

Providing Value-Added Services for Medicare-Medicaid Enrollees: Considerations for Integrated Health Plans

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IN BRIEF

Health plans integrating Medicare and Medicaid services may choose to provide additional “value-added” services for their dually eligible members, many of whom often have complex clinical conditions and functional limitations, as well as other social service and non-health related needs. As more states enroll individuals with complex needs into managed care arrangements, innovative health plans are working to develop approaches to equitably allocate value-added services and assess return-on-investment. This brief explores how health plans participating in *PRIDE (Promoting Integrated Care for Dual Eligibles)*, a project made possible by The Commonwealth Fund, are addressing members’ service needs beyond the scope of traditionally covered Medicare and Medicaid services to improve health outcomes and address social determinants of health. The brief also discusses several policy considerations related to the provision of value-added services.

Many states have implemented integrated Medicare-Medicaid programs for dually eligible beneficiaries to better coordinate care and improve health outcomes. These individuals often face a combination of poverty, co-existing chronic physical and behavioral health conditions, cognitive disabilities, and functional limitations. As a result, many have complex social, environmental, and other non-medical needs, often referred to as social determinants of health.¹ Research demonstrates that many non-medical factors can influence health outcomes even more than the health services received.² In response, many federal and state policymakers are pursuing efforts to address social determinants of health as a critical component of improving outcomes and reducing health care spending for high-need beneficiaries.³

In many integrated care programs, a managed care plan receives a capitation payment from both Medicare and Medicaid in return for assuming the financial risk of providing all of a member’s acute and primary care, behavioral health care, and long-term services and supports (LTSS). Managed care plans may also provide additional “value-added” services to better support members’ non-medical needs beyond the required benefits.^{4,5} This flexibility may improve a plan’s ability to address members’ unmet needs and prevent high-risk individuals from further medical or functional decline that would require admission to a hospital or nursing facility, or other more expensive services.

This technical assistance brief explores why and how managed care plans provide value-added services for their dually eligible members. It draws from the experiences of eight health plans participating in *Promoting Integrated Care for Dual Eligibles (PRIDE)*, a national initiative made possible by The Commonwealth Fund that is focused on advancing high-quality integrated care for dually eligible beneficiaries. The eight *PRIDE* plans,⁶ which are locally based and have special expertise in serving this population, have developed various approaches to delivering targeted, value-added services to meet their members’ needs. The plans are not paid to provide value-added services described in this brief (i.e., value-added services are not included in rate-setting calculations), but the plans often offer them because they anticipate that doing so will improve

health and cost outcomes. This brief details the extent of state influence on plans' use of value-added services, and why plans provide them. It describes issues related to allocating these services equitably across members and how plans assess the value of providing these services. Finally, the brief examines policy considerations for providing value-added services to Medicare-Medicaid enrollees in integrated care programs.

Defining Value-Added Services

For this brief, we define “value-added services” as additional services outside of the Medicare and Medicaid benefit package (i.e., State Plan and/or Medicaid managed care contract) that are delivered at managed care plans' discretion and are not included in capitation rate calculations. Value-added services seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.^{7,8} In its May 2016 Medicaid managed care rule, the Centers for Medicare & Medicaid Services (CMS) recognized that a managed care organization may voluntarily provide additional services, although the costs of these services may not be included when determining payment rates.⁹ It also specifically refers to these as “value-added” services.¹⁰

Managed care plans serving dually eligible individuals have other vehicles to provide additional services to members beyond required Medicare and Medicaid benefits, such as Medicare supplemental benefits and Medicaid in-lieu of services. Below are descriptions of these vehicles, which we exclude from the definition of value-added services addressed in this brief:

- **Medicare supplemental services.**¹¹ Medicare Advantage organizations (MAOs) can offer supplemental benefits to members that are primarily health-related.¹² In addition, pending CMS approval, Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) that are highly integrated with Medicaid plans (i.e., coordinate delivery of covered Medicare and Medicaid primary, acute, and long-term care services throughout their entire service area) and meet minimum quality standards may offer supplemental benefits beyond health-related areas, such as assistance with Activities of Daily Living or Instrumental Activities of Daily Living. However, these benefits may not duplicate state Medicaid or local benefits for members. Supplemental benefits must be uniformly available and offered to all members, and require CMS approval. Examples of supplemental benefits include hearing and vision services, over-the-counter allowances, and additional non-medical transportation services not covered under Medicaid. MAOs must provide a list of proposed supplemental benefits to CMS for approval in the plan's bid and submitted plan benefit package.
- **Medicaid in-lieu-of services.** Some state Medicaid agencies allow managed care plans to authorize in-lieu-of services or provide care in settings that are not included under required Medicaid benefits but that are a medically appropriate, cost-effective substitute to a covered service.¹³ The service provided must be related to a similar service that is covered under the State Plan and must be voluntary.¹⁴ According to the Medicaid managed care rule, finalized on May 6, 2016, in-lieu-of services may be included in calculations of the medical portion of managed care capitation rates.¹⁵ For example, a plan may offer home visits for high-risk individuals as a substitute for in-office visits under certain circumstances.
- **Additional benefits included in financial alignment demonstrations.** Several states with capitated financial alignment demonstrations require Medicare-Medicaid Plans to offer additional benefits, such as diversionary behavioral health and community support services (Massachusetts); community transition services and adaptive medical equipment and supplies (Michigan); and palliative care (South Carolina), among others. These services are defined in the three-way contracts between CMS, the state, and the Medicare-Medicaid Plan, and are accounted for in setting rates.¹⁶

Provision of Value-Added Services

State Role in the Provision of Value-Added Services

At a high level, the structure of states' Medicaid programs can influence the provision of value-added services. Many *PRIDE* plans reported that the decision to provide value-added services is related in part to how generous their state's Medicaid benefit package is, particularly for LTSS. In states with robust LTSS offerings, plans often see less need for providing additional benefits.

On an operational level, some states leave the decision about whether and how to offer value-added services entirely to the managed care plan's discretion, while other states with a more prescriptive approach have established formal mechanisms by which plans can offer value-added services. Following are examples of how states define a set of value-added services that managed care plans may provide to members:

- **California** established Care Plan Option (CPO) services in 2013 (see Exhibit 1).¹⁷ CPOs are optional LTSS that plans in Cal MediConnect, the state's Medicare-Medicaid Financial Alignment Initiative demonstration, can provide to members at their discretion to enhance care, promote an individual's ability to remain in their home, and/or prevent costly and unnecessary hospitalizations or prolonged care in institutional settings. CPOs are enhancements to the required LTSS that individuals are assessed to need, eligible to receive, and are not included in rate calculations. The California Department of Health Care Services requires managed care plans to submit quarterly reports on LTSS utilization, including CPO assessments, referrals, approvals, and denials.¹⁸
- **Minnesota** permits contracted Medicaid managed care plans to offer "Additional Services" that must be available to all enrollees who demonstrate a medical need.¹⁹ Plans have full discretion to determine what these services should be, and given that they must be made broadly available, may conduct an extensive and formal review process, such as financial analyses and clinical discussions with care managers, before authorizing them. Plans report Additional Services offered to the state. For example, UCare offers services that: are preventive (additional dental sealants); are proven to prevent injury/illness (car seats); promote health (health club memberships/discounts, community education discounts, additional dental exam); and provide health education (books, DVDs). Plan costs associated with Additional Services are excluded from calculation of capitation rates paid to plans.

In contrast, managed care plans in other states have significant discretion to offer a broad range of services. *iCare* reports that in Wisconsin, managed care plans use a resource allocation decision-making model to develop comprehensive care plans. They have considerable flexibility to work with members and their families and care team members to develop a list of services that best meet members' desired outcomes in the most cost-effective manner possible.

Exhibit 1. Defined Value-Added Services in California



In **California**, Care Plan Option services can include:²⁰

- Respite care in home or out-of-home;
- Additional personal care and chore-type services beyond covered benefits;
- Habilitation;
- Nutritional assessment, supplements and home-delivered meals;
- Home maintenance and minor home or environmental adaptation;
- “Other services” that may be deemed necessary by the health plan, which could include personal emergency response systems, assistive technology, in-home skilled nursing care, and other items;
- Supplemental protective supervision;
- In-home skilled nursing care and therapies services for chronic conditions;
- Care in licensed residential care facilities;
- Non-medical transportation (beyond the supplemental benefit level); and
- Similar LTSS and home- and community-based (HCBS) waiver services.

Tennessee allows its health plans to provide what it calls Cost-Effective Alternative (CEA) services to covered benefits in certain circumstances (see Exhibit 2).²¹ While the CEA services that can be provided and the rationale for providing them is similar to value-added services, because the CEAs provided may be included in the capitation payment rate, they are slightly different from the other value-added services described in this brief. Plans may provide a CEA if it: (1) is an actual alternative to a covered Medicaid service, cost-effective, and achieves the same benefit for the member; or (2) would prevent or avoid an individual from developing a condition that would require more costly treatment in the future, including institutionalization.²² Managed care plans report the provision of CEAs under CHOICES, the state’s managed long-term services and supports program, to TennCare on a monthly basis.

Exhibit 2. Examples of Tennessee’s Cost Effective Alternative Services (CEAs)



In **Tennessee**, Cost Effective Alternative services can include:²³

- Adult day health services;*
- Bed bug treatment to prevent hospitalization or placement in a nursing facility (members of CHOICES Group 2 or CHOICES Group 3);²⁴
- Dental care;*
- HCBS in excess of \$15,000 expenditure cap for CHOICES Group 3 members who would otherwise require home health services to ensure that their needs are safely met in the community;
- HCBS in excess of the prescribed benefit limits as a cost effective alternative to institutional care;²⁵
- Transition allowance for CHOICES members transitioning from CHOICES Group 1 to CHOICES Group 2;
- Inpatient rehabilitation facility services;*
- Mileage reimbursement in-lieu-of non-emergency transportation for persons who have used TennCare-sponsored non-emergency transportation within the previous six months;
- Non-medical adaptive devices such as reactors, buttonhole adaptive devices, etc.;
- Nutritional programs and supplements;*
- Over-the-counter medical supplies;*
- Short-term continuous care, to include Level 2 nursing facility care, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge; *²⁶ and
- Vision services and eyeglasses or contact lenses.*

**For adults aged 21 and older*

Why Provide Value-Added Services?

Regardless of states' approaches to providing value-added services, *PRIDE* plans report significant flexibility to offer these services and see many benefits in doing so. They believe that value-added services have helped to: (1) fill gaps in care between required Medicare and Medicaid services; (2) divert individuals from institutional care and otherwise support members' ability to reside in the community; and (3) improve physical health via non-medical interventions. Following are examples of outcomes that *PRIDE* plans have achieved by providing value-added services:

1. Fill gaps in care. *PRIDE* plans use value-added services to close gaps in Medicare and Medicaid-covered services and offer supports that would unlikely be available in a fee-for-service system. For example, in Massachusetts, Commonwealth Care Alliance increased limits on already-covered services on an ad hoc basis, authorizing additional transportation services, expanding allowances for home modifications, or adding extra hours of personal care assistance to supplement family caregivers.

In California, the Health Plan of San Mateo is using value-added services to facilitate transitions for nursing facility residents, such as providing support services for individuals who move from a nursing home to a residential care facility or purchasing items to help beneficiaries set up a new home. The Health Plan of San Mateo also offers more flexibility when administrative complexities might delay the provision of certain needed benefits, particularly when an individual is transitioning out of a hospital or post-acute care facility. Examples include getting personal care workers into members' homes more quickly than the current county-sponsored personal care program can respond or allowing a "trial run" for adult day health services for people unsure of whether they want to participate.

In Minnesota, pursuant to contracts with the state, UCare waives all Medicaid co-pays in products for people with special needs (i.e., seniors age 65 and over and people ages 18-64 who have certified disabilities) to ensure that there are no financial limitations to receiving certain services. In Wisconsin, iCare developed an algorithm to identify over- and under-utilizing members with significantly higher-than or lower-than average acute or LTSS spending, respectively. Both instances can indicate a need to better target care management activities, and iCare prioritizes these individuals to receive targeted services such as telehealth, health coaches, and supportive care.

2. Divert enrollees from inpatient admissions or nursing facility placements. Managed care plans often use value-added services to provide LTSS to individuals who are at-risk of, but do not yet require, a nursing facility level of care with the goal of avoiding or postpone the need for institutional or other LTSS services. California's Inland Empire Health Plan identifies individuals at risk of needing LTSS or current LTSS users at risk of requiring more extensive benefits. Processes include reviewing utilization patterns such as multiple hospitalizations; monitoring care plans for increased difficulties with activities of daily living; and accepting referrals from the plan's expansive network of community-based organization partners. Inland Empire Health Plan also partners with Charter Healthcare, which provides in-home transitional care services to members with chronic medical conditions and/or comorbidities such as behavioral health conditions, and who have recently been discharged from a hospital or have frequent emergency department visits. The plan often uses CPO services to support these members.

Addressing social determinants of health is another important factor in diverting more expensive care. Commonwealth Care Alliance, for example, provided optional housing-related services to

help several members who need assisted living supports, remain in a building that was being converted to an independent living unit. Commonwealth Care Alliance developed modified service plans to put supports in place to allow members to stay, and it also contracted with the property management company to continue dining room meal plans. In addition, Commonwealth Care Alliance has authorized and paid for moving services when a move to new housing has been deemed medically necessary to prevent risk of harm or homelessness, and when all other options and informal supports have been exhausted.

Health Plan Perspectives on the Effects of Social Determinants of Health

PRIDE plans report that social determinants of health are often linked to their members' medical status, which can impact health outcomes and costs. For example:

- **Housing-related supports.** Housing-related supports were the most frequently cited area of need, and several plans noted that lack of stable, adequate housing is the primary factor in driving someone at-risk of needing facility-based LTSS to that level of care.
- **Non-medical transportation.** Although states must cover some form of non-emergency medical transportation, plans reported a need for additional transportation for other purposes, such as socialization activities, trips to the supermarket, and other health-related activities such as a health club. Several plans noted that this was a difficult benefit to authorize because of lack of service eligibility criteria, but reiterated that transportation was critical for building community linkages and meeting social needs.
- **Nutritional supports.** Integration of medical benefits with existing nutritional programs could have significant impacts on obesity, diabetes, and other major chronic conditions. Meal benefits and nutritional support would be helpful for members who must comply with a specific diet but who might not have the ability or means to do that.
- **Opportunities of socialization.** Social isolation, particularly for an often less-mobile population, can have adverse outcomes on health. Increasing social activities and combatting isolation faced by many people with functional limitations and other disabilities is a key element for good overall health. Socialization supports are included in care plans for several *PRIDE* plans, and they are seeking innovative ways to provide and pay for these activities.



The Health Plan of San Mateo found that addressing social isolation is a key to successfully transitioning individuals out of institutional care, particularly as many are leaving a very structured environment. It is examining new types of peer supports and other related services to address isolation. The plan contracts with an organization called Wider Circle, which facilitates an activity-based, social group led by peers to support individuals with day-to-day living tasks. Wider Circle also emphasizes physical activity and collects some data on health outcomes. The plan acknowledged that authorizing these services often requires extensive internal review, but it will continue to provide these activities based on very positive feedback from members.

PRIDE plans also use value-added services in the form of non-traditional home modifications to help keep members living at home. For example, Ohio's CareSource paved a member's driveway so that he could get his wheelchair into the van that transported him to his doctor appointments. Inland Empire Health Plan provided a washer and dryer to someone with late-stage cancer who was no longer able to get to a laundromat.

3. Improve physical health. *PRIDE* plans also provide value-added services that directly improve physical health for individuals requiring LTSS. For example, several *PRIDE* plans offer the Silver Sneakers program, a Medicare supplemental benefit that encourages Medicare enrollees to join a health club and exercise. However, many dually eligible beneficiaries do not have easy access to a health club. CareSource implemented an in-home exercise program for people who have difficulty leaving their home or nursing facility to ensure that a physical activity benefit was available to all members. UCare offers therapy or specialized exercise programs for people with neuro-muscular disorders to increase their physical comfort and to avoid more costly adverse health outcomes. It has a formal authorization process in place for this and also conducts assessments to measure program effectiveness and member outcomes. In addition, UCare realized that several members lacked access to grocery stores, even in urban areas, and funded a mobile market with fresh food that serves local communities. As one compelling example, the plan helped a woman who was buying her food from vending machines. *iCare* is developing a new service to be offered in January 2017 that will provide video telehealth visits for members in urban areas who do not like to leave their homes to attend appointments.²⁷

Decision Points for Providing Value-Added Services

Decisions about which members should receive which value-added services are usually left to managed care plans' discretion. While *PRIDE* plans currently have few tools to guide their decision-making, they ultimately seek to tie the provision of value-added services to improved outcomes in health status, functional ability, or quality of life.

Which Members Should Receive Value-Added Services?

Most plans would like to offer value-added services on an ad hoc basis to members with demonstrated needs. In many cases, the request of a plan's care manager is sufficient for the member to receive the service. Other plans hold interdisciplinary care team meetings with the care manager, often a medical director, and other staff who are involved in a member's care to discuss whether an optional service should be offered. Both these methods are subjective, making it more difficult for a plan to consistently and equitably allocate optional (and unreimbursed) services. To the extent possible, *PRIDE* plans want requests for value-added services to be supported by assessments and clinical documentation.

BlueCare Tennessee uses a planning tool to determine whether a Medicaid-covered service or CEA would be a better option. This tool assesses what services would best meet members' needs and calculates how much each intervention would cost. If care coordinators determine that a CEA is a better option, they submit the recommendation to the medical director for approval. Plans also noted that they often receive recommendations from partner community-based organizations about additional services that would support an individual's ability to remain at home. Final decisions about whether to offer value-added services are often made by plans' medical directors. In some cases, states also play a role in deciding who should receive value-added services. In Tennessee, some service request authorizations for CEAs are sent to the Bureau of TennCare. BlueCare Tennessee reports that these requests are almost always addressed quickly.

What Services Should be Offered?

Some *PRIDE* plans have or are developing more specific protocols or criteria to determine which value-added services they should offer and when. For example, Commonwealth Care Alliance's care

managers use a decision support tool to ascertain which services should be provided to the members it manages. The tool helps identify needed services—both those covered by Massachusetts Medicaid and, in some cases, additional value-added services provided on an ad hoc basis. The plan can add new services into the decision-support tool when it: (1) receives multiple requests by different care managers for a service that is outside of the benefit package or that emerges as a result of new care patterns; and (2) can establish reasonable authorization criteria to make the service more broadly available. For example, the plan received several requests for packing and moving services, and recently decided to assess if this service could be added to the decision support tool.

The Health Plan of San Mateo will use data collected through its Community Care Settings Pilot to build a tool to help make decisions about which CPOs to offer.²⁸ The pilot supports individuals transitioning out of institutions to the community by providing intensive case management, housing assistance services (which are optional services), and medical care, as well as several other CPO services. The pilot provides a testing ground for the plan to analyze CPO service use, costs, and subsequent outcomes through a set budget, defined parameters for service authorizations, and a specific, high-risk population that has frequent contact with a care manager (and thus, provides for several data collection opportunities). The Health Plan of San Mateo eventually wants to use the information it collects to develop budget targets for CPO service requests and objective protocols for offering certain CPO services. The plan's goals include: (1) linking the provision of CPOs to specific outcomes; (2) developing a standardized application for these services; (3) developing CPO targeting criteria for specific populations (e.g., individuals with dementia, families who need respite care, individuals with five or more chronic conditions, etc.); and (4) setting an annual budget for provision of all CPO services that will include a list of preferred vendors in the community and pre-established pricing.

Do Value-Added Services Actually Add Value?

Assessing the “value” of providing value-added services (i.e., the potential improvement of health outcomes and quality of life as well as the associated financial costs) can be difficult without defined service eligibility criteria and/or when services not provided uniformly to all plan members. However, understanding the clinical benefit and financial cost of providing these services is important to plans operating capitated budgets and with finite resources.

Several *PRIDE* plans are analyzing the return-on-investment for providing value-added services and conducting financial forecasting to determine if they should offer them more broadly to members. Some plans make projections about the percentage of members with similar needs or characteristics of the members who currently receive a value-added service to determine if they can afford to offer the service more broadly. UCare conducts regular internal market scans and external market reviews, and convenes product development cycle meetings to identify gaps in the services it provides, and then analyzes if it is financially viable to add more services to its benefit package or enhance existing Additional Benefits (e.g., allow a greater discount or provide them more often). BlueCare Tennessee's care management planning tool, described above, calculates the cost of providing a CEA and compares that to the estimated costs if the plan did not provide the service. *PRIDE* plans noted two important considerations for assessing value: (1) the ability to keep people in the community; and (2) reductions in acute care costs.

1. Community tenure. *PRIDE* plans serve a large number of members with LTSS needs; for these individuals, the primary reason to provide value-added services was to lengthen tenure in the

community for both individuals currently receiving as well as at-risk of requiring LTSS. Indicators that plans are successfully keeping people in the community include an increase in the number of transitions out of institutional settings and a decrease in the number of enrollees who reside in institutional settings during a defined period of time. Monitoring service use to identify individuals who are at risk of decline is another key indicator. Inland Empire Health Plan monitors several data elements to identify individuals at-risk of becoming LTSS users or require additional LTSS after an inpatient admission or other related event that may increase risk of a nursing facility admission. The plan uses an extensive network of community-based organizations to provide CPOs and other wraparound services to ensure smooth transitions out of acute care settings or to avoid an admission to a nursing facility.

2. Reductions in acute care costs. Some *PRIDE* plans have found that providing value-added services reduces acute care costs. Several *PRIDE* plans also operate Medicare-Medicaid Plans in financial alignment demonstrations, which are built upon assumptions that expanded community-based services will reduce Medicare acute care costs and result in shared savings for both the federal government and states. One plan reports that among members over age 65, LTSS spending exceeds spending on acute care, but as LTSS spending increased, spending on inpatient care decreased. As noted above, *iCare* expects the average ratio of dually eligible members' costs to be 25 percent acute care and 75 percent LTSS. Its information system generates an outlier report if a member's costs deviate significantly from this average ratio. Although spending outside of the expected ratio may indicate a need for a care management intervention, the plan noted that oftentimes the higher-than-average LTSS spending reflects its success at keeping acute care costs low by meeting a member's needs at home.

PRIDE plans described several challenges with assessing the return-on-investment of value-added services, including:

- Lack of specific methodologies and consistent data to understand the impact of offering services to different members in an ad hoc manner;
- Assessment of “intangible” factors to measuring overall member well-being, such as improved quality of life by living at home;
- The impact of cost avoidance, rather than actual spending, as appropriate. For example, it is difficult to measure how many people *would* have been admitted to a nursing facility without these value-added services;
- General internal capacity to conduct the resource-intensive analyses needed to determine a return-on-investment; and
- Difficulty in projecting additional demand for value-added services.

Policy Considerations

The November 2016 election results may have as yet undetermined implications for how publicly financed health care programs will operate, but there is a general sense that efforts to create more effective and efficient programs will continue to be supported by policymakers. This should include innovations that reduce fragmentation, institutionalization, and the costs of treatment for people with chronic conditions, which managed care plans can continue to advance with a flexible approach to providing targeted services. Following are several policy considerations raised by *PRIDE* plans

related to the provision of value-added services to meet the needs of members with complex medical, behavioral health, and social support needs:

Managing Financial Implications

Plans expressed a desire to have these services included in payment rate calculations, particularly as interest among states and the federal government to understand the impact of social determinants of health and non-medical interventions on health outcomes and costs is growing. Plans are more likely to invest in value-added services that decrease medical utilization and more costly institutional placement. However, if plans are successful at reducing overall spending captured in claims and encounters, this can result in new, lower capitation rates that are calculated using that historical data. In addition to ensuring that plans have enough capital to cover the provision of value-added services, this potential to lower payment rates also creates a disincentive to cover additional services. *PRIDE* plans see an opportunity to review traditional capitation rate-setting structures that are based on medical encounters and may not reflect true cost drivers and effective interventions in these programs, a concern shared by many states, managed care plans, and other key stakeholders with expertise in setting rates for high-need populations.²⁹ Efforts to calculate the return-on-investment for providing value-added services, particularly those that directly address social determinants of health but also reduce the costs of medical services, will be very important to make the case for revising rate setting methodologies.

Another rate-related issue may arise in integrated or MLTSS programs that incorporate several HCBS waiver programs—each with different benefit and payment structures—into one. One plan that manages services for five legacy waiver programs in a single benefit package through a financial alignment demonstration explained that the scope of services differed across waivers. Rates were developed based on the projected number of people who would receive services under individual waivers in the fee-for-service program. However, under the demonstration, the plan provides access to all covered benefits regardless of which legacy waiver its members would have enrolled. For example, the limit on allowable spending for home modifications differed from waiver to waiver. Under the demonstration, all enrollees have access to home modifications up to the most generous waiver’s spending limit, but the rates were set based on populations enrolled in fee-for-service waivers, under which many people did not qualify for the highest limit. Likewise, the plan has assessed significant unmet need for many waiver services among people who had not previously had access to them, and is now responsible for providing these home modifications for more members than is supported by rate calculations.

Balancing Flexibility and Prescriptiveness

Although *PRIDE* plans want flexibility and the authority to provide services targeted to members’ individual needs, plans noted some standardization could be helpful. As one plan noted, the “devil is in the details” when striking this balance. A few themes from the plans’ perspective in this area include:

- **Latitude to make service determinations.** Although CEAs are slightly different than value-added services, BlueCare Tennessee reports that TennCare’s “structured flexibility” works well because the plan still has significant latitude to make service determinations. This approach might be of interest to other states that want to encourage health plans to be innovative with additional services. TennCare holds quarterly meetings with managed care plans to discuss issues with current benefits and hear recommendations about new services to add to the CEA list. One plan-

recommended change was to lift limits on the number of hours of attendant care that could be authorized per year. This decision was made after plans demonstrated that increasing the number of hours of unskilled support helped to move people out of nursing facilities.

- **Interest in expanding state involvement in overseeing new, non-traditional providers.** As managed care plans build new relationships with community-based organizations and other providers of non-medical supports, one plan suggested that some state regulatory presence could provide some protection from fraud, waste, and abuse. States offer similar oversight and protections for more traditional LTSS, such as those provided by home health agencies. As plans consider how to spend their finite resources, having information about providers of new types of services that could be at-risk for abuse could support these value calculations.
- **Value in some reporting that does not significantly increase administrative burden.** Several *PRIDE* plans have been providing value-added services since they began serving dually eligible individuals. Formally reporting and discussing the provision of these services with the state can help build the case for: (1) adding new services to the programs; and (2) increasing transparency across participating plans to level the playing field between plans that would provide these services anyway and plans that would be less inclined to do so. Although a state would be unlikely to require provision of value-added services outside the official benefit package or through special demonstration authority,³⁰ making members, providers, and other stakeholders aware of value-added services could encourage more plans to offer these benefits, like California's public list of CPO services. California Medicare-Medicaid Plans began submitting quarterly reports on CPO and other LTSS to the state in 2016.

Expanding LTSS Services to Individuals At-Risk of Meeting a Nursing Facility Level of Care³¹

Most HCBS waiver services are limited to individuals who would qualify for nursing facility placement (i.e., nursing home level of care). However, *PRIDE* plans have found significant unmet need for individuals at-risk of meeting nursing facility level of care criteria, and the plans believe that the provision of "low-level" HCBS waiver services could slow or deter functional decline. Examples of services often limited to individuals who meet nursing facility level of care criteria under fee-for-service but that could be extremely valuable to those at-risk populations include: limited personal care hours; minor home modifications (e.g., grab bars, shower stalls, or a safety assessment); nutritional supports and pest control; among others. For example, one *PRIDE* plan offered pest control for bed bugs to anyone with a demonstrated need, even though individuals must be enrolled in an HCBS waiver to receive this service under the fee-for-service program. This service cost to the plan is approximately \$2,000-3,000/member and made a critical difference for keeping individuals in their homes. However, as noted above, capitation rates for these programs are based on the number of individuals who meet a level of care for HCBS waiver eligibility, not the unmet needs of individuals at risk of deteriorating. All plans were interested in expanding LTSS to at-risk individuals before they qualify for needing LTSS, but most do so on an ad hoc and limited basis because few plans have the means to provide these services on a larger scale.

Partnering with Community-Based Organizations to Address Social Determinants of Health

As described above, addressing social determinants of health may have a large impact on overall health outcomes and quality of life. Several plans are collaborating with state agencies and

community-based organizations to learn about other social and related supports that their members use but that are not included in the Medicaid benefit package. One activity that could systematically help plans to better determine what services were available and target those services to members who need them is to improve collection of data on service availability and use. By working with the state, waiver service providers, and other community-based organizations, plans can identify which services their members need and expand their service offerings.

Fine-Tuning Policies Related to Care-Giving and Respite

Plans are interested in policy solutions to make family caregivers more active partners in individuals' care plans and to expand respite services. One caution about expanding involvement of family care givers in care planning is that plans must protect against potential inequities that could arise. For example, plans should not be rewarded for enrolling individuals with family members who are willing and able to provide unpaid services that substitute for paid support, over enrollees who do not have such supports available. In addition, several *PRIDE* plans emphasized how important respite services are to members and their families and caregivers. Although most programs include respite services in some form, one plan noted that it would be valuable for states and plans could work together to better tailor the scope of respite services in programs to ensure resources were targeted effectively to people who needed them most for individuals with different circumstances and conditions.

Conclusion

PRIDE plans have developed innovative approaches to identifying and addressing members' needs for interventions that go beyond the scope of covered Medicare and Medicaid services to improve their outcomes. The plans report considerable value across different state benefit structures in having the flexibility to offer services that: (1) fill gaps in care; (2) avoid or delay the need for more costly services, including institutional care; and (3) meet both health and non-health related needs and have a direct impact on health outcomes. As more states enroll individuals with complex needs into managed care arrangements, the plans participating in *PRIDE* and other innovative health plans are developing systematic approaches to allocate value-added services equitably across members. Plans are also focused on assessing and communicating the return-on-investment for offering these services, particularly as they deter the need for more expensive care, to continue to offer these benefits to more members who need them.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

- ¹ As defined by the United States Department of Health and Human Services, Healthy People 2020 initiative: Social determinants of health are 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. Refer to: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
- ² A. Spencer, J. Lloyd, and T. McGinnis. "Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons." Center for Health Care Strategies, December 2015. Available at: <http://www.chcs.org/media/Supportive-Services-Brief-Final-120315-1.pdf>.
- ³ Ibid.
- ⁴ Ibid.
- ⁵ Services that may be covered by a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), 42 CFR §438.3 (e), 2016.
- ⁶ The eight *PRIDE* plans are: BlueCare Tennessee (Tennessee); CareSource (Ohio); Commonwealth Care Alliance (Massachusetts); Health Plan of San Mateo (California); Independent Care Health Plan (*iCare*) (Wisconsin); Inland Empire Health Plan (California); UCare (Minnesota); and VNSNY CHOICE Health Plans (New York).
- ⁷ D. Bachrach, J. Guyer, and A. Levin. "Medicaid Coverage of Social Interventions: A Road Map for States." Manatt Health, July 2016. Available at: http://www.milbank.org/uploads/documents/medicaid_coverage_of_social_interventions_a_road_map_for_states.pdf.
- ⁸ Although value-added services may not be included in developing capitation rates, these services can be included as incurred claims in the numerator for the medical loss ratio calculation. Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.
- ⁹ Services that may be covered by an MCO, PIHP, or PAHP, 42 CFR §438.3(e), 2016.
- ¹⁰ Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.
- ¹¹ Supplemental Benefits, 42 CFR §422.102(e), 2012.
- ¹² Centers for Medicare & Medicaid Services. "Medicare Managed Care Manual. Chapter 4 - Benefits and Beneficiary Protections." Section 30: Supplemental Benefits. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>.
- ¹³ D. Bachrach et al. July 2016.
- ¹⁴ An exception is the new authority that states have to cover short stays in institutions for mental diseases (IMD), which may be an in-lieu-of service to address a shortage of short-term psychiatric and substance use disorder services but is not covered in the Medicaid State Plan.
- ¹⁵ D. Bachrach et al. July 2016.
- ¹⁶ M. Muscumi. "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS." Kaiser Family Foundation, December 2015. Available at: <http://kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/>.
- ¹⁷ California Department of Health Care Services. "Duals Plan Letter 13-006: Care Plan Option Services." December 2013. Available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/DPL2013/DPL13-006.pdf>.
- ¹⁸ Final reporting requirements are under discussion as of December 2016. Proposal for increased LTSS reporting requirements: California Department of Health Care Services. "2016 Coordinated Care Initiative Program Improvements." April 2016. Available at: <http://www.calduals.org/wp-content/uploads/2016/04/4.7.16-CCI-Program-Improvement.pdf>.
- ¹⁹ Minnesota Department of Human Services. "Contract Model Template for Minnesota Senior Health Options and Minnesota Senior Care Plus Services." January 1, 2017. Available at: http://mn.gov/dhs/assets/2017-seniors-model-contract_tcm1053-269766.pdf. Minnesota Department of Human Services. "Contract Model Template for Special Needs Basic Care Program Services for People with Disabilities." January 1, 2017. Available at: http://mn.gov/dhs/assets/2017-snbc-model-contract_tcm1053-269768.pdf.
- ²⁰ California Department of Health Care Services. Duals Plan Letter 13-006: Care Plan Option Services. December 2013. Available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/DPL2013/DPL13-006.pdf>.
- ²¹ TennCare Policy Manual. Policy No: BEN 08-001(Rev8): Cost Effective Alternatives. December 2014. Available at: <https://www.tn.gov/assets/entities/tenncare/attachments/ben08001.pdf>
- ²² TennCare Policy Manual. Policy No: BEN 08-001(Rev8).
- ²³ TennCare Policy Manual. Policy No: BEN 08-001(Rev8).

²⁴ TennCare CHOICES in LTSS (or CHOICES for short) is TennCare’s program for adults (age 21 and older) with a physical disability and seniors (age 65 and older). It includes nursing facility services and HCBS.

²⁵ State of Tennessee, Department of Finance and Administration, Bureau of TennCare. “Statewide Contract with Amendment 5.” January 1, 2017. Available at: <https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf>.

²⁶ Nursing facility care is covered in the State Plan; however, it is considered a long-term service and support (LTSS) rather than short-term, episodic care and requires a level of care evaluation (referred to as a “PreAdmission Evaluation” or “PAE”).

²⁷ Wisconsin’s Medicaid program already covers telehealth services for beneficiaries living in rural areas.

²⁸ B. Ensslin and D. Brodsky. “Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot.” Center for Health Care Strategies, March 2016. Available at: <http://www.chcs.org/media/HPSM-CCS-Pilot-Profile-032916.pdf>.

²⁹ D. Lipson, M. Dominiak, M. Soper, and B. Ensslin. “Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations.” Center for Health Care Strategies, January 2016. Available at: http://www.chcs.org/media/MLTSS-Rate-Setting_Final-2.pdf.

³⁰ Some states required Medicare-Medicaid Plans to offer additional services in addition to covered Medicare and Medicaid services in financial alignment demonstrations.

³¹ Although out of scope of this paper, we note that recent CMS guidance clarified that qualifying Medicare Advantage Dual Eligible Special Needs Plans may offer a flexible Medicare supplemental benefit that would be covered under Medicaid to those enrollees who are not eligible to receive the identical Medicaid service as long as those services are not duplicative of benefits for enrollees who are eligible to receive identical Medicaid services. See: Centers for Medicare & Medicaid Services, Center for Medicare. “Clarification of Benefit Flexibility and Coverage Guidance for Dual Eligible Special Need Plans and Process to Request to Offer Flexible Supplemental Benefits in Contract Year 2017.” January 2016. Available at: http://www.chcs.org/media/CY-2017-D-SNP-Benefit-Flexibility_01082016.pdf.