Addressing Social Determinants of Health in Demonstrations Under the Financial Alignment Initiative

June 30, 2020

Addressing Social Determinants of Health in Demonstrations Under the Financial Alignment Initiative

June 30, 2020

Prepared for

Centers for Medicare &
Medicaid Services
Center for Medicare and
Medicaid Innovation
Mail Stop WB-0605
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted by

Amy E. Chepaitis, PhD
Amarilys Bernacet, MPH
Cleanthe (Cleo) Kordomenos, BA
Angela M. Greene, MS, MBA
Edith G. Walsh, PhD
RTI International
P.O. Box 12194
Research Triangle Park, NC
27709-2194
https://www.rti.org/

CMS Contract No. HHSM5002 HHSM-500-2014-00037i TO#7
RTI Project Number 0214448.001.007.000.000.012

This project was funded by the Centers for Medicare & Medicaid Services under contract no. HHSM-500-2014-00037i TO#7. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

In Brief

Policymakers, researchers, payers, practitioners, and other stakeholders are increasingly paying attention to social determinants of health (SDOH) as they realize that improving population health and reducing health care spending requires approaches that go beyond increasing access to health care and treating a medical condition.

The Financial Alignment Initiative (FAI), funded by CMS, is testing, in partnership with States, integrated care and financing models for Medicare-Medicaid enrollees. The State demonstrations under the FAI were specifically developed to coordinate care across the two separate Medicare and Medicaid systems, and to address the complex needs of dually eligible individuals, including health and health-related social needs.

In this issue brief, we use qualitative findings from stakeholder interviews, beneficiary focus groups and other activities conducted from 2015 through 2018 by RTI under the CMS-sponsored evaluation to summarize approaches that FAI States, managed care plans, and care coordination entities are taking across the demonstrations to address a wide range of enrollees' SDOH. We provide case studies for three States—Washington, Minnesota and South Carolina—that highlight promising efforts in this area. We also include supplemental information from beneficiary focus groups conducted by another CMS contractor.

CMS, States, plans, providers, advocates, and quality improvement stakeholders can use the information in this issue brief as they consider ways to address SDOH and improve the beneficiary experience for dually eligible enrollees. A greater understanding of how FAI demonstrations are delivering benefits to address SDOH could advance policies and practices that help health care systems, managed care organizations, and integrated health networks outside of the FAI to plan for and implement relevant interventions, services, or benefits for vulnerable populations.

Introduction

The health care conversation in America is changing. As a nation, we are beginning to acknowledge and act on growing research that recognizes the importance of social determinants of health (SDOH). SDOH are defined as the “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks” (ODPHP, 2019). They include, among other things, safe and affordable housing, access to education, public safety, and availability of healthy foods.

Examples of SDOH

- Availability of resources to meet daily needs
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources to support community living and recreation
- Transportation options
- Public safety
- Social support
- Social norms and attitudes
- Exposure to crime, violence, and social disorder
- Socioeconomic conditions
- Residential segregation
- Language/literacy
- Access to mass media and emerging technologies
- Culture
- Natural environment
- Built environment
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements

Source: ODPHP, 2019.

Social determinants shape health for everyone, and can have positive or negative correlations with health. For example, higher income is associated with better health, whereas lower income is associated with worse health, as individuals may not be able to afford care or medication, may have difficulty getting to or making time for appointments or follow-up care, or may lack access to nutritious food or safe spaces to enable a healthy lifestyle.

SDOH have far greater effects on health than does clinical care—in fact, SDOH drive two or more times the variation in health outcomes (Bookse et al., 2010; Galea et al., 2011; Schroeder, 2007). Policymakers, researchers, payers, practitioners, and others increasingly recognize that improving population health and reducing health care spending requires approaches that go beyond increasing access to health care.

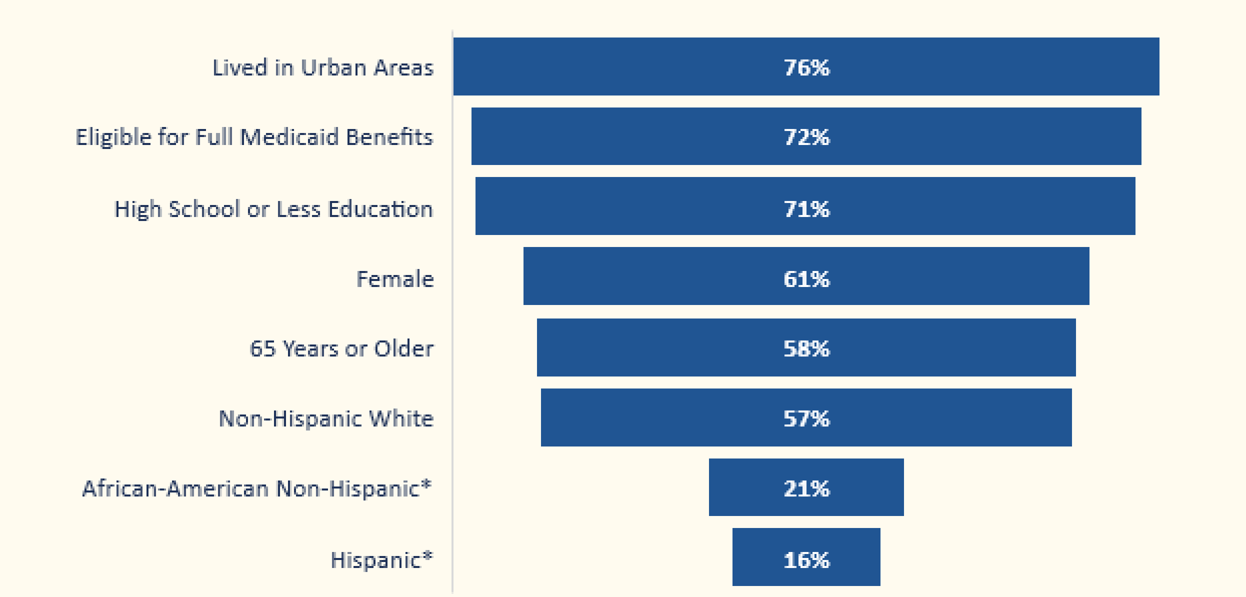
Nuances in Terminology

- SDOH are social forces or conditions that affect health.
- Social risk factors are adverse social conditions associated with poor health.
- Social needs are immediate nonmedical yet health-related needs of individuals, as identified and prioritized by the individuals.

Recently, experts have brought attention to nuances in SDOH-related terminology, noting the distinctions between *SDOH*, *social risk factors*, and *social needs, or health-related social needs*.[i] These terms overlap, may be used interchangeably, and in some literatures are beginning to be refined into distinct and separate ideas. When a social determinant—such as housing instability—is associated with poor health, it is considered a *social risk factor*. Social risk factors place individuals and specific population groups at a disadvantage for good health (Alderwick & Gottlieb, 2019). Efforts can be made to assess social risk factors and address *social needs*, the immediate health-related social needs of individuals. This precise terminology is important to accurately advocate for, plan, implement, and evaluate efforts that address SDOH, social risk factors, and/or social needs. For example, efforts to address individuals' social needs will not directly affect broader social forces, or SDOH, whereas policy changes or legislation may affect broader systemic or institutional change. In this issue brief, we use these distinct terms where appropriate (i.e., actors assess social risk factors, and try to address or accommodate social needs). Otherwise, we refer to the more commonly used term SDOH. For example, we characterize broader efforts to both identify social risk factors and meet social needs as efforts to address SDOH.

Individuals enrolled in both Medicare and Medicaid—also known as *Medicare-Medicaid enrollees* or *dually eligible beneficiaries*—are, by definition, low-income per the income and asset requirements for Medicaid eligibility. Many also have physical, developmental, or psychiatric disabilities (a requirement for Medicare eligibility in the under 65 population), or may have decreased physical or cognitive function developed with age. Current estimates indicate there are 12.2 million dually eligible beneficiaries, almost 20 percent of total Medicare beneficiaries (CMS, 2019a). They are especially disadvantaged by social risk factors such as language and cultural barriers, housing issues, poor health literacy, rurality, and food insecurity (Sorbero et al., 2019). An Office of The Assistant Secretary for Planning and Evaluation (ASPE) study found that among Medicare beneficiaries, dual enrollment status, as a marker of social risk factors, was the most powerful predictor of poor outcomes on many quality measures (ASPE, 2016). See ***Figure 1*** for more demographic information on dually eligible beneficiaries.

Figure 1. Demographic characteristics of dually eligible beneficiaries (2013)



*These percentages are greater in the dually eligible beneficiary population than they are in the general population.

Source: Feng (2018) analysis of 2013 Federal Medicare and Medicaid data provided in the data book jointly produced by MedPAC & MACPAC (n.d.).

Dually eligible beneficiaries must navigate both Medicare and Medicaid—two separate complex programs with differing rules and processes—often without any help to coordinate their care. Social risk factors add another layer of complexity and make it all the more difficult for beneficiaries to access care.

Historically, most dually eligible beneficiaries have received their Medicare and Medicaid services through fee-for-service (FFS) arrangements. However, recent enrollment in Medicare Advantage or Medicaid managed care has grown significantly (CMS, 2014). Between 2006 and 2013, enrollment of dual eligible beneficiaries in Medicare managed care grew from 9 percent to 24 percent (CMS, 2014). In 2018, 34 percent of dual eligible beneficiaries were enrolled in either a Medicaid managed long-term services and supports (MLTSS) plan or a comprehensive Medicaid managed care plan that included LTSS (CMS, 2020a).

As dually eligible beneficiaries increasingly enroll in managed care, policymakers and advocates are focusing on new ways to identify and address SDOH through managed care. For example, Medicare Advantage plans have long been allowed to offer "primarily health related" supplemental benefits (e.g., dental care and vision services) to complement the services offered by Medicare and Medicaid and meet beneficiary needs. The enactment of the Bipartisan Budget Act of 2018 introduced Special Supplemental Benefits for the Chronically Ill (SSBCI), and recent CMS guidance reinterprets and expands the definition of "primarily health related" supplemental benefits. These changes have given Medicare Advantage plans new flexibility to provide a wider array of optional supplemental benefits that address the LTSS needs and social risk factors of beneficiaries (CMS, 2020b; CMS, 2019b; CMS, 2018).[ii]

In 2011, CMS created the Financial Alignment Initiative (FAI) to test, in partnership with States, integrated care and financing models for Medicare-Medicaid enrollees. The State demonstrations under the FAI were specifically developed to address the complex needs of dually eligible individuals. These integrated delivery models are expected to improve the experience of beneficiaries who access Medicare- and Medicaid-covered services by aligning processes and improving coordination of benefits.

The FAI made two models available to States: a capitated model and a managed fee-for-service (MFFS) model. [iii] Additionally, one State, Minnesota, is implementing an alternative model.[iv] As of January 1, 2020, there were 11 States undertaking demonstrations (California, Illinois, Massachusetts, Michigan, Minnesota, New York [Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities, or FIDA-IDD],[v] Ohio, Rhode Island, South Carolina, Texas, and Washington). Two other demonstrations (in Virginia and Colorado) ended on December 31, 2017; another demonstration (New York FIDA) ended on December 31, 2019.[vi] In December 2019, there were a total of 383,836 enrollees in FAI capitated model demonstrations (ICRC, 2020).

Medicare-Medicaid plans (MMPs) in *capitated model demonstrations* provide or facilitate access to four types of benefits: (1) the full range of Medicare benefits, (2) the Medicaid benefits provided in their State, (3) enhanced benefits specifically added to coverage by the State or individual MMPs,[vii] and (4) benefits provided at the care coordinators' discretion to individual enrollees.[viii] Examples of enhanced benefits—also called supplemental or flexible benefits—are vision and dental benefits, and over-the-counter drugs. With discretionary benefits, care coordinators[ix] provide or link enrollees to additional social services such as housing, food assistance, and reduced rates for various services such as home modifications, help with activities of daily living (ADLs), and pest control. Enhanced and discretionary benefits are intended to address the entire continuum of care and services that beneficiaries need, thus addressing social and health care needs.

In the two *MFFS demonstrations*, care coordination entities are (in Washington) or were (in Colorado) responsible for organizing enhanced integration of primary, acute, behavioral, and LTSS services across existing delivery systems for Medicare-Medicaid enrollees, and facilitating access to additional social services. The Minnesota *administrative model demonstration* addressed SDOH through a specific application of some of its demonstration implementation support funds (see **Minnesota: Cultural Outreach Grants)**.

In this issue brief, we present examples of what some FAI States, MMPs, and care coordination entities are doing to identify enrollees' social risk factors and address their social needs. Using qualitative findings from the CMS-sponsored evaluation of the FAI (conducted by RTI) and reports on focus groups conducted in 2018 by another CMS contractor in four States (California, Illinois, Ohio and Rhode Island), we discuss:

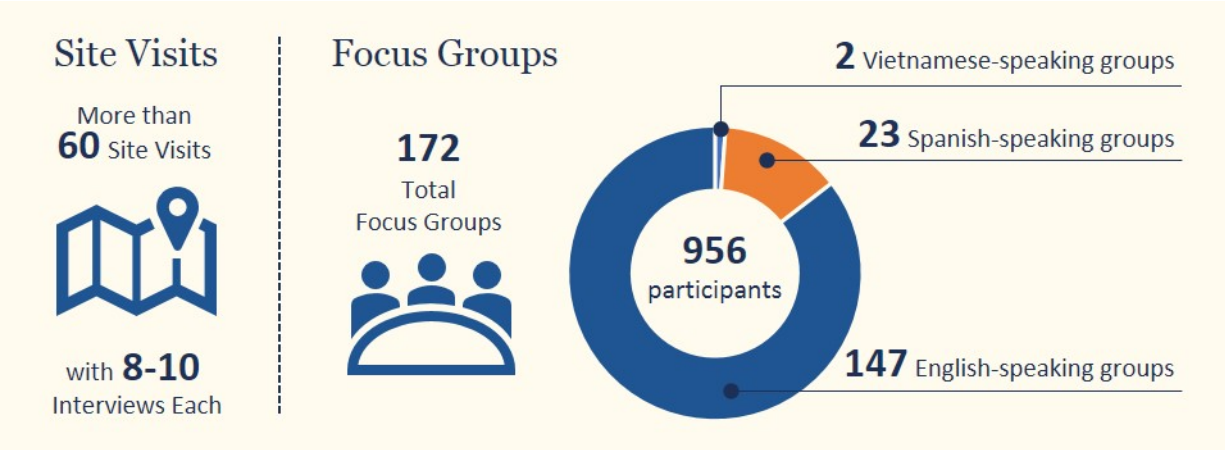
- the SDOH that are especially relevant to demonstration enrollees,
- efforts of States, MMPs, and care coordination entities to identify social risk factors and address social needs,
- challenges they face in these efforts, and
- beneficiaries' experiences with benefits that target SDOH.

CMS, States, plans, providers, advocates, and quality improvement stakeholders can use the information in this issue brief as they consider ways to address SDOH and improve the beneficiary experience for dually eligible enrollees. A greater understanding of how FAI demonstrations are delivering benefits to address SDOH could advance policies and practices that help health care systems, managed care organizations, and integrated health networks outside of the FAI to plan for and implement relevant interventions, services, or benefits for vulnerable populations.

Methods

The information included in this issue brief covers the period from the start of each demonstration, with the earliest demonstrations beginning in 2013, through early 2019. We have drawn primarily from annual site visit interviews conducted by the RTI evaluation team, and beneficiary focus groups conducted by RTI from 2015 through 2017 (see ***Figure 2***). We also used information from other sources such as quarterly monitoring calls with the States and CMS, publicly-available documents such as the three-way contracts for each demonstration and State demonstration materials. Where appropriate,[x] we also use data provided to us in reports on focus groups conducted in 2018 by another CMS contractor in four States (California, Illinois, Ohio and Rhode Island) to supplement our findings.

Figure 2. Primary data sources



This issue brief reflects the perspectives of States, MMPs, Regional Care Collaborative Organizations (in Colorado only), health homes (in Washington only), and beneficiaries, as well as CMS, provider groups, and beneficiary advocacy organizations. The data we used are wholly qualitative; at the time of this issue brief we do not have quantitative data on how often MMPs or others provide discretionary benefits.

We took an iterative approach to organize and analyze our data. After an initial review of the data to see what types of SDOH emerged as relevant for the FAI enrollee population, we compared them to the SDOH in several prominent frameworks.[xi] The SDOH categories in the National Academies of Sciences, Engineering, and Medicine's framework (NASEM, 2017)–such as acculturation, housing, living alone and dual eligibility–aligned most clearly with our data. We used or adapted relevant elements of that framework to organize and present the information in this issue brief (see ***Figure 3***).

SDOH Across Demonstrations Under the FAI

To provide comprehensive care that takes SDOH into account, care coordinators must identify social risk factors and beneficiary priorities. Demonstration States recognize this by contractually requiring, facilitating, or encouraging appropriate efforts. For example, all capitated FAI States require an assessment of social risk factors as part of an enrollee's initial health risk assessment (HRA). Many three-way contracts require social goals to be documented in enrollees' interdisciplinary care plans (ICPs).

Washington

CASE STUDY

Person-Centered Planning, Self-Activation and Motivational Interviewing

Several key components of the Washington MFFS demonstration are instrumental in assessing and addressing enrollees' health and social risk factors and needs: use of Predictive Risk Intelligence SysteM (PRISM) score to identify the highest risk beneficiaries, develop and implement of Health Action Plans (HAPs), conduct in-home care coordination visits, and care coordinator training in motivational interviewing.

Care coordinators and enrollees collaborate in developing and implementing HAPs to promote person-centered planning and improve self-management skills. A HAP includes an enrollees' priorities and action steps for improving his or her own health, and identifies other interventions and supports that will help the enrollee achieve his or her goals. The supports offered are wide ranging and individualized. For example, they include health education, transportation services, social engagement activities, and nutritional support in addition to any health, LTSS or behavioral health services needed. Care coordinators make monthly visits to monitor and assist with goal attainment.

Washington has provided health home care coordinator staff with motivational interviewing training to help care coordinators build trust with enrollees, encourage enrollees to openly share their true health and social needs, and promote enrollee self-action.

Enrollees expressed appreciation for their care coordinators who use these approaches to help enrollees identify their needs, discuss service options, and set personal goals. For example, in late 2019 and early 2020, in in-depth individual phone interviews conducted by CMS with Washington demonstration beneficiaries, participants described the HAP as a helpful, motivational form of guidance to help them meet their goals and improve their health and life. The HAPs and other efforts described here have helped health home enrollees reach various health and social goals, including improved blood sugar levels, weight loss, more social connections, better relationships with providers, and fewer emergency department and hospital visits (Justice et al., 2017).

> **"The one thing that makes this program work here in Washington is the training that the care coordinators get on how to do the motivational interviewing and get to the crux of the problem. They meet the client where the client needs to be met. It's meeting the client on their turf, so they're comfortable enough to talk about things. That's how they determine if there are any social determinants of health that need to be addressed."**
>
> **— State official (2019)**

In the capitated model States, MMPs take a variety of approaches to comply with these contractual provisions. In the MFFS model States (Washington and Colorado), care coordination entities make similar investments (see, for example, **Washington: Person-Centered Planning and Motivational Interviewing**). Many States also provide relevant training to demonstration stakeholders. For example, Massachusetts offers training to providers, community-based organizations (CBOs), and MMPs on topics such as cultural competency, strategies for enhancing care to persons experiencing homelessness, and approaches to helping enrollees with social isolation and loneliness.

Approaches Used to Address SDOH In Demonstrations Under the FAI

SDOH that emerged in our evaluation fall into the domains shown in ***Figure 3***. We use these domains to organize our discussion of SDOH-specific approaches, which States and MMPs use in conjunction with the broad approaches discussed above (e.g., HRAs and care planning).

Figure 3. SDOH domains

Cultural Context

Nativity—which includes country of origin, immigration status, length of time in the United States, and acculturation[xii]—may impact health and access to care. Cultural competence in health care is essential for providing equitable care to diverse populations (HHS, 2018). Recognizing this, most three-way contracts between CMS, a State, and an MMP require that MMP staff, particularly interdisciplinary care team members, undergo cultural competency training. MMPs also foster cultural competency in care provision.[xiii]

MMPs in Illinois, California, and other States prioritize cultural and ethnic diversity in hiring practices and in building provider networks to meet enrollee preferences. Vietnamese enrollees in California described provider networks with ample numbers of Vietnamese providers. These efforts stand out in the broader context of enrollee preferences: while enrollees with limited English proficiency often noted preferring to engage with providers, care coordinators and MMP staff who speak their preferred language, staffing resources are at times insufficient to meet this need. See **Minnesota: Cultural Outreach Grants** for another example.

Minnesota

Cultural Outreach Grants

CASE STUDY

The Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience uses a unique administrative alignment model. In this model, the State and CMS are focusing on administrative changes to better align the Medicare and Medicaid operational components of the existing Minnesota Senior Health Options (MSHO) program, an integrated program that is built on Medicare Special Needs Plans and Medicaid managed care organizations.[xiv] CMS and the State are modifying existing processes to create a more integrated care experience for beneficiaries enrolled in these plans.

Although Minnesota is one of the healthiest States in the nation, it also has some of the largest health disparities, driven by SDOH such as structural racism and inequitable economic and educational opportunities (Minnesota Department of Health, 2014). To address these inequities, the State used Federal demonstration implementation funds to improve the quality of and accessibility to MSHO programs for members of the Hmong, Lao, Somali, and broader African American communities. To improve outreach efforts to these communities, the State first conducted qualitative and quantitative research to understand community needs and to identify how different communities learned about and participated in the program.

In fall 2015, the State used its research findings and Federal demonstration funds to support four MSHO cultural outreach grants to CBOs. The aims were to ensure more equitable access to the MSHO program through increased outreach and education, and to collect data on the program's cultural responsiveness. In 2015–2016, grantees established community partnerships to educate minority beneficiaries about MSHO, hosted open house events, provided one-on-one enrollment assistance, and shared culturally responsive materials.

Examples of approaches included creating events for Somali community leaders to learn about MSHO so they could tell their community members about them; creating radio ads for Somali, Hmong, and African American populations; attending local cultural festivals; visiting local Lao-owned businesses; and doing outreach in churches, barbershops, and salons in African American communities.

Feedback from these enrollee engagement activities indicated that community members did not know or were confused about MSHO, were wary of joining MSHO, and did not perceive MSHO as culturally responsive. Specifically, they cited a lack of ethnic concordance among care coordinators and insufficient engagement of family members in beneficiaries' care.

With this feedback, the State developed key short- and long-term recommendations to help build MSHO's cultural responsiveness. For example, short term recommendations included the State creating and distributing culturally responsive educational materials; and identifying and involving a trusted family member in enrollees' education and care. Long-term recommendations included prioritizing stakeholder engagement among culturally diverse groups; and investing in recruitment efforts for more African American care coordinators. In 2019, several years after considering feedback from the cultural outreach grants, the State noted that the grants have led to effective outreach to minority populations that are now aging into the MSHO and Minnesota Senior Care Plus programs.

Language barriers can also negatively impact health care access and health outcomes (NASEM, 2017). Enrollees in several States noted that it was important to receive materials in their preferred language, and they appreciated access to translated materials and interpreter services. Spanish-language participants in California said they were less satisfied when they were paired with providers who did not speak Spanish.

> **"I like that the plan asks if you are bilingual, American, [or] someone who just speaks only Spanish."**
>
> **— Beneficiary focus group participant (Massachusetts, 2017)**

Some States went over and above Federal language accessibility requirements,[xv] and worked to facilitate better communication and access for members with limited English proficiency. For example, in cooperation with the Michigan Disability Rights Coalition, Michigan conducted targeted outreach, education and counseling about the demonstration to several subpopulations of eligible beneficiaries, including those with limited English proficiency, those experiencing homelessness, and those with disabilities. In Massachusetts, the ombudsman program for the demonstration and other Medicaid beneficiaries conducts outreach to and dedicates resources for persons who are deaf or hard of hearing. These include a video phone line for inquiries, complaints and questions about the demonstration and an ombudsman that communicates in American Sign Language (in addition to other staff who speak a variety of languages, including Spanish, Portuguese, French, Cantonese and Mandarin).[xvi]

In all demonstration States, consistent with State regulations, MMPs are required to have materials and translation or interpretation services available in enrollees' respective primary or prevalent languages. For example, in California, there are more than 10 prevalent languages in some counties. However, despite the language requirements and significant efforts to address them, some language needs were not met. For example, a survey of enrollees in the California demonstration revealed that one-half of the non-English speaking survey participants reported they could never get a medical interpreter when they needed one.[xvii]

Socioeconomic Context

> **"My [care coordinator] … helped me to, like, apply for school. They helped me to get on food stamps. They [helped with] … other public assistance programs."**
>
> **— Beneficiary focus group participant (Ohio, 2018)**

Low-income enrollees identify low or no copayments for medical services as one of the benefits they appreciate most. In addition, MMPs identify and address social risk factors related to *income* through various avenues. During needs assessments and care planning conversations, care coordinators ask enrollees about food insecurity. Many plans cover limited meal delivery services in their benefits, or care coordinators connect or bring enrollees to local community programs, such as Meals on Wheels or meal sites. Enrollees described care coordinators linking them to other types of income-related help such as utility and education assistance. In many States, enrollees struggle to access and maintain stable housing. In these States, plans use additional resources to maintain ongoing communication with homeless enrollees and a few plans collaborate with local organizations to help enrollees secure housing. In Massachusetts, for example, an MMP partners with a shelter to provide cellphones to homeless enrollees so that they can communicate with their care coordinators and providers. One MMP in California stocks "supply closets" in areas where homeless persons are;

the closets serve as contact points to find enrollees and give them hygienic supplies such as shampoo, toothpaste, deodorant, and adult briefs. External limitations, such as limited affordable housing, make addressing income-related risk factors particularly challenging, and highlight the importance of relationship building with CBOs to navigate and address these needs.

> **"I live in an apartment on the third floor with these bad knees. So, my [MMP] asked me about where I live at and to let them know when I was ready to move, that they would help me find a spot."**
>
> **— Beneficiary focus group participant (Virginia, 2017)**

Community Context

Enrollees in RTI focus groups often noted that reliable *transportation* played a key role in whether they were able to take care of their basic needs, particularly in terms of accessing health care and social services. In all capitated model demonstration States, plans supplement basic transportation benefits covered through the State Medicaid benefits package with additional nonmedical transportation assistance. In Virginia, New York, and Massachusetts, for example, care coordinators provided transportation to social gatherings such as baseball games or church services, facilitating social engagement for beneficiaries.

Living in a rural area intensifies transportation needs, and resources to accommodate health and social needs may be scarce. For example, many beneficiaries who live in rural parts of South Carolina and Virginia have limited access to health care facilities and services, and the facilities they *do* have access to often have limited resources. Care coordinators and health navigators connect rural enrollees to needed benefits and services. These connections often require concerted, sustained efforts.

> **"I can even get bus tickets sent to my house if I can't [find] a way to get to my doctor's appointments because some of the [demonstration-facilitated] transportation people aren't available in that day."**
>
> **— Beneficiary focus group participant (Ohio, 2017)**

Environment

Environmental safety can noticeably impact beneficiaries' health, well-being, quality of life, and independence. Enrollees may need home modifications and home safety services such as installing ramps or handrails, providing coverage for pest control services, or deep cleaning neglected homes. Care coordinators in many States use supplementary benefit funds (if available in the demonstration) or other means (such as coordinating with community organizations or home visits) to identify and meet these needs (see, for example, **South Carolina: Home Assessments**).

> **"When I first got my wheelchair, [my care coordinator] let me know about a program that the people would come and build a ramp for me. I wouldn't have to pay for it."**
>
> **— Beneficiary focus group participant (Washington, 2017)**

Social Relationships

Social relationships and *social engagement* have also been linked to health outcomes, with studies suggesting that social isolation can lead to adverse outcomes, particularly a negative impact on mental health (Novotney, n.d.). In their care plans, some enrollees include personal goals such as increased social and community engagement. Enrollees, MMPs, and other stakeholders in various States identified successful efforts to support social engagement for enrollees. In the New York FIDA-IDD demonstration, for example, care coordinators identify social activities that match enrollee interests such as a social group or dance studio where enrollees could dance in their wheelchairs.

Many of the aforementioned approaches undertaken by States to address SDOH are also ways to mitigate social isolation. For example, transportation to church enhances social engagement, as does having stable housing or living in a safe neighborhood where an enrollee can regularly meet and form relationships with their neighbors. Having a care coordinator who paid attention and called or visited made some enrollees feel less alone.

> **"I've been offered [help] to take my dad [an enrollee] to a recreation area where they have people who are disabled and have other issues. My father can go there and maybe join in. They have a pool in there and games that they can play."**
>
> **— Beneficiary focus group participant (Texas, 2017)**

South Carolina

Home Assessments

CASE STUDY

In the South Carolina Healthy Connections Prime demonstration, the comprehensive assessment includes social, functional, medical, behavioral, wellness, and prevention domains; caregiver status and capabilities; and the enrollee's preferences, strengths, and goals.

Initially, in-home assessments were conducted for all demonstration enrollees. With amendments to the three-way contract in July 2018, these in-home assessments are now only required for high-risk enrollees. High-risk enrollees are home and community-based services (HCBS) waiver and nursing facility resident enrollees. Low- and medium-risk enrollees generally receive telephonic assessments.

When visiting new enrollees, particularly in remote rural areas, MMP care coordinators or qualified contractors (community health navigators) evaluate whether basic resources are available to meet enrollees' daily needs. These resources include food, a working refrigerator, indoor plumbing, and safe housing features such as secure doors. When these resources are insufficient, care coordinators identify alternatives in the community—e.g., food banks and volunteer repair services offered by church groups—to address the needs.

The State, MMPs, and providers all felt that it was essential to assess these social risk factors for the demonstration population because of rural isolation, lack of family or other informal caregiver support, and general conditions of poverty for some enrollees. Many enrollees, particularly those from rural communities, noted the importance of their care coordinator's in-home visits and assistance in connecting them to resources.

The enrollee, his/her family supports, the care coordinator, and providers use the assessments to develop care plans, which include enrollees' language, culture, service history, and medical, behavioral, functional, and psychosocial needs. Home assessment data and other information about SDOH are included in the State's electronic home and community-based services record system.

> **"My care coordinator came to my house and we sat on the front porch and talked about whatever we want to talk about. [The home visit] is basically [about] your healthcare and they get an inventory of how well you're doing and what you're doing, and who takes care of you and do you still bathe by yourself. Those kinds of things."**
>
> **— Beneficiary focus group participant (2017)**

In ***Table 1***, we summarize examples of these and other approaches that States have taken to identify social risk factors and address social needs. We also summarize related challenges. The examples are not exhaustive—they do not represent every approach any or all States are taking, or every challenge they face. Although some approaches and challenges are State-specific, many apply to several or all States.

Table 1. Approaches and challenges to addressing social risk factors across demonstrations under the FAI

SOCIAL RISK FACTORS	APPROACHES	CHALLENGES
Cultural Context *(nativity, acculturation, language barriers)*	• Contractually require, provide, or encourage cultural competency trainings for MMP staff. • Prioritize cultural and ethnic diversity in hiring practices and in building provider networks. • Conduct communications and language needs assessment. • Conduct special outreach efforts for beneficiaries with limited English proficiency and in areas with concentrated ethnic populations. • Maintain dedicated resources for the deaf, hearing impaired, and blind populations. • Include additional State requirements for provision of translated materials beyond the Federal requirements.	• Lack of providers who speak enrollees' preferred languages. • Difficulties enforcing MMP or provider compliance with access-to-interpreter or translation requirements. • Gaps in MMP, provider, or enrollee knowledge of language accessibility provisions. • Lack of understanding of cultural beliefs that affect enrollees' care. • Persistent structural racism.[xviii]
Socioeconomic Context *(housing, food insecurity, education, income)*	• Offer low or no copayment benefits. • Identify social needs and connect enrollees to community resources for unmet needs. • Provide travel stipends or reimbursements to facilitate beneficiary participation in demonstration stakeholder meetings. • Provide or facilitate home delivered meals or connect enrollees to community food banks or meals. • Offer over-the-counter medication benefit. • Provide cell phones to enrollees who are experiencing homelessness to facilitate ongoing communication with their care coordinator. • Conduct outreach to find and engage members experiencing homelessness, e.g., through an outreach vendor. • Help members experiencing homelessness to access permanent supportive housing through an initiative that pairs housing and rental assistance programs with supportive services (e.g., intensive case management). • Provide moving assistance. • Provide advocacy for enrollees, e.g., to landlords, to avoid relocation or homelessness. • Identify appropriate educational or workforce opportunities.	• Variation in level of effort and resource limitations. • Limited supply of affordable housing or housing resources in some demonstration areas. • Lack of awareness among some enrollees that MMPs offer this type of help. • Difficulty locating and maintaining contact with persons experiencing homelessness. • Limited community resources.

Table 1. Approaches and challenges to addressing social risk factors across demonstrations under the FAI

SOCIAL RISK FACTORS	APPROACHES	CHALLENGES
Socioeconomic Context (continued) *(housing, food insecurity, education, income)*	• Offer community resource centers where plan staff are co-located with other resources like social services, programs for utility assistance, and educational/workforce opportunities and training.	
Community Context *(transportation, living in a rural area)*	• Expand scope of transportation benefits available to cover nonmedical trips (e.g., to religious or community activities). • Develop new ways of reaching enrollees in rural areas, such as telehealth. • Provide reimbursement for rideshare or public transportation services. • Subcontract with Lyft for transportation to and from non-urgent medical appointments. • Donate vehicles to community partners serving persons experiencing homelessness or formerly incarcerated persons, to improve their access to care and basic needs.	• Unreliable transportation vendors and ride scheduling problems. • Vendors' lack of experience serving clients with limited mobility or other disabilities or needs (e.g., behavioral health). • Lack of sufficient specialists or providers in rural areas. • Long distances and travel time to access specialists.
Environmental *(home modifications and other home safety needs)*	• Include questions in beneficiary assessment to identify safe housing needs. • Connect enrollees to community resources or advocate on their behalf to address unmet need. • Conduct home visits for in-home safety and other assessments. • Provide home modifications or service coverage (e.g., pest control).	• Discretionary (offered on a case-by-case basis) or limited-in-reach benefits. • Lack of awareness among some enrollees that MMPs offer this type of help.
Social Relationships *(social isolation)*	• Use information from the comprehensive assessment to identify social activities that match enrollee interests. • Help enrollees find new housing in a town where they would be less isolated and better connected to medical care. • Encourage enrollees to get out of the house, participate in activities. • Transition enrollees from nursing facilities back to their homes. • Implement pilot program to address social isolation among frail enrollees. • Refer enrollees to adult day services.	• Lack of awareness among some enrollees that MMPs offer this type of help.

Source: RTI analysis of key informant interviews 2014–2019.
Notes: MMP = Medicare-Medicaid Plan

Awareness, Uptake, and Perceived Impact of SDOH-Related Benefits

To take advantage of SDOH-related services, enrollees must be aware of relevant available benefits and services. MMPs, care coordinators, and providers are responsible for identifying social risk factors and letting enrollees know about the services available. Across and within demonstrations, enrollee focus group participants described variation in the extent to which they were offered these benefits, variation in and some confusion about the specific benefits offered, and some challenges with care coordinator follow-through.[xix]

Some enrollees reported being pleasantly surprised when they became aware of these benefits and services. Most often, when enrollees *did* know about these benefits, they learned about them from their care coordinators, from plan materials or providers, or through word-of-mouth among enrollees. For example, low or no copayments, offered by many MMPs, are a major and much appreciated benefit for low-income enrollees, and these are communicated to enrollees in these ways. Some enrollees did not remember all that was offered initially upon enrollment and at other times during enrollment. Other enrollees already knew about some benefits such as those offered through organizations or venues with which enrollees had prior experience, like food banks. Most often, availability of SDOH-related benefits came up organically in care coordinator or provider conversations with enrollees, e.g., when discussing care plans or goals, or life situations.

Despite some challenges, in general, enrollees expressed great appreciation that these benefits were offered, and in many cases, the benefits made a noticeable impact on the enrollees' quality of life or health. For example, many of these benefits helped enrollees get out of their homes to engage in the community and achieve a greater sense of independence. They helped enrollees make noticeable progress toward improving their health status. Many enrollees were able to achieve multiple health and social goals, and credited their care coordinators, MMPs, or broadly, being enrolled in the demonstration, for these achievements.

> **"I spend a lot on rent. I have so many bills. My health insurance has helped me with everything. [My plan] sent me a list of apartments, they sent someone over to my house to help me, a counselor. And in addition to that, they tell me, 'Don't worry, whatever you need—we can't help you with absolutely everything in your life, but we can help you in medical terms, and we can help you get what you need.'"**
>
> **Beneficiary focus group participant (Rhode Island, 2017)**

Conclusions

States, health plans, and health homes serving beneficiaries under the FAI are identifying enrollees' SDOH in numerous ways. Although care coordination is a key mechanism across all demonstrations, approaches taken to address enrollee SDOH vary. Locally available resources, contract requirements, plan processes and enrollee-specific circumstances and needs lead to varied actions. This brief provides examples of the social risk factors experienced by dually eligible enrollees, the approaches participating entities undertake to address social needs, and associated challenges. In this section, we identify promising practices for consideration by others who wish to address SDOH.

Focus on person-centered care. Organizations that use comprehensive HRAs can include social risk factors in those assessments. Care coordinators describe meeting enrollees "where they are at"—i.e., recognizing each enrollee's unique capacities, goals, needs, and situations. Involving beneficiaries in care planning and decision-making, and asking about their needs and preferences is a key factor in identifying their most pressing needs and developing effective care plans. Home visits yield special opportunities to identify environmental needs that may affect people's health and safety, including needed home modifications and other resources. Ongoing enrollee-care coordinator communication can identify changing needs and diminish social isolation. Organizations must also have infrastructure and staffing in place to act on information gathered by the care coordinator to improve care.

Provide mechanisms for the flexible and creative provision of SDOH-related connections and services. Social risk factors are many and varied, and many may be best addressed by organizations outside the health care system, like Area Agencies on Aging and other CBOs. States, plans, and health homes have had success in addressing SDOH by learning about potential community partners and establishing effective linkages—which might include payment for CBO-supplied services for members who do not meet CBO program eligibility. Some demonstrations under the FAI approached this by using a dedicated funding stream, folding into capitated payments to providers or plans, or using administrative overhead or surplus to address SDOH. Care coordinators are well positioned to identify enrollee-specific needs, so may be best able to address SDOH.

Include SDOH-related requirements in plan, provider, and partner contracts. Although flexibility in accommodating enrollee-specific needs is valuable, it is also helpful to standardize and enforce some SDOH-related requirements through contracting arrangements. All capitated FAI States require social risk factor assessment as part of an enrollee's initial HRA, and many three-way contracts reference social goals in documentation requirements in enrollees' ICPs. This ensures that these critical tasks are implemented consistently for all enrollees.

Educate enrollees about the availability of these supports. Because there are no clear guidelines or requirements for plans to provide assistance for nonmedical needs[xx], plans may be cautious in publicizing the availability of this sort of assistance. Although some plans participating in the demonstrations include information in their marketing materials, enrollee focus group participants made it clear that many enrollees are unaware of these benefits. Ideally, member materials should provide clear information on SDOH-related benefits, and care coordinators would regularly discuss enrollee needs and available options for addressing those needs during care planning activities.

Explore options for collecting and integrating SDOH data in health information technology (HIT) systems, such as patient portals, electronic health records, and health information exchanges. At least one State (South Carolina) integrates information about SDOH into its electronic health record system (see **South Carolina: Home Assessments**). Collecting and integrating SDOH data in HIT systems has the potential to provide clinicians with a full picture of a patient's health and social risk factors, and of the resources needed or accessed by individual enrollees. This approach can help organizations assess where patients' health is improving as a result of SDOH-related interventions. It could also support State and CMS efforts to improve access to and exchange of data.[xxi]

Collecting and integrating SDOH data is challenging for many reasons, and requires

- provider and stakeholder buy-in,[xxii]
- sufficient health system, provider, and CBO capacity (Palacio et al., 2017; Lewis et al., 2016; Nuruzzaman et al., 2015),
- requirements or incentives to collect SDOH data (Cantor & Thorpe, 2018; ASPE, 2018), and
- standardized SDOH data collection.

Identifying and recording whether referrals to CBOs have resulted in service delivery is also a challenge. Organizations, providers and other stakeholders in the public and private health care and social support sectors continue to explore, often in partnership, potential solutions to these challenges.[xxiii]

References

Alderwick, H., & Gottlieb, L. M.: Meanings and misunderstandings: A social determinants of health lexicon for health care systems. Milbank Quarterly, 97(2): 407–419. https://doi.org/10.1111/1468-0009.12390. 2019. As obtained on December 11, 2019.

Bookse, B. C., Athens, J. K., Kindig, D. A., Park, H., & Remington, P. L.: County health rankings: working paper. Different perspectives for assigning weights to determinants of health. https://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf. 2010. As obtained on December 17, 2019.

Cantor, M. N., & Thorpe, L.: Integrating data on social determinants of health into electronic health records. Health Affairs, 37(4). https://doi.org/10.1377/hlthaff.2017.1252. 2018. As obtained on March 17, 2020.

Centers for Medicare & Medicaid Services (CMS): Data Analysis Brief: Managed care enrollment trends among dually-eligible and Medicare-only beneficiaries. https://www.cms.gov/files/document/managedcareenrollmenttrendsdatabrief.pdf. 2020a. As obtained on March 12, 2020.

Centers for Medicare & Medicaid Services (CMS): Medicare and Medicaid Programs; Contract Year 2021 and 2022 policy and technical changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. 85 FR 9002. https://www.federalregister.gov/documents/2020/02/18/2020-02085/medicare-and-medicaid-programs-contract-year-2021-and-2022-policy-and-technical-changes-to-the. 2020b. As obtained on March 9, 2020.

Centers for Medicare & Medicaid Services (CMS): Z Codes utilization among Medicare Fee-for-Service (FFS) beneficiaries in 2017. https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf. 2020c. As obtained on March 26, 2020.

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Coordination Office FY 2019 Report to Congress. https://www.cms.gov/files/document/mmco-report-congress.pdf. 2019a. As obtained on March 16, 2020.

Centers for Medicare and Medicaid Services (CMS): Managed care enrollment by program and population (Duals). https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/388z-vsy3. 2019b. As obtained on July 29, 2019.

Centers for Medicare and Medicaid Services (CMS): Implementing supplemental benefits for chronically ill enrollees. https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf. 2019c. As obtained on January 23, 2020.

Centers for Medicare and Medicaid Services (CMS): Medicare and Medicaid Programs; Policy and technical changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care programs for years 2020 and 2021. 84 FR 15680. https://www.federalregister.gov/documents/2019/04/16/2019-06822/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare. 2019d. As obtained on March 24, 2020

Centers for Medicare and Medicaid Services (CMS): Reinterpretation of "primarily health related" for supplemental benefits. https://www.aarp.org/content/dam/aarp/ppi/2018/10/reinterpretation-of-primarily-health-related-for-supplemental-benefits.pdf. 2018. As obtained on January 23, 2020.

Centers for Medicare and Medicaid Services (CMS): Medicare-Medicaid dual enrollment from 2006 through 2013. Data analysis brief. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment20062013.pdf. 2014. As obtained on December 11, 2019.

Centers for Medicare and Medicaid Services (CMS): The Accountable Health Communities Health-Related Social Needs Screening Tool. https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf. N.d. As obtained on November 4, 2019.

Feng, Z.: Dual eligibles: Who are they and why are they important? Public Policy & Aging Report, 28(2): 56–63. https://doi.org/10.1093/ppar/pry013. 2018. As obtained on March 18, 2020.

Galea, S., Tracy, M., Hoggatt, K. J., Dimaggio, C., & Karpati, A.: Estimated deaths attributable to social factors in the United States. 2011. American Journal of Public Health, 101(8):1456–1465. http://dx.doi.org/10.2105/AJPH.2010.300086. As obtained on December 17, 2019.

GreatCall, Inc.: Fighting social isolation among older adults. https://www.greatcall.com/docs/default-source/newsroom-files/fighting-social-isolation-among-older-adults.pdf. N. d. As obtained on September 13, 2013.

Health Leads: The Health Leads Screening Toolkit. https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/. 2018. As obtained on November 4, 2019.

ICD10data.com: ICD-10-CM Codes > Persons with potential health hazards related to socioeconomic and psychosocial circumstances. [webpage] https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65. 2019. As obtained on November 4, 2019.

Integrated Care Resource Center (ICRC): Monthly enrollment in Medicare-Medicaid plans by plan and by state, February 2019 to February 2020. https://www.integratedcareresourcecenter.com/sites/default/files/MMP_Enroll_by_State_February_2020.pdf. As obtained on March 11, 2020.

Justice, D., Holladay, S., Waidmann, T., et al.: Financial Alignment Initiative Annual Report: Washington Health Homes MFFFS Demonstration. Contract No. HHSM500201000021i TO #3. Waltham, MA, RTI International. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalReport.pdf. Updated July 18, 2017. As obtained on January 9, 2010.

Lewis, J. H., Whelihan, K., Navarro, I., Boyle, K. R., & SDH Card Study Implementation Team.: Community health center provider ability to identify, treat and account for the social determinants of health: A card study. BMC Family Practice 17(1).:121. 2016.

Medicare Payment Advisory Commission (MedPAC), & Medicaid and CHIP Payment and Access Commission (MACPAC): Data book: beneficiaries dually eligible for Medicare and Medicaid—January 2018. https://www.macpac.gov/wp-content/uploads/2017/01/January-2018-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-Data-Book.pdf. N.d. As obtained on March 26, 2020.

Minnesota Department of Health: Advancing health equity in Minnesota. Saint Paul, MN. 2014

National Academies of Sciences, Engineering, and Medicine: Accounting for Social Risk Factors in Medicare Payment. Washington, DC: The National Academies Press. https://doi.org/10.17226/23635. 2017. As obtained on November 4, 2019.

National Association of Community Health Centers (NACHC): PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. [webpage]. http://www.nachc.org/research-and-data/prapare/. 2019. As obtained on November 4, 2019.

Novotney, A. The risks of social isolation. Monitor on Sociology, 50(5). https://www.apa.org/monitor/2019/05/ce-corner-isolation. 2019. As obtained on March 6, 2020.

Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P.: Making the social determinants of health a routine part of medical care. Journal of Health Care for the Poor and Underserved, 26(2): 321–27. 2015.

Office of the Assistant Secretary for Planning and Evaluation (ASPE).: Incorporating social determinants of health in electronic health records: A qualitative study of perspectives on current practices among top vendors. https://aspe.hhs.gov/pdf-report/incorporating-social-determinants-health-electronic-health-records-qualitative-study-perspectives-current-practices-among-top-vendors. 2018. As obtained on March 7, 2020.

Office of the Assistant Secretary for Planning and Evaluation (ASPE): Report to Congress: Social risk factors and performance under Medicare's value-based purchasing programs. https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs. 2016. As obtained on March 17, 2020.

Office of Disease Prevention and Health Promotion (ODPHP): Social determinants of health. [webpage]. Office of the Assistant Secretary for Health, Office of the Secretary, U. S. Department of Health and Human Services, Rockville, MD. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. 2019. As obtained on December 11, 2019.

Palacio, A., Suarez, M., Tamariz, L., & Seo, D.: A road map to integrate social determinants of health into electronic health records. Population Health Management, 20(6): 424–26. 2017.

Powell, J. A.: Structural racism: Building upon the insights of John Calmore. North Carolina Law Review, 86:791–816. https://heinonline.org/HOL/LandingPage?handle=hein.journals/nclr86&div=30&id=&page=. 2008. As obtained on March 18, 2020.

Schroeder, S. A.: We can do better—improving the health of the American people. New England Journal of Medicine, 357(12):1221–1228. http://dx.doi.org/10.1056/NEJMsa073350. 2007. As obtained on December 17, 2019.

Sorbero, M. E., Kranz, A. M., Bouskill, K. E., Ross, R., Palimaru, A. I., & Meyer, A.: Addressing social determinants of health needs of dually enrolled beneficiaries in Medicare Advantage. RAND Corporation. Prepared for ASPE. https://aspe.hhs.gov/system/files/pdf/259896/MAStudy_Phase2_RR2634-final.pdf. 2018. As obtained on December 18, 2019.

US Department of Health and Human Services (HHS): The National CLAS Standards. [webpage]. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. 2018. As obtained on November 26, 2019.

Endnotes

---

[i] See, for example, “When Talking About Social Determinants, Precision Matters," Health Affairs Blog, October 29, 2019. DOI: 10.1377/hblog20191025.776011. As obtained on December 4, 2019.

[ii] Given the newness of the SSBCI opportunity, relatively few plans are offering these benefits as Medicare supplemental benefits, and there is not much data available yet about how these benefits are being used. Generally speaking, then, MMPs and FIDE-SNPS probably have greater flexibility at the moment to meet enrollees’ social needs through their provision of Medicare and LTSS and other benefits than do D-SNPs.

[iii] In the *capitated model*, demonstrations are jointly administered and monitored by CMS and the States. Three-way contracts between CMS, the States, and Medicare-Medicaid Plans (MMPs) are designed to address the programmatic challenges of providing integrated care and to better align program incentives. The *MFFS model*, directed through an agreement between CMS and the State, adds strategies onto existing FFS delivery systems (i.e., Regional Care Collaborative Organizations [RCCOs] in Colorado and Medicaid health homes in Washington State) to improve care coordination, quality, and access; increase accountability; and contain costs. *RCCOs* are either insurance companies or consortia of local providers that were responsible for coordinating enrollees’ care across medical, long-term services and supports (LTSS), and behavioral health delivery systems. RCCOs often subcontracted with provider groups, through a variety of delegated arrangements, for care coordination services. The Washington Health Homes MFFS demonstration leverages Medicaid *health homes*, established under Section 2703 of the Affordable Care Act. See https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf for additional information.

[iv] Minnesota has an *alternative model* demonstration, based on its Minnesota Senior Health Options (MSHO) program, which is testing approaches to improve administrative alignment between Medicare and Medicaid. Information on each demonstration is available at https://innovation.cms.gov/initiatives/financial-alignment/. As obtained on November 6, 2019. While the Minnesota administrative model is not formally part of the FAI, it is included in the RTI evaluation and provides insights into activities that other states could learn from.

[v] The Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration integrates care for Medicare-Medicaid beneficiaries with intellectual and/or developmental disabilities. It is the first comprehensive managed care demonstration serving individuals with IDD in the nation.

[vi] Although the vast majority of the NY FIDA demonstration ended December 31, 2019, its integrated appeals and grievances component continues using FAI demonstration authority. It is a limited extension of FIDA.

[vii] More details on the enhanced or supplemental benefits offered by Medicare-Medicaid Plans in contract year 2019 are described in more detail in this resource at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPSupplementalBenefitsCY201901162019.pdf. As obtained on December 6, 2019.

[viii] MMPs in FAI capitated model states use various funding mechanisms to support discretionary benefits, including plan administrative or case management funds, or

---

supplementary benefit funds. For example, MMPs in California can use Care Plan Option (CPO) benefit funds to provide discretionary services to postpone institutionalization or prevent higher levels of care for frail beneficiaries. These discretionary services include home modifications, Meals on Wheels, authorization of additional home care worker hours, or similar services to ensure enrollees can remain in the community. Under this option, plans may elect to provide CPOs from their capitated payments. They may authorize services not otherwise available through local agencies or other means.

[ix] In some FAI demonstrations, care coordinators are called *care managers* or other state-specific titles. However, their roles are essentially similar across the demonstrations, with some distinctions. In this issue brief, we use “care coordinator” to refer to all of these roles, except when we describe in more detail South Carolina’s efforts. Then we use the state-specific term, care manager.

[x] Alan Newman Research, the CMS contractor, conducted a total of 30 focus groups across California, Ohio, Illinois, and Rhode Island, with a total of 308 participants. Two of the focus groups in California were comprised of Spanish-speaking participants.

[xi] We reviewed frameworks from the Centers for Medicare & Medicaid’s Accountable Health Communities program (CMS, n.d.), Healthy People 2020 (ODPHP, 2019), ICD-10-CM (ICD10data.com, 2019), the National Association of Community Health Centers (NACHC, 2019), Health Leads (Health Leads, 2018), and the National Academies of Sciences, Engineering, and Medicine (NASEM, 2017).

[xii] Acculturation can be defined as the extent to which an individual adheres to the social norms, values, and practices of his or her own ethnic group or home country or to those of the United States (NASEM, 2017).

[xiii] For additional information on developing a language access plan, see https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf

[xiv] This demonstration authorizes a set of administrative activities designed to better align the Medicare and Medicaid policies and processes involved in the MSHO program; and (2) formalizes certain prior informal agreements between CMS and Minnesota that allowed flexibility for the Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) participating in MSHO, because of the integrated nature of the program. The demonstration does not fundamentally change benefits packages, choice of plans and providers for beneficiaries, the way in which the MSHO plans contract with either the State or CMS, or the prevailing enrollment process for MSHO.

[xv] Many Federal regulations mandate language services for limited English proficiency patients. The Affordable Care Act extends previous mandates and explicitly requires insurers and healthcare institutions to provide written translation and interpreting services for limited English proficiency individuals of qualifying language groups. For more information, see https://www.languagescientific.com/a-quick-primer-on-affordable-care-act-language-service-requirements/. As obtained on January 9, 2020.

[xvi] For additional information on improving access for people with disabilities, see https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/Getting-the-Care-You-Need.pdf

---

[xvii] This survey was conducted by San Francisco State University. See https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/assessing_the_experiences_of_dually_eligible_beneficiaries_in_CMC_final_091018.pdf. As obtained on February 21, 2020.

[xviii] Structural racism is the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities—including health inequities - among racial and ethnic groups (Powell, 2008).

[xix] For additional resources on how to help beneficiaries navigate their health care coverage and access care that is right for them, see https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/from-coverage-to-care

[xx] CMS has recently given new flexibilities to Medicare Advantage plans to provide supplemental benefits that address LTSS needs and SDOH among their members. With the enactment of the Bipartisan Budget Act of 2018 (Public Law No. 115-123) and new regulations issued by CMS, Medicare Advantage plans can now cover a wider array of extra benefits than was previously allowed. Beginning in calendar year 2019, CMS expanded the definition of "primarily health related" to consider an item or service as primarily health related if it is used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduces avoidable emergency and healthcare utilization (CMS, 2018). Beginning in calendar year 2020, Medicare Advantage plans can offer Special Supplemental Benefits for the Chronically Ill (SSBCI) to better tailor benefit offerings for the chronically ill population, address gaps in care, and improve specific health outcomes. SSBCI include supplemental benefits that are not primarily health related and/or offered non-uniformly to eligible chronically ill enrollees (CMS, 2019b).

[xxi] For example, as of January 1, 2021, many Dual Eligible Special Needs Plans (D-SNPs) will be required to notify their state Medicaid agencies (or the state's designee) when certain high-risk enrollees are admitted to a hospital or skilled nursing facility (SNF) (CMS, 2019d). The goal is to ensure timely initiation of Medicaid care management activities around care transitions. If data on enrollees' SDOH were also available, it could enhance care managers' ability to link enrollees to needed services, which, in turn, may help lower readmission rates and more effectively support enrollees' ability to remain in the community.

[xxii] For example, providers may see collecting information on SDOH as outside the scope of clinical practice, and thus, not their responsibility or a priority. Health system leaders may not appreciate the role that SDOH play in patients' health and wellbeing, and may hesitate to invest in capacity to collect these data.

[xxiii] For example, one development that could address some of these challenges would be increased use of a subset of ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) codes available for flagging SDOH in electronic medical records. This subset of codes, called Z-codes, includes such codes as "problems with education and literacy" and "problems related to housing and economic circumstances." Within each of these SDOH-related codes are several subcodes that can capture even finer details of the relevant SDOH. Although research has shown limited documentation of SDOH using these codes (CMS, 2020c), public-private sector work continues in this area, for example, in refining and adding relevant codes or subcodes.