Enrolled and Other High-Cost, High-Need Beneficiaries .....	13

## Tables

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Table 2.1. Key Informant Interviews.....	6
Table 8.1. Potential Questions for Further Evaluation with Qualitative Studies.....	34



## Summary

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Medicare Advantage (MA) plans that serve a high proportion of beneficiaries who are dually enrolled in both Medicare and Medicaid have lower performance and lower MA Star Ratings, on average, than plans serving a lower proportion of these beneficiaries. Dual enrollment is a marker for living in poverty. The Centers for Medicare and Medicaid Services (CMS) uses the Star Rating program to measure the quality of MA plans, publicly report plan performance, and determine quality bonus payments and rebates for MA plans. However, the reasons for these disparities in performance are not completely understood. Moreover, some MA plans that care for a high proportion of dually enrolled beneficiaries or other high-cost, high-need beneficiaries are high performers. This suggests that, with appropriate strategies, it is feasible to provide high-quality care and achieve good outcomes even in high-risk populations. Understanding more about the types of services provided to dually enrolled or complex beneficiaries that result in high performance, as well as the costs of providing the services, is critical to informing future quality-improvement efforts in the context of value-based payment models, as well as informing the design of plans and demonstrations that seek to improve care for dually enrolled beneficiaries. Given that similar patterns are seen across payment programs in many care settings, as reported in the Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs* (ASPE, 2016), such understanding could also have implications for care delivery more broadly.

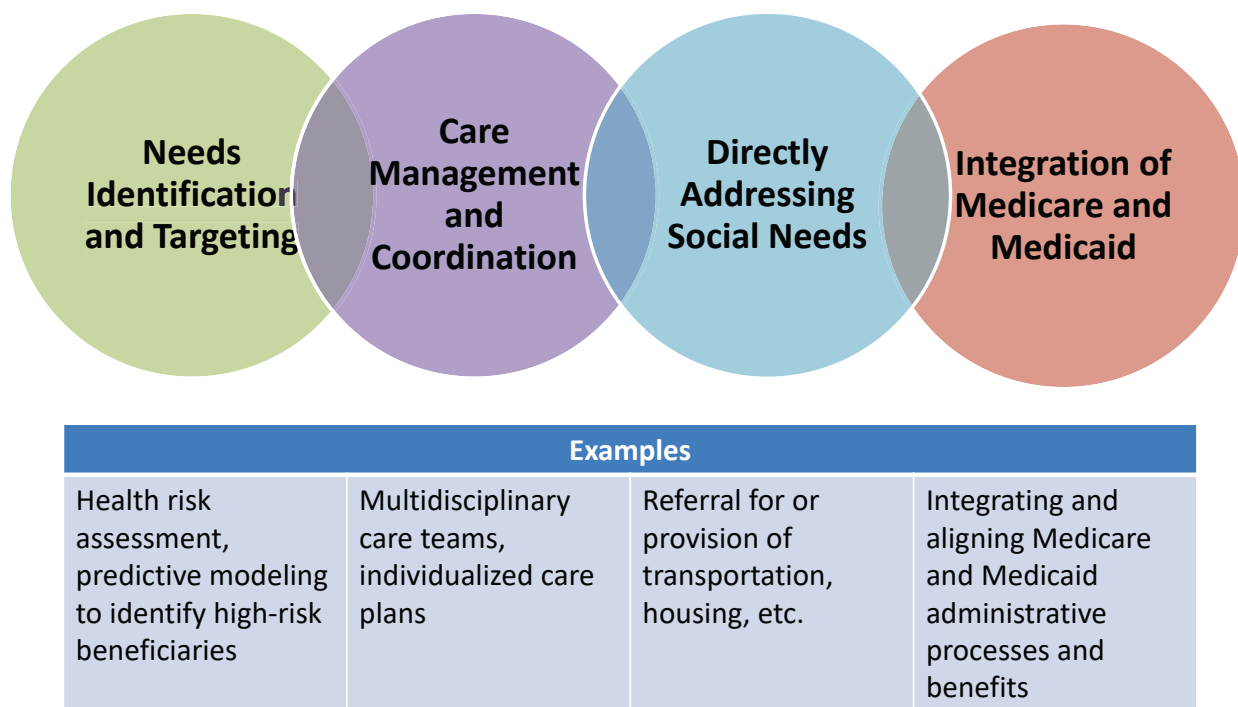
The purposes of this qualitative project were to (1) characterize the needs of dually enrolled beneficiaries and the degree to which these needs overlap with those of high-cost, high-need individuals more broadly; (2) identify the additional services that health plans and providers deliver while caring for dually enrolled Medicare beneficiaries or other high-cost, high-need beneficiaries; (3) identify the range of additional costs and resources used 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. This qualitative study is divided into two phases: a preliminary phase with an environmental scan and key informant interviews, the results of which are presented here, and a second phase with in-depth case studies.

Our first finding is that the needs of dually enrolled beneficiaries largely parallel the needs of high-cost, high-need patients more broadly. This is likely because social and medical risks are often intertwined. For example, a recent National Academy of Medicine report described determinants of health that included medical system determinants (e.g., advancing illness and multiple chronic conditions), individual behavioral determinants (e.g., serious mental illness and

substance abuse), and social determinants (e.g., socioeconomic status and housing insecurity) that additively affect health and collectively define *need* (Long et al., 2017).

Our second finding is that health plans, providers, and community partners adopt a variety of strategies to meet the varied needs of dually enrolled and other high-cost, high-need beneficiaries. The activities we identified can be grouped into four categories: (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 (see Figure S.1). Similar innovations in identifying, targeting, and referring patients to social support services are also occurring in health systems, accountable care organizations, and community health centers and not solely in MA plans with a high share of dually enrolled beneficiaries.

**Figure S.1. Typology of Strategies Used by Medicare Plans to Improve Care for Dually Enrolled and Other High-Cost, High-Need Beneficiaries**



These four strategies can affect access to care and health care utilization and ultimately improve health outcomes and health care costs, but the evidence base is still developing. Care coordination for selected chronic conditions has the strongest evidence base. Also, CMS has initiated a variety of programs in recent years that span these four strategies to support meeting

the needs of dually enrolled and other complex, high-cost, high-need beneficiaries; these efforts include Special Needs Plans, Fully Integrated Dual Eligible Special Needs Plans, Medicare-Medicaid Plans, accountable care organizations, the new Accountable Health Communities Model, and efforts by community health centers to screen for social needs and address them. It is still too early to know the full effect of many of these innovations. Examples of specific types of services; their impacts; and, when available, the associated range of costs associated with these innovations are provided in the report.

Our third finding is that little information is available about resources or costs required to implement and sustain these strategies, other than about the staff involved in care teams. The available information suggests that the range of costs or payments vary for each of the four types of services, depending on the plan type, approach, and type of worker providing the service. For example, the literature provides a range of estimates of caseloads for care managers, based on patient risk and care setting. Health risk assessments in a clinical setting are typically performed as part of a broader annual wellness visit or other visit; therefore, little information exists on the incremental costs. The resources for delivering services depend on whether the plan refers patients to existing social service agencies or directly covers the costs of the service. Although little information is available on the costs of better integrating Medicare and Medicaid processes and services, ongoing evaluations of the Financial Alignment Initiative demonstration program may provide greater insight.

Our fourth finding is that a strong, consistent evidence base is lacking around many of the strategies described. Long-term follow-up is still lacking, because many programs are new. Many studies examine only associations, and there are few randomized trials of such strategies. Many studies are of single programs or single centers. Care coordination for selected chronic conditions has the strongest evidence base.

Finally, many questions remain regarding how the needs of dually enrolled and other high-cost, high-need beneficiaries are met; these questions may be important to address in future work. For example, what is the prevalence of these identified services and activities, and how do they affect quality of care for beneficiaries and plans' performance on certain metrics? What are the costs for plans to identify, target, and deliver supporting social services to beneficiaries? What are the roles of the community, Medicaid state agencies, and the state environment regarding whether dually enrolled beneficiaries receive the social support services they need? These questions could be evaluated through a larger sample of health plans and providers via interviews, in-depth case studies, or surveys. The answers could help improve care and outcomes for dually enrolled beneficiaries and other high-cost, high-need patients more broadly.

## Acknowledgments

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## Abbreviations

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ACO	accountable care organization
AHC	Accountable Health Communities
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CMS	Centers for Medicare and Medicaid Services
C-SNP	Chronic Special Needs Plan
D-SNP	Dual Eligible Special Needs Plan
FFS	fee-for-service
FIDE	Fully Integrated Dual Eligible
GAO	U.S. Government Accountability Office
LTSS	long-term services and supports
MA	Medicare Advantage
MMP	Medicare-Medicaid Plan
MSHO	Minnesota Senior Health Option
PRAPARE	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
SNP	Special Needs Plan

# 1. Introduction

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## Background

Medicare Advantage (MA) is the program that allows Medicare beneficiaries to elect to receive their Medicare benefits via private health plans rather than through the fee-for-service system. Enrollment continues to grow, and, in 2017, one-third of Medicare beneficiaries received their benefits through an MA plan (Jacobson et al., 2017). The Centers for Medicare and Medicaid Services (CMS) evaluates all MA contracts annually in terms of performance on clinical, patient experience, customer service, and complaint measures. Scores on the individual measures are combined to create the Star Rating, ranging from one star to five stars, and these ratings are used for multiple purposes. The ratings are publicly reported on the Medicare Plan Finder to inform Medicare beneficiaries' plan selections (Medicare.gov, undated). Star Ratings also support Medicare's value-based reimbursement approach in MA. Contracts with ratings of at least four stars receive a quality bonus payment. The Star Ratings affect the size of the MA rebates that plans use to fund supplemental benefits or buy down beneficiary premiums. Finally, ratings may directly affect enrollment, because beneficiaries may switch to a five-star plan at any point in the year, and plans receiving less than three stars are unable to enroll beneficiaries online.

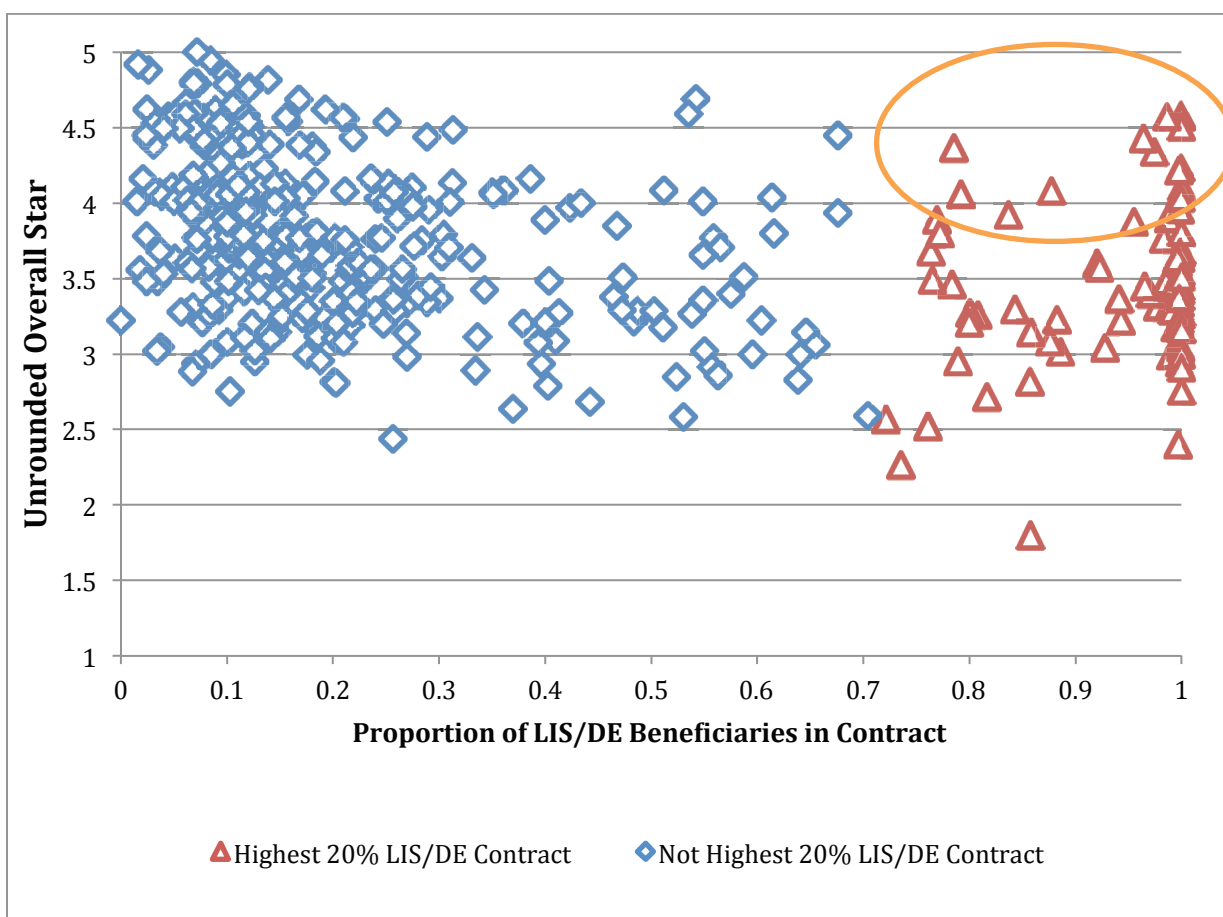
MA plans that serve a high proportion of beneficiaries who are dually enrolled in both Medicare and Medicaid have lower performance and lower MA Star Ratings, on average, than plans serving a lower proportion of these beneficiaries. The finding that dually enrolled beneficiaries receive care from lower-performing providers is consistent across Medicare's value-based purchasing programs, as described in the Office of the Assistant Secretary for Planning and Evaluation's (ASPE's) *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs* (ASPE, 2016). However, the reasons for these disparities in performance are incompletely understood. Some researchers and stakeholders have expressed concern that this may be due, in part, to a lack of risk adjustment in MA quality measures for dually enrolled beneficiaries, who represent a high-need population with limited resources, or other measures of socioeconomic status (CMS, 2015).

Prior evidence suggests that dually enrolled beneficiaries differ in meaningful ways from their nondual counterparts. For example, dually enrolled beneficiaries are more likely to be under age 65, be disabled, live in poverty, and report poorer health than Medicare beneficiaries who are not dually enrolled (Medicare Payment Advisory Commission, 2015). Dually enrolled beneficiaries have, on average, six chronic conditions, while those who are not dually enrolled average four chronic conditions (Bipartisan Policy Center, 2016). A higher proportion of dually enrolled beneficiaries have "disability" listed as their primary reason for Medicare entitlement;

Medicare beneficiaries with disabilities are younger, poorer, and in worse self-reported health than those who qualify for Medicare because of age (Iezzoni, 2006). These complex patients account for a disproportionate share of Medicare expenditures; in 2012, dually enrolled beneficiaries represented 20 percent of Medicare beneficiaries but 34 percent of Medicare spending (CMS, 2018a).

Despite the complexity of these beneficiaries, there are some plans that perform very well (the plans in which the highest quintile of beneficiaries are dually enrolled or receive a Part D low-income subsidy; see the circled plans in Figure 1.1), suggesting that high performance is possible even with a more complex patient population.

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



SOURCE: ASPE, 2016.  
 NOTE: DE = dually enrolled; LIS = low-income subsidy.

Thus, high-performing MA plans represent an important learning opportunity as CMS and the plans themselves work to improve outcomes for vulnerable populations and reduce disparities in care.

Unfortunately, little is currently known about how high-performing plans and their contracted providers achieve better performance or about the types of services that high-performing plans offer to beneficiaries and the costs associated with doing so. It is possible, for example, that these plans do a better job of addressing the medical and behavioral needs of their high-cost, high-need beneficiaries, regardless of whether or not they are dual-enrolled. It is also possible that these plans coordinate benefits better between Medicaid and Medicare for their dually enrolled beneficiaries or provide key wraparound medical services (e.g., pharmacist or nurse visits) or nonmedical services (e.g., transportation, social work) that lead to better quality of care and patient outcomes. Furthermore, it is possible that these plans operate in communities where greater resources are available to support socially at-risk beneficiaries and populations served by Medicare more broadly. Understanding more about these services and whether and how they are targeted toward dually enrolled beneficiaries, as well as the costs of providing them, can inform future quality-improvement efforts in the context of value-based payment models. And this analysis can inform the design of plans and demonstrations that focus on improving care for dually enrolled beneficiaries.

## Purpose

The purpose of this qualitative project was to (1) characterize the needs of dually enrolled beneficiaries and the degree to which these needs overlap with those of high-cost, high-need individuals more broadly; (2) identify the additional services that health plans provide to care for dually enrolled Medicare beneficiaries or other high-cost, high need beneficiaries; (3) identify the range of additional costs and resources used 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. This qualitative study was planned to have two phases: (1) a preliminary phase with environmental scan and key informant interviews and (2) in-depth case studies.

The first phase of the project, described in this report, includes an environmental scan of publicly available publications and semistructured interviews with key informants to explore the types of additional services and interventions that plans provide to address the needs of dually enrolled beneficiaries (and the additional costs and resources required to do so). The goal was to develop a typology of services that plans provide for dually enrolled and other high-cost, high-need beneficiaries and to understand the ways that plans account for costs of these services. These efforts can help guide questions in later case studies. Through the literature review, we also sought to identify potential factors that differentiate high-performing MA plans with a large portion of dually enrolled beneficiaries from similar plans with lower performance. These factors could be explored further in the second phase, through case studies of high- and low-performing MA plans. MA Star Ratings (at the contract level) were used to distinguish high- and low-



performing plans. We also identified plans engaged in activities focused on dually enrolled beneficiaries, and these plans are candidates for case studies in the second phase of the project.

## Outline of the Report

In Chapter Two, we describe our approach to both the environmental scan and the interviews. Chapter Three provides an overview of the MA contract structure. In Chapters Four through Seven, we describe our findings from the environmental scan and interviews, focusing on key types of dually enrolled beneficiaries, challenges faced by the different types of dually enrolled beneficiaries, strategies used by health plans to improve quality of care for dually enrolled beneficiaries and other high-cost beneficiaries (including information we identified on required resources and evidence of success), the role of providers, and the role of community organizations and local government. In Chapter Eight, we identify potential questions for further evaluation, and Chapter Nine summarizes our conclusions. Appendix A presents the discussion guide used during the interviews, Appendix B provides descriptive information on the financial alignment demonstrations, Appendix C provides examples of the risk stratification approaches used by Medicare-Medicaid Plans (MMPs), and Appendix D provides candidate health plans for phase 2 case studies.

## 2. Approach

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### Environmental Scan

A research librarian at RAND conducted a systematic search of the academic literature in the PubMed and Business Source Complete databases using combinations of keywords, such as “Medicare Advantage,” “dual eligible,” “Medicaid,” “Medicare,” “special needs plan,” and “low income subsidy.” Databases were searched for literature from 2006 to August 2017. We also searched the grey literature using the *Grey Literature Report* (New York Academy of Medicine, 2006–2016) and the Foundation Center’s IssueLab database (Foundation Center, undated). In addition, we performed advanced Google searching and targeted web searches of organizations that focus on dually enrolled beneficiaries, such as the Center for Health Care Strategies. Given the limited literature identified, we then broadened our searches to include selected publications from the literature on care coordination and high-cost, high-need patients; a systematic review of the broader literature was outside the scope of this project.

### Key Informant Interviews

The project team conducted up to one-hour semistructured interviews via telephone with a convenience sample of 14 individuals at six organizations (including one health plan and one provider organization). These individuals were identified through the literature review, previous experience with relevant organizations, suggestions from ASPE, and snowball sampling based on suggestions from other interviewees. We summarize the numbers and types of interviewees in Table 2.1. Interviewees were in administrative or clinical leadership positions and were familiar with MA, the Star Rating program, and working with dually enrolled beneficiaries. We were restricted in the number of interviews we could perform. Although we did not reach full saturation of topics discussed, there was a great deal of consistency in interviewees’ responses.

Interviews focused on the types of challenges that dually enrolled beneficiaries and other socially at-risk Medicare beneficiaries face as they seek care; additional services, interventions, supports, and resources that MA health plans provide to dual beneficiaries; estimates, where available, of the resources and costs of additional activities to support dually enrolled beneficiaries; the impact of these activities on patient care and outcomes, as well as how this impact is assessed; the ways in which 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; and nominations regarding which MA plans to include in case studies in the second phase of the project. We also sought suggestions from interviewees for the types of staff at health plans to interview as part of the case studies. The interview guide is provided in Appendix A.

**Table 2.1. Key Informant Interviews**

<b>Organization Type</b>	<b>Number of Organizations (Interviewees)</b>
MA contract with D-SNP	1 (2)
Health plan association	2 (3)
Policy organization	1 (3)
Provider at health center serving low-income population	1 (1)
CMS	1 (5)

NOTE: D-SNP = Dual Eligible Special Needs Plan.

### 3. Medicare Advantage Contract Structure

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The focus of the environmental scan was to identify approaches and services that dual-focused plans might have adopted to address the complex needs of their dually enrolled population. These approaches could inform nonspecialized MA plans, as well as low-performing MA plans with high dual enrollment. One key reason for the development of dual-focused plans was the recognition that dually enrolled beneficiaries face challenges in coordinating benefits and services covered by separate payers.

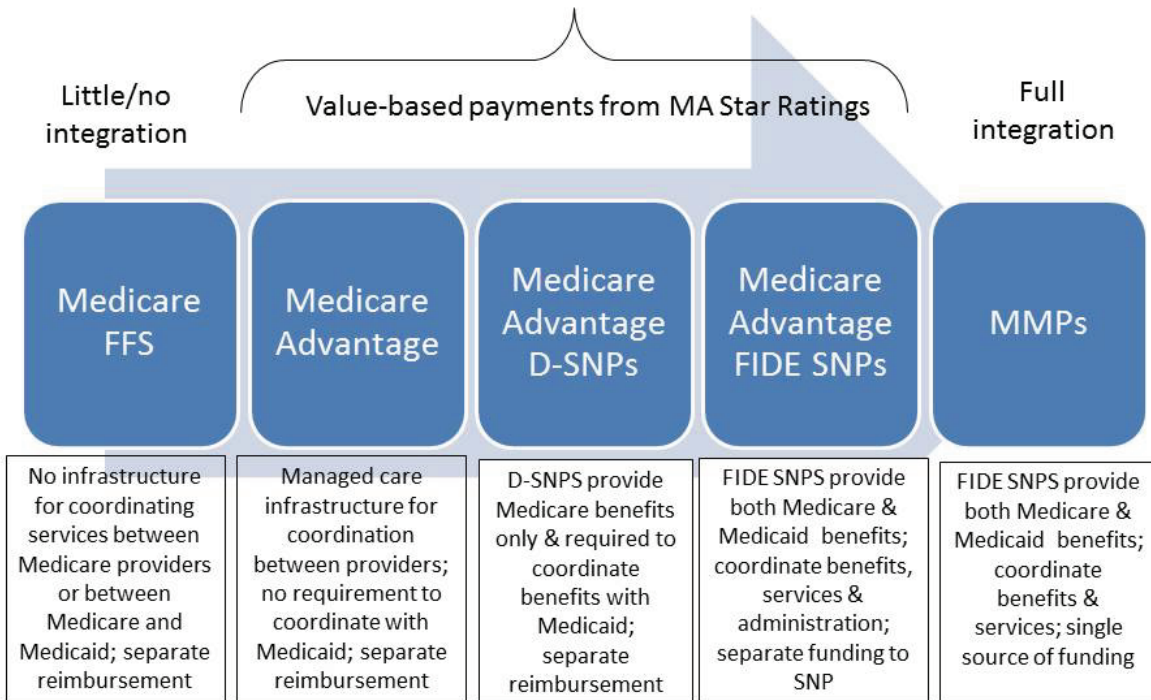
Beneficiaries enrolled in both Medicare and Medicaid receive benefits from two separate payers, which may or may not be coordinated in their approaches. The extent to which beneficiaries have assistance coordinating services covered by Medicare or Medicaid depends on the beneficiaries' type of Medicare coverage (see Figure 3.1). Fee-for-service Medicare does not provide an infrastructure that assigns responsibility for coordinating services to meet beneficiaries' needs. On the other hand, enrollees in MA receive coverage (benefits and services) through managed-care plans, which have the infrastructure to coordinate clinical care between providers. However, MA plans vary dramatically in the extent to which they have dually enrolled beneficiaries, and specialized plans have the additional responsibility to coordinate with Medicaid benefits if they focus on dually enrolled beneficiaries. Special Needs Plans (SNPs) were authorized by the Medicare Modernization Act (Pub. L. 108-173, 2003) and are MA plans tailored to a specific subgroup of Medicare beneficiaries. D-SNPs enroll beneficiaries eligible for both Medicare and Medicaid, have contracts with state Medicaid agencies in addition to Medicare, and coordinate the benefits of the two programs, although the D-SNPs themselves are required to include only Medicare benefits in the benefit packages. Recognizing that dually enrolled beneficiaries would benefit from further coordination, the Affordable Care Act (Pub. L. 111-148, 2010) established Fully Integrated Dual Eligible (FIDE) SNPs, which 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);<sup>1</sup> and coordinate enrollment, member materials, communications, grievance and appeals, and quality improvement for both Medicare and Medicaid. To bridge the gap between services covered by Medicare and Medicaid, highly integrated D-SNPs and FIDE SNPs may seek approval from CMS to provide benefits beyond what MA plans may offer (U.S. Government Accountability Office [GAO], 2014).

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<sup>1</sup> There is a range of services that LTSS can provide 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, is inversely related to receipt of institutional services (Minnesota Department of Human Services, 2015).

**Figure 3.1. Integration and Coordination with Medicaid, by Type of Medicare Coverage**

## Continuum of Coordination and Integration with Medicaid Available to Dual Eligible Beneficiaries in Medicare



NOTE: FFS = fee-for-service.

Demonstrations are also under way to further innovate ways to better integrate benefits and services for dually enrolled beneficiaries in different states. CMS announced the Financial Alignment Initiative in 2011 (CMS, 2018c). The objective of this demonstration is to test ways to better coordinate care for fully dually enrolled beneficiaries, with a focus on integrating primary care, acute care, behavioral health care, and LTSS. Between August 2012 and July 2015, CMS entered into a memorandum of understanding with 12 states to test two types of demonstration models: (1) a capitated payment model based on Medicaid managed care and MA called MMPs and (2) a managed FFS model in states where Medicaid is paid under a FFS model but enrollees are in MA plans. Under the capitated model being implemented in ten states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia), CMS, the state, and the health plan have a three-way contract under which the plan receives a comprehensive capitated payment to provide services covered by both Medicare and Medicaid in a coordinated manner. Through the second managed FFS model,

which is 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 for its D-SNPs. Minnesota is not fully participating in the Financial Alignment Initiative because its fully 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). A summary of the dates of implementation, eligibility requirements, and enrollment is located in Appendix B. Although the MMPs are subject to quality-reporting requirements, they do not participate in the MA Star Rating Program, which is CMS’s value-based purchasing program for MA contracts.

This continuum—from no coordination under Medicare FFS, to partial coordination of Medicaid and Medicare benefits and services under MA SNPs, to full coordination under FIDE SNPs and MMPs—is laid out in Figure 3.1.

## 4. Dually Enrolled Beneficiaries and Challenges to Obtaining Care

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### Types of Dually Enrolled Beneficiaries

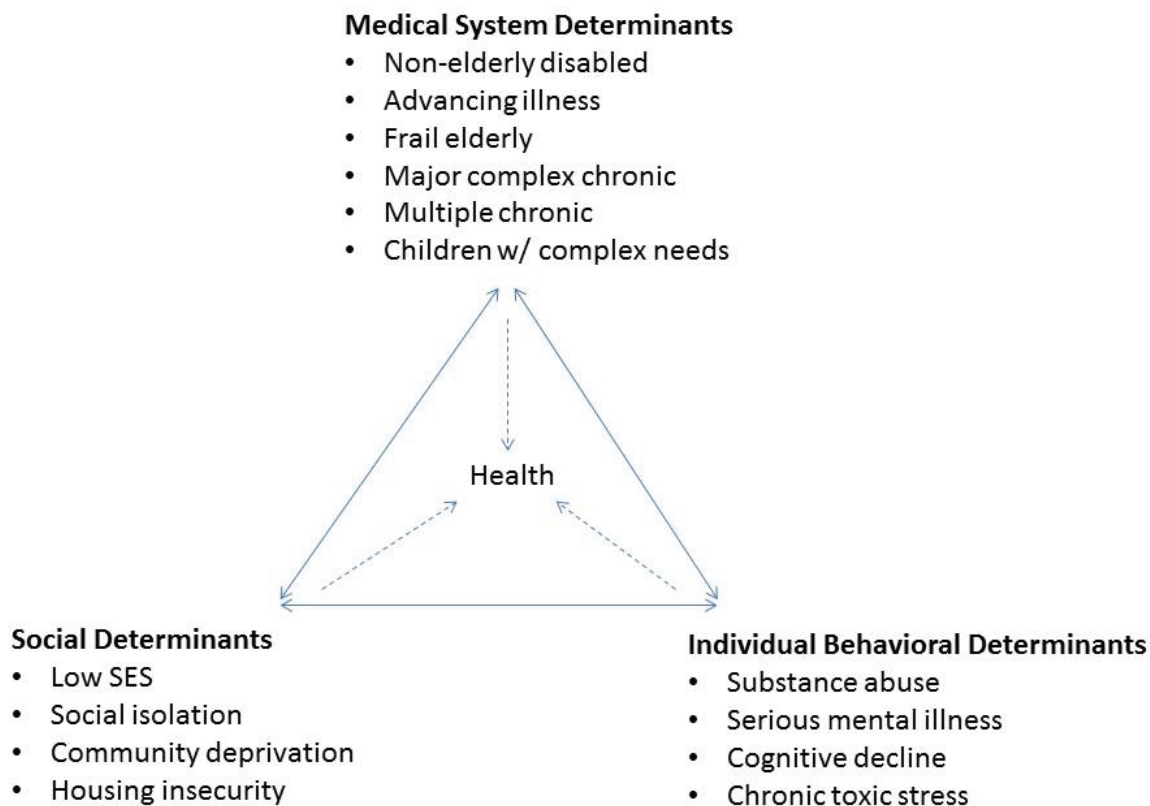
The first main finding of the environmental scan and interviews was that dually enrolled beneficiaries are heterogeneous, a fact that likely affects the challenges experienced with the health care system. Some interview respondents described subgroups of dually eligible beneficiaries and highlighted that the different patient populations that make up the “dual” category face distinct challenges. The identified groups, however, were not entirely consistent. One respondent split the dual beneficiaries into two groups: those who seek care solely for acute needs and those who routinely seek care for chronic conditions. Another respondent described four subgroups of dual beneficiaries: (1) the *community well*, or beneficiaries without major health issues; (2) beneficiaries with physical disabilities; (3) beneficiaries with serious mental health issues; (4) and beneficiaries with chronic conditions. Although not mutually exclusive, these categories represent the issues that most frequently drive and influence beneficiaries’ interactions with the health care system. A third respondent split dual beneficiaries into those who are over and under age 65. He then stratified beneficiaries over age 65 into two groups: those who are generally healthy but who qualify for Medicaid because of income and those with long-term care needs. He divided those who are under 65 into three categories: those with serious mental illness, those with physical disabilities, and those who were eligible because of other reasons.

Among respondents who referenced dual subgroups, three referenced those with mental health issues, two referenced those with chronic conditions, and two referenced those with disabilities. Two also referenced what might be broadly termed the *community well* group: beneficiaries who qualify because of age and income but do not have significant health issues. These broad categories are generally supported by the literature. Approximately 40 percent of dually enrolled beneficiaries experience mental health conditions and 68 percent have three or more chronic conditions (CMS, 2018a). Approximately half of dually enrolled beneficiaries originally qualified for Medicare because of disability (Medicare Payment Advisory Commission, 2015). According to the 2010 Medicare Current Beneficiary Survey, 21 percent of dually enrolled beneficiaries reported being in very good or excellent health, which could be considered the community well group (Medicare Payment Advisory Commission, 2015).

In contrast, the literature suggests that many MA plans without a focus on dual beneficiaries do not market to or track the dual-enrollment status of their members, and dual beneficiaries are managed in the same way as traditional MA members. This suggests missed opportunities to tailor care to the unique needs of dually enrolled beneficiaries (Gold, Wang, and Jacobson, 2013).

It is also important to note that the population of dually enrolled beneficiaries in many ways parallels high-cost, high-need patients more broadly. A recent National Academy of Medicine report described characteristics that could be used to identify high-cost patients for targeted interventions (Long et al., 2017). These characteristics encompass not only medical system determinants (e.g., advancing illness and multiple chronic conditions) and individual behavioral determinants (e.g., serious mental illness and substance abuse) but also social determinants, such as social economic status and housing insecurity. The National Academy of Medicine’s proposed segmentation approach recognizes the triad of medical, individual behavioral, and social determinants of health that characterize different patient populations, which a clinically based risk-stratification approach may not take fully into account (Figure 4.1). The characteristics used to identify high-cost patients are also common characteristics of dually enrolled beneficiaries.

**Figure 4.1. Characteristics of High-Cost, High-Need Patients**



SOURCE: Developed by David Labby, former chief medical officer of Health Share of Oregon, in Abrams and Milstein, 2016, slide 10. Used with permission.  
 NOTE: SES = socioeconomic status.

## Key Challenges Faced by Dual Beneficiaries

Just as dually enrolled beneficiaries are highly diverse in terms of age and illness burden, so are their care needs. Key informants described a variety of challenges faced by dually enrolled



beneficiaries in seeking and obtaining health care. A number of respondents referenced social challenges in accessing care, including housing (two respondents), transportation (four respondents), lack of food security (one respondent), and lack of support from the family (one respondent). Once patients access care, they face issues with understanding how the health care and insurance systems works (one respondent); health literacy more broadly, in terms of understanding their conditions and how to treat or control them (two respondents); language barriers (one respondent); and a resulting lack of compliance with the recommended treatment (two respondents). One respondent also highlighted issues with coordinating across the Medicare and Medicaid programs, which can give rise to difficulties with identifying dual needs and meeting those needs. Another respondent described potential socioeconomic challenges related to the ability to afford insurance copayments and obtain leave from a job to make an appointment.

The literature corroborates these challenges for dually enrolled beneficiaries seeking care. Dually enrolled beneficiaries more often report problems with access to care and affordability than beneficiaries who are not dually enrolled (Cubanski and Neuman, 2010; Medicare Payment Advisory Commission, 2015), which may adversely affect their quality of care. Dually enrolled beneficiaries may also experience other barriers to care. Prior studies have shown that patients with low socioeconomic status disproportionately experience barriers, such as limited transportation and lower health literacy (Fung et al., 2013; Hsu et al., 2008; Ngo-Metzgar et al., 2012; Phelan, Link, and Tehranifar, 2010).

The different care needs among the heterogeneous subpopulations of dually enrolled members present a challenge for health plans. Specifically, dually enrolled members under age 65 typically qualify for Medicare because of disability or end-stage renal disease, frequently have behavioral health issues, and present with needs that are different from that of the over-65 population. The fact that physical and behavioral health care are not fully integrated can lead to particular challenges in the under-65 population (Verdier, Au, and Gillooly, 2011).

## 5. Strategies Used by Health Plans, Providers, and Community Partners

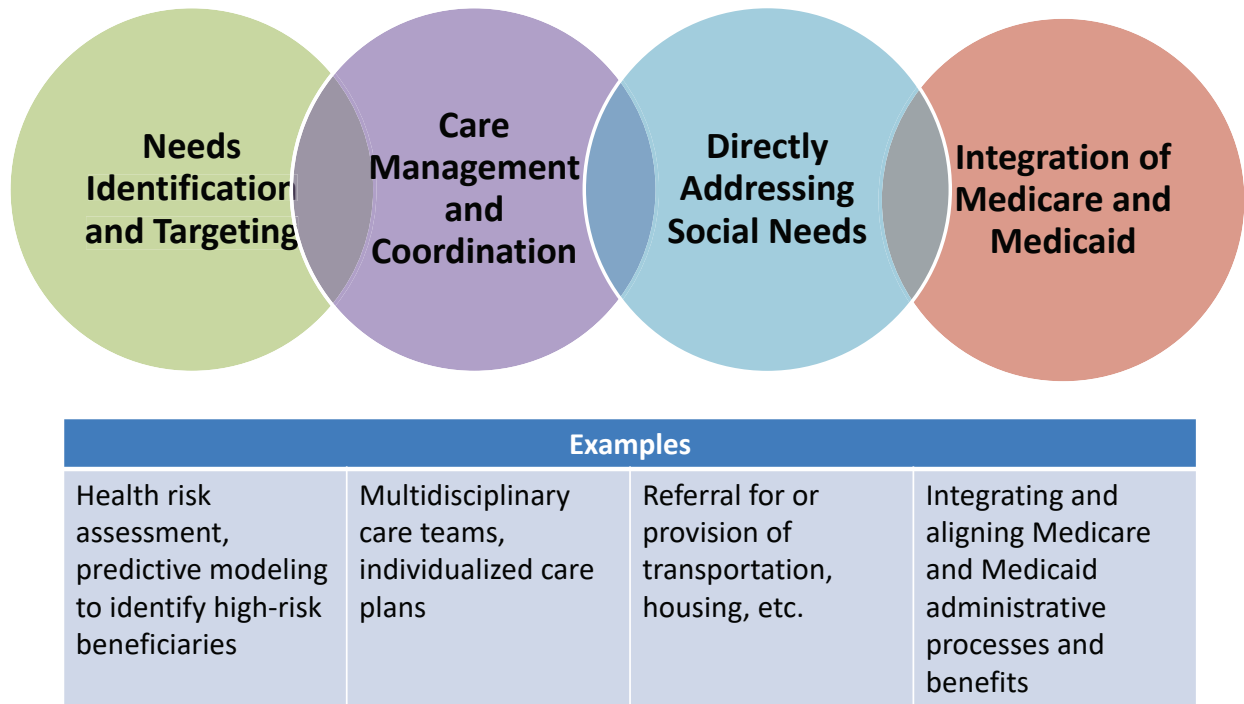
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Our second major finding is that health plans, providers, and their community partners use a variety of strategies and interventions to address the challenges faced by dually enrolled beneficiaries and other high-cost, high-need patients.

The activities we identified can be grouped into four categories:

1. identifying and targeting needs: identifying needs and data analytics to better target programs toward patients at high risk for hospitalization, readmissions, and nursing home admission
2. managing and coordinating care: addressing clinical needs through care management and coordination, frequently with multidisciplinary teams
3. directly addressing social needs through targeted interventions: meeting the social needs of dually enrolled and other beneficiaries by either referring them to existing programs that address housing, food security, and transportation needs or providing these services
4. integrating benefits and processes: undertaking administrative actions to better integrate Medicare and Medicaid (see Figure 5.1).

**Figure 5.1. Typology of Strategies Used by Medicare Plans to Improve Care for Dually Enrolled and Other High-Cost, High-Need Beneficiaries**



## Identifying and Targeting Needs

A key strategy adopted by MA plans is to identify beneficiary needs through needs assessments and then target services to beneficiaries based on those identified needs, using risk-stratification or other targeting approaches, such as referrals and patient navigation to services.

### *Needs Identification—Beneficiary Needs Assessments*

Many health plans perform risk assessments of all beneficiaries upon their initial enrollment to create individualized care plans based on their needs (Verdier, Au, and Gillooly, 2011), and several health plans also reported using periodic comprehensive needs assessments to identify physical, behavioral, and social needs (National Academies of Science, 2016; Schmitz et al., 2008; Lukens, Murphy, and Blum, 2007). Initial assessments are required for capitated MMPs participating in the Financial Alignment Initiative, although the timing of the assessments varies from state to state. For example, Ohio requires assessments to be performed within 15 to 75 days of enrollment, while California requires them between 45 and 90 days, based on the level of perceived risk for each beneficiary.

Additionally, state requirements for the content of the risk assessments used by MMPs varies: Some states require only brief health risk assessments, while others require more-comprehensive assessments that address both clinical and social needs (Barth and Ensslin, 2014). The perceived risk can be determined from a variety of data sources. California uses Medicare utilization data, Medi-Cal utilization data, results of previously administered assessments, and other tools administered at the individual or population level; Ohio and Virginia use similar data but also use referrals from individuals, family members, and providers, as well as other information (see Appendix C) (Barth and Ensslin, 2014). To meet the state's requirements for the timeliness of risk assessment and care-plan development, some states, including California, have started working with CMS to share claims data with MMPs prior to the start of the person's coverage (Barth and Ensslin, 2014).

Providers serving at-risk populations also use assessments to identify patient needs. In 2014, the National Association of Community Health Centers and its partners began developing a standardized tool—the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)—to collect information about the social determinants of health to help health centers better understand their patients' needs. The tool includes 16 core measures (e.g., housing stability, insurance, transportation, income, employment) and four optional measures (e.g., incarceration history, domestic violence) (National Association of Community Health Centers, undated). The tool has been incorporated into four electronic health record (EHR) systems: NextGen, eClinical Works, Centricity, and Epic; approximately 60 percent of

community health centers use one of these EHR systems, and more than 610 entities have signed up to use the EHR templates for the screening tool.<sup>2</sup>

In addition, the Association of Asian Pacific Community Health Organizations developed a standardized data collection tool for community health centers to document the types of enabling services they provide to each patient, using an encounter form with standardized coding for each type of service and documentation of time (in ten-minute increments) spent providing services to the patient (Association of Asian Pacific Community Health Organizations, 2017, 2018). The eight specific categories of enabling services are case management assessment, case management treatment and facilitation, case management referral, financial counseling/eligibility assistance, health education/supportive counseling, interpretation services, outreach services, and transportation, as well as a category for “other.” The association also developed an implementation guide for health centers about conducting a needs assessment of enabling services, training staff, and collecting data on services provided (see Association of Asian Pacific Community Health Organizations, 2017, 2018).

Some accountable care organizations (ACOs) also actively screen their patients for social determinant needs. For example, the Mission Health Partners ACO uses the Pathways Hub Model (Agency for Healthcare Quality and Research, 2016b), wherein a care manager at the care coordination center (the “hub”) completes a needs assessment that addresses clinical and social determinants (Fields, 2017). When unmet needs are identified, the care manager refers the patient to a community partner.

In 2017, CMS announced 32 new organizations participating in the Accountable Health Communities (AHC) model that will strive to address the gap between clinical care and services available in the community. The primary goal of the AHC model is to identify and address unmet social needs related to health through partnerships among state Medicaid agencies, clinical providers, and community services providers (Ahn, 2017). This five-year model is testing whether screening community-dwelling Medicare and Medicaid beneficiaries for health-related social needs, and then addressing identified needs through clinical-community coalitions, can affect health care utilization and spending. CMS developed the AHC screening tool, which is a standardized tool for use in clinical settings to identify health-related social needs (Billioux et al., 2017). The tool consists of ten questions, focusing on transportation, housing instability, food insecurity, interpersonal safety, and utility needs. Bridge organizations (e.g., local health departments, county governments, universities, hospitals, and health care systems), which are the recipients of the awards from the Center for Medicare and Medicaid Innovation, can also select additional needs to target based on their community needs assessments. There are two AHC tracks: assistance (screening, referral, and community service navigation) and alignment

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<sup>2</sup> Phone communication with Michelle Proser, Director of Research at National Association of Community Health Centers on September 12, 2017.

(screening, referral, community service navigation, and partner alignment). Bridge organizations in both tracks will assemble an inventory of local community services and conduct screening for health-related social needs among Medicare and Medicaid beneficiaries, including two high-risk, high-need patient groups—dually enrolled beneficiaries and those with two or more emergency department visits in the past year. The screening will be used to identify those with unmet health-related social needs for referral to community services.

### *Targeting—Risk Stratification*

Some plans use additional risk-modeling techniques to further stratify members who could benefit from particular interventions (Verdier, Au, and Gillooly, 2011; Schmitz et al., 2008; Gold, Wang, and Jacobson, 2013). States involved in the Financial Alignment Initiative are using claims-based algorithms and incorporating other relevant criteria (such as housing status, support system, use of a waiver for home- and community-based services) to stratify beneficiaries for the purposes of allocating care coordination resources, as well as determining payment levels and developing care plans (Chepaitis et al., 2015). Again, there is significant variation across states in the criteria they are using to assess risk and the number of risk-based categories to which they are assigning beneficiaries. Risk-modeling approaches can vary from rule-based algorithms that place beneficiaries into categories based on the presence or absence of conditions or needs to sophisticated models that apply weights to predictors to determine risk categories. Both approaches are used by MMPs.

## Managing and Coordinating Care

A strategy that is used by health plans, ACOs, and other providers and commonly reported in published documents and interviews involves care coordination. *Care coordination* is a broad term used to refer to a variety of interventions that can be broad approaches (e.g., patient-centered medical homes, enhanced primary care, care management, medication management) or specific activities (e.g., assessing patient needs, creating a care plan, linking to community resources); it is applied to a range of clinical populations in multiple clinical settings (McDonald et al., 2007; Agency for Healthcare Research and Quality, 2016a). The National Coalition on Care Coordination defined *care coordination* as “a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed and services are managed and monitored by an identified care coordinator following evidence-based standards of care” (quoted in Brown, 2009).

Although there is variation in the care management and coordination approaches described in the MA literature focusing on dually enrolled beneficiaries, common features exist. Health plans stress the importance of devoting resources to primary care and delivery models, such as the patient-centered medical home, to help their coordination efforts (Burwell, Saucier, and Walker,

2010; Verdier, Au, and Gillooly, 2011; Gold, Wang, and Jacobson, 2013). One health plan interviewee described earning higher Star Ratings for MA plans in which beneficiaries use patient-centered medical homes. The health plan provides the practices with data, performance on metrics, awards, and shared savings. Another interviewee described a situation in which a health plan invested heavily in a Federally Qualified Health Center to improve its data systems and to embed a care manager. Multidisciplinary team-based care is often a particular focus, typically with teams anchored by a primary care physician, and including a care manager who acts as a layer of support between the physician and patient (Burwell, Saucier, and Walker, 2010). Some health plans have teams made up of nurse practitioners, nurses, behavioral health clinicians, social workers, and peer counselors (Community Catalyst, 2008; Schmitz et al., 2008; Gold, Wan, and Jacobson, 2013; Lukens, Murphy, and Blum, 2007), while others include pharmacists, home health aides, and family caregivers (National Academies of Sciences, Engineering, and Medicine, 2016; Lukens, Murphy, and Blum, 2007). These teams and, particularly, a care manager often focus on care coordination and, specifically, transitions from one setting to another or back into the community.

Interviewees described care management activities ranging from “low touch” to “high touch,” depending on the needs of the various types of dually enrolled beneficiaries. Low touch may consist of telephonic care management for those beneficiaries whom the plan is able to reach and engage. A higher-touch approach is embedding health plan nurse practitioners, registered nurses, or social workers in practices or skilled nursing facilities to address chronic health conditions, mental health issues, and coordination of care. The highest-touch care management may involve (1) deploying community-based care managers focused on beneficiaries in the midst of a care transition, those with multiple hospital admissions, and those requiring unplanned care or (2) using regional care teams that focus on particular zip codes with high concentrations of dually enrolled beneficiaries. This intensive community-based intervention might involve five to six phone calls and five to six in-person visits in the first two months of interaction. A health plan interviewee described tailored approaches for different types of dually enrolled beneficiaries: “For each subpopulation we’ve identified on a geographic or other grouping level, there’s a need for thoughtful and intensive programming.”

Although the states participating in the Financial Alignment Initiative provided care management to some dually enrolled beneficiaries prior to the demonstration, MMPs are extending the services to additional people and are covering a wider array of services, such as behavioral health and LTSS. Coordinating mental health, substance use, and physical health services is a particular focus for MMPs, given the prevalence of mental health conditions among dually enrolled beneficiaries (Philip, Kruse, and Soper, 2016). MMPs also have a focus on transition planning, with many reporting that they focus on educating patients about their care regimens and needs (Philip, Kruse, and Soper, 2016). Transition support also consists of coordinating with other providers on behalf of the patient (e.g., home health agency, primary care physician), medication management, and support available 24 hours a day. Several MMPs

use telehealth to facilitate their care management activities and increase access to care, especially for those patients in rural areas or those who have disabilities that prevent them from traveling to a provider’s office or clinic (Philip, Kruse, and Soper, 2016). Telehealth approaches include recording and tracking patient data on a tablet and remotely monitoring vitals, such as blood pressure and blood glucose levels. In Illinois, MMPs employ “SNFists”—clinicians who coordinate beneficiary care in nursing home facilities (Chepaitis et al., 2015).

There is some evidence in the literature that plans, including MMPs, outsource particular care management activities, and this was confirmed by an interviewee. One D-SNP has contracts with a company to provide a physician or nurse practitioner to serve as the main provider for home- or facility-based primary care for particularly high-risk members, who often have issues with access to care (Burwell, Saucier, and Walker, 2010). Two MMPs contract with vendors to provide care management for members in nursing facilities; however, the specifics of the vendors’ activities were not described (Philip, Kruse, and Soper, 2016). An interviewee mentioned a successful relationship with Area Agencies on Aging, in which an agency is contracted to coordinate long-term care and shares a common information system with the health plan. Several states require their MMPs to contract with community organizations to coordinate LTSS.

## Directly Addressing Social Needs Through Targeted Interventions

In addition to a general focus on care management, health plans often devote resources to developing specialized targeted interventions for their dually enrolled beneficiaries. These often include interventions specifically designed to prevent avoidable care, such as rehospitalizations or nursing home admissions (Burwell, Saucier, and Walker, 2010). For example, one health plan created a specialized role for a nurse who focuses solely on discharge planning, patient follow-up to help patients understand and follow their care plans, and collaboration with the care manager to ensure that an individualized treatment plan is developed (Burwell, Saucier, and Walker, 2010). Noting the importance of recreation and socialization on health outcomes, one MMP takes a novel approach by hiring a full-time “recreational therapist” to work with the care manager to help members find social activities that may be of interest to them (Philip, Kruse, and Soper, 2016).

### *Member Engagement and Outreach*

Health plans are focused on finding the most-effective ways to reach and engage their dually enrolled members. Dually enrolled members present unique challenges for outreach and engagement because of their economic and social circumstances. For example, some duals have trouble maintaining a phone line because they cannot afford their monthly payments. Taking this into account, one health plan calls members during the first week of each month to increase the likelihood of making contact (Barth and Ensslin, 2014). In addition, some health plans have

dedicated staff for tracking and following members when they move or have any change in their contact information (Barth and Ensslin, 2014). One health plan complements these efforts by engaging members' neighbors or relatives to monitor their whereabouts (Barth and Ensslin, 2014). Health plans often aim to make routine contact with their dually enrolled members to ensure that they are constantly engaged. Often, these are high-touch contacts employed by both D-SNPs and Chronic Special Needs Plans (C-SNPs), such as routine home visits to check in on members (Burwell, Saucier, and Walker, 2010; Schmitz et al., 2008). MMPs describe a variety of strategies to locate beneficiaries. This may include going to places frequented by beneficiaries, such as dialysis centers, soup kitchens, and day centers; reviewing pharmacy data to find more-recent contact information; or contacting providers (Chepaitis et al., 2015). Some plans do this investigative work themselves, while others contract with outside entities to obtain contact information (Chepaitis et al., 2015).

### *Social Determinants and Services*

Many health plans and providers have become increasingly aware of the impact of social determinants of health and have pursued social and community services for their dually enrolled and socially high-risk members. This often entails contracting with local agencies, such as Area Agencies on Aging, to provide additional resources for members (Barth and Ensslin, 2014; Lukens, Murphy, and Blum, 2007). ACOs may include social services agencies as key partners and even have them participate on leadership boards, as is done by Hennepin Health in Minnesota (Corrigan and Fisher, 2014). Several health plans have stressed the importance of stable housing. Some health plans offer housing assistance and partner with local housing agencies, and one has even built a Federally Qualified Health Center that has nearly 80 lofts for the formerly homeless (National Academies of Sciences, Engineering, and Medicine, 2016). One interviewee described a partnership between health plans and an organization that provides housing for the homeless, as well as “recuperative care” for homeless individuals discharged from the hospital (Association for Community Affiliated Plans, 2014). Another interviewee described a health plan’s joint venture with a local housing support agency to provide U.S. Department of Housing and Urban Development–funded housing for beneficiaries. He went on to say that the health plan has observed that beneficiaries see their doctors more often, are more likely to take their medications, have fewer emergency department visits, and have fewer readmissions when they have housing. Other plans may have housing experts on their staffs to help arrange such services. The Health Plan of San Mateo implemented a program that identified a range of housing alternatives and facilitated moves for residents who wanted to transition from a skilled nursing facility to the community (Association for Community Affiliated Plans, 2014). In general, these programs are small in scale. Other programs support minor home modifications to facilitate high-risk elders safely staying in their homes. An example of this is the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program in Maryland (Ahn, 2017).



As a result of comprehensive needs assessments, some plans assist with activities of daily living or with securing transportation services to appointments (Cronin, 2008). Other plans may assist with access to food through partnerships with local food pantries—for example, providing a grant to use a truck to bring fresh produce to underserved areas. These programs are frequently paired with nutrition-education programs. For example, CareSource created a diabetic-friendly package of prepared food that served as a focal point for the care management team to discuss self-management (Association for Community Affiliated Plans, 2014).

Most plans described in the literature did not pay for these services, and other funding sources are required, but some D-SNPs use Medicare rebates to pay for services such as transportation and minor updates to members' homes (such as bathroom fixtures) (Gold, Wang, and Jacobson, 2013). One interviewee said, and others echoed, that some MMPs and health plans are financing these interventions based on the notion that “social determinants of health really do affect medical care, access, compliance, and, ultimately, plans' Star Ratings.” One interviewee said that health plans that are investing in housing and food access are seeing returns. The Bipartisan Policy Center identified three regulatory barriers to the provision of non-Medicare-covered supports and services by MA plans to high-cost, high-need beneficiaries who are not dually enrolled: (1) the uniform benefit requirement prevents targeting services to the most in-need enrollees, and the cost of providing coverage of the services to everyone is prohibitively expensive; (2) the requirement that supplemental benefits be primarily health-related raises questions about the appropriateness of covering services that lack an evidence base; and (3) plans frequently cannot include the costs of noncovered supports as supplemental benefits toward the medical loss ratio (Bipartisan Policy Center, 2017).

In some cases, care managers are helping beneficiaries take advantage of programs for which they are eligible but not enrolled. These might include property tax and rent rebate programs, food stamps, and Medicare savings programs. An interviewee noted that the health plan is “recognizing that there are all of these income supports that people should be accessing to increase their basic quality of life, which would affect their health.”

In addition to partnering with community organizations, health plans are increasingly cognizant of the differences in their members' races and ethnicities and the impact these differences can have on health outcomes. Some hire peer counselors and other nonclinical staff who are members of the community. These individuals can sometimes act as liaisons between the health plan and members because they are intimately involved with and connected to the community and its resources, and the staff are sometimes bilingual to help with communication (Barth and Ensslin, 2015). One clinic manager with whom we spoke mentioned that all of the patient liaisons and medical assistants are from the community and fluent in both Spanish and English.

## Integrating Medicare and Medicaid Benefits and Processes

The lack of integration between Medicare and Medicaid is a challenge for both plans and dually enrolled beneficiaries. This often leads to administrative burden and duplication because each funder has different requirements (e.g., for care planning or patient assessment) (Burwell, Saucier, and Walker, 2010). Plans also report that there is sometimes overlap and duplication in care management roles, and the absence of a comprehensive health information technology system prevents them from accurately monitoring care management activities in real-time.

Some types of plans integrate Medicare and Medicaid benefits and create specialized provider networks. FIDE SNPs integrate benefits based on their state Medicaid program. They leverage these benefits to provide fully integrated care programs with one managed care organization coordinating both Medicare and Medicaid benefits (Verdier, Au, and Gillooly, 2011). MMPs take integration a step further and have a single funding stream for care provided to dually enrolled beneficiaries.

The lack of integration between Medicare and Medicaid can create financial challenges for health plans. For example, health plans cite the lack of state payments for Medicare cost-sharing for dually enrolled members as a challenge (Gold, Wang, and Jacobson, 2013). It can take a long time for interventions focused on dually enrolled beneficiaries to realize savings because duals are expensive and require significant care management. Moreover, these savings are attributed to Medicare as the primary payer instead of Medicaid, while Medicaid may be better positioned to provide some of the services. Therefore, states have been reluctant to support capitated Medicaid managed care programs for the dual-enrolled population (Verdier, Au, and Gillooly, 2011). Some MMPs have reported that payments within the dual demonstrations do not fully cover the cost of care (Association for Community Affiliated Plans, undated).

An additional barrier for some dually enrolled beneficiaries is the lack of alignment of providers participating in Medicare and Medicaid. To address this, some plans create networks to ensure that they have the capability to offer coordinated care, such as in one health plan described by an interviewee that creates networks of primary care practices, specialists, and durable medical equipment vendors.

## 6. Resources Required to Implement Strategies

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Our third finding is that there is little mention in the literature of the resources or costs required to implement and sustain these strategies, aside from, for example, listing the staff involved in care teams and caseloads for care managers. This is a major gap in the literature and proved to be difficult for interviewees to describe in detail, although an evaluation of the Financial Alignment Initiative may provide some evidence about the cost of some of these strategies. After six months of implementation, the MMPs reported investing heavily in specialized training for care coordinators and developing information systems to support their work (Chepaitis et al., 2015).

### Resources to Support Care Management and Coordination

Care manager caseloads varied substantially across plans and by enrollee risk category. Two health plans reported that they use one care manager for roughly every 50 members, although this does vary by setting: one care manager for every 48 members in home-based care, 60 members in assisted living facilities, and 120 members in skilled nursing facilities (Burwell, Saucier, and Walker, 2010). The MMPs in Ohio have case management staffing levels that vary by level of risk: the intensive (highest risk) group has one care manager for 25–50 enrollees, the high-risk group has 51–75 enrollees per care manager, the medium-risk group has 76–100 enrollees per care manager, the low-risk group has 101–250 enrollees per care manager, and the monitoring group (lowest risk) has 251–350 enrollees per care manager (Barth and Ensslin, 2014).

### Resources to Support Identification and Targeting of Services

The costs of screening for patient needs varies depending on who conducts the screening but can be estimated from the in-home health risk assessments conducted upon initial enrollment by MA plans. These assessments include enrollees' physical, psychosocial, and functional needs; medication reviews; and home risks. These assessments are part of Medicare's annual wellness visit available to all Medicare beneficiaries but are thought to be valuable to MA plans because conditions identified from the assessments could be used in the MA payment hierarchical condition category–adjustment model and increase MA payments (Johnson, 2015). MA plans are also known to ask providers to complete patient health risk assessments to identify and document comorbidities in medical records and, in some cases, pay providers for performing risk assessments. In the initial announcement of the model, the Center for Medicare and Medicaid Innovation proposed paying \$2 per person per year for screening and referrals (Alley et al., 2016), with bridge organizations expected to screen at least 75,000 beneficiaries per year, as

stipulated in the subsequently issued funding opportunity announcement. This is considerably less than the \$5 to \$15 per health risk assessment that is typically charged by vendors that perform assessments as part of wellness programs (Wellness Proposals, 2017). The initial Center for Medicare and Medicaid Innovation announcement also proposed a payment of \$86 per person per year for high-risk beneficiaries in the Assistance and Alignment Track of the Accountable Health Communities who elect intensive community service navigation services to help connect patients to community services (Alley et al., 2016).

## Resources to Provide Services That Directly Address Social Needs

The Bipartisan Policy Center estimated the per-beneficiary per-month (PBPM) cost of providing selected non-Medicare-covered support services to community-dwelling Medicare beneficiaries who are not on Medicaid and have at least three chronic conditions and functional or cognitive impairment (Bipartisan Policy Center, 2017). The average cost of weekly frozen in-home meal delivery was estimated to be \$36 per eligible beneficiary per month. Assuming that only 20 percent of the targeted beneficiaries would receive the service, this translates to \$1.25 PBPM across the entire enrolled population. Assuming that only 10 percent of the targeted beneficiaries sought minor home modifications, the increase would be just \$0.25 PBPM. The estimate for nonemergent medical transportation is assumed to average 1.25 round trips per targeted beneficiary per month, for an estimated increase of \$1.75 PBPM. Lastly, if targeted case management were received by approximately 20 percent of the targeted beneficiaries, it would be \$1.00 PBPM (Bipartisan Policy Center, 2017), for a combined \$4.25 PBPM across the four services. For reference, in 2017, MA plans received an average PBPM rebate amount of \$89 (Bipartisan Policy Center, 2017).

## Resources to Support Integration

Currently, there is little information published about plans' administrative costs to integrate benefits and processes, but evaluations of the Financial Alignment Initiative demonstration programs are expected to provide greater insight.

Finally, although this environmental scan focused on specific strategies that plans and providers employ to improve care and outcomes for their high-risk populations, it is worth noting that many such interventions require broader, more-coordinated support, at the level of the health system, to be truly transformational. A recent National Academy of Medicine report identified a set of six system practices that have been adopted by some health plans and health systems to care for their socially at-risk populations (National Academies of Sciences, Engineering, and Medicine, 2016). These practices range from an organizational commitment to health equity to comprehensive needs assessments and collaborative partnerships. Some health plans have adopted these broader practices to incorporate health equity into their organizations and permeate how they identify and address potential disparities in care for vulnerable patients with social risk

factors, including dually enrolled beneficiaries. More information on systems-based approaches to social risk can be found in the National Academy of Medicine report (National Academies of Sciences, Engineering, and Medicine, 2016).

## 7. Evidence of Success

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Our fourth main finding is that the evidence for efficacy of the studied strategies is of moderate quality. In the previous chapters, we described activities undertaken to support dually enrolled and other high-cost, high-need beneficiaries, and here we summarize the literature assessing the effectiveness of these strategies. Many studies have limited follow-up time or examine associations rather than provide the kind of strong evidence that comes from randomized designs. Appendix E lists the cited literature, some of which may not be peer reviewed.

### Studies Focused on Dually Enrolled Beneficiaries

#### *D-SNP Evaluations*

One study focused on the factors that distinguished high- and low-performing D-SNPs (Dobes and Bernstein, 2016). The authors stratified D-SNPs by the Healthcare Effectiveness Data and Information Set (HEDIS) star measure for blood sugar control; they defined low-performing plans as those with one or two stars and high-performing plans as those with four or five stars. Using data from the CMS Health Plan Management System and HEDIS, they compared the characteristics of low- and high-performing plans. They found that high-performing plans were more likely to be nonprofits and perform health risk assessments. The high-performing plans also conducted more assessments of body mass index, which is also measured by the Star Rating program; this suggests that the plans that performed well on the blood sugar control measure might have systems in place to support high performance on many Star Rating measures. In addition, high-performing plans used interdisciplinary teams for care management and health and wellness coaches for patient self-management, and some used interactive voice response systems to remind patients to take their medications. It should be noted that this study compared results among only seven plans and did not use any statistical significance testing.

We also identified three evaluations in the non-peer-reviewed literature. The first evaluation examined Mercy Care, a D-SNP that focused its efforts on care coordination and management, with a variety of components, including health risk assessments, patient-centered medical homes, evidence-based guidelines, tools to support providers, health coaching and education, medication management, linked medical data, and predictive modeling to target interventions (Murugan, Drozd, and Dietz, 2012). Risk-adjusted analyses compared the plan's performance with Medicare FFS dually enrolled beneficiaries nationally for calendar year 2009. Mercy Care had 3 percent more access to preventive health services, a 31 percent lower discharge rate, 43 percent

fewer days spent in the hospital, 19 percent lower average length of stay, 9 percent lower rate of emergency department utilization, and a 21 percent lower readmission rate.

The second evaluation compared service delivery patterns of dually enrolled beneficiaries age 65 and older enrolled in MSHO (the fully integrated Medicare-Medicaid program described previously) with those enrolled in Minnesota Senior Care Plus (MSC+), a Medicaid-only program with managed care plans in which case managers assist beneficiaries in obtaining Medicaid-covered services. Seniors enrolled in MSC+ have the option of enrolling in either Medicare FFS or an MA plan for their Medicare-covered services. MSHO provides care coordinators to assist beneficiaries with both Medicare- and Medicaid-covered services. After the researchers controlled for observable beneficiary characteristics and case mix, they saw that MSHO enrollees had significantly fewer hospitalizations, fewer outpatient emergency department visits, fewer specialist visits, and fewer assisted living services than MSC+ enrollees did. MSHO enrollees were also more likely to receive home- and community-based services and hospice care. There were no significant differences in long-term nursing home admissions (Anderson, Feng, and Long, 2016).

The third evaluation assessed the effect of SCAN's D-SNP, which included care management teams with case managers focused on coordinating services across providers and settings, information and assistance tailored to the individual beneficiaries, and provider support for use of evidence-based practice guidelines (Avalere Health, 2012). Compared with FFS beneficiaries, the D-SNP beneficiaries had 14 percent fewer hospitalization, and had almost 25 percent fewer readmissions.

A GAO report compared D-SNPs with traditional MA plans on process-of-care measures, outcomes, and utilization to assess whether integration with Medicaid was associated with improved quality of care and reduced Medicare spending (GAO, 2014). Compared with traditional MA plans, D-SNPs had better performance on measures for process of care and health outcomes for disabled dually enrolled beneficiaries in 2011; D-SNPs performed better on two-thirds of the process measures examined, with average performance ranging from 6 percentage points lower to 9 percentage points higher than traditional MA plans (no significance testing was reported). D-SNPs performed better on average than traditional MA plans for all seven health outcome measures examined, with the difference in performance ranging from 3 to 6 percentage points higher for D-SNPs. The difference in performance was even greater among disabled dually enrolled beneficiaries with at least six chronic conditions. Similarly, average performance for aged dually enrolled beneficiaries was better in D-SNPs than in traditional MA plans.

Compared with traditional MA plans, disabled dually enrolled beneficiaries in D-SNPs had similar utilization of inpatient stays, readmissions, and emergency department visits. Among disabled dually enrolled beneficiaries with six or more chronic conditions, traditional MA plans and D-SNPs had similar inpatient stays and readmissions, but those in D-SNPs had more emergency room visits. Aged dually enrolled beneficiaries in D-SNPs had similar use of inpatient stays, readmissions, and emergency department visits as those in traditional MA plans

(GAO, 2014). GAO concluded that the level of integration that D-SNPs have with Medicaid is unlikely to reduce Medicare spending, but performance on measures for process of care and health outcomes would likely be better for disabled dually enrolled beneficiaries.

### *FIDE-SNPs*

There is limited evidence on the effectiveness of FIDE-SNPs. A 2014 GAO report assessed the potential for FIDE-SNPs to increase quality while reducing Medicare and Medicaid spending for disabled dually enrolled beneficiaries (GAO, 2014). In 2013, FIDE-SNPs were higher quality, on average, than other D-SNPs. The 14 FIDE-SNPs identified as high quality in 2013 all operated in four states through which D-SNPs fully integrated Medicare and Medicaid benefits (California, Massachusetts, Minnesota, and Wisconsin).<sup>3</sup> Interviews with executives from high-quality FIDE-SNPs more often reported the implementation of care-transition staff in hospitals and financial incentives for providers than executives from other D-SNPs did (GAO, 2014). FIDE-SNPs are less likely than other D-SNPs to serve disabled dually enrolled beneficiaries (27 percent versus 64 percent, respectively).<sup>4</sup> Only two of the high-quality FIDE-SNPs served disabled beneficiaries (GAO, 2014).

One approach to understanding whether the additional services and coordination provided by FIDE-SNPs and D-SNPs had a return on investment is to compare the risk-adjusted bids with Medicare FFS spending. On average, FIDE-SNP bids were 6 percent above Medicare FFS spending, and less than 25 percent of FIDE-SNPs submitted bids that were lower than Medicare FFS spending in 2013. The bids of other D-SNPs were 4 percent below Medicare FFS spending, on average. This indicates that the overall costs associated with FIDE-SNPs are higher than both other D-SNPs and Medicare FFS and that other D-SNPs have lower overall costs than Medicare FFS (GAO, 2014). This, in turn, suggests that the additional operating expenses of FIDE-SNPs are not completely offset by reductions in health care spending.

### *Financial Alignment Initiative*

A 2015 report on the implementation of the Financial Alignment Initiative describes the early experiences of seven demonstrations that began by May 1, 2014 (Chepaitis et al., 2015). The findings are a result of site-visit interviews with stakeholders, quarterly data submissions by the states, quarterly meetings between the evaluator and state representatives, reports from states' internal evaluators, and additional state-specific documentation. This initial report primarily describes issues associated with implementing integration of Medicare and Medicaid systems

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<sup>3</sup> California, Massachusetts, and Minnesota participate in the Financial Alignment Initiative. FIDE-SNPs that receive at least four stars in the Part C rating operate in California, Massachusetts, Minnesota, Wisconsin, and New York. New York is also a Financial Alignment Initiative state.

<sup>4</sup> A plan with at least ten disabled enrollees was considered to serve disabled beneficiaries.



and policies, enrollment, implementing care coordination, and stakeholder engagement. Subsequent annual reports for each demonstration and annual cross-state reports will provide evidence on beneficiary experience, quality of care, access, and cost as additional data become available.

The first annual report for the Washington and Massachusetts demonstrations were released in August 2016 and September 2016, respectively. Reports for other states are not yet available. The Washington demonstration focuses on a high-cost, high-risk population and emphasizes patient engagement and care coordination (RTI International, 2016a). Health homes were implemented to act as a bridge between the existing delivery systems; a completed health action plan is required before enrollees receive care coordination through the health homes. State officials reported that the care coordination model improves enrollee health and reduces repeat hospitalizations and emergency department use. Focus groups with 32 beneficiaries indicated that more than half experienced improved health or quality of life since the beginning of the demonstration. They viewed their care coordinators as helpful in accessing services, health information, and other resources, as well as with goal setting and the development of a plan to achieve health goals, although some found the differentiation between care coordinators and service-specific case managers confusing. Quantitative analyses indicated that dually enrolled beneficiaries enrolled in the demonstration had higher in-patient, emergency department, skilled nursing facility, and ambulatory care utilization than eligible beneficiaries not in the demonstration, which could indicate that the demonstration filled previously unmet needs. Further, enrollees who engaged with their care coordinators and received health home services had higher utilization than enrollees who had not yet been contacted by a care coordinator, which could reflect prioritization to those with greater need. Although there was a greater increase in the use of pneumococcal vaccination among eligible beneficiaries between the baseline and demonstration periods than in the comparison groups, other patterns of utilization and quality of care were similar between the two groups (RTI International, 2016a).

The Massachusetts demonstration (One Care) is limited to nonelderly adult, dually enrolled beneficiaries enrolled in Medicare Parts A and B who are eligible for Part D and have no other comprehensive insurance. It is estimated that 70 percent of these beneficiaries have behavioral health needs (Barry et al., 2015). The demonstration fully integrates Medicare and Medicaid, including eligibility determination, enrollment, care delivery, quality management, grievances, and appeals. Care coordination for services overall is offered to all enrollees in the demonstration, with an additional coordination for LTSS available from community-based organizations (RTI International, 2016b). The MMPs in Massachusetts experienced losses in their first year, in part because of the start-up resources required to integrate the programs; one of the three initially participating plans withdrew in October 2015. Plans experienced problems processing enrollment and locating enrollees for initial assessments during the passive enrollment period (Barry et al., 2015; RTI International, 2016b). State officials and stakeholders reported that care coordination was valuable for connecting enrollees with both new and

previously existing services and resources. The additional coordinator for LTSS was also viewed as an important part of the demonstration. Enrollees who participated in focus groups reported overall satisfaction with the demonstration and the new services available to them, although some concerns were expressed about the quality of the transportation services. Although enrollees expressed satisfaction with the care coordinator, a number were unsure whether they had also received LTSS coordination services. Quantitative analyses of utilization and quality measures showed few positive effects of the demonstration, which may reflect the difficulties experienced in locating beneficiaries (RTI International, 2016b).

### *Evaluations of Targeted Interventions in SNPs*

There are a limited number of formal evaluations in the peer-reviewed literature of interventions used by SNPs. One study of an over-65 population enrolled in a D-SNP found that a community-care-manager model, in which registered nurses provided home visits and coordinated care via telephone calls, had a positive effect on rates for quality improvement of primary care physicians across measures related to falls, dementia, depression, nutrition, urinary incontinence, and end-of-life care (Roth et al., 2012). Another report studied the effect of a medication-adherence intervention on adherence rates and CMS Part D Star Ratings (Leslie et al., 2014). This intervention identified nonadherent patients and used care managers and coordinators to call patients regarding their medication. In these calls, they inquired about patient medication-taking habits and educated patients on their medications. Members were offered a home-delivery service to help with their adherence and fill rates. The researchers found that adherence rates increased by as much as 15 percentage points, and there was a corresponding increase in the Part D Star Rating from three to three and a half stars.

Mattke and colleagues evaluated a house-call program for members of a C-SNP (Mattke et al., 2015). These were annual home visits for qualified members in which a physician or nurse practitioner provided a physical examination, medication review and reconciliation, depression screening, lab tests, and nutritional assessment. The results of these visits were shared with the patients' primary care providers, and necessary follow-up visits were coordinated by the health plan. The researchers found that members receiving the intervention had as much as a 14 percent reduction in hospital admissions and a 1.3 percent lower risk of nursing home admission. These members also had 2–6 percent more office visits.

Cohen and colleagues evaluated the effect of a model of care for enhanced primary care and coordinating services for diabetics—specifically, the use of physician office visits and hospital days in the Care Improvement Plus C-SNP (Cohen et al., 2012). The multipronged model of care included (1) house calls by trained nurse practitioners and physicians, including a health risk assessment used to develop a tailored care plan; (2) nurse care management that included a hotline and coaching calls; (3) the PharmAssist program through which pharmacists evaluated medication use to identify problems, such as incorrect drugs or doses, duplicate medications, drug interactions, side effects, and gaps in care; (4) the coordination of social services by

contractual arrangements; (5) a transitions-in-care program that had transition coaches who work to improve continuity of care, ensure that caregivers and providers are informed, and prevent hospital readmissions; and (6) an advanced-illness program that used nurse care managers to discuss end-of-life preferences with terminal beneficiaries. Compared with FFS diabetic beneficiaries, C-SNP diabetic beneficiaries used 7 percent more physician office visits, and risk-adjusted hospital days were almost 20 percent lower among diabetics in the C-SNP.

Guerard and colleagues studied the effect of a comprehensive wellness assessment on medication adherence for D-SNP members of an MA plan (Guerard et al., 2016). This annual evaluation, which was completed at the patient's preferred location (e.g., home, office), was performed by a nurse practitioner and aimed to improve self-management and patient engagement for D-SNP members with diabetes. The researchers found that members receiving the assessment improved monthly adherence rates by 3.9 percentage points.

## Care Coordination Literature

The broad literature on care coordination has the strongest evidence to support its use for congestive heart failure, diabetes, severe mental illness, recent stroke, and depression. Effective care coordination provides health care and social support interventions in settings ranging from the home to post-acute care settings (Peikes et al., 2009). Evidence about the key components of care coordination is weaker (McDonald et al., 2007). However, analyses of the 15 programs in the Medicare coordinated care demonstration identified six components that differentiated programs that successfully reduced hospitalizations from less successful interventions: (1) risk assessment and stratification to target interventions to those at high risk for hospitalizations; (2) regular in-person contact with patients in addition to telephone contact; (3) timely information about hospital admissions and emergency department visits; (4) teamwork between care coordinators and primary care physicians that includes face-to-face interaction; (5) interventions that focus on patient assessment, care planning, patient education, monitoring, and coaching on self-management, as well as the ability to arrange or coordinate with social support services, such as assistance with activities of daily living and transportation; and (6) staffing care coordination programs with registered nurses and social workers (Brown, 2009). Although the programs differed in their approaches, features common to all programs were use of care coordinators (level of training varied), assessment of patient needs, development of patient care plans, and provision of patient reports to physicians (Peikes et al., 2009). All but one of the programs provided patient education.

Only one of the programs in the Medicare coordinated care demonstration significantly reduced annual hospitalizations, compared with controls, although a second program approached statistical significance. None of the programs significantly reduced Medicare expenditures, compared with controls. There were few statistically significant differences in clinical process-of-care measures, and no one program distinguished itself (Peikes et al., 2009). A follow-up

evaluation of the 11 programs that CMS extended for an additional two years produced similar results (Brown et al., 2012). Two of those programs reduced hospitalizations among enrollees by 11 to 12 percent. However, four programs reduced hospitalizations among enrollees at high risk of a hospitalization by 8 to 33 percent.<sup>5</sup> Among these four programs, the reduction in Medicare expenditures offset the care management fees, making the effective programs cost-neutral. The evaluators identified six care manager activities that were present in at least three of the four successful programs and not present in most or all of the ineffective programs: (1) frequent (approximately monthly) in-person meeting with patients in addition to telephone calls, (2) occasional in-person meetings with providers, (3) serving as a communication hub for providers, (4) providing patient education that is evidence-based, (5) providing medication management that includes obtaining medication information from sources other than the patient and consulting with a pharmacist about medication problems, and (6) providing transitional care for hospitalizations that involved visiting the patient while still in the hospital and obtaining discharge instructions.

A model of care coordination for use in a Medicare population is the Geriatric Resources for Assessment and Care of Elders (GRACE) program. Although its adoption appears to be limited, it has some similarities with the more-intensive models of care coordination used by MA plans focusing on dually enrolled beneficiaries and MMPs. GRACE involves the use of an in-home assessment performed by a nurse practitioner and social worker to develop an individualized care plan in conjunction with a broader multidisciplinary care team made up of a geriatrician, pharmacist, physical therapist, mental health social worker, and community-based services liaison (Bielaszka-DuVernay, 2011; Counsell et al., 2006). A randomized controlled trial of almost 1,000 dually enrolled adults showed greater physician satisfaction, lower annual hospitalization rates, and after three years total health care costs were \$1,500 lower (Bielaszka-DuVernay, 2011). The estimated implementation costs of GRACE were approximately \$1,260 per patient per year and included, for each group of 250 patients, a two-person support team (the nurse practitioner and social worker), two full-time equivalent (FTE) nurse practitioners, two FTE social workers, 0.5 FTE administrative assistant, and 0.1 FTE for each of the following: geriatrician, pharmacist, physical therapist, mental health social worker, community-based services liaison, and practice manager (Counsell et al., 2009).

A pilot test of another care coordination model—Promoting Effective Advance Care for Elders (PEACE), an in-home interdisciplinary care management intervention delivered by long-term care providers with input from a geriatrics and palliative care interdisciplinary team from a local hospital—included 80 patients. PEACE emphasizes symptom management, medication

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<sup>5</sup> High-risk enrollees were defined as either (1) having at least one of three major chronic conditions (congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease) and at least one hospitalization in the year prior to enrollment or (2) having at least one of nine chronic conditions and more than one hospitalization in two years prior to enrollment.

reconciliation, consumer activation, goal setting, and coaching for advanced care planning. There were no significant differences in symptom control, quality of life, or other main outcomes between the PEACE and comparison groups at 12 months, although the sample size was small. It was estimated that the intervention cost \$942 per patient per year, assuming a caseload of 100 clients per PEACE provider (Radwany et al., 2014).

## Literature on High-Cost, High-Need Patients

The literature that focuses broadly on high-cost, high-need patients (who may or may not be dually enrolled patients) indicates that there are a number of strategies that have improved care for patients and may also reduce the cost of care. The ability to successfully target these patients and assess which ones will likely benefit from more-intensive services is a critical first step (Davis et al., 2015; Anderson et al., 2015; McCarthy, Ryan, and Klein, 2015). Interventions aimed at individuals who are not amenable to change are unlikely to improve outcomes and may be a drain on scarce resources. Recent reviews of evidence indicate that the most-effective care management programs for improving care quality and reducing hospitalizations for patients with complex needs are those focused on care transitions, particularly hospital-to-home transitions (Anderson et al., 2015; McCarthy, Ryan, and Klein, 2015). Some studies also show strong evidence of an improvement in quality of care for care management provided on-site in primary care practices (McCarthy, Ryan, and Klein, 2015). Another successful strategy is the engagement of patients and family caregivers in self-care through frequent face-to-face contact in a physician's office, in a hospital, or at home (Anderson et al., 2015; McCarthy, Ryan, and Klein, 2015). Finally, addressing the nonmedical needs of high-cost, high-need patients, such as housing and nutritional assistance, can improve their health and reduce their shealth care costs (Taylor et al., 2015). The effective use of health information technology to provide timely data and facilitate coordination of care across providers and services is an important facilitator of all of these strategies (Anderson et al., 2015; McCarthy, Ryan, and Klein, 2015).

Davis and colleagues identified nine care delivery and payment innovations for high-cost Medicare beneficiaries that have some evidence of improved care and outcomes, better patient experience, and lower cost (Davis et al., 2015). Seven of the nine innovations involved enhanced care management or coordination consistent with the Wagner chronic care model, such as a team approach to care, nonmedical personnel as part of the team, patient engagement, family and provider education, and information systems to provide timely information to providers. One of the models involved home repairs to address problems with activities of daily living.

## 8. Unanswered Questions and Next Steps

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The information presented here describes a range of services that plans and health care providers deliver and how they meet the needs of dually enrolled beneficiaries. However, a number of questions remain regarding how the needs of dually enrolled and other high-cost, high-need beneficiaries are met. What is the prevalence of these identified services and activities? How do they affect quality of care for beneficiaries and plans' performance on related metrics? What does it cost for plans to identify, target, and deliver supportive social services to beneficiaries? What is the role of the community, Medicaid state agencies, and the state environment in determining whether dually enrolled beneficiaries receive the social support services they need? These questions are discussed in this chapter and summarized in Table 8.1. Such questions could be evaluated through a larger sample of health plans and providers via interviews, in-depth case studies, surveys, or other mechanisms.

### Prevalence of Identified Services

Many of the services and activities identified represent best practices used by plans that are designed to meet the needs of dually enrolled beneficiaries and emerged from the literature focused on D-SNPs, FIDE-SNPs, and MMPs rather than MA plans more broadly. It is unclear how universally these services and activities are adopted by these types of plans. It is also unknown how often MA plans that are not SNPs, some of which have a high proportion of beneficiaries who are dually enrolled, provide these services. Although the majority of dually enrolled beneficiaries in MA are in SNPs, many are still in traditional managed care plans. It is unclear whether these plans direct services to meet the needs of dually enrolled beneficiaries. It is also unknown how plans' characteristics, such as profit status or the characteristics of the communities in which plans operate, affect their activities.

The available information also does not definitively answer how these services are related to plan performance as measured by Star Ratings. Because we only interviewed one health plan, we do not know how often plans that perform well with dual beneficiaries implement additional services and whether plans that perform poorly do not implement additional services or just do not perform them as well. There are no quantitative studies or nationally representative surveys that have assessed the frequency with which these types of services are delivered and whether there is a correlation with plan performance. We also do not know whether these services are the reasons high-performing plans do better or whether there are other contextual reasons, such as leadership commitment, different local and community resources, or state policy environment.

**Table 8.1. Potential Questions for Further Evaluation with Qualitative Studies**

Domain	Potential Research Question
Prevalence of identified services and activities and plan performance	<ul style="list-style-type: none"> <li>• How widespread are the adoption of activities and services identified in the environmental scan?</li> <li>• Do traditional MA plans target programs for dually enrolled and other high-cost, high-need beneficiaries?               <ul style="list-style-type: none"> <li>○ What are the barriers to targeting programs?</li> </ul> </li> <li>• How do plans' characteristics, such as profit status and leadership commitment, affect their activities?</li> <li>• How do the services provided vary by the characteristics of dually enrolled beneficiaries?</li> <li>• How are services related to plan performance?               <ul style="list-style-type: none"> <li>○ How often do plans that perform well with dual beneficiaries implement additional services?</li> <li>○ Do poorly performing plans not implement additional services or not implement services as well as high-performing plans?</li> </ul> </li> </ul>
Cost of identifying need, targeting, and delivering services	<ul style="list-style-type: none"> <li>• What is the cost of providing additional services? Are these costs offset by reduced health care spending?</li> <li>• What are the most-efficient ways to deliver effective care coordination?</li> <li>• What is the most effective mix of clinical and social interventions to support dually enrolled beneficiaries, and how does this vary by the type of beneficiary?</li> <li>• How can care coordination be provided efficiently, and how does caseload need vary by type of beneficiary or beneficiary risk?</li> <li>• What data and strategies are most effective for identifying high-risk dually enrolled and other high-cost, high-need beneficiaries?</li> </ul>
Role of the community, Medicaid program, and state environment	<ul style="list-style-type: none"> <li>• How does the availability of community resources affect the ability of plans to meet the social needs of their beneficiaries?</li> <li>• Does the availability of community resources affect the activities undertaken by plans?</li> <li>• How do the activities undertaken by the state Medicaid agencies and Medicaid plans affect actions taken by MA plans?</li> <li>• Is there a minimum level of Medicare and Medicaid integration that is necessary to adequately decrease barriers experienced by dually enrolled beneficiaries?</li> <li>• To what extent does the quality and generosity of Medicaid affect MA plan performance?</li> </ul>

## Costs of Identified Services

Little information was available about the cost of these services, although the information available suggests that the additional costs are not fully offset by reductions in health care spending. The literature also suggests that care coordination activities may be cost-neutral in the best circumstances and indicates that additional research is needed to identify cost-effective ways to deliver care management and target resources toward high-risk enrollees.

## Role of Community, Medicaid State Agencies, and State Environment

The extent to which state Medicaid agencies have an impact on the activities undertaken by MA plans is also unknown. The environmental scan and early reports on FIDE-SNPs and MMPs suggest that Medicaid policies and infrastructure may play a role, but it is too early to tell

without final evaluation results. Some of the services and activities identified, such as addressing social needs, are often performed by Medicaid agencies rather than MA plans. Medicaid programs may also take the lead in integration and coordination activities and offering LTSS. Thus, a high-quality Medicaid program may need to be present before MA plans are able to meet the needs of dually enrolled beneficiaries. Medicaid programs may be reluctant to make investments in certain types of services and activities because reduced health care spending in the form of reduced hospitalizations, readmissions, emergency department visits, and outpatient specialty care would accrue to the Medicare program rather than to Medicaid.

## Future Research

The questions we have raised would require in-depth case studies to better understand and describe the role of the factors we have discussed and how they interact with services provided by plans to influence performance and patient outcomes. It may be that targeted plan services for dual beneficiaries are a necessary but insufficient component to overcoming barriers and providing high-quality care. The case studies could target plans that are high performing or low performing, have a high or average share of duals, and are located in states with or without financial alignment demonstrations, for example. The types of individuals who would ideally be included in the case studies include plan leadership, quality program leaders who could address the role of care managers and their caseloads, and personnel with financial responsibilities who could address the resources required for programs. Appendix D provides a list of MA plans and MMPs that the environmental scan and interviews suggest are appropriate candidates for case studies because they are either high performing or have implemented innovative models or care or interventions.



## 9. Summary and Conclusions

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It is increasingly recognized that dually enrolled and other high-cost, high-need Medicare beneficiaries experience challenges to 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, but some MA plans that care for a high proportion of dually enrolled beneficiaries, or other high-cost high-need beneficiaries, are high performers. These findings suggest that some plans that focus on dual beneficiaries have identified effective ways to meet the needs of their dually enrolled beneficiaries.

In this environmental scan, we found that the needs of dually enrolled beneficiaries largely mirror the needs of high-cost, high-need patients more broadly. Health plans, providers, and their community partners adopt a variety of strategies to meet the varied needs of dually enrolled and other high-cost, high-need beneficiaries. The activities we identified can be grouped into four categories: (1) identifying needs and data analytics to better target programs toward patients at high risk for hospitalization, readmissions, 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; and (4) undertaking administrative actions to better integrate Medicare and Medicaid.

The findings we presented here can be used in the development of a second research phase that features a series of case studies with high- and low-performing MA plans. Currently, little information is available about resources or costs required to implement and sustain these strategies, aside from staff directly involved in patient care. Additionally, the evidence base for these strategies is only moderate in strength. Many questions remain regarding how the needs of dually enrolled and other high-cost, high-need beneficiaries are met that may be important to address in future work. Answering such questions could help improve the health and clinical outcomes of dually enrolled and other high-cost, high-need patients.

## Appendix A. Discussion Guide

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The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 calls for the Secretary of Health and Human Services, acting through ASPE, to evaluate the effect of an individual's SES on quality measures included in Medicare programs, explore variables other than dual enrolment, and conduct qualitative work to inform the other data analytics. This appendix contains the discussion guide used with health plan representatives as part of this research.

### IMPACT Act Qualitative Study of Medicare Advantage Health Plans: Types and Costs of Services for Dual Beneficiaries

#### *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 of 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 eligibles and socially at-risk Medicare beneficiaries as they seek care?
  - a. 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.
  - b. Please describe subgroups of dual eligible that may experience greater challenges.
  - c. What role do health plans play in addressing these challenges?
2. What additional services, interventions, supports and resources do health plans/contracts provide to dual beneficiaries?
  - a. Are these services targeted to duals, or are they available to any individual with particular needs?
  - b. What factors motivate health plans to focus on duals?
  - c. What role does leadership/management play in implementing additional services for dual beneficiaries?
  - d. How do health plans identify services or interventions to provide to dually eligible beneficiaries?
  - e. Which additional resources would health plans need to best provide care for dual beneficiaries?
  - f. How do services vary by MA plan type (e.g., size, SNP status)?
  - g. How do high-dual contracts interact with state Medicaid programs or community-based organizations to provide services?
  - h. 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?
  - a. What types of resources (both in terms of people and other resources) are necessary to provide additional services to dual beneficiaries?
  - b. How do plans budget and account for these approaches, services or extra resources?
  - c. 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?

- a. How do health plans assess the impact of services to support duals?
  - b. Are evaluations performed or the return on investment assessed to justify the continued provision of services?
  - c. 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?
  6. How do health plans work with other groups in the community including social or community providers to support the needs of dual eligible?
    - a. What types of organizations do health plans work with?
    - b. 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?
      - i. Probes: social services, church organizations, patient advocacy groups.
      - ii. What types of services or supports do they provide?
    - c. What other resources in the community are missing but would be helpful in supporting the needs of dual beneficiaries?
  7. Do you have suggestions for MA health plans that we should consider, including in case studies, and what makes them good candidates?
  8. Is there anything else that you would like to add?
  9. If we have clarifying questions as we are preparing our summary, may we contact you again?

Thank you for your time today.

## Appendix B. Financial Alignment Demonstrations

Model and State	Demonstration Name	Implementation Date	Eligible Medicare-Medicaid Population	Enrollment (as of June 2016)
Capitated model				
California	Cal MediConnect	April 1, 2014	Age 21 and older	122,905
Illinois	Medicare-Medicaid Alignment Initiative	March 1, 2014	Age 21 and older	48,468
Massachusetts	One Care	October 1, 2013	Ages 21–64 <sup>a</sup>	13,106
Michigan	MI Health Link	March 1, 2015	Age 21 and older	40,884
New York	Fully Integrated Duals Advantage	January 1, 2015	Age 21 and older who require particular types of LTSS	5,516
	Fully Integrated Duals Advantage: Intellectual/Developmental Disabilities		Age 21 or older with intellectual or developmental disabilities	206
Ohio	MyCare Ohio	May 1, 2014	Age 18 and older	62,981
Rhode Island	Medicare-Medicaid Alignment Integrated Care Initiative Demonstration	June 1, 2016	Age 21 and older	N/A
South Carolina	Healthy Connections Prime	February 1, 2015	Age 65 or older who reside in community at the time of enrollment	5,614
Texas	Dual Eligible Integrated Care Demonstration Project	March 1, 2015	Age 21 and older who qualify for Supplemental Security Income or Medicaid home- and community-based services	42,924
Virginia	Commonwealth Coordinated Care	April 1, 2014	Age 21 and older	27,768
Managed FFS model				
Colorado	Financial Alignment Demonstration	September 1, 2014	Age 21 and older	24,860
Washington	Health Homes Managed Fee-for-Service	July 1, 2013	All ages	20,179

SOURCE: Philip, Kruse, and Soper, 2016, pp. 8–10.

NOTE: N/A = not applicable.

<sup>a</sup> Only individuals ages 21–64 at the time of enrollment are eligible, but beneficiaries may remain enrolled in their MMPs once they turn 65, as long as they maintain dually eligible status.

## Appendix C. Examples of Risk Stratification Used by Medicare-Medicaid Plans

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State	Stratification Levels	Basis of Stratification
California	Two: high, low	<ul style="list-style-type: none"> <li>• On oxygen within past 90 days</li> <li>• Hospitalized in past 90 days or at least three hospitalizations in past year for behavioral health conditions</li> <li>• Receive In-Home Supportive Services for at least 195 hours per month</li> <li>• Enrolled in Multipurpose Senior Service Program</li> <li>• Receive Community-Based Adult Services</li> <li>• Have end-stage renal disease, AIDS, or recent organ transplant</li> <li>• Currently treated for cancer</li> <li>• Prescribed antipsychotic medication in past 90 days</li> <li>• Prescribed 15 or more medications in past 90 days</li> <li>• Have other condition as determined by MMP</li> </ul>
Ohio	Five: intensive, high, medium, low, monitoring	<ul style="list-style-type: none"> <li>• Duration of 1915(c) home- and community-based services waiver enrollment</li> <li>• Current waiver acuity level</li> <li>• Change in existing care manager relationship</li> <li>• Presence and severity of chronic conditions</li> <li>• Polypharmacy</li> <li>• Nursing facility or assisted-living facility placement</li> <li>• Functional or cognitive deficits</li> <li>• Risk factors for being institutionalized</li> <li>• Inpatient or emergency department utilization</li> <li>• Residential housing status</li> <li>• Gaps in care</li> <li>• Stability of support system</li> </ul>
Virginia	Four: community well; vulnerable subpopulation; elderly or disabled with consumer direction vulnerable subpopulation; nursing facility vulnerable subpopulation	<ul style="list-style-type: none"> <li>• Intellectual or developmental disabilities</li> <li>• Cognitive or memory problems</li> <li>• Physical or sensory disabilities</li> <li>• Serious and persistent mental illness</li> <li>• End-stage renal disease</li> <li>• Complex or multiple chronic conditions</li> <li>• Enrolled in 1915(c) Elderly or Disabled with Consumer Direction waiver and would otherwise require care in nursing facility</li> <li>• Residing in nursing facilities</li> </ul>

SOURCE: CMS, 2018b.

## Appendix D. Potential Targets for Case Studies Identified Through Environmental Scan and Interviews

<b>Health Plan</b>	<b>Type of Plan</b>	<b>State</b>	<b>Named in Environmental Scan Documents</b>	<b>Mentioned in Interviews</b>
Aloha Care	D-SNP	HI		X
Care Improvement Plus	D-SNP	AR, MO, GA, SC, TX, WI	X	
Geisinger Health Plan <sup>a</sup>	D-SNP	PA	X	
Health Partners	D-SNP	MN	X	X
Independent Care Health Plan (iCare)	D-SNP	WI	X	X
Kaiser Foundation Health Plan <sup>a</sup>	D-SNP	CA	X	X
Mercy Care	D-SNP	AZ	X	
NaviCare	D-SNP	MA	X	
People's Health	D-SNP	LA	X	
SCAN Long Term Care	D-SNP	AZ	X	
Senior Whole Health	D-SNP	MA	X	
UCare	D-SNP	MN	X	
UnitedHealth Care	D-SNP	FL	X	
UPMC Health Plan <sup>a</sup>	D-SNP	PA	X	X
VNSNY Choice <sup>a</sup>	D-SNP	NY	X	X
WellCare Health Plan	D-SNP	CT, FL, GA, HI, KY, LA, NJ, NY, TX		X
CalOptima	MMP	CA	X	
CareSource <sup>a</sup>	MMP	OH	X	
Commonwealth Care Alliance <sup>a</sup>	MMP	MA	X	X
Community Health Group of San Diego <sup>a</sup>	MMP	CA	X	
Elderplan	MMP	NY	X	
GuildNet <sup>a</sup>	MMP	NY	X	
Health Plan of San Mateo <sup>a</sup>	MMP	CA	X	X
Inland Empire Health Plan	MMP	CA	X	
Neighborhood Health Plan of Rhode Island <sup>a</sup>	MMP	RI	X	X
Santa Clara Family Health Plan	MMP	CA	X	
VillageCareMax	MMP	NY	X	X
Virginia Premier Health Plan <sup>a</sup>	MMP	VA	X	

<sup>a</sup> Noted for collaboration with social and community services.

## Appendix E. Literature Cited in Chapter Seven, “Evidence of Success”

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- Anderson, Gerard F., Jeromie Ballreich, Sara Bleich, Cynthia Boyd, Eva DuGoff, Bruce Leff, Claudia Salzburg, and Jennifer Wolff, “Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals,” *American Journal of Managed Care*, Vol. 21, No. 11, 2015, pp. e597–e600.
- Anderson, Wayne L., Zhanlian Feng, and Sharon K. Long, *Minnesota Managed Care Longitudinal Data Analysis*, Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, Office of the Assistant Secretary for Planning and Evaluation, March 2016. As of June 18, 2018:  
<https://aspe.hhs.gov/sites/default/files/pdf/204996/MNmclda.pdf>
- Avalere Health, *Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions*, Washington, D.C., March 2012. As of June 18, 2018:  
[http://www.nchc.org/wp-content/uploads/2016/04/20120401\\_scan-dual-eligibles-analysis\\_final\\_for-posting.pdf](http://www.nchc.org/wp-content/uploads/2016/04/20120401_scan-dual-eligibles-analysis_final_for-posting.pdf)
- Barry, Colleen, Lauren Riedel, Alisa Busch, and Haiden Huskanp, *Early Insights from One Care: Massachusetts’ Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries*, Menlo Park, Calif.: Kaiser Family Foundation, 2015. As of June 18, 2018:  
<https://www.kff.org/medicaid/issue-brief/early-insights-from-one-care-massachusetts-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/view/footnotes/>
- Bielaszka-DuVernay, Christina, “The ‘GRACE’ Model: In-Home Assessments Lead to Better Care for Dual Eligibles,” *Health Affairs*, Vol. 30, No. 3, 2011, pp. 431–434.
- Brown, Randall S., Deborah Peikes, Greg Peterson, Jennifer Schore, and Carol M. Razafindrakoto, “Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions of High-Risk Patients,” *Health Affairs*, Vol. 31, No. 6, 2012, pp. 1156–1166.
- Chepaitis, Amy, Angela M. Greene, Sonja Hoover, Galina Khatutsky, Brienne Lyda-McDonald, Catherine Ormond, Edith G. Walsh, Nan (Tracy) Zheng, Maureen Booth, Julie Fralich, Diane Justice, and Alice M. Weiss, *Report on Early Implementation of*



*Demonstrations Under the Financial Alignment Initiative*, Waltham, Mass.: RTI International, 2015.

Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan, “Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients,” *Health Affairs*, Vol. 31, No. 1, 2012, pp. 110–119.

Counsell, Steven R., Christopher M. Callahan, Amna B. Buttar, Daniel O. Clark, and Kathryn I. Frank, “Geriatric Resources for Assessment and Care of Elders (GRACE): A New Model of Primary Care for Low-Income Seniors,” *Journal of the American Geriatrics Society*, Vol. 54, No. 7, 2006, pp. 1136–1141.

Counsell, Steven R., Christopher M. Callahan, Wanzhu Tu, Timothy E. Stump, and Gregory Arling, “Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention,” *Journal of the American Geriatrics Society*, Vol. 57, No. 8, 2009, pp. 1420–1426.

Davis, Karen, Christine Buttorff, Bruce Leff, Quincy M. Samus, Sarah Szanton, Jennifer L. Wolff, and Farhan Bandiali, “Innovative Care Models for High-Cost Medicare Beneficiaries: Delivery System and Payment Reform to Accelerate Adoption,” *American Journal of Managed Care*, Vol. 21, No. 5, 2015, pp. e349–e356.

Dobes, A. M., and R. H. Bernstein, “Successful Strategies for Reducing Disparities in Quality of Care: Lessons From Dual-Eligible Special Needs Plans,” *Journal of Ambulatory Care Management*, Vol. 39, No. 1, January–March 2016, pp. 63–75.

GAO—See U.S. Government Accountability Office.

Guerard, Barbara, Vincent Omachonu, Blake Perez, and Bisakha Sen, “Improvement in Oral Diabetes Medication Adherence After a Comprehensive Wellness Assessment in a Dual Eligible Population,” *Population Health Management*, Vol. 19, No. 6, 2016.

Leslie, R. Scott, Breanne Tirado, Bimal V. Patel, and Philip J. Rein, “Evaluation of an Integrated Adherence Program Aimed to Increase Medicare Part D Star Rating Measures,” *Journal of Managed Care and Specialty Pharmacy*, Vol. 20, No. 12, December 2014, pp. 1193–1203.

Mattke, Soeren, Dan Han, Asa Wilks, and Elizabeth Sloss, “Medicare Home Visit Program Associated with Fewer Hospital and Nursing Home Admissions, Increased Office Visits,” *Health Affairs*, Vol. 34, No. 12, December 2015, pp. 2138–2146.

McCarthy, Douglas, Jamie Ryan, and Sarah Klein, “Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis,” Commonwealth Fund, October 29, 2015. As of June 19, 2018:

<https://www.commonwealthfund.org/publications/issue-briefs/2015/oct/models-care-high-need-high-cost-patients-evidence-synthesis>

- McDonald, Kathryn M., Vandama Sundaram, Dena M. Bravata, Robyn Lewis, Nancy Lin, Sally A. Kraft, Moira McKinnon, Helen Paguntalan, and Douglas K. Owens, *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*, Vol. 7: *Care Coordination*, Kaveh G. Shojania, Kathryn M. McDonald, Robert M. Wachter, and Douglas K. Owens, eds., Rockville, Md.: Agency for Healthcare Research and Quality, June 2007.
- Murugan, Varnee, Ed Drozd, and Kevin Dietz, *Analysis of Care Coordination Outcomes: A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries*, Washington, D.C.: Avalere Health, 2012.
- Peikes, Deborah, Arnold Chen, Jennifer Schore, and Randall Brown, “Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials,” *JAMA*, Vol. 301, No. 6, 2009, pp. 603–618.
- Radwany, S. M., S. E. Hazelett, K. R. Allen, D. J. Kropp, D. Ertle, T. H. Albanese, S. M. Fosnight, and P. S. Moore, “Results of the Promoting Effective Advance Care Planning for Elders (PEACE) Randomized Pilot Study,” *Population Health Management*, Vol. 17, No. 2, 2014, pp. 106–111.
- Roth, Carol P., David A. Ganz, Lorraine Nickels, David Martin, Robin Beckman, and Neil S. Wenger, “Nurse Care Manager Contribution to Quality of Care in a Dual-Eligible Special Needs Plan,” *Journal of Gerontological Nursing*, Vol. 38, No. 7, July 2012, pp. 44–54.
- RTI International, *Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration; First Annual Report*, Waltham, Mass., July 13, 2016a.
- , *Financial Alignment Initiative Annual Report: Once Care: MassHealth Plus Medicare; First Annual Report*, Waltham, Mass., September 1, 2016b.
- Taylor, Lauren A., Caitlin E. Coyle, Chima Ndumele, Erika Rogan, Maureen Canavan, Leslie Curry, and Elizabeth H. Bradley, *Levering the Social Determinants of Health: What Works?* Boston: Blue Cross Blue Shield Foundation of Massachusetts, June 2015. As of June 19, 2018:  
[http://www.bluecrossfoundation.org/sites/default/files/download/publication/Social\\_Equity\\_Report\\_Final.pdf](http://www.bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf)
- U.S. Government Accountability Office, *Disabled Dual Eligible Beneficiaries: Integration of Medicare and Medicaid Benefits May Not Lead to Expected Medicare Savings*, Washington, D.C., GAO-14-423, August 2014. As of September 30, 2016:  
<http://www.gao.gov/assets/670/665491.pdf>

## References

---

Abrams, Melinda, and Arnold Milstein, “Matching Patients to Tailored Care Models: A Strategy to Enhance Care, Improve Outcomes, and Curb Costs,” presented at the National Academy of Medicine Workshop Series on High-Need Patients, October 21, 2016. As of August 31, 2018:

<https://nam.edu/wp-content/uploads/2016/12/Taxonomy-and-care-model-presentation-FINAL.pdf>

Agency for Healthcare Research and Quality, “Care Coordination,” webpage, last reviewed July 2016a. As of June 18, 2018:

<http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>

———, *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes*, Rockville, Md., 2016b.

Ahn, Roy, *HCIA Complex/High-Risk Patient Targeting: Third Annual Report*, Bethesda, Md.: NORC at the University of Chicago, February 2017. As of June 18, 2018:

<https://downloads.cms.gov/files/cmimi/hcia-chspt-thirdannualrpt.pdf>

Alley, Dawn E., Chisara N. Asomugha, Patrick H. Conway, and Darshak M. Sanghavi, “Accountable Health Communities—Addressing Social Needs Through Medicare and Medicaid,” *New England Journal of Medicine*, Vol. 374, No. 1, 2016, pp. 8–11.

Anderson, Gerard F., Jeromie Ballreich, Sara Bleich, Cynthia Boyd, Eva DuGoff, Bruce Leff, Claudia Salzburg, and Jennifer Wolff, “Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals,” *American Journal of Managed Care*, Vol. 21, No. 11, 2015, pp. e597–e600.

Anderson, Wayne L., Zhanlian Feng, and Sharon K. Long, *Minnesota Managed Care Longitudinal Data Analysis*, Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, Office of the Assistant Secretary for Planning and Evaluation, March 2016. As of June 18, 2018:

<https://aspe.hhs.gov/sites/default/files/pdf/204996/MNmclda.pdf>

ASPE—See Office of the Assistant Secretary for Planning and Evaluation.

Association for Community Affiliated Plans, *ACAP Plans and the Duals Demonstrations: Early Progress, Innovations and Challenges*, Washington, D.C., undated. As of September 28, 2016:

<http://communityplans.net/Portals/0/Fact%20Sheets/ACAP%20Plans%20and%20Duals%20Demonstrations%20-%20Early%20Progress.pdf>

- , *Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way*, Washington, D.C., 2014.
- Association of Asian Pacific Community Health Organizations, *Enabling Services Data Collection Implementation Companion*, San Leandro, Calif., 2017. As of August 15, 2018: [http://www.aapcho.org/resources\\_db/enabling-services-data-collection-implementation-packet/](http://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/)
- , *Documenting Social Determinants of Health through Enabling Services: Webinar Resources*, San Leandro, Calif., June 21, 2018. As of August 15, 2018: [http://www.aapcho.org/resources\\_db/documenting-sdoh-interventions-through-enabling-services-webinar-resources/](http://www.aapcho.org/resources_db/documenting-sdoh-interventions-through-enabling-services-webinar-resources/)
- Avalere Health, *Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions*, Washington, D.C., March 2012. As of June 18, 2018: [http://www.nchc.org/wp-content/uploads/2016/04/20120401\\_scan-dual-eligibles-analysis\\_final\\_for-posting.pdf](http://www.nchc.org/wp-content/uploads/2016/04/20120401_scan-dual-eligibles-analysis_final_for-posting.pdf)
- Barth, Sara, and Brianna Ensslin, *Contacting Hard-to-Locate Medicare and Medicaid Members: Tips for Health Plans*, Hamilton, N.J.: Center for Health Care Strategies, 2014.
- , *Building a Culture of Engagement for Medicare-Medicaid Enrollees: Health Plan Approaches*, Hamilton, N.J.: Center for Health Care Strategies, 2015.
- Barry, Colleen, Lauren Riedel, Alisa Busch, and Haiden Huskanp, *Early Insights from One Care: Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries*, Menlo Park, Calif.: Kaiser Family Foundation, 2015. As of June 18, 2018: <https://www.kff.org/medicaid/issue-brief/early-insights-from-one-care-massachusetts-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/view/footnotes/>
- Bielaszka-DuVernay, Christina, “The ‘GRACE’ Model: In-Home Assessments Lead to Better Care for Dual Eligibles,” *Health Affairs*, Vol. 30, No. 3, 2011, pp. 431–434.
- Billieux, Alexander, Katherine Verlander, Susan Anthony, and Dawn Alley, *Standardized Screening for Health-Related Social Needs in Clinical Settings. The Accountable Health Communities Screening Tool*, Washington, D.C.: National Academy of Medicine, 2017.
- Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, Washington, D.C., 2016. As of June 18, 2018: <https://bipartisanpolicy.org/wp-content/uploads/2016/09/BPC-Health-Dual-Eligible-Recommendations.pdf>

- , *Improving Care for High-Need, High-Cost Medicare Patients*, Washington, D.C., 2017.  
As of June 18, 2018:  
<https://cdn.bipartisanpolicy.org/wp-content/uploads/2017/04/BPC-Health-Improving-Care-for-High-Need-High-Cost-Medicare-Patients.pdf>
- Brown, Randall, *The Promise of Care Coordination: Models That Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses*, Princeton, N.J.: Mathematica Policy Research, 2009.
- Brown, Randall S., Deborah Peikes, Greg Peterson, Jennifer Schore, and Carol M. Razafindrakoto, “Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions of High-Risk Patients,” *Health Affairs*, Vol. 31, No. 6, 2012, pp. 1156–1166.
- Burwell, Brian, Paul Saucier, and Lisa Walker, *Care Management Practices in Integrated Care Models for Dual Eligibles*, Washington, D.C.: AARP Public Policy Institute, 2010.
- Centers for Medicare and Medicaid Services, *Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, Baltimore, Md., April 6, 2015. As of June 18 2018:  
<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>
- , “People Enrolled in Medicare and Medicaid Fact Sheet,” April 2018a. As of September 15, 2016:  
[http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_Factsheet.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf)
- , “Capitated Model,” webpage, last updated May 1, 2018b. As of August 6, 2018:  
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.html>
- , “Financial Alignment Initiative for Medicare-Medicaid Enrollees,” webpage, last updated July 26, 2018c. As of August 6, 2018:  
<https://innovation.cms.gov/initiatives/Financial-Alignment/>
- Chepaitis, Amy, Angela M. Greene, Sonja Hoover, Galina Khatutsky, Brienne Lyda-McDonald, Catherine Ormond, Edith G. Walsh, Nan (Tracy) Zheng, Maureen Booth, Julie Fralich, Diane Justice, and Alice M. Weiss, *Report on Early Implementation of Demonstrations Under the Financial Alignment Initiative*, Waltham, Mass.: RTI International, 2015.
- CMS—See Centers for Medicare and Medicaid Services.

- Cohen, R., J. Lemieux, J. Schoenborn, and T. Mulligan, “Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients,” *Health Affairs*, Vol. 31, No. 1, January 2012, pp. 110–119.
- Community Catalyst, *Medicare Special Needs Plans: A Critical Need for Quality Standards of Care*, Boston, 2008.
- Corrigan, J. M., and E. S. Fisher, *Accountable Health Communities: Insights from State Health Reform Initiatives*, Lebanon, N.H.: The Dartmouth Institute for Health Policy and Clinical Practice, 2014.
- Counsell, Steven R., Christopher M. Callahan, Amna B. Buttar, Daniel O. Clark, and Kathryn I. Frank, “Geriatric Resources for Assessment and Care of Elders (GRACE): A New Model of Primary Care for Low-Income Seniors,” *Journal of the American Geriatrics Society*, Vol. 54, No. 7, 2006, pp. 1136–1141.
- Counsell, Steven R., Christopher M. Callahan, Wanzhu Tu, Timothy E. Stump, and Gregory Arling, “Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention,” *Journal of the American Geriatrics Society*, Vol. 57, No. 8, 2009, pp. 1420–1426.
- Cronin, J. Joseph, Jr., *Florida Transportation Disadvantaged Programs: Return on Investment Study*, Tallahassee: Florida State University College of Business, March 2008. As of June 18, 2018:  
[http://tmi.cob.fsu.edu/roi\\_final\\_report\\_0308.pdf](http://tmi.cob.fsu.edu/roi_final_report_0308.pdf)
- Cubanski, Juliette, and Patricia Neuman, “Medicare Doesn’t Work as Well for Younger, Disabled Beneficiaries as It Does for Older Enrollees,” *Health Affairs*, Vol. 29, 2010, pp. 1725–1733.
- Davis, Karen, Christine Buttorff, Bruce Leff, Quincy M. Samus, Sarah Szanton, Jennifer L. Wolff, and Farhan Bandeali, “Innovative Care Models for High-Cost Medicare Beneficiaries: Delivery System and Payment Reform to Accelerate Adoption,” *American Journal of Managed Care*, Vol. 21, No. 5, 2015, pp. e349–e356.
- Dobes, A. M., and R. H. Bernstein, “Successful Strategies for Reducing Disparities in Quality of Care: Lessons from Dual-Eligible Special Needs Plans,” *Journal of Ambulatory Care Management*, Vol. 39, No. 1, January–March 2016, pp. 63–75.
- Fields, Robert, “Mission Health Partners: A Community-Based Social Determinants Driven Accountable Care Organization,” *North Carolina Medical Journal*, Vol. 78, No. 4, July–August 2017, pp. 245–247.
- Foundation Center, IssueLab, database, undated. As of June 20, 2018:  
<https://www.issuelab.org>

- Fung, Vicki, Mary Reed, Mary Price, Richard Brand, William H. Dow, Joseph P. Newhouse, and John Hsu, “Responses to Medicare Drug Costs Among Near-Poor Versus Subsidized Beneficiaries,” *Health Services Research*, Vol. 48, 2013, pp. 1653–1668.
- GAO—See U.S. Government Accountability Office.
- Gold, Marsha, Winnie Wang, and Gretchen Jacobson, *Medicare Health Plans and Dually Eligible Beneficiaries: Industry Perspectives on the Current and Future Market*, Menlo Park, Calif.: Kaiser Family Foundation, 2013.
- Guerard, Barbara, Vincent Omachonu, Blake Perez, and Bisakha Sen, “Improvement in Oral Diabetes Medication Adherence After a Comprehensive Wellness Assessment in a Dual Eligible Population,” *Population Health Management*, Vol. 19, No. 6, 2016.
- Hsu, John, Vicki Fung, Mary Price, Jie Huang, Richard Brand, Rita Hui, Bruce Fireman, Joseph P. Newhouse, “Medicare Beneficiaries’ Knowledge of Part D Prescription Drug Program Benefits and Responses to Drug Costs,” *JAMA*, Vol. 299, No. 16, 2008, pp. 1929–1936.
- Iezzoni, L. I., “Quality of Care for Medicare Beneficiaries with Disabilities Under the Age of 65 Years,” *Expert Review of Pharmacoeconomics and Outcomes Research*, Vol. 6, No. 3, 2006, pp. 261–273.
- Jacobson, G., A. Damico, T. Neuman, and M. Gold. *Medicare Advantage, 2017 Spotlight: Enrollment Market Update*, Menlo Park, Calif.: Kaiser Family Foundation, June 2017.
- Johnson, Andy, *Medicare Advantage Coding Intensity and Health Risk Assessments*, presentation, Washington, D.C.: Medicare Payment Advisory Commission, October 8, 2015.
- Leslie, R. Scott, Breanne Tirado, Bimal V. Patel, and Philip J. Rein, “Evaluation of an Integrated Adherence Program Aimed to Increase Medicare Part D Star Rating Measures,” *Journal of Managed Care & Specialty Pharmacy*, Vol. 20, No. 12, December 2014, pp. 1193–1203.
- Long, Peter, Melinda Abrams, Arnold Milstein, Gerald Anderson, Katherine Lewis Apton, Maria Lund Dahlberg, and Danielle Whicher, eds., *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Values, and Health*, Washington D.C.: National Academy of Medicine, 2017.
- Lukens, Ellen, Lisa Murphy, and Jon Blum, *Medicare Advantage Special Needs Plans/Six Plans’ Experience with Targeted Care Models to Improve Dual Eligible Beneficiaries’ Health and Outcomes*, Washington, D.C.: Avalere Health, 2007. As of June 18, 2018:  
<http://www.nhpg.org/media/5932/acapcasstudies.pdf>
- Mattke, Soeren, Dan Han, Asa Wilks, and Elizabeth Sloss, “Medicare Home Visit Program Associated with Fewer Hospital and Nursing Home Admissions, Increased Office Visits,” *Health Affairs*, Vol. 34, No. 12, December 2015, pp. 2138–2146.

- McCarthy, Douglas, Jamie Ryan, and Sarah Klein, “Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis,” Commonwealth Fund, October 29, 2015. As of June 19, 2018:  
<https://www.commonwealthfund.org/publications/issue-briefs/2015/oct/models-care-high-need-high-cost-patients-evidence-synthesis>
- McDonald, Kathryn M., Vandama Sundaram, Dena M. Bravata, Robyn Lewis, Nancy Lin, Sally A. Kraft, Moira McKinnon, Helen Paguntalan, Douglas K. Owens, *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*, Vol. 7: *Care Coordination*, Kaveh G. Shojania, Kathryn M. McDonald, Robert M. Wachter, and Douglas K. Owens, eds., Rockville, Md.: Agency for Healthcare Research and Quality, June 2007.
- Medicare.gov, “Medicare Plan Finder,” webpage, undated. As of June 19, 2018:  
<https://www.medicare.gov/find-a-plan/questions/home.aspx>
- Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Washington, D.C., 2015. As of June 19, 2018:  
[http://www.medpac.gov/docs/default-source/reports/mar2015\\_entirereport\\_revised.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/mar2015_entirereport_revised.pdf?sfvrsn=0)
- Minnesota Department of Human Services, *Status of Long-Term Services and Supports: Adult Mental Health Aging and Adult Services Children’s Mental Health Disability Services; Nursing Facility Rates and Policy*, St. Paul, August 2015. As of June 19, 2018:  
<https://www.leg.state.mn.us/docs/2015/mandated/150873.pdf>
- Murugan, Varnee, Ed Drozd, and Kevin Dietz, *Analysis of Care Coordination Outcomes: A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries*, Washington, D.C.: Avalere Health, 2012.
- National Academies of Sciences, Engineering, and Medicine, *Systems Practices for the Care of Socially At-Risk Populations*, Washington, D.C.: The National Academies Press, 2016.
- National Association of Community Health Centers, “What Is PRAPARE?” webpage, undated. As of September 1, 2017:  
<http://www.nachc.org/research-and-data/prapare/>
- New York Academy of Medicine, *Grey Literature Report*, New York, 2006–2016. As of June 20, 2018:  
<http://www.greylit.org>
- Ngo-Metzger, Q., D. H. Sorkin, J. Billimek, S. Greenfield, and S. H. Kaplan, “The Effects of Financial Pressures on Adherence and Glucose Control Among Racial/Ethnically Diverse Patients with Diabetes,” *Journal of General Internal Medicine*, Vol. 27, 2012, pp. 432–437.



- Office of the Assistant Secretary for Planning and Evaluation, *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*, Washington, D.C.: U.S. Department of Health and Human Services, December 2016.
- Peikes, Deborah, Arnold Chen, Jennifer Schore, and Randall Brown, "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials," *JAMA*, Vol. 301, No. 6, 2009, pp. 603–618.
- Phelan, Jo C., Bruce G. Link, and Parisa Tehranifar, "Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications," *Journal of Health and Social Behavior*, Vol. 51, 2010, S28–S40.
- Philip, Ann Mary, Alexandra Kruse, and Michelle Herman Soper, *ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons*, Hamilton, N.J.: Association for Community Affiliated Plans, 2016.
- Public Law 108-173, Medicare Prescription Drug, Improvement, and Modernization Act, December 8, 2003.
- Public Law 111-148, Patient Protection and Affordable Care Act, March 23, 2010.
- Radwany, S. M., S. E. Hazelett, K. R. Allen, D. J. Kropp, D. Ertle, T. H. Albanese, S. M. Fosnight, and P. S. Moore, "Results of the Promoting Effective Advance Care Planning for Elders (PEACE) Randomized Pilot Study," *Population Health Management*, Vol. 17, No. 2, 2014, pp. 106–111.
- Roth, Carol P., David A. Ganz, Lorraine Nickels, David Martin, Robin Beckman, and Neil S. Wenger, "Nurse Care Manager Contribution to Quality of Care in a Dual-Eligible Special Needs Plan," *Journal of Gerontological Nursing*, Vol. 38, No. 7, July 2012, pp. 44–54.
- RTI International, *Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration; First Annual Report*, Waltham, Mass., July 13, 2016a.
- , *Financial Alignment Initiative Annual Report: Once Care: MassHealth Plus Medicare; First Annual Report*, Waltham, Mass., September 1, 2016b.
- Schmitz, Robert, Angela Merrill, Jennifer Schore, Rachel Shapiro, and Jim Verdier, *Evaluation of Medicare Advantage Special Needs Plans*, Princeton, N.J.: Mathematica Policy Research, 2008.
- Taylor, Lauren A., Caitlin E. Coyle, Chima Ndumele, Erika Rogan, Maureen Canavan, Leslie Curry, and Elizabeth H. Bradley, *Levering the Social Determinants of Health: What Works?* Boston: Blue Cross Blue Shield Foundation of Massachusetts, June 2015. As of June 19, 2018:  
[http://www.bluecrossfoundation.org/sites/default/files/download/publication/Social\\_Equity\\_Report\\_Final.pdf](http://www.bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf)

U.S. Government Accountability Office, *Disabled Dual Eligible Beneficiaries: Integration of Medicare and Medicaid Benefits May Not Lead to Expected Medicare Savings*, Washington, D.C., GAO-14-423, August 2014. As of September 30, 2016:  
<http://www.gao.gov/assets/670/665491.pdf>

Verdier, James M., Melanie Au, and Jessica Gillooly, *Managing the Care of Dual-Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans*, Princeton, N.J.: Mathematica Policy Research, 2011.

Wellness Proposals, “Health Risk Appraisal,” webpage, 2017.