Medicare Advantage Special Needs Plans /

Six Plans' Experience with Targeted Care Models to Improve Dual Eligible Beneficiaries' Health and Outcomes

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Executive Summary

Congress authorized Special Needs Plans (SNPs) through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to encourage health plans to develop targeted programs to more effectively care for high-risk beneficiaries. Plans have the statutory authority to limit enrollment to one of three special needs populations: beneficiaries dually eligible for Medicare and Medicaid, institutional beneficiaries, and those suffering from severe or disabling chronic conditions. Since the program's inception, the number of SNP plans and the aggregate SNP enrollment has grown dramatically, to over 477 plans with more than 1 million enrollees. This growth has attracted the attention of policymakers and raises questions about the value of the program and the ability of these plans to design and deliver programs that meet the unique needs of special needs individuals.

SNPs serving beneficiaries eligible for both Medicare and Medicaid (dual eligibles) have attracted particular attention, as these plans make up the majority of SNPs and have the highest aggregate enrollment. The characteristics of this population demonstrate that it is a population with special needs. Compared to the non-dual Medicare population, dual eligible beneficiaries are sicker, report lower health status, have lower functional status, and are more likely to be disabled. Medicare spending on a per capita basis is considerably higher for dual eligible beneficiaries ($10,884) than Medicare spending for non-dual eligible beneficiaries ($5,975)[1].

This report focuses on how six not-for-profit, Medicaid managed care health plans are using the SNP authorization to serve dual eligible members through focused programs that are tailored to meet their needs. The case study plans are diverse and vary by geography, plan size, and relationship to Medicaid programs. Despite this variation, all of the plans invest across four key dimensions that they deem as critical to serving this population, including:

Coordination of the Medicare and Medicaid Benefit All plans coordinate the Medicare and Medicaid benefit and have staff dedicated to helping members navigate Medicare, Medicaid, social services, and the health system. These plan staff, often called patient navigators or Medicare advocates, serve as a single point of contact for members and assist with Medicare and Medicaid eligibility, Medicaid waiver eligibility and applications, obtaining medical appointments, securing transportation, and other member needs. While not all plans are in states that have dual eligibles enrolled in Medicaid managed care, all plans perform this coordination function, relying on their Medicaid plan experiences and relationships to do so.

Intensive Case Management for High-Risk Members All six plans have multi-pronged approaches to identify high-risk members and place them in intensive medical case management programs. Both the composition of the care teams and the method of interaction with members are tailored towards the special needs of this population. Case managers and/or care teams may include social workers, pharmacists, and other disciplines as well as registered nurses (RNs). The health plans rely on a high-touch model, which provides frequent contact between plan staff and members to educate patients on their condition, address member concerns, monitor health status, and identify healthcare needs.

[1]Medicare Payment Advisory Commission, June 2007 Data Book, Section 3, p. 34
http://www.medpac.gov/chapters/Jun07DataBookSec3.pdf

Links to Community Social Services The six case study plans also link members to key community and social resources to address the non-medical stressors caused by poverty that often lead to poor health outcomes and increased healthcare costs if left unaddressed. Plans believe that linking members with essential social service supports that address needs such as homelessness, hunger, and lack of heating is critical to members' ability to participate in their own healthcare. The plans leverage their experiences with low-income populations and community social service providers to understand member needs and connect them with appropriate social service networks.

Benefit Design Plans use their Medicare supplemental dollars to fund enhanced care coordination services to help members navigate the healthcare system. In addition, they use these supplemental dollars to eliminate coverage gaps, such as dental care, that neither Medicaid nor Medicare may cover.

The six health SNPs profiled in this report are employing new models of care to better identify, treat, and manage the healthcare needs of persons dually eligible for both Medicare and Medicaid. As Congress and the Centers for Medicare & Medicaid Services (CMS) look to promote innovative models to serve high-risk populations such as dual eligibles, these case studies suggest that SNPs that have programs to meet the social and healthcare needs of the population hold promise of improved access, quality, and reduced costs.

Currently, Congress and other policymakers are examining the SNP program, and they are considering additional requirements to ensure these plans are truly meeting the needs of special needs individuals. Stronger requirements and criteria may contribute to greater consensus around the role of SNPs in providing tailored services to these populations. The SNP designation provides an administrative vehicle for policymakers to set and expect high standards for plans serving special needs individuals. Such standards can also serve to inform the current CMS and National Committee for Quality Assurance initiative to develop quality measures for SNPs that reflect the population and measure plans' success at improving access and quality and reducing costs.

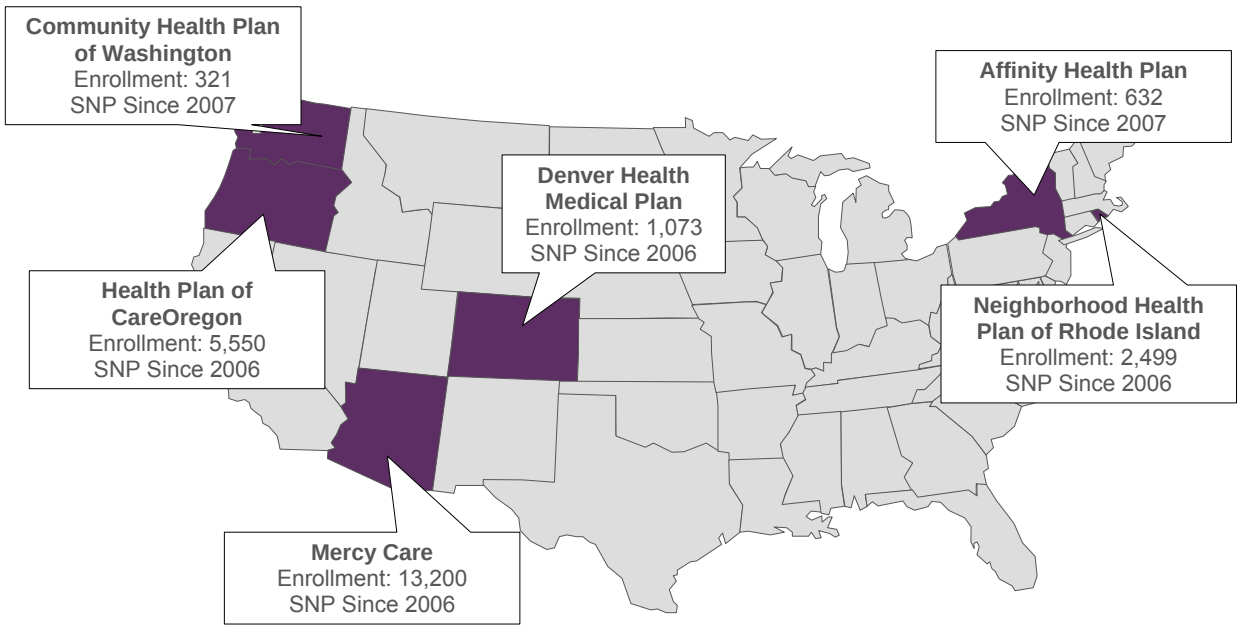
Introduction

Background

Congress authorized Special Needs Plans (SNPs) in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to encourage health plans to develop targeted programs to more effectively care for high-risk beneficiaries. The SNP program is one of several congressional and CMS initiatives focused on improving health status and reducing Medicare expenditures for high-risk beneficiaries.[2] These efforts are fueled, in part, by concerns about rapid Medicare spending growth for beneficiaries with multiple chronic conditions.

This report focuses on how six not-for-profit, Medicaid managed care health plans are using the SNP authorization to serve dual eligible members through focused care models.

Figure 1. Case Study Plans



Dual Eligible Beneficiaries

Individuals who qualify for both Medicare and Medicaid are known as "dual eligibles." These Medicare beneficiaries qualify for Medicaid based on their low-income status. Fifty-nine percent of dual eligible beneficiaries live below the federal poverty level (FPL), which, for 2007, was set at $10,210 for a single person and $13,690 for a household of two people; 96 percent live below 200 percent of the FPL.[3] Compared to the non-dual Medicare population, dual eligibles are sicker, more likely to report poor health status, and have lower functional status. Dual eligibles are also much more likely to be disabled; 40 percent of duals are under 65 and disabled compared to 10 percent of the non-dual Medicare population[4].

[2]Other programs include the Medicare Coordinated Care Demonstration, Medicare Physician Group Practice Demonstration, Medicare Health Support Program, and Consumer-Directed Chronic Outpatient Services Demonstration
[3]Medicare Payment Advisory Commission, June 2007, p. 32
[4]Medicare Payment Advisory Commission, June 2007 Data Book, Section 3, http://www.medpac.gov/chapters/Jun07DataBookSec3.pdf

Table 1. Poverty and Health Status Indicators for Medicare Dual Eligible Beneficiaries Versus Non-Dual Beneficiaries

Characteristic	Dual Eligible Beneficiaries	Non-Dual Eligible Beneficiaries
Under 65 and Disabled	40%	10%
Living Below 100% Federal Poverty Level	59%	9%
Living Below 200% Federal Poverty Level	96%	39%
Report Poor Health Status	21%	7%
Reside in Institutions	19%	2%
Limitation in 1 or More Activity of Daily Living (ADL)	53%	29%

Source: Medicare Payment Advisory Commission, June 2007 Data Book, Section 3. Data from 2004,

Dual eligible beneficiaries use more medical services than non-dual eligible Medicare beneficiaries. In 2004, dual eligibles accounted for approximately 25 percent of Medicare expenditures although they constituted only 16 percent of the total Medicare population. On a per capita basis, Medicare spends 1.8 times more per dual eligible beneficiary ($10,884) versus non-dual eligible beneficiary ($5,975).[5] If all payer sources are considered—Medicare, Medicaid, supplemental insurance, out-of-pocket payments—dual eligibles average more than twice the spending of non-dual beneficiaries ($23,543 compared to $11,736)[6].

Table 2. Medicare and Total Spending per Dual Eligible and Non-Dual Eligible Beneficiary

Average Spending per Beneficiary	Dual Eligible Beneficiaries	Non-Dual Eligible Beneficiaries
Medicare Spending Only	$10,884	$5,975
Total Spending (includes Medicare, Medicaid, supplemental insurance, and out-of-pocket)	$23,543	$11,736

Source: Medicare Payment Advisory Commission, June 2007 Data Book, Section 3. Data from 2004.

Research suggests low-income status is associated with decreased access to medical care and poor health outcomes. Low-income patients are more likely to use the emergency room for their healthcare and less likely to have a regular source of care.[7],[8] These individuals, living at or near the FPL, are less likely to receive preventive services (e.g., pneumococcal vaccines) and are more likely to have poor health outcomes both in terms of mortality and morbidity.[9] In order to improve patient outcomes, SNPs must address some of the underlying access, treatment, and psychosocial issues that inhibit care and ultimately lead to poor health outcomes.

Dual eligibles also face considerable administrative challenges due to the complexity of qualifying for multiple sources of health coverage. The eligibility issues and processes can be extremely complex and confusing for many beneficiaries, often resulting in difficulty

[5]Ibid, p. 29
[6]Ibid, p. 34
[7]National Healthcare Disparities Report, 2005. Full Report. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/nhdr05/fullreport/, table 3.5
[8]Ann Emerg Med., Use of the ED as a regular source of care: associated factors beyond lack of health insurance. 1997 Sep;30(3):286-91
[9]2005 National Healthcare Disparities Report, U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, pp. 47, 131

accessing healthcare services. The SNP authorization coincided with implementation of the Medicare Part D benefit, which transitioned dual eligibles' drug coverage from Medicaid to a Medicare privately-administered Part D plan. After implementation of Part D, most dual eligibles have three sources of health coverage (Medicare, Medicaid, and Medicare Part D). This division could mean a dual eligible beneficiary has three or more health insurance cards/programs to negotiate. The fragmented system requires dual eligible beneficiaries to negotiate multiple benefit packages, provider networks, and coverage requirements in order to receive care. The SNP model enables integration of the Medicare and Medicaid benefits, offering beneficiaries a single plan to help the member navigate eligibility and other administrative processes.

Given the proportion of total Medicare spending associated with these beneficiaries and their poorer health outcomes, SNPs may provide important insights into how focused, coordinated care models impact health status and reduce Medicare spending through better integration of Medicare and Medicaid services and funding.

Overview of Special Needs Plans

Congress established SNPs to grant plans the authority and incentive to "develop targeted clinical programs to more effectively care for high-risk beneficiaries."[10] With existing federal and state demonstrations such as the Program of All-Inclusive Care for the Elderly (PACE), Minnesota Senior Health Options (MSHO), and Evercare serving as prototypes, the SNP program expanded these existing offerings, targeting a broader group of high-cost, high-need beneficiaries. Beneficiaries eligible for enrollment into a SNP are defined as those who are institutionalized, dually eligible for Medicare and Medicaid, or chronically ill with a severe or disabling chronic condition. Due to Congressional Budget Office (CBO) concerns about increased federal costs, SNPs were given a limited five-year authorization that expires December 31, 2008. Congress will have to reauthorize SNPs for them to operate in their current form after December 31, 2008.

Since its inception, the SNP designation has generated a level of interest that has greatly exceeded most policymakers' expectations. In 2006, CMS approved 276 SNPs. By 2007, the number of approved SNPs grew by more than 70 percent to 477. As of October 2007, there are 320 for dual eligibles, 84 for institutionalized beneficiaries and 73 for beneficiaries with severe or disabling chronic conditions. As of October 2007, overall enrollment in SNPs had reached 1.05 million, with the majority of beneficiaries (737,000) enrolled in duals-focused SNPs.

Table 3. Number of Special Needs Plans and Enrollment by Plan Type

SNP Type	Number of Plans, 2006	Number of Plans, 2007 YTD	October 2007 Enrollment
Chronic or Disabling Condition	13	73	168,762
Dual Eligible	226	320	737,125
Institutional	37	84	144,748
Total	276	477	1,050,635

Centers for Medicare and Medicaid Services SNP Comprehensive Report, October 2007

[10]Conference Agreement, Section 231

SNP Regulatory Requirements and Payment

SNP Requirements In general, SNPs are subject to the same CMS rules and requirements as all other MA plans. There are two factors, however, that differentiate SNPs from traditional MA plans. First, SNPs have statutory authority permitting them to limit enrollment to one of the special needs populations, permitting them to tailor benefits and provider networks to best meet the needs of its members. Secondly, all SNPs are required to provide the Part D drug benefit. Since dual eligible beneficiaries may change their plans monthly, SNPs are able to enroll dual eligible members at any time of year, enabling them to market to potential members year-round.

SNP Payment Medicare pays SNPs in the same manner as all other Medicare Advantage (MA) plans, for traditional Medicare services and the Medicare Part D benefit. Historically, MA plan payments have been risk adjusted based on the demographic characteristics of their enrollees. To more accurately reflect the cost of caring for higher-risk members, CMS began in 2000 to phase in a new risk-adjusted payment system called the CMS Hierarchical Condition Category (CMS-HCC) that places a greater emphasis on each enrollee's predicted health status. While the new risk-adjusted payment formula applies to all MA plans, the formula is of particular importance to SNPs due to their large proportion of members with high-cost, chronic medical conditions.

Similar to the historic, demographic payment model, the risk-adjusted formula includes additional payments of 8 percent for dual eligibles, 8 percent for long-term institutionalized elderly, and 21 percent for long-term institutionalized disabled.[11] Beginning in 2007, all Medicare Advantage Prescription Drug (MA-PD) plans—including SNPs—are paid using a 100 percent risk-adjusted payment under the CMS-HCC. The CMS-HCC payment system continues to use demographic characteristics such as age and sex, but these factors have less weight than in the past.

Some SNPs receive a separate payment from state Medicaid programs for dual eligible members if they have secured a separate contract from the state. The contract may cover cost sharing and premium responsibilities for dual eligible members as well as additional benefits such as dental coverage. In some cases, the contract may also cover Medicaid-financed long-term care services.

Key Findings of Six Case Studies

The six health plans interviewed are diverse in their geography, organizational design, history, and state Medicaid relationships. Despite this variation, the plans consistently invest along four key dimensions that they believe are critical to serving this population, including:

- **Coordination of the Medicare and Medicaid Benefit** All case study plans actively coordinate the Medicare and Medicaid benefits through dedicated health plan staff working with members to identify necessary services, schedule appointments, arrange transportation, and counsel members on Medicaid waiver benefits for which they may be eligible. All plans perform this coordination function irrespective of whether the member receives Medicaid services through the plan.

  Plans suggest this coordination function is critical to identify members' needs and ensure dual eligible members receive necessary medical care. This population is at increased risk due to poverty, is more likely to be disabled, and in many cases is suffering from

[11]National Health Policy Forum, Issue Brief – No. 808, November 11, 2005, Medicare Advantage SNPs: A New Opportunity for Integrated Care?, p. 12

multiple chronic conditions. The SNPs help simplify processes and benefits–such as Medicaid waiver applications—so that members may understand and obtain services. SNPs also assist members in navigating administrative processes with both programs including eligibility recertification and home and community-based services (HCBS) waiver applications. Plans leverage their experiences with Medicaid and their relationship with the states to assist members in navigating Medicare, Medicaid, and the healthcare system.

Plans responsible for both the Medicare and Medicaid benefits are combining the benefit packages and marshalling resources in innovative ways to reduce downstream expenditures. For example, Mercy Care has nurse practitioners (NPs) visit members residing in nursing homes. These NPs monitor and track member's health status that, among other things, enables early detection and treatment of conditions that could otherwise result in a hospital admission.

- **Intensive Case Management for High-Risk Members** All six plans have developed protocols to identify high-risk members and place these members in intensive, medical case management programs. These programs are specially designed to meet the needs of this population. The plans use "high-touch" models, which provide frequent contact between plan staff and members via phone and in-person.

  The numerous challenges of day-to-day life interfere with many members' ability to comply with care plans or treatment protocols. In some cases, almost half of the plan members are disabled, with many suffering from chronic mental illness. The plans have designed their care management function around the specific needs of this population, which often requires more phone calls, visits, and contact from the plan than a non-dual Medicare population in order to ensure compliance. For example, when a member is discharged from the hospital for congestive heart failure, commercial plans may expect him or her to evaluate and report status indicators (e.g., blood pressure, pulse) to the plan via telemonitoring. One of the SNPs noted that many dual eligible members are less able to follow such protocols. Instead, this SNP has developed a post-hospital congestive heart failure (CHF) program that relies less on self-directed patient tracking and reporting and more on staff-focused education and counseling to help members recognize symptoms that should prompt a call to their doctor.

- **Links to Community Social Services** The six case study plans promote enrollee health by looking beyond medical care to other social and community factors that impact health status and contribute to healthcare costs. For instance, plans may install safety bars in the home of a member at risk of falling or connect a member with a community food bank. All the case study plans actively link members with social and community services, such as housing assistance, food needs, and home heating programs so that their members can focus on better managing their healthcare needs.

  The case study SNPs believe that, in ensuring these social and community needs are met, members are less likely to experience adverse health outcomes. In addition, these SNPs believe that members who are linked to the appropriate community resources are also less likely to rely on or require expensive medical resources as a substitute for social service supports. The six plans rely on their experiences with low-income populations and community social service providers to understand member needs and link them with the appropriate social service networks.

- **Benefit Design** Plans use their supplemental dollars to fund enhanced care coordination services. These enhanced services enable plans to actively guide their dual eligible members through the continuum of securing needed healthcare resources – from

assisting members with Medicaid applications and renewals, to ensuring patients can get necessary appointments and assisting members in accessing community services critical to maintaining health, such as home heating assistance.

In addition to enhanced care coordination services, many plans offer additional supplemental benefits, which are carefully tailored to fill gaps in existing Medicare and Medicaid coverage. For example, the plans provide enhanced transportation and dental benefits, which are often limited due to Medicaid statutory benefits or too few participating Medicaid providers.

Key Considerations

The case studies suggest that these plans offer innovative approaches in caring for dual eligible members, and that plans are investing in "high-touch" care models that they believe will result in better patient outcomes and reduced program costs. CMS and National Committee for Quality Assurance (NCQA) are in the process of developing measures that reflect the special needs populations and measure SNPs' successes in improving access and quality and reducing costs. As Congress and policymakers focus on better understanding SNPs' performance, the case study plans suggest that both Medicare and Medicaid expenditures must be considered in the analysis. Many plans believe that they will reduce or delay the need for Medicaid long-term care services. Quality and outcome measures that take into account all program costs, rather than examining only Medicare costs, will more accurately capture the promise of these care models.

Case Studies

The report is divided into six case studies. Each case study describes a not-for-profit, Medicaid managed care health plan's SNP program. The case studies are ordered based on enrollment as follows:

Southwest Catholic Health Network Corporation (Mercy Care Plan)

Health Plan of CareOregon

BlueCross & BlueShield of Rhode Island and Neighborhood Health Plan of Rhode Island

Denver Health Medical Plan

Affinity Health Plan

Community Health Plan of Washington

Southwest Catholic Health Network Corporation (Mercy Care Plan)

Founded in 1985 as a nonprofit corporation cosponsored by Catholic Healthcare West and Carondelet Health Network, the Southwest Catholic Health Network Corporation operates several health plans under the name Mercy Care Plan. Mercy Care provides Medicaid coverage for nearly 300,000 Arizona residents and offers a Medicaid long-term care plan as well as a separate plan through a state-based program for small businesses. It contracts with Schaller Anderson to manage its Mercy Care Plan.

Mercy Care believes that managing all of a patient's acute and long-term care needs results in better care, outcomes, and lower costs. Mercy Care received CMS approval to offer a dual eligible SNP in January 2006. Since Mercy Care contracts with the state of Arizona to cover both Medicaid acute and Medicaid long-term care services, Mercy Care is managing dual eligible beneficiaries' Medicare and Medicaid acute coverage as well as the Medicaid long-term care benefit.

Arizona has a high concentration of both Medicaid and Medicare managed care. Many dual eligibles must navigate between two different managed care plans with differing provider networks, prior authorization requirements, and coverage responsibilities, which can be challenging, in particular for a vulnerable population. Mercy Care's SNP model enables dual eligibles to receive fully coordinated care through one program, greatly reducing the complexity of multiple payers and enabling quality care management.

As of July 2007, Mercy Care's SNP is one of the top 15 plans in the US in terms of dual-eligible enrollment.

Table 4. Mercy Care Plan Description

Southwest Catholic Health Network Corporation (Mercy Care Plan) Mercy Care Advantage Special Needs Plan	
Operating Since	January 1, 2006
Service Area	State: Arizona Counties: Maricopa, Pima, Santa Cruz. (SNP program)
Dual Eligible Capitation Sources	Medicare and Medicaid (acute care and long-term care services)
SNP Enrollment	13,200
SNP Membership Profile	38% male, 62% female 50% under 65
Other Plans Offered	Medicaid Other state healthcare plan
Total Plan Enrollment (Excluding SNP)	302,600

Source: As reported by Southwest Catholic Health Network Corporation, June 2007.

Care Coordination

Mercy Care believes that there are five key elements to maximize the impact of a care management program:

- Link key data (claims, pharmacy, lab, procedures, DME, behavioral health, referrals, PCP use, care management tool)
- Integrate these data with self-reported functional, social, behavioral, and cognitive indicators

- Use predictive modeling to target care management interventions, but leave opportunity for self- and community referral
- Measure pharmacy adherence for key medications
- Make care plans accessible to members and their community of providers

Mercy Care relies on a team-based approach to actively manage care incorporating these five elements. Every member who uses long-term care and other at-risk members are assigned to a case manager, who guides the member through the medical care delivery system. The case manager is supported by clinicians: registered nurses and physician medical directors who manage the patient's clinical needs.

Table 5. Care Coordination Roles and Functions

Role	Function	Target Population	Description
Medical Director and Nursing Staff	Intensive medical case management	High-risk members or members with an acute episode	Develop individual care plan for each member Aggressive medical management to maintain best possible health and functional status – may include nurse visits once or twice a week to the home, twice weekly telephone calls Ongoing tracking of indicators to assess risk
Case Manager	Usher member through medical system, coordinate care, link with social services	All members who use LTC services (about 35% of total SNP membership)	Assist members with appointments, preventative care, social, and compliance issues

Medical Case Management for High-Risk Members

Mercy Care also employs several strategies to identify high-risk members, including predictive modeling, self-reported health status, and community referrals. Each member is asked to complete a health risk assessment (HRA), to collect the member's self-reported health status. Mercy Care has found that follow-up is often necessary to ensure members complete the HRA fully and accurately; case managers contact members over the phone and through mailings and often contact the patient's physicians.

Mercy Care has also developed a multivariate predictive model that ranks members according to expected utilization, enabling Mercy Care to prioritize case management. The model uses authorization and claims data, as well as prescription drug, imaging/X-ray, and lab data to predict utilization. Those members identified as high-risk are placed in intensive case management. Mercy Care reviews member profiles once a month to determine whether any members should be re-categorized as needing more care or support.

Table 6. Strategies to Identify High-Risk Beneficiaries

Strategy	Description
Predictive modeling tool	Calculates risk based on several measures: 12-month claims/utilization data Prescription drug Lab X-ray Comorbidities
Health risk assessment	Self-reported health status questionnaire
Community referral	Referral from a provider or social worker

Highest-risk members are contacted twice a week by their case manager. Mercy Care describes the case manager as functioning as an extension of the family, providing oversight for care delivery and visiting the member's home or nursing home to help identify and address any social or compliance issues.

Mercy Care's medical management team collaborates with the case manager and provides support on clinical issues. For all patients residing in nursing homes, nurse practitioners visit patients on-site, taking lab samples, such as blood and sputum cultures, which enable them to detect, treat, and manage infections more effectively while avoiding disease progression. Such progression could lead to patient morbidity and increased healthcare costs.

In addition, case managers ensure that members make and keep appointments, obtain needed preventive care such as flu vaccinations, provide clinical authorizations for hospital stays, and arrange for transportation or durable medical equipment. The level and frequency of interaction between the member and the case manager varies based on the severity of the individual's illness.

Through its case management program, Mercy Care has seen an average 10 percent reduction in hospital admits per thousand in its SNP population over the last year. Plan officials attribute much of this reduction to its case management program. The increased healthcare utilization that would result from less-intense care management would, they believe, increase costs to the point of being financially untenable for the plan to continue operations.

Coordination of Medicare Parts A, B, D, and Medicaid Benefits

Mercy Care has designed its program to fully integrate all Medicare and Medicaid benefits from the provider and member perspective. In addition to integrating the benefit, Mercy Care provides case management support to all members to ensure they can access this integrated benefit package. More than 80 percent of Mercy Care long-term care users are dual eligible, with 60 percent receiving both Medicare and Medicaid benefits through Mercy Care.

One strategy Mercy Care uses to provide integrated Medicare and Medicaid benefits is by using the same provider network for its Medicaid plan and its SNP. Recruiting physicians who are willing to see all of Mercy Care's members helps SNP members identify providers who will provide their care regardless of the source of payment. The plan identified Arizona's high Medicaid provider reimbursement levels, which pay based on the same fee schedule as Medicare, as a key factor in its ability to recruit providers to the Mercy Care

network. Providers may submit one bill to Mercy Care since it manages the accounting for both programs internally.

The integrated payment model is intended to align all incentives and enable better care coordination, resulting in more efficient use of resources. For example, Mercy Care finds that hospitals can often shorten a length of stay or substitute a post-discharge Skilled Nursing Facility (SNF) placement with home care if the Medicare benefit is supplemented by Medicaid. In many cases, with the additional support of Medicaid home health and personal care services, the individual can remain at home. Mercy Care believes that this intensive care coordination is much easier with a single SNP model, rather than under FFS or two separate managed care plans.

Assistance Navigating Mental and Behavioral Health Services

A high proportion of Mercy Care's members have psychiatric care needs, including major depressive, bipolar, and paranoid disorders, which collectively are one of the five most common diagnoses for Mercy Care's SNP population. As a result, the plan ensures coordination between case managers and medical providers to identify and manage members' mental health needs. The SNP's licensed clinical social workers who staff the SNP's case management program are trained to identify mental health issues and screen members for depression and other mental health problems. Once identified, the plan integrates members' mental and behavioral healthcare through the PCP relationship. A letter is sent to the member's PCP informing them that a particular mental health referral has been completed for the patient. Every 90 days the care manager requests that the behavioral health provider send records to the member's PCP in order to facilitate the care integration.

Links to Community-Based Social Services

Mercy Care believes that dual eligibles' social issues have a direct impact on their health status and medical care utilization. For example, some of their members live alone in sub-standard housing without sufficient support systems. As a result, members often do not follow medical regimens. They also experience nutritional and environmental issues, which exacerbate their medical conditions and cause hospital admissions. Mercy Care believes that unless members' social issues are addressed, they will continue to have high medical utilization and "a revolving door admission pattern in the hospital and emergency room."

All of Mercy Care's long-term care members are assigned to a social worker, who links the member to community resources. The social workers often link members to advocacy groups, such as the Alzheimer's Association, the Parkinson's Association, and the Area Agency on Aging for friendly visiting programs and other non-covered benefits.

For the quarter ending June 30, 2007, case managers provided 84 referrals to agencies such as domestic violence resources, dental program assistance, and food program assistance.

Benefit Offerings

Mercy Care offers supplemental benefits focused on the unique needs of its dual eligible population. These include the case management program, chiropractic, dental, vision, and podiatry care.

Table 7. Plan Benefits

Service	Description
Medicare	
Medicare fee-for-service benefits	Plan covers all Medicare FFS benefits
Case management program	Social worker visits every 90 days or as needed (long-term care members)
Chiropractic	Member pays 0% of the cost for manual manipulation of the spine to correct subluxation (up to 12 visits per year)
Dental	Oral exams, cleanings, fluoride treatment up to 1 visit every six months; dental X-rays up to 1 visit per year
Vision	Routine eye exam limited to 1 exam per year; or as needed for the diagnosis and treatment of diseases and conditions of the eye Glasses or contact lenses limited to 1 pair
Podiatry	0% of the cost for each Medicare covered visit (medically necessary foot care). 0% of the cost for each routine visit up to 1 visit(s) every three months
Medicaid	
For long-term care members:	
Residential placement in SNFs	Long-term placement in a skilled nursing facility (SNF)
Assisted living	An alternative to skilled nursing facility placement
Attendant care services	Assistance with activities of daily living in one's own home
Adult day health	Day program for the elderly
Home delivered meals	Hot meal arrives at home each day

Experience with Low-Income Populations

Mercy Care drew upon its more than 20 years of experience serving Medicaid beneficiaries to create their dual eligible SNP. Standard plan materials are sent to members in both English and Spanish, and they are available in five other languages on request.

Mercy Care has relied on its Medicaid experience in developing specific strategies to address the needs of a population that is disenfranchised and often difficult to engage in the health system. Mercy Care characterizes previous Medicaid experience as "invaluable" in designing their SNP. From this experience it has developed distinct outreach services, including weekly phone calls to high-risk members; outreach through mail and phone; contacting the members' physician; and visiting the members' home.

Relationships with the State

Arizona, in which nearly one-fifth of the total population is eligible for Medicaid, has been contracting with managed care plans for Medicaid services since 1982. The state's extensive history with Medicaid managed care has led to strong relationships with health plans such as Mercy Care, and, as a result, the state has been supportive of integrated care through SNP. Mercy Care officials have a positive relationship with the state and were encouraged by the state to apply for SNP status.

Mercy Care Plan: Jorge's Story

Jorge* is 48 years old and has been HIV positive for the last nine years. Jorge became eligible for Medicare in 2005. Prior to selecting Mercy Care Advantage, Jorge was enrolled in fee-for-service Medicare, a Medicare Part D plan, and Mercy Care Medicaid.

In April 2006, Jorge switched Part D prescription drug plans. Jorge had difficulty obtaining his HIV medications under this new Part D plan as the plan had not received the required justification from Jorge's physician. Jorge went several days without his HIV medications, finally ending up in the emergency room. Jorge was diagnosed with shingles and thrush and was admitted to the hospital for a five-day stay.

The hospital social worker told Jorge about the Mercy Care SNP, which he enrolled in May 2006. Since Jorge has been enrolled in the Mercy Care plan, Jorge has had no hospitalizations and has received all medications on a timely basis.

* Not his real name.

Health Plan of CareOregon

CareOregon was founded in 1993 by a nonprofit group of safety net providers, whose stated mission is to "ensure that Oregon's vulnerable populations receive access to high-quality healthcare from a stable network by a well-managed, financially sound organization."

CareOregon received CMS approval to create its dual eligible SNP plan in September 2005. It participated in the passive enrollment process for current Medicaid members, and began operations in January 2006. After implementation of the Part D drug benefit, CareOregon noted that dual eligible beneficiaries would likely face the scenario of having to coordinate among four payers: Medicare, Medicare Part D, Medicaid, and—since the mental health benefit is carved out of Oregon Medicaid—a separate plan for Medicaid-covered mental health services. CareOregon anticipated that this fragmentation would exacerbate the existing challenge of coordinating dual eligible beneficiaries' care.

CareOregon viewed the SNP designation as an opportunity to fully integrate dual eligibles' medical benefits, as well as other social supports. CareOregon contracts with the state of Oregon to provide Medicaid-covered acute care services for its dual eligible beneficiaries, permitting them to cover and manage all of their members' acute care needs. The state does not currently contract with managed care organizations for long-term care services, and, as a result, CareOregon does not provide these services.

Table 8. CareOregon Plan Description

Health Plan of CareOregon CareOregon Advantage	
Operating Since	January 1, 2006
Service Area	State: Oregon Counties: Clackamas, Clatsop, Columbia, Marion, Multnomah, Polk, Washington
Dual Eligible Capitation Sources	Medicare and Medicaid (for acute care services)
SNP Enrollment	5,550
SNP Membership Profile	56% male, 44% female 61% under 65
Other Plans Offered	Medicaid
Total Plan-Sponsor Enrollment (Excluding SNP)	90,000

Source: As reported by Health Plan of CareOregon, June 2007.

Care Coordination

CareOregon has developed a team-based, multidisciplinary case management program, called CareSupport, to serve its high-risk members. Lower-risk members receive coordination services through another support system, called Member Support. The following table provides an overview of the functions and roles of these two programs, which are described in greater detail below.

Table 9. Care Coordination Roles and Functions

Role	Function	Target Population	Description
▪ CareSupport Team ▪ Nurse ▪ Healthcare Guide ▪ Pharmacist ▪ Behavioral Health Specialist (most of these are social workers)	Intensive biopsychosocial case management	High-risk SNP members or members with an acute episode	Identifies medical, mental health, social, and environmental risk factors Multidisciplinary care team develops a plan of care to manage or modify the patients' risk Behavioral health specialists are included in the care team, depending on the patients' needs
Member Support	Administrative and social support services	All members	Schedule appointments for members, arrange for transportation, link members with community support services, and support members eligibility processing

Medical Case Management for High-Risk Members

CareOregon uses several strategies to identify high-risk members, who are referred to the CareSupport program. These strategies include concurrent review of hospital admissions and emergency room (ER) visits, predictive claims-based modeling to estimate future medical utilization, and referrals from case workers and providers.

Table 10. Strategies to Identify High-Risk Beneficiaries

Strategy	Description
Health risk assessment	Written tool that is delivered via telephone calls to member
Concurrent review of hospital admissions and ER visits	Conducted by nurses both onsite and via telephone through medical management department
Predictive claims-based modeling	Johns Hopkins ACG-PM software
Referrals from caseworkers and providers	Caseworkers and providers refer their patients to CareSupport
Medication therapy management program (MTMP)	Use MTMP criteria to identify members for case management
Emergency room census	Receive daily ER reports from major hospitals and identify potential candidates
Facility discharge census	Run a report several times per week to identify members who have been discharged from facilities; permit further identification of case management candidates
Interface with PBHI (delegated benefit management for mental health services)	Coordinate with PBHI to identify mental health patients with medical needs

Once a member is identified as high risk, a CareSupport team member calls the patient to identify their modifiable risks. The team member administers an assessment to evaluate the patient's medical and mental health status and also explores social and environmental risk factors. Based on this assessment, members are assigned to a multidisciplinary intervention team made up of a nurse and a health care guide (the equivalent of a medical assistant), and, depending on the patient's needs, a pharmacist and/or a behavioral health specialist.

The CareSupport team develops a care plan to manage or modify the member's risk. Example interventions include facilitating consultations with the member's primary care physician, specialist, or a pharmacist; coaching the member on how to receive the most out of a provider visit; coordinating translation services; motivational coaching to encourage better self management of a chronic condition; or arranging for durable medical equipment (DME) or home health services.

Approximately 10 percent of CareOregon's SNP members are enrolled in the CareSupport program. For other SNP members, CareOregon provides short-term intensive care coordination services during an acute episode, such as discharge planning and post-discharge follow-up. These functions are performed to ensure that members' have the medications, equipment, and follow-up appointments they need. CareOregon provides all SNP members access to Member Support, which assists members in scheduling appointments and transportation, links members with community support services, supports members in recertifying for Medicaid and in applying for Medicaid waiver services, and otherwise facilitates members' access to medical care.

While CareOregon is not able to isolate health outcomes for its entire SNP population, outcomes data for members in the CareSupport program indicate improvements for the plan population as a whole. Members of CareOregon's plans scored significantly lower than average on a Kaiser-developed Health Utilities Index (HUI), which measures a patient's perception of functional health status in nine areas: vision, hearing, speech, ambulation, dexterity, pain, emotion, cognition, and self-care. On a scale ranging from -0.36 (worst health status) to 1.00 (perfect health), CareOregon's high-risk members had a mean score of 0.19 compared with the U.S. average of 0.84, indicating challenges in self-management and cognitive skills, as well as challenges with mobility, ambulation, and pain. However, CareOregon reports that after four months of participating in the CareSupport program, members' scores improved, on average, by 0.05. Thirty percent of members had improved scores on cognition, emotion, and ambulation and 25 percent had improved control of chronic pain.

Plan data also show decreases in medical utilization, especially hospitalization rates, for members enrolled in CareSupport. From 2004 to 2005, CareSupport participants reduced hospitalization rates by 43 percent, compared with an increase of nearly 11 percent for members with no intervention. Members with only short-term contact with the CareSupport program reduced hospital use by nearly 17.5 percent Plan officials estimate that the reductions in utilization resulted in savings of over $20,000 per high-risk member per year.

Refer to the accompanying text box to learn more about CareOregon's CareSupport program.

Coordination of Medicare Parts A, B, D, and Medicaid Benefits

By providing both the Medicare and Medicaid acute care benefits to their dual eligible SNP members, CareOregon is able to offer a single, integrated product. CareOregon's previous experience serving the Medicaid population underscored the importance of integrated

benefits. Dual Eligible beneficiaries, in particular those with cognitive impairments or mental illness, often found the disparate Medicare and Medicaid coverage, provider networks, and administrative processes confusing and ultimately these administrative barriers impeded access to care. Furthermore, coordination among healthcare providers was limited.

CareOregon officials found, for example, that if a dual eligible is in fee-for-service (FFS) Medicare they will have separate rules for Medicare Parts A and B, a separate health plan for Medicare Part D, and yet another set of requirements for Medicaid medical and mental health benefits. Absent intervention, there is no mechanism to facilitate any coordination between the primary care physician (PCP) who treats the member for medical conditions, the psychiatrist who manages and prescribes mental health drugs, the pharmacist who fills both medical and mental health prescriptions, and the Medicaid provider that renders services not covered by Medicare. They found that without a central focal point, dual eligibles received duplicative, inefficient, and suboptimal quality of care.

Offering a SNP with an integrated Medicaid managed care component provides CareOregon the opportunity to link Medicare and Medicaid benefits in a way that is seamless to the member, improving members' overall health. In the example cited above, CareOregon serves as the focal point that coordinates information and serves as the central point of contact among the PCP, psychiatrist, and pharmacist. This care coordination function is not limited to those members enrolled in the intensive CareSupport program. CareOregon provides this central coordination function to all its members when, for example, physicians call with a prescription or a mental health provider requests to connect with a PCP. CareOregon officials state, that due to this coordination, the plan is already seeing a drop in inpatient mental health utilization and an increase in outpatient mental health therapy. They believe these results are due to the personal contact made by CareSupport and other staff with the member and their providers, especially after discharge from the hospital.

Assistance Navigating Mental and Behavioral Health Services

Oregon's Medicaid program has carved-out mental health from its Medicaid managed care program. The state contracts with a separate managed care plan for mental health services. While CareOregon does not cover mental health services, they do manage the mental health pharmacy benefit through Part D. Although CareOregon does not "own" mental health benefits for its members, it believes that its strong relationships with mental health providers, in this case, largely community mental health centers, are critically important to caring for this population.

CareOregon dedicates staff to coordinate services with PacifiCare Behavioral Health, Inc. (PBHI), the state's mental health vendor, and community mental health centers. The coordination is intended to ensure CareOregon's patients' medical needs are coordinated with their mental health and substance abuse treatment. CareOregon found that many of its mentally ill members often do not have a primary care physician and seek little medical care. CareOregon cites developing strong relationships with the community mental health providers as a key component of its success in treating this population. Specifically, these mental health providers assist CareOregon in addressing patient fear and other barriers to accessing necessary medical care. Further, CareOregon believes that covering the Part D portion of the benefit facilitates this care management; mental health drugs comprise about half of CareOregon's drug costs.

Links to Community-Based Social Services

CareOregon officials believe that linking members to social supports is an essential service provided by their SNP that improves its members' health status. High-risk members requiring social support services are connected through the social worker on their CareSupport team. For lower-risk beneficiaries who are not enrolled in CareSupport, CareOregon offers assistance on an as-needed basis. Common issues faced by CareOregon members include mental health issues, food scarcity, housing problems, safety concerns, lack of social supports, and substance abuse problems. Examples of support provided by CareOregon staff include arranging for Meals on Wheels, facilitating caregiver support services, connecting the member to a cultural group, coordinating family or friend support, and providing referrals to grief counseling. CareOregon believes that this "person focus" is critical to improve patient engagement and self-management. By providing these services, more intensive healthcare interventions are often avoided.

Provided Benefits

The CareOregon SNP provides all Medicare Parts A and B benefits, and Part D prescription drug coverage. For supplemental benefits, CareOregon focuses its resources on care coordination services for its high-need, high-cost members.

Table 11. Plan Benefits

Service	Description
Medicare	
Medicare fee-for-service benefits	Plan covers all Medicare FFS benefits
CareSupport program	Multidisciplinary, team-based case management program
Palliative care	Joint effort of internal staff and home health agencies
Unlimited physical exams	The number and frequency of preventive services is established by the PCP based on member needs
Hearing aids	
In-home assessment	Performed by licensed home health nurses
Medicaid	
Medical equipment and supplies	Most incontinence supplies and some other medical equipment and supplies not covered by Medicare.
Unlimited hospital days	Supplements the Medicare benefit periods
Chemical dependency	More extensive benefits and provider network than covered by Medicare
Mental health	More extensive benefits and provider network than covered by Medicare

Experience with Low-Income Populations

CareOregon describes their members as "medically and socially stressed with few resources." This high-utilization, high-need population often requires frequent office visits or may seek longer appointments in order to have questions answered, receive more basic explanations, or simply for social contact. Because these longer visits could easily overwhelm physicians not accustomed to this population, CareOregon works closely with its network providers to identify issues and barriers to successful treatment as well as

ensure patients are linked to the CareOregon CareSupport program or member support services for social and community service needs.

Relationships with the State

The state of Oregon works closely with the SNPs in the state. Through a CMS waiver, state caseworkers are able to file an enrollment form directly with the SNP, eliminating the need for the dual eligible member to file a separate enrollment form. In addition, CareOregon is approved for seamless enrollment of beneficiaries previously enrolled in its Medicaid managed care plan into its SNP.

Because of this state-facilitated enrollment and an Oregon prohibition of marketing directly to Medicaid beneficiaries, CareOregon's marketing strategy is focused on educating state caseworkers. The plan educates caseworkers about plan benefits and services so they can assist beneficiaries in determining whether CareOregon will meet their needs.

CareOregon officials indicated an interest in working with the state to promote even greater, more seamless integration of Medicare and Medicaid benefits, which may include the mental health benefit and long-term care.

CareOregon's CareSupport Program: Henry's Story

Henry* suffered from multiple chronic conditions, including diabetes and renal failure as well as congestive heart failure (CHF). After a hospital admission for his CHF, Henry was contacted by a health-care guide in CareOregon's CareSupport program, as part of the plan's initiative to reduce 30-day readmission rates for CHF. Henry was resistant to this intervention at first; wary that someone from his health plan was contacting him. He worried that they were calling to tell him that his hospital stay was not covered, and that he would owe a significant amount of money.

The health care guide reassured him that this was not the case, and simply asked him if he was interested in getting help to meet his medical needs, so that he could better manage his conditions. Still unsure, Henry would only agree that the healthcare guide could call him back one week later. The second week, Henry's healthcare guide called back, but again, Henry seemed resistant. Despite his reluctance, he agreed to a third call the next week.

Over time, he became more comfortable talking with his health care guide and actually looked forward to hearing from her. As they established a trusting relationship, Henry's health care guide was able to educate him about potential warning signs of CHF and what to do if he had symptoms. She made sure he had the medication and equipment he needed, that he was breathing comfortably at night, and that he had transportation to his appointments. The health care guide told Henry that if he ever had a problem, she would call his doctor for him, or send a nurse to his house.

Henry was able to monitor his CHF, and he completed the 30-day program without returning to the hospital. In addition, his health care guide continues to check on him periodically to ensure he is still managing his conditions.

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CareOregon's CareSupport staff emphasize the importance of building rapport with the members. While commercial health plans may use telemonitoring devices to track a member's blood pressure, pulse, or other indicators, CareOregon has found that members like Henry respond better to one-on-one interaction. Many dual eligibles, especially those with mental health issues, would be fearful of and resistant to telemonitoring devices or have a much higher need for social support. CareOregon relies on its health care guides to develop a rapport with members to increase their confidence in recognizing their symptoms and calling their physician when appropriate.

* Not his real name.

BlueCross & BlueShield of Rhode Island and Neighborhood Health Plan of Rhode Island

The nonprofit BlueCross & BlueShield of Rhode Island (BCBSRI), in operation since 1939, offers a variety of commercial and Medicare managed care plans to over 700,000 Rhode Island residents. BCBSRI is the largest Medicare Advantage plan sponsor in the state. Neighborhood Health Plan of Rhode Island (NHPRI), the state's largest Medicaid managed care plan, was founded in 1993 by Rhode Island's 13 community health centers.

NHPRI's experience serving Medicaid recipients prompted BCBSRI to form a partnership with them to offer a dual eligible SNP beginning in January 2006. BCBSRI manages the contract with CMS and is responsible for sales and marketing, enrollment, claims, pharmacy, provider contracts, network management, and underwriting. NHPRI acts as a subcontractor and is responsible for customer service, care management, and outreach activities for the SNP.

The two plans describe their collaboration on the SNP as a way to serve the community and provide a better, more targeted managed care option for dual eligibles, who are automatically disenrolled from Medicaid managed care when they age into Medicare. BCBSRI and NHPRI believe the division of SNP responsibilities allows them to build on BCBSRI's experience in Medicare and NHPRI's experience with the Medicaid population. Both NHPRI and BCBSRI view the dual eligible population as unique and better served with more intensive, frequent health plan interaction.

Rhode Island's Medicaid program does not offer Medicaid managed care for dual eligible beneficiaries. The SNP plan, therefore, does not have a contract with the state to serve dual eligibles and receives no Medicaid payment from the state for these beneficiaries.

Table 12. BCBSRI and NHPRI Plan Description

Blue Cross & Blue Shield of Rhode Island and Neighborhood Health Plan of Rhode Island BlueCHiP for Medicare Optima	
Operating Since	January 1, 2006
Service Area	State: Rhode Island Counties: All
Dual Eligible Capitation Sources	Medicare only
SNP Enrollment	2,499
SNP Membership Profile	26% male, 74% female 34% under 65
Other Plans Offered	*BCBS-RI:* Prescription Drug Plan Medicare Advantage Medicare Advantage – Prescription Drug plan Medigap Federal Employee Health Benefits Program Commercial (group and individual) plans *NHPRI:* Medicaid
Total Plan Enrollment (Excluding SNP)	*BCBS-RI:* Approximately 700,000 (40,000 in Medicare Advantage) *NHPRI:* Over 75,000

Source: As reported by Blue Cross & Blue Shield of Rhode Island and Neighborhood Health Plan of Rhode Island, June 2007.

Care Coordination

BCBSRI and NHPRI coordinate care through several means depending on the specific member's needs. All members have access to dedicated SNP customer service representatives who assist members in understanding and accessing their Medicare and Medicaid benefits. Members identified as high-risk receive intensive case management while moderate-risk members with specific chronic conditions may be enrolled in a disease management program. The following table provides an overview of the plan's care coordination functions and roles, which are described in greater detail below.

Table 13. Care Coordination Roles and Functions

Role	Function	Ratio of Staff/ SNP Members	Target Population	Description
Care Management Program – team typically includes a nurse (RN), behavioral health, and a non-clinical care coordinator	Intensive medical case management	1:75	High-risk members or members with an acute episode	Develop individual care plan covering medical, social, and behavioral health needs Specific interventions depend on needs but may include: ongoing telephone contact, member education, coaching the patient on provider interactions, assistance with heating, utility bills, food, and coordination of Medicaid benefit
Disease Management Nurse	Disease management for specific chronic conditions	1:3,000	Moderate-risk members	Telephone outreach to members to educate them about their condition and health coaching
Dedicated SNP Customer Service Representatives	Coordinate services, link members to social services	1:1,000	All members	Support members in scheduling medical appointments, transportation, understanding and applying for Medicaid benefits, including waiver programs

Medical Case Management for High-Risk Members

NHPRI stratifies SNP members according to risk, placing the highest risk beneficiaries in their intensive case management program. NHPRI identifies at-risk members through several methods including: a self-completed health risk assessment, physician referrals, recommendations from utilization management nurses following a hospital admission, BCBSRI's claims-based modeling, and based on customer service referrals after a new member welcome call. The various screening methods work together to identify a member's risks based on social or clinical criteria, such as multiple comorbidities, a need for better access to providers, or lack of self-knowledge about the member's conditions. At-risk members are then assessed to determine whether they require intensive case management. While most assessments are conducted by phone, the plan will sometimes send nurses to the member's home to identify member needs and stratify them by risk.

Table 14. Strategies to Identify High-Risk Beneficiaries

Strategy	Description
Health risk assessment	Written survey tool that is administered via telephone calls to members
Physician referrals	Physicians identify patients that may benefit from care management program
Referral from utilization management nurses	Utilization management nurses identify potential patients and refer them via phone to care management
Claims-based predictive modeling	Johns Hopkins ACG-PM software
Customer service	Patients identified by customer service staff, calls transferred to medical case management

SNP members who are enrolled in the care management program are assigned to both a care coordinator and a medical coordinator, as needed. An individual care plan is then developed for the member; the plan covers medical, social, and behavioral health needs. The specific activities undertaken depend on the members' needs, but generally include ongoing telephone contact with the member, educating the member about their condition, providing information on how to identify and control symptoms, answering questions about medications, visiting the member's providers if needed, and coaching the member on to how to get the most from a physician visit.

The specific interventions, however, depend on the needs identified in the assessment. For example, if the assessment identifies a risk of falling, a nurse or physical therapist visits the patient's home and coordinates the installation of bars or other safety measures. A patient identified as socially isolated and depressed may be enrolled in adult day care.

Members identified as having a short-term need—for example, managing discharge from the hospital, need for durable medical equipment—are also supported by the case management team.

NHPRI offers disease management services for moderate risk members suffering from diabetes, asthma, chronic obstructive pulmonary disease, and hypertension. These members receive telephone calls educating them about their illness, coaching them on how to advocate for themselves in the doctor's office, and general condition management.

Members at all risk levels receive care coordination services. High-risk members, who are assigned specific care coordinators, receive assistance in arranging transportation, scheduling appointments, and accessing social services and community resources. Dedicated SNP customer service representatives perform this coordination and support function for lower-risk members on an as-needed basis.

Coordination of Medicare Parts A, B, D, and Medicaid Benefits

The SNP plan provides all Medicare Parts A, B, and D services. Although BCBSRI does not receive capitation payments from Rhode Island for Medicaid services, the SNP does coordinate services provided by Medicaid through its care management program. Care coordinators and SNP customer service staff at NHPRI are familiar with Medicaid coverage and processes and help members access covered Medicaid services. Rhode Island has several different home and community-based waivers that are administered through various state agencies. For example, one waiver specifically targeted to the over 65 population provides homemaker services, minor home modifications, and specialized medical equipment to prevent institutionalization. NHPRI care manager and customer

service staff help members identify waiver programs for which they may be eligible and guide members through the complex application process.

NHPRI also assists members in maintaining Medicaid eligibility. NHPRI notes that many members lose eligibility due to their failure to return recertification information. NHPRI helps members understand the requested information and facilitates their recertification process.

Links to Community-Based Social Services

According to plan officials, SNPs must focus on the myriad social issues members face related to their low-income status. Addressing these issues can help members better manage their healthcare needs. Members who do not have their basic needs met—food, security, shelter—will not be able to follow a healthcare plan.

The plan relies on NHPRI's social service infrastructure to identify these needs and connect members with social services. The SNP customer service staff is trained to listen for cues of potential social and community risks and needs. NHPRI has found that older members have a strong sense of pride and are reluctant to ask for help. Staff is trained to be sensitive to the members' needs and provide assistance in a way that makes the member comfortable. The SNP's care coordinators and customer service staff are knowledgeable about community resources, and they connect members with local food banks, senior centers, and other service providers.

Benefit Offerings

In addition to required Medicare benefits, the SNP provides additional benefits, including transportation, dental coverage, and enhanced care coordination services.

Table 15. Plan Benefits

Service	Description
Medicare	
Medicare fee-for-service benefits	Plan covers all Medicare FFS benefits
Case management program	Individualized health care plan
Dedicated customer service representatives	Customer service staff specifically trained for this product and this population
Disease management program	Telephone and mail programs to educate members about their condition
Transportation	Plan offers 10 vouchers for medical appointments in addition to Medicaid-covered services
Hearing	$1,200 every 3 years toward the purchase of a hearing aid plus routine and diagnostic exams
Vision	$200 allowance toward the purchase of glasses, frames and/or contact lenses every calendar year as well as diabetic and routine eye care
Health club membership	$15 per month
Smoking cessation	Telephonic smoking cessation program for members with chronic conditions
Health education classes	Programs focused on specific clinical conditions such as diabetes, congestive heart failure, and coronary artery disease

Through NHPRI's experience serving Medicaid beneficiaries, the plans identified two services in particular, transportation and dental coverage, as providing little access, despite being covered by Medicaid. The Medicaid-covered transportation services require one to two weeks notice for scheduling, which does not accommodate members who have an urgent need to see a physician. BCBSRI was able to arrange a network of taxis and it provides 10 one-way rides per year to SNP members who are unable to access Medicaid-covered transportation. Additionally, it provides its members access to BCBSRI's dental network, which is much more extensive than the state's Medicaid program.

In addition to supplementing Medicaid's transportation and dental benefits, the SNP offers hearing and vision coverage, smoking cessation programs, health education classes, and disease management programs.

Experience with Low-Income Populations

Both BCBSRI and NHPRI recognized that while BCBSRI's experience with Medicare was helpful, the dual eligible population has much more in common with the Medicaid population. The partnership between the two plans enabled BCBSRI to leverage NHPRI's experience serving Medicaid beneficiaries in order to design medical and care management strategies for duals and provide an infrastructure to address members' social needs, as described above.

Plan officials have identified communication barriers as another key difference in serving dual eligibles. Whereas the mainstream Medicare population is generally easy to reach by phone similar to commercial members, contacting Medicaid beneficiaries and dual eligibles may require more effort on the part of the plan. The plan offers bilingual English/Spanish materials and has bilingual care management and customer service staff. The plan also offers telephone interpretation service for other languages, providing customer services in hundreds of languages.

Relationships with the State

Plan officials cite the inability to integrate Medicare and Medicaid funding for dual eligibles as a key challenge for their SNP. Although the state has mandatory managed care enrollment for Medicaid beneficiaries, duals are automatically disenrolled when they become eligible for Medicare, requiring SNPs to coordinate with the state's fee-for-service Medicaid coverage. The plan describes the state as supportive of their SNP but not actively promoting an integrated Medicare/Medicaid model with capitated payments for dual eligibles.

BCBSRI and NHPRI: Carol's Story

Carol* is a 55-year-old grandmother recently diagnosed with lung cancer. She is the primary caregiver for her preschool grandchildren. She came to the attention of case management through the customer service department around the December holidays. She was feeling very ill from her chemotherapy and had no means of transportation to see her oncologist. She did not want to go to the emergency room. Case management worked with customer service to secure transportation and an urgent visit with her oncologist.

During the process of working with Carol, it became evident that she had many psycho-social stressors. She was very concerned for her grandchildren because she feared she would become ill and not be able to care for them. She also was deeply saddened at the prospect of a Christmas with no gifts or treats to share with her family. She had serious financial burdens and no extra money for the holidays. The social care coordinator was able to assist Carol to obtain gifts and services from community agencies in her local area to help make the holidays more enjoyable.

The medical case manager discussed Carol with her partner in behavioral health during weekly rounds. She wondered if Carol may also have a clinical depression as she had reported some difficulty sleeping and changes in appetite. The behavioral health case manager arranged for a complete evaluation. Carol was monitored closely by a behavioral health professional for several weeks. Her sleep and appetite reversed when some of the psycho-social stressors resolved and her chemotherapy protocol was adjusted.

* Not her real name.

Denver Health Medical Plan

Denver Health Medical Plan is a nonprofit health maintenance organization (HMO) affiliated with Denver Health, a safety net health system that operates the Denver Health Medical Center, 20 neighborhood and school clinics (eight of which are Federally Qualified Health Centers), the city's 911 system, and its public health department. The Medical Plan has been in operation since 1997 and offers health plan products for Denver area residents eligible for Medicaid, the State Children's Health Insurance Program, and Medicare.

Denver Health serves as the predominant source of medical care for low-income patients in the greater Denver area. Denver Health became interested in offering a SNP plan after passage of the MMA, principally because they viewed the SNP option as an opportunity to serve their current patient population. In addition, Denver Health was concerned that the addition of the Part D drug benefit may further fragment care for dual eliglbles by adding an additional payer to an already complicated system of coverage. The SNP would also allow Denver Health to maintain coverage of this population as they became eligible for Medicare benefits. Without a SNP plan offering, Denver Health's patients would no longer be covered under the Denver Health plan when they became eligible for Medicare.

Denver Health received CMS approval to offer a dual eligible SNP in May 2005, and began operating January 1, 2006. The Denver Health SNP is focused on recruiting and serving members who use the Denver Health system provider network for their medical care.

Denver Health contracts with the state of Colorado to provide all Medicaid-covered acute care services for its dual eligible members. At present, Colorado Medicaid does not offer managed care long-term care benefits, and, as a result, Denver Health is not able to provide these benefits.

Table 16. Denver Health Plan Description

Denver Health Medical Plan Denver Health Medicare Choice	
Operating Since	January 1, 2006
Service Area	State: Colorado Counties: Denver
Dual Eligible Capitation Sources	Medicare and Medicaid (for acute care services)
SNP Enrollment	1,073
SNP Membership Profile	38% male, 62% female 38% under 65
Other Plans Offered	Medicaid State Children's Health Insurance Program Medicare Advantage – Prescription Drug Plan Commercial Plan
Total Plan Enrollment (including SNP enrollment)	56,225

Source: As reported by Denver Health Medical Plan, June 2007.

Care Coordination

Denver Health developed its care coordination program in collaboration with its network providers who have considerable experience treating low-income populations. The plan assigns a "case manager" and "health coach" to each high-risk member. The case manager is principally responsible for the medical management of the patient, and he/she develops the initial plan of care while the health coach has ongoing, in some cases daily, contact with the member to coordinate the patient's care.

Lower risk members are served through the network of Denver Health clinics, which employ social workers to guide patients through administrative processes—for example, paperwork related to Medicaid eligibility—as well as link patients to social and community services.

Table 17. Care Coordination Roles and Functions

Role	Function	Target Population	Description
Care Coordination Team: Case Manager – Nurse (RN) Health Coach – RN, MSW, or MPH	Intensive medical management	High-risk members or members with an acute episode	Educate member about condition and key behaviors for managing their disease Assist member access clinical, mental health, and social services Coordinate the members care - review procedure requests, monitor Rx and appointment compliance, identify mental health issues
Community-Based Social Support Services – Social Worker in Clinics	Coordination of community resources and social support for low-risk members	Low-risk members	Assist members with administrative functions, including Medicaid applications, link patients with community services

Medical Case Management for High-Risk Members

Denver Health created its case management program to educate high-risk members about their conditions and key behaviors for managing their disease. Plan officials found that many doctors no longer have adequate time to spend on patient education, particularly for low-literacy, non-native English-speaking individuals. The plan has designed its program to identify high-risk members and provide varying levels of support to provide education, care coordination services, and facilitate connections with social services.

All members and their physicians are asked to complete a risk assessment questionnaire to help identify those most in need of the care management program. Physicians are asked about the patient's risk for future hospitalization and to identify specific actions the plan can take to help manage the member's health. New members are sent a short questionnaire with their welcome packet, and responses are used to identify those who need a more in-depth assessment. The plan then selects high-risk members to participate in its program, primarily those with diabetes, asthma, chronic obstructive pulmonary disease, and heart failure. In addition, members with multiple comorbidities or those at high risk for hospital re-admission are likely to be enrolled.

Table 18. Strategies to Identify High-Risk Beneficiaries

Strategy	Description
Member completed health risk assessment	Responses are used to identify candidates for a more in-depth assessment
Physician-completed health risk assessment	Assess patient's risk for future hospitalization and to identify specific actions the plan can take to help manage the member's health

Members enrolled in the program are assigned to a health coach who assesses both the medical and psycho-social aspects of care. The case manager oversees care and medications, facilitating necessary home care, DME or nursing home placements. The health coach, who is a nurse, social worker, or master's level health educator, helps the member access clinical, mental health, and social services. The health coach acts as a care coordinator, connecting the member to a variety of services, reviewing procedure requests for appropriate care coordination among providers, and in some cases helping to identify previously unrecognized mental health problems. The plan ensures that the health coach and care managers have close ties with Denver Health's clinics so that they can work closely with members' healthcare providers.

Denver Health enlists staff at various levels to conduct care management activities for its SNP members. Pharmacy case managers check for drug interactions and social workers and other clinic staff are available to provide assistance with accessing community services.

One example of the services provided through Denver Health's care management program is glucose monitoring of its members with diabetes. First, the plan identifies members with elevated glucose levels who have not visited a doctor in six months or more. A health coach calls the member to determine the member's current status, helps arrange an appointment to see a physician, and coordinates transportation to the physician if required. For all care management members with diabetes, the plan sends the member a quarterly report card tracking their glucose levels, information about the member's care, and educational materials about how to improve their management of the disease.

Similarly, the plan is developing protocols to identify members who are late in refilling certain prescriptions. Once those members are identified, the health coach calls the member to find out why the prescription has not been filled and then informs the provider about the member's situation. The health coach works with the member and provider to understand and improve compliance, identifying possible side effects, easier-to-swallow formulations, and transportation barriers.

According to baseline first year Healthcare Effectiveness Data and Information Set (HEDIS) measures for Comprehensive Diabetes Care, Denver Health scored in the 95th percentile for HbA1C testing, 59th percentile for eye exams, 82nd percentile for low-density lipoprotein (LDL) cholesterol screening, and 98th percentile for medical attention for nephropathy.

For all members, the plan has found that its affiliation with the Denver Health system provides the ability to tightly monitor and manage care and improves physicians' ability to coordinate treatment on behalf of their patients. Denver Health employs an electronic medical record system. The system provides clinicians with access to records of all of the care the member has received through Denver Health, which includes all of the member's primary care and much of their specialty care. Access to utilization data enables Denver Health to flag potential issues early – such as missed prescriptions or appointments – and

intervene before the non-compliance leads to an emergency room visit or inpatient hospital stay.

Coordination of Medicare Parts A, B, D, and Medicaid Benefits

Similar to all SNPs, Denver Health provides required Medicare Part A, Part B, and Part D benefits. Denver Health receives a monthly capitated payment from the state for the Medicaid acute care wraparound benefit. From the member perspective, the services are totally integrated and there is no distinction made between those services covered by Medicare versus Medicaid.

Many of Denver Health's dual eligible SNP members have some mental disability or may simply be confused by the coverage differences between Medicare and Medicaid. Thirty-eight percent of members are under 65, having qualified for Medicare due to a disability. Plan officials have found that offering both benefits, including Medicare prescription drugs, in a single managed care plan makes coordinating benefits far more understandable for the member. By integrating the Medicare SNP offering with Medicaid benefits, members have a single source of care and a point of contact for all of their health coverage questions, eliminating any concerns about copayments or paperwork.

Through its integrated plan, Denver Health is able to monitor members' dual eligibility and prospectively identify members who are at risk of losing Medicaid eligibility. The plan works with the member to ensure that any required forms are submitted to the state prior to the member's redetermination date so that the individual can maintain eligibility if possible.

Links to Community-Based Social Services

Denver Health provides two avenues for assistance in finding community services to meet members' needs. For high-risk SNP members enrolled in the care management program, their health coach identifies social services to assist with issues such as food insecurity, homelessness, family issues, and other problems. Health coaches also arrange transportation or provide a voucher for a cab or public transportation.

Denver Health ensures that social workers are available in all clinics to assist members with social and community needs. Low-risk SNP members are connected with social services, such as food banks and housing assistance. They also receive assistance with any eligibility-related paperwork including Medicaid redetermination applications. The social workers are staff of the clinics and not direct employees of the plan, but provide this service to all clinic patients, including SNP members.

Benefit Offerings

In addition to required Medicare benefits, Denver Health's SNP offers a variety of supplemental benefits. These benefits were selected based on provider and member feedback on perceived gaps in Medicare and Medicaid benefits. In addition, Denver Health provides a care management program for high-risk SNP members, as described above.

Table 19. Plan Benefits

Service	Description
Medicare	
Medicare fee-for-service benefits	Plan covers all Medicare FFS benefits
Care management program	Comprehensive intensive case management program for high-risk beneficiaries
Dedicated customer service representatives	Link members with medical care, social and community supports
Dental care	Up to $1,000 per year, including dentures
Hearing	Up to $1,500 every three years for hearing aids
Vision	Up to $100 every two years for eyewear
Transportation	Up to 10 round-trips per year
Medicaid	
Non-Part D prescription drug	Members have coverage for drugs not covered under Part D including barbiturates, benzodiazepines, cough and cold products, over-the-counter (OTC) medications, and prescription vitamins and minerals

Experience with Low-Income Populations

Based on its experience serving low-income patients, Denver Health has developed a variety of tools and strategies for communicating with its SNP members. The plan supports its diverse membership by offering translation services in 10 languages and targeting plan materials at a sixth-grade reading level. All written materials are available in English and Spanish.

The plan has also found that it can be difficult to maintain accurate addresses for dual-eligible members, and as a result it researches address changes on all returned mail and confirms correct address information whenever there is member contact.

Denver Health relies on its network of safety net health centers and hospitals to serve as the predominant source of care for its SNP members. These providers have extensive experience with low-income populations, understand well the stressors faced by their members, and have tailored their treatment and care programs accordingly. For example, providers recognize that patients may have little time for diet and exercise, but may improve medication adherence with education and coaching.

Relationships with the State

Denver Health is currently the only Medicaid managed care plan operating in Colorado. The plan has had limited interaction with the state on the SNP. If enrollment grows substantially, Denver Health expects the state to become increasingly engaged and interested in the program.

Denver Health's Care Management Program: Shonda's Story

Shonda* is a 42-year-old disabled woman who suffers from multiple chronic conditions—diabetes, chronic obstructive pulmonary disease, hypertension, congestive heart failure, gout—and depression. Shonda was referred to the care manager program after a hospital admission.

The case manager in collaboration with the health coach reviewed Shonda's care-to-date and identified several issues. Shonda was not filling her prescriptions and was failing to show up for follow-up appointments with her PCP. The case manager and health coach worked with Shonda to understand the underlying issues that were contributing to the missed appointments and prescriptions. Shonda felt overwhelmed by her chronic illnesses and needed additional support. She also had difficulty accessing transportation, which was a key factor in her missed appointments and prescriptions.

The health coach educated Shonda on how to access the transportation benefit and sent Shonda taxi cab vouchers. The health coach also assisted Shonda in setting-up mail order prescriptions to ensure Shonda could easily get her prescriptions filled, facilitating medication adherence. The case manager and health coach recognized that Shonda needed additional support in order to be able to focus on managing her chronic illnesses. The health coach helped Shonda apply for home and community-based services to help with house chores and connected Shonda with Project Angel Heart for meals.

The health coach continues to provide ongoing psychological and emotional support to help Shonda cope with her illnesses. The coach is available to help Shonda overcome barriers, such as lack of transportation, and comply with her care plan.

* Not her real name.

Affinity Health Plan

Affinity Health Plan has been providing managed care programs to low-income residents in the New York City metropolitan area for more than 20 years. These programs include 1) a Medicaid managed care program for Temporary Assistance for Needy Families, Safety Net, and SSI beneficiaries, 2) Family Health Plus, a Medicaid expansion program for adults, 3) Child Health Plus, New York's State Children's Health Insurance Program, and 4) UniCare, a state-subsidized program for low-income uninsured individuals who do not qualify for the public health insurance programs. More than 208,000 members are currently enrolled in these programs. In addition, in 2006, Affinity received CMS approval to offer two SNPs for dual eligibles and began to enroll SNP members on January 1, 2007. One of the SNPs, Affinity Medicare Ultimate, is available only to full dual eligibles. Affinity has a contract with the state, separate from its Medicaid managed care contract for non-duals, to offer a Medicaid Advantage (MA) rider to accompany its Medicare Ultimate product. The second SNP, Affinity Medicare Solutions, is offered to all dual eligibles—both full and partial dual eligibles—and does not have a counterpart Medicaid rider.

Affinity became interested in SNP coverage after the designation was created in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The health plan saw the SNP program as an opportunity to integrate Medicare and Medicaid coverage for dual eligibles, and provide its members continuity of health plan coverage once they become dually eligible. This integrated option was not available to beneficiaries prior to passage of the MMA. In New York, Medicare dual eligibles are excluded from the Medicaid managed care program and are automatically disenrolled from their Medicaid managed care plan when they become Medicare eligible. Plan officials were concerned that automatic disenrollment could cause confusion and stress for members who had developed relationships with plan customer service staff and care managers. Offering a SNP presented the only way for Affinity to enroll and continue serving dual eligible members without disrupting their coverage or service delivery relationships.

Affinity regards healthcare as a much broader concept than the medical care covered by the benefit package. Confirmed by their extensive Medicaid experience, Affinity recognizes that the health and care-seeking behavior of low-income beneficiaries is affected by socio-economic and psycho-social challenges, such as adequate housing, access to transportation, and low literacy and health literacy levels. These factors often impede timely access to and use of appropriate services. Many low-income beneficiaries turn to hospital emergency rooms and inpatient facilities rather than more appropriate ambulatory care (e.g., a primary care medical home) or other social support services. Affinity officials contend that investing in programs and services that link beneficiaries with primary care and critical social services reduce inappropriate emergency room and hospital use as well as improve quality of care. Consequently, Affinity has invested in extensive customer service and beneficiary advocacy to provide these linkages.

Under a contract with the New York State Department of Health, Affinity offers its Medicaid Advantage rider to full duals who select the Affinity Medicare Ultimate SNP. The Affinity Medicare Ultimate SNP benefit package incorporates all major Medicaid entitlement services. This rider covers copayments required by the Ultimate SNP and a few Medicaid benefits such as non-Medicare covered home health services, private duty nursing, dental, and non-emergency medical transportation. Affinity does not currently cover Medicaid-financed long-term care services in either its Medicare or Medicaid Advantage products. Beneficiaries who do not opt for the Medicaid Advantage rider receive their Medicaid benefits through the state fee-for-service system.

Table 20. Affinity Health Plan Description

Affinity Health Plan Affinity Medicare Ultimate and Affinity Medicare Solutions	
Operating Since	January 1, 2007
Service Area	New York City (five boroughs)
Dual Eligible Capitation Sources	Medicare and Medicaid (for acute care benefits)
SNP Enrollment	632
Other Plans Offered	Medicaid managed care (TANF, SN, SSI) Family Health Plus (Medicaid expansion for adults) State Children's Health Insurance Program UniCare (State-subsidized program for low-income uninsured individuals)
Total Plan Sponsor Enrollment	208,500

Source: As reported by Affinity Health Plan, October 2007.

Care Coordination

Affinity coordinates care for its members on multiple levels and with varying intensity depending on its members' needs. The following table provides an overview of the functions and roles, which are described in greater detail in the sections below.

Table 21. Care Coordination Roles and Functions

Role	Function	Target Population	Description
Nurse Case Manager	Intensive medical case management	SNP members identified as high-risk based on self-reporting, clinical information, and criteria sets	For members identified as high-risk, develops detailed care plans, interacts with members and providers, assists with care coordination, and monitors adherence to the care plan
Medicare Advocate	Intensive customer service	All SNP members	Assists members in accessing Medicare- and Medicaid-covered services; provides information; connects members with community and social services

Coordination of Medicare Parts A, B, D, and Medicaid Benefits

Both of Affinity's SNPs offer comprehensive benefit packages, including Medicare Parts A, B, and D services. Full dual eligibles enrolled in the Affinity Medicare Ultimate product receive most of their Medicaid services through the Medicare benefit package; those enrolled in the Affinity Medicare Solutions product receive most of their Medicaid services through the state fee-for-service program. Regardless of the source of Medicaid coverage, Affinity assists its SNP enrollees in understanding and accessing both their Medicare and Medicaid benefits.

During Affinity's SNP planning stage, focus groups confirmed its assumption that "personal service" was of great importance to Medicare beneficiaries. They had many choices of health plans, each offering comprehensive coverage and value-added supplemental benefits. Plan officials found that beneficiaries wanted a health plan that was easy to contact, provided clear and useful information, and showed an interest in their well-being. As a result, Affinity created its Medicare Advocate program to provide members with a

single point of contact within the health plan to help members navigate its program and service delivery system.

Medicare Advocates are dedicated customer service representatives with specialized training in Affinity SNP benefits, Medicaid coverage, and both Affinity and community support services. They assist members in scheduling appointments, educate them about Medicaid- and Medicare-covered services, obtain referrals, arrange transportation to and from appointments, and help link members with community organizations.

Currently, each of Affinity's Medicare Advocates is assigned approximately 70 SNP members, providing an opportunity for extensive interaction.

Refer to the accompanying text box to learn more about Affinity's Medicare Advocates.

Medical Case Management for High-Risk Members

Affinity uses a health risk assessment (HRA) instrument, which stratifies members based on their medical risk scores, and utilization data such as real-time pharmacy data, to identify high-risk members for referral to their care management program. About half of all SNP members completed a HRA in the first six months of SNP operations.

Members enrolled in intensive care management services are served by nurses in Affinity's Medical Management Department. These clinicians work with the members' providers to coordinate and manage high-risk enrollees' acute needs, such as transitions in and out of the hospital, as well as ongoing chronic care needs. The nurses develop a detailed plan of care for each member based on Affinity's defined care protocols, which guide the complex care management program.

Links to Community-Based Social Services

Affinity employs several strategies to connect members with community services. Most Affinity staff live in the communities served by the organization and, thus, are familiar with community services. Affinity also maintains a database of community contacts. Affinity's community relations department is responsible for creating relationships with community organizations, and gathering information for the database about groups offering social services.

After the Medicare Advocate identifies the appropriate service, the member may be linked in several ways. In most cases, the Medicare Advocate makes calls on members' behalf, schedules appointments, and works with members to complete any necessary paperwork. In other cases, the Medicare Advocate provides the phone number or location to the member, which the member will then pursue. The Medicare Advocate often follows up with the member to ensure contact was made.

Affinity identifies members' community needs through phone calls from members, provider referrals, and outreach Medicare Advocate calls.

Benefit Offerings

In addition to the benefits described above, Affinity provides supplemental benefits, including coverage for preventive services, such as annual physicals, vision care, routine foot care, and hearing care. In addition, Affinity offers enhanced coverage of inpatient hospital and skilled nursing facility stays.

Since full dual eligibles have access to basic dental coverage through Medicaid, Affinity provides coverage for specialty dental services, such as periodontal services, through its SNP. Affinity also offers preventive dental services to partial dual eligible members.

Experience with Low-Income Populations

Affinity emphasizes that their plan is "a part of the community" in which they serve. The organization's offices are located in the plan's service area and much of the staff comes from or lives in the community. Plan officials believe their approach enables staff to develop relationships with members and build knowledge of community resources. Another aspect of the plan's community focus is its Community Service Centers, storefront offices used for marketing, enrollment, customer service, and health education activities. Affinity has arranged for other organizations to offer services at their Community Service Centers, thus expanding access to those organizations for area residents. For example, the United States Department of Agriculture Food Stamp Program staff have scheduled hours in an Affinity Community Service Center, offering a convenient neighborhood location for completing a Food Stamp Program application. Similarly, the New York State Department of Labor and New York City Department of Health and Mental Hygiene post information and educational materials in Affinity's Community Service Centers.

Plan officials also designed their medical treatment models to reflect the special needs of this low-income population. For example, many commercial plans' Medication Therapy Management Programs (MTMPs) rely on members to enroll themselves in the program in response to a letter from the plan. Affinity structured its MTMP to remove that barrier to participation, instead automatically enrolling members who qualify and providing an option to disenroll. The plan believes this method will result in better MTM and, consequently, improved health outcomes.

Given the diversity of the population within Affinity's service area, the provider network is also culturally, racially, and linguistically diverse. Furthermore, since the SNP network is substantially the same as Affinity's Medicaid network, the plan offers providers who have extensive experience serving low-income populations.

Relationships with the State

New York offers the opportunity for plans to offer Medicare-Medicaid integration through its Medicaid Advantage program. As described above, Medicaid Advantage is offered as a rider to SNPs that include most Medicaid entitlement benefits. The state's rider option permits the plan to integrate most of the care provided to its dual eligible members and thus better coordinate and manage administrative, health care, and social service delivery processes.

Affinity's Medicare Advocate Program: V. J.'s Story

Ms. V.J.* is a 67-year-old woman who was referred for case management based on her responses to Affinity Health Plan's new enrollee survey assessment tool.

The RN case manager conducted a thorough medical and psychosocial assessment of V.J. and found that V.J. suffered from hypertension, morbid obesity, osteoarthritis of the knees, diabetes mellitus (DM) Type 1- uncontrolled, depression, had frequent falls, and low self-esteem. Through discussions with V.J., the RN case manager discovered that V.J. did not adhere to her diet, was homebound, did not consistently check her blood glucose levels, had infrequent visits for primary care services, and multiple emergency room visits.

The case manager established a therapeutic relationship with V.J., educating her about her conditions and reinforcing key learning through educational literature mailings and follow-up calls. V.J. learned about the appropriate role of her primary care physician (PCP) and an urgent appointment was scheduled for her. The case manager discovered that V.J.'s diabetes-related non-adherence was due to her not having a working glucometer. The case manager requested V.J.'s PCP have prescriptions for her diabetic supplies faxed to V.J.'s local pharmacy and delivered to her home. Home Care RN visits were scheduled to assist V.J. with her blood glucose monitoring, dietary needs, and exercise.

To address V.J.'s depression and low self-esteem, the case manager assisted V.J. with her mental health benefits and helped her schedule an appointment with a therapist. The case manager ensured that V.J. was approved for ambulette services to facilitate her medical appointments and successfully assisted V.J. with Access-A-Ride services to provide transportation to her non-medical appointments. The case manager also provided information about available community services, such as Meals on Wheels, soup kitchens, food pantries, senior centers, community centers, and local church groups. An application for food stamps was mailed to V.J., and she was informed of Section 8 housing benefits.

The case manager discovered V.J. fell a lot because she did not use her cane in public. The case manager taught her about fall/safety precautions and the possible risks associated with not using her cane. A home care social worker evaluation was approved by Affinity to reinforce and assist with ongoing health and psychosocial needs.

V.J.'s health status has improved dramatically as a result of these interventions. Her blood glucose is now controlled, thus reducing her risk for complications related to diabetes. She has established a relationship with her PCP, resulting in reduced emergency room visits. V.J. has not fallen since she is now using her cane on a regular basis. She was approved for $90/month in food stamps, and she now frequents the senior center where she has made several friends. Her Access-A-Ride application was approved and she is able to visit friends, family, and live more independently. Due to the case manager's therapeutic relationship with V.J. and her continued participation in mental health therapy, V.J. recently said, "this is the first time I have ever been treated like a person, and felt like a person."

* Not her real name.

Community Health Plan of Washington

The fifth-largest health program in the state, Community Health Plan (CHP) of Washington was established in 1992 by a statewide network of community health centers. The health centers continue to govern CHP, and its primary care provider network remains predominately health center-based.

CHP received CMS approval to offer a dual eligible SNP beginning January 2007. CHP's leadership viewed the SNP as a way to expand the plan's ability to serve health center patients once they became eligible for Medicare. CHP serves 130,000 Medicaid members but it does not cover the Medicaid benefits once they become eligible for Medicare (i.e., dual eligible). Washington, outside of a handful of pilot projects, does not enroll dual eligibles in Medicaid managed care.

CHP experimented with Medicare managed care in the late 1990s but found it financially untenable. Its leadership viewed te new Medicare Advantage (MA) SNP as an opportunity to enter the Medicare managed care market with a greater chance at viability. In their view, the SNP designation provides the flexibility to focus directly and exclusively on the healthcare needs of dual eligible beneficiaries and the potential for future integration of Medicare and Medicaid coverage of this population. CHP believes this targeted focus will enable them to better attract and serve dual eligible beneficiaries who receive services through CHP's health center network. The SNP was viewed as a natural extension of the organization's overall strategy of providing community-focused managed care to low-income individuals, who have unique demographic characteristics and clinical needs.

As mentioned above, CHP does not contract with the state of Washington for acute or long-term care Medicaid coverage for its dual eligible members. CHP would like to begin contracting with the state for acute care Medicaid wraparound services, believing that integrated funding will enable improved care coordination. For CHP, this philosophy is not limited to its SNP offering. CHP is also implementing a pilot program to integrate Medicaid medical and mental health coverage—currently carved-out of Medicaid managed care in Washington—for its most vulnerable Medicaid member segment known as the General Assistance-Unemployable population.

Table 22. CHP of Washington Plan Description

Community Health Plan of Washington Community HealthFirst Medicare Advantage Special Needs Plan	
Operating Since	January 1, 2007
Service Area	Washington state Counties: Adams, Benton, Chelan, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, Island, King, Kitsap, Lewis, Lincoln, Mason, Okanogan, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Yakima
Dual Eligible Capitation Sources	Medicare only
SNP Enrollment	321
SNP Membership Profile	31% male, 69% female 60% under 65
Other Plans Offered	Medicaid ("Healthy Options") State Children's Health Insurance Program Medicare Advantage Medicare Advantage – Prescription Drug "Basic Health"
Total Plan Enrollment	234,213

Source: As reported by Community Health Plan of Washington, June 2007.

Care Coordination

CHP assigns every SNP member to a patient navigator to address logistical coordination issues, such as making medical appointments and arranging transportation. Members requiring more intensive medical case management are referred to a clinical care coordinator or a case manager. CHP views its case managers as serving members' long-term chronic care needs and its clinical care coordinators as managing patients during an acute care episode. The table and sections below describe these roles in greater detail.

Table 23. Care Coordination Roles and Functions

Role	Function	Ratio of Staff/ SNP Members	Target Population	Description
Case Manager	Ongoing medical management of chronically ill, high-risk members	Serve all health plan members equally – no SNP dedicated staff	Members with long-term chronic care needs	Identifies member risk factors Develops plan of care Ongoing interaction with patient to ensure medical treatment needs are being met – assistance accessing specialists, ensuring DME is in place
Clinical Care Coordinator	Medical management of patients through short-term episode	Serve all health plan members equally – no SNP dedicated staff	Member with an acute episode	Follows the patient during and after the acute episode to ensure appropriate discharge planning, follow-up appointments, DME and/or other supports are in place
Patient Navigator	Logistical coordination for the member	1.0 FTE for approximately 80 members	All SNP members	Scheduling appointments, transportation Assisting member in locating services – for example housing, meals, legal, and charity care Linking patient with social services Assist members with Medicaid and other program applications
Clinic Outreach Coordinators	Logistical coordination	Varies per clinic	Clinic patients	Works collaboratively with member and patient navigator to ensure appointments scheduled, transportation needs met, interpreter scheduled, etc.

Medical Case Management for High-Risk Members

When members enroll in the CHP SNP, they are asked to complete a health risk assessment (HRA). The HRA is sent by mail with the plan's welcome materials, but patient navigators also call each member to facilitate completion of the HRA. CHP estimates that this outreach effort leads to approximately 80 percent of SNP members completing the HRA questionnaire. The 17-question HRA survey is used to identify high-risk individuals who will require specialized services from the trained nurses in CHP's care management group. CHP generally categorizes members as high risk if they have certain medical conditions (e.g., cancer or diabetes) or have certain personal characteristics (e.g., being over 75 or blind).

Table 24. Strategies to Identify High-Risk Beneficiaries

Strategy	Description
Health risk assessment	Use of PraPlus™ (a nationally recognized health appraisal instrument) to generate risk score
Patient navigator initial interview	In-depth conversation with member about self-reported answers to questions on PraPlus™ and development of non-clinical options to address member needs (referrals made to Case Management and Disease Management as needed)
Disease management health risk assessments and disease management interviews	Disease specific HRAs and interviews for referred members
Case management screening and assessment	Member specific screening and treatment

Beneficiaries identified as high risk are assigned to nurse case managers. The case manager assesses the patient and then, taking a holistic view of the patient's needs, develops a plan of care. The case manager helps the patient access care providers and supplies. He/she also manages the delivery of the care across many different types of services, for example, rehabilitation and long-term equipment use. The case managers also consider the member's need for social supports. For example, a member showing signs of depression and possibly expressing suicidal thoughts receives immediate intervention to prevent self-harm. A member showing signs of depression without any serious symptoms receives a referral to a physician for consideration of medication, a referral to counselors for mental healthcare, and a referral to community support groups for ongoing support in dealing with chronic mental health complaints.

For short-term interventions, such as one-time hospital stays, members are assigned to a clinical care coordinator, who may assist with discharge planning or arrange for home oxygen service following the discharge. SNP members who require longer-term or chronic care support after their hospital discharge are assigned to case managers. In general, members eligible for these services are those who will likely regularly require medical equipment and extensive rehabilitation, as well as beneficiaries with high-risk chronic conditions.

The case managers and clinical care coordinators work collaboratively with the patient navigators. For instance, if the patient requires medical equipment, the patient navigator may call to schedule delivery and schedule a nurse visit to educate the patient on how to use the equipment.

Coordination of Medicare Parts A, B, D, and Medicaid Benefits

CHP assigns all SNP members to a patient navigator with expertise in the plan's covered services as well as other coverage available to dual eligibles through the state's Medicaid fee-for-service program. Each patient navigator is assigned to approximately 80 SNP members, providing an opportunity for "high-touch" service to all members, including for some members a daily check-in call. Patient navigators provide logistical assistance in scheduling medical appointments or working with the patient's primary care physician to coordinate transportation services. Patient navigators also answer members' questions regarding Medicaid program applications and eligibility, claims and explanations of benefits, and assisting members access out-of-network providers and suppliers. CHP's patient navigators help Medicaid-eligible members enroll in Medicaid and retain their Medicaid

benefits on an on-going basis. Patient navigators also help beneficiaries access Medicaid services, such as referring members to dental providers who accept Medicaid patients, or helping members access Medicaid transportation vendors.

In May 2007, patient navigators facilitated 36 appointments with primary care physicians and specialists for the plan's 320 members. They facilitated more than 95 referrals to community services, assisting members in accessing counselors, legal assistance, meals, prescription assistance, and other community resources. Patient navigators perform 120-150 interventions a month on average, a number which will increase as enrollment increases.

Links to Community-Based Social Services

CHP provides training and resources to their patient navigators so that they are able to link members to community social services. Patient navigators may help members determine what social service benefits they are eligible for and can provide referrals to community resources, such as local food banks, financial assistance, alternative living situations, counseling, household help, and other outlets. CHP has developed a list of hundreds of community resources for these member referrals.

In addition, CHP officials emphasize the importance of ensuring that patient navigators are embedded in their communities so they can provide tailored referrals to SNP members. For example, an Asian immigrant may be better served by a particular food bank that regularly stocks rice and other traditional Asian foods. In this way, CHP believes that patient navigators can ensure that their SNP members are able to access the most appropriate community services to meet their needs. Official believe that close relationships between patient navigators and the geographic areas they serve is imperative to improve health and corresponding social outcomes.

Benefit Offerings

Similar to all SNPs, CHP provides required Medicare Part A, Part B, and Part D benefits. The plan's challenge was to design a package of supplemental benefits that could complement but not supplant Washington's Medicaid benefits, which include transportation services as well as dental, hearing, and vision benefits.

In early focus groups with prospective SNP members, many dual eligibles said while they had dental coverage through Medicaid, they often had difficulty finding dentists who accept Medicaid patients. Based on these focus groups and other market research, coupled with a burgeoning interest in integrating medical and related services (e.g., dental, mental health), CHP considered offering a supplemental dental benefit for 2007. The dental benefit proved too complex for a 2007 rollout and CHP, instead, decided to provide enriched coverage for vision and hearing. For 2008, CHP has addressed the challenges in offering a dental benefit and will scale back its vision and hearing coverage in order to fund what it believes will be a highly valuable dental benefit for its SNP membership.

By operating as a SNP, CHP feels it has the ability to best tailor its benefits to the specific needs of its dual eligible population.

Table 25. Plan Benefits

Service	Description	
	2007	2008
Medicare fee-for-service benefits	Plan covers all Medicare FFS benefits	Plan covers all Medicare FFS benefits
Dental	Not covered	Comprehensive dental coverage up to $1,200 annual maximum
Routine hearing exam	1 exam every 2 years	1 exam every 2 years
Hearing aids	Up to $1,500 every 2 years	Not covered
Routine eye exam	1 exam every year	1 exam every 2 years
Vision hardware	$360 every year	$360 every 2 years
Routine physical exams	Unlimited	Unlimited
Worldwide emergency coverage	Not covered	Covered up to $25,000 annual maximum with 20% coinsurance
Innovative Administrative Services		
Patient navigator program	Yes	Yes

The accompanying text box describes one member's experience with CHP's patient navigator program.

Experience with Low-Income Populations

Through its network of community health centers, CHP has more than 15 years of experience serving the needs of low-income members. It relied on its understanding of the specific challenges faced by this population when developing its plan materials, case management protocols, and clinical care models. For example, CHP's plan materials are written at a 6th grade reading level or below and are provided in many languages to meet the linguistic and literacy needs of low-income, disabled, and immigrant populations.

CHP relies on its safety net provider network to meet the unique needs of the dual eligible population. These providers also understand the unique healthcare needs of low-income populations. Moreover, interventions, such as the case management and clinical care coordinator function, are designed to ensure the needs of this more vulnerable population may be met. And finally, its nurses provide varying levels of support, depending on the patient's ability to function in a more self-directed way.

Relationships with the State

Washington is currently running two demonstration projects with other SNPs to determine how to best integrate Medicare and Medicaid services and funding for dual eligibles. While CHP was not selected to participate in these demonstrations, CHP fully supports such integration efforts and hopes to work with the state to demonstrate the clinical and financial advantages of coordinating Medicare and Medicaid funding and benefit coverage through SNPs.

CHP's Patient Navigator Program: David's Story

David* had been using oxygen services for many years to help him manage his Chronic Obstructive Pulmonary Disease. Like others with his condition, his oxygen levels varied from day to day, but his need for oxygen services was consistent. When David first joined CHP's Community HealthFirst, his need for long-term oxygen had not yet been documented by the plan. When the vendor providing oxygen services tested the level of oxygen in David's blood, his oxygen saturation levels were near normal, so the vendor refused to provide additional oxygen supplies.

David was very anxious when he called his patient navigator to explain the problem. While he was having an occasional "good day," he knew that he would need more oxygen supplies than he currently had. David was concerned that because he was new to CHP, it would be difficult to get the supplies he needed to manage his condition.

David's patient navigator was able to diffuse the situation and reassure David that the vendor's refusal to provide oxygen would be resolved. The patient navigator was able to refer David to a provider who could document his need for oxygen and to ensure that the equipment he needed would be available before his existing supplies ran out. What could have been a complex, frightening, and administratively burdensome process for David was resolved with one call to his patient navigator.

* Not his real name.

Conclusion

The policy concerns that drove Congress to authorize Special Needs Plans (SNPs) in 2003 are no less of a reality today. High-risk beneficiaries continue to consume a disproportionate and growing share of total Medicare and Medicaid spending and dual-eligible individuals receive care in a complex, fragmented system with little coordination between Medicare and Medicaid. Policymakers continue to push the Medicare and Medicaid programs to tailor services to better meet the needs of dual eligible beneficiaries and other vulnerable populations.

The health plans profiled in this report are developing targeted programs aimed at addressing these challenges. Some policymakers have expressed concern at the dramatic increase in SNP enrollment, which now exceeds over 1 million beneficiaries. Some are questioning whether SNPs should be reauthorized and the importance of the SNP program. The case study findings suggest that the SNP designation is an important factor in attracting these plans to provide tailored services to dual eligible beneficiaries and that the designation represents a vital tool to help policymakers further their goals of identifying targeted care models to better manage high-risk beneficiary costs and outcomes.

For all six health plans profiled in this report, the SNP designation was a key factor in their decision to offer a Medicare Advantage plan. Prior to the SNP designation, none of the case study health plans participated in Medicare Advantage. These historically Medicaid managed care plans serve predominately low-income beneficiaries. The SNP designation served as a catalyst for these plans to develop targeted programs designed to meet the unique needs of a population, dual eligible beneficiaries, who face many of the same challenges as the plans' non-Medicare members.

The SNP program also serves to support Congress and CMS's research activities on care and medical management models for high-risk beneficiaries. Currently, there are several ongoing demonstrations to test the impact of disease and care management models on high-risk beneficiaries' healthcare utilization and outcomes. These six case studies suggest the SNP designation is important in fostering innovation beyond these demonstrations to help policymakers understand how targeted care models may improve health outcomes. These programs are employing new models of care to better identify, treat, and manage the healthcare needs of persons eligible for Medicare and Medicaid supporting the goal of fostering innovations in coordinated care.

The SNP designation is also important in that it serves as an administrative vehicle for Congress and CMS to impose additional requirements on plans that serve special needs beneficiaries. The separate designation provides policymakers an ability to require plans to focus specifically on the unique needs of dual eligible and other vulnerable beneficiaries, rather than the needs of the Medicare population as a whole. Policymakers have expressed a desire to impose additional requirements for plans to qualify for the SNP designation in the future, and some members of Congress have suggested additional criteria as a condition for the program's reauthorization. Such stronger requirements and criteria may contribute to greater consensus around the role of SNPs in providing tailored services to these populations.

Since these plans are so new, there is little data on costs and quality. All of the case study plans expressed support for continued development of a uniform set of measures for quality assessment. The National Committee on Quality Assurance is currently developing SNP-specific measures. These measures may help define SNPs' promise for improved access, quality, coordination, and reduced costs. Moreover, enhanced SNP program criteria and reporting requirements may contribute to greater consensus around SNPs' value and mitigate concerns around program growth.

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