Exploring Emerging Practices to Improve the Health Status of Medicaid Managed Care Populations Through a Social Determinants of Health Approach

EXPLORING EMERGING PRACTICES TO IMPROVE THE HEALTH STATUS OF MEDICAID MANAGED CARE POPULATIONS THROUGH A SOCIAL DETERMINANTS OF HEALTH APPROACH

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Abstract

This work was undertaken to critically examine whether and how a managed care organization can address the social determinants of health for vulnerable Medicaid populations. Unprecedented changes are taking place in the U.S. health system, and more scrutiny has been devoted to publicly financed healthcare spending and outcomes. Fostering and funding efforts that find innovative ways to meet the distinct needs of Medicaid populations have risen to the top of state and federal policy agendas. Complementary to this shift, the broader social conditions and the social determinants of health (SDoH) that structurally influence the health outcomes of populations are receiving increasing attention.

To examine the prospects for Medicaid managed care organizations to meaningfully address the social determinants of health, I undertook a literature review and an immersive 9-month, field-based, professional experience within one of the largest Medicaid managed care organizations (MCO) in the U.S. I joined this MCO as it was building out its infrastructure to expedite the launch of new SDoH programs through creating brick and mortar community centers that provide walk-in services to health plan members and local community members. The new programs aimed to offer critical support to these populations, in linking them up with various social services, such as housing, transportation and employment. Both endeavors helped me to expand my expertise on the nature of social service integration efforts being led by Medicaid MCOs. And, they both led me to uncover what is known and not known about past and current MCO-led programs and their ability to achieve success in creating access to social services for Medicaid populations. Several programs are testing and

exploring the sustainability of putting forward new SDoH interventions to create synergies for Medicaid members and their various service providers. Other categories of interventions are beginning to permeate the formerly fixed boundaries between the social services and healthcare services sectors, including services led by the Medicaid MCO that I was immersed within.

Throughout this Doctoral Engagement in Leadership and Translation for Action (DELTA) thesis project, I describe important dimensions of MCO intervention design and implementation. These descriptions are both based on my first person observation within an MCO and my comparative analysis of intervention descriptions found in the public domain. I note the accommodations, partnerships, policies, and funding streams being used or that are needed to take these efforts further. I find that over the last 2 decades momentum has been building toward addressing social determinants in Medicaid managed care. However, collective knowledge is lacking with regard to which SDoH interventions might produce the largest gains in the health status of Medicaid beneficiaries. To ensure success in improving the health and social well-being of underserved Medicaid populations, a clear framework for funding, designing, implementing, and evaluating new interventions focused on social service supports is critical.

Importantly, I conclude that state Medicaid agencies and Medicaid health plans must be better enabled and incentivized to invest in social determinants of health interventions through policy and regulatory guidance that allows flexible spending and blended payment structures. As best practices are absent in this space, a set of emerging practices and gaps in the published literature are offered based on many of the interventions that have been implemented thus far by Medicaid MCOs across the United States. The ultimate goal of this

work was to translate and apply my core learnings from the emerging practices and gaps in the published literature that I developed to the real-time, field-based implementation, evaluation, and scaling of local SDoH programs being developed by my host organization.

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Introduction

Like slavery and apartheid, poverty is not natural. It is man-made and it can be overcome and eradicated by the actions of human beings. And overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life. While poverty persists, there is no true freedom.
–Nelson Mandela (BBC News, 2005)

The Medicaid program, which provides health insurance coverage to more than 20% of all American citizens and lawful permanent residents, is the largest source of public health insurance in the United States and in 2015 constituted 17% of all national healthcare spending, roughly accounting for $545 billion annually (Centers for Medicare & Medicaid Services, 2016a). Upon the Congressional enactment of amendments to the Social Security Act in 1965 and the full creation of state Medicaid programs beginning that year, select groups of the lowest income, socioeconomically disadvantaged families and individuals in the nation became entitled to basic healthcare coverage through public insurance for the first time.

More than 50 years later, however, a new population health-based approach to the provision of Medicaid services is needed to better meet the complex needs of low-income, disabled, pregnant, and otherwise vulnerable populations who receive such coverage (Crawford et al., 2015; Bindman, 2015). This new approach should go beyond traditional Medicaid coverage schemes focused primarily on paying for necessary treatment, and instead work to "encourage the development of health care entities that both deliver and coordinate a fuller spectrum of health, educational, nutritional, and social services" (Rosenbaum et al., 2017). Most experts agree that if health care programs for the poor are to be effective, they

must find a way to address the social determinants. Thus, new models of care are needed that expand access to needed services and enable a higher quality of life for Medicaid covered individuals and families (Allen et al., 2000; Fiscella & Shin, 2005).

Of primary concern is that state Medicaid programs continue to struggle to sufficiently address the complex social needs and social causes of disease burden among Medicaid populations amidst significant political scrutiny and budgetary challenges at the federal and state levels. These challenges have persisted as state Medicaid programs in recent years have simultaneously experienced beneficiary enrollment growth and a perceived need for fiscal constraints given total cost growth at state and federal levels (see Figure 1).

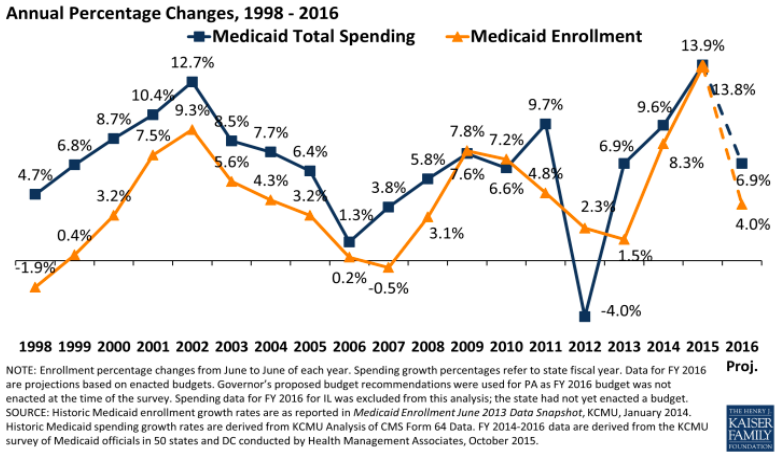

Figure 1. Medicaid enrollment and total spending (Rudowitz et al., 2015).

Despite their coverage status, Medicaid populations have historically experienced greater disparities in access to care and poorer health outcomes than other populations (Allen et al., 2000). This is in large part due to the social, economic, environmental, behavioral and political factors that influence the health and disease distribution of populations, and how these factors have adversely impacted the Medicaid population in particular (Bravemen et al.,

2011). Moreover, there is a dearth of evidence on the policy and programmatic interventions that can affect these broader social determinants of health for the 73 million Medicaid and Children's Health Insurance Program (CHIP) beneficiaries across the U.S. (Centers for Medicare & Medicaid Services, 2016b). These acutely vulnerable populations continue to struggle with the many hardships and challenges associated with living under and near the federal poverty level (FPL) and with needing to access services and programs to meet their most basic material needs, including food, shelter, and safety. Thus, an evaluation of emerging and promising innovations to more sufficiently link these populations to new and already available social services designed to serve them is needed (Gottlieb et al., 2016a; Taylor et al., 2015).

Though it has become increasingly evident that the health system alone cannot assure optimal health outcomes nor fully address the nonmedical drivers of health (McGinnis et al., 2002), how best to improve overall health outcomes for low-income Medicaid populations needs further exploration. Rosenbaum et al. (2017) noted:

> In communities with concentrated poverty and food insecurity, and their attendant health risks, there is an even greater justification for community-wide interventions that can change living circumstances to promote health. How Medicaid as an insurer aligns its coverage and payment policies with these broader efforts to enhance community- wide social interventions – such as covering clinical care offered in supportive housing satellite locations, nursing and health counseling services in high-poverty schools, or connecting patients to federal nutrition programs – thus becomes a key issue. (p. 18)

Given the current U.S. healthcare landscape, the expansion of state Medicaid enrollment, and the growth of risk-bearing managed care arrangements between states and healthcare payers, Medicaid managed care organizations (MCOs) have a critical role to play (Smith et al., 2016). These healthcare entities can improve access to quality healthcare through their health plan offerings and through creating innovative, community-based partnerships and interventions specifically targeting the upstream social determinants of health (SDoH) (Silow-Carroll & Rodin, 2013). Through competitively bid state-based contractual agreements, these payers continue to be held more accountable for the provision of care for the various Medicaid populations (Summer & Hoadley, 2014) and are demonstrating burgeoning interest in innovation with respect to the social determinants of health (Association for Community Affiliated Plans, 2014). The determinants that they have sought to address have included homelessness, unemployment, food insecurity, and several other broader social needs. However, the most effective levers for systems change interventions are still largely unknown, and building the collective evidence base on these innovations is essential for the network of nearly 300 Medicaid MCO plans across the nation to become more effective in systematically identifying and addressing these social needs.

To support the broader inquiry of whether and how MCOs can be successful in addressing social determinants, the following question guided this work: "What evidence exists on the effectiveness of interventions that Medicaid managed care organizations have led in the last 20 years to better meet the social services and social determinants of health-based needs of Medicaid populations?" To explore this question, this thesis includes several key sections.

In the Analytic Platform I present the socio-historical nature and consequences of the lack of integration between the medical care and the health-related social needs of Medicaid populations. I then discuss the rationale for focusing on solutions led by Medicaid managed care organizations. The section ends with a discussion of the DELTA project strategy carried out to both seek and apply evidence from published literature and practice-based field knowledge.

Next, the Report of Results provides the following information:

1. The breadth of approaches taken by Medicaid MCOs to address the social determinants of health, based on a literature review and my 9-month field-based professional experience immersed in an MCO.
2. A description of emerging practices based on evidence of previous interventions' success with simultaneously improving health, lowering costs, and improving experiences of care (see "Triple Aim," Berwick et al., 2008).
3. An analysis of gaps in the literature and current practice that can inform future action and policy.

Finally, in the Conclusion I discuss the DELTA project organizational context and practical learnings and offer implications of this work for the future of Medicaid managed care and social determinants of health-based policy and practice in the U.S.

Analytic Framework

Background on the Health and Social Services Sectors

To understand the nature and consequences of the overall lack of integration between the medical care and social needs of the populations enrolled in Medicaid, I explored a socio-historical view spanning the last century (see Table 1). The analysis shows the bifurcated approaches that have been taken by the health and social service sectors over time to address U.S. poverty and the needs of low-income populations. Historical analyses of the U.S. health and social services sectors also help explain their present-day fragmentation in the funding, scope, and eligibility rules for means-tested programs, and the low level of investment in social services compared to other economies. The comparative analysis suggests that services have been siloed in response to the social and economic conditions of low-income individuals and communities. Although a cohesive national agenda is lacking, over time both systems have experienced policy shifts at the local, state, and federal levels that have resulted in fragmentation and integration between the sectors. This has largely been based on U.S. societal values and ideologies, and the negative and even stigmatizing views towards low-socioeconomic groups that have influenced national and local social policy.

Consequently, the social services sector continues to be poorly funded and has undergone incremental reform when compared to the highly specialized healthcare industry and the medical-industrial complex that the sector supports (DeMilto & Nakashian, 2016; Relman, 1980; Squires & Anderson, 2015). It can be hypothesized that more integration between the health and social services sectors might yield a better social-to-healthcare

spending ratio as policies in the social domain are increasingly understood to be health influencing policies (Adler et al., 2016). Moreover, given the present-day federal governance of the two sectors, arrangements and policies focused on creating direct linkages among services at the local and community levels might be more promising in the near-term in seeking to transform front-line benefit and service delivery.

Table 1. Abbreviated 20th Century History of U.S. Health and Social Services

1900-1910	- Religious and civic charitable organizations primarily provide healthcare for the "deserving poor" through "poorhouses," - Health insurance plans first introduced, - Local government public welfare department first created in Kansas City, Missouri, - Goodwill Industries of America founded
1910- 1920	- Catholic Charities USA founded, - Children's Bureau Act enacted (creating separate federal child welfare agency), - United Way founded, - Flexner Report on US medical education published
1920-1930	- U.S. Veterans Bureau created (later becomes the Veterans Administration), - Bureau of Indian Affairs Health Division created (later becomes the Indian Health Service)
1930- 1940	- Social Security Act passed (bringing unemployment, income support, medical and public health programs under one umbrella for first time), - National Housing Act passed (creates public housing), - Aid to Families with Dependent Children created
1940-1950	- Hill Burton Act enacted, - National school lunch program created
1950- 1960	- Social Security disability insurance enacted, - Economic Opportunity Act enacted
1960-1970	- Medicare and Medicaid enacted, - Federal support of community health centers (CHCs) begins, - Food Stamp Act enacted, - National school breakfast program created, - Supplemental Security Income program begins
1970-1980	- Special Supplemental Food Program for Women, Infants, and Children (WIC) created, - Earned Income Tax Credit begins
1980-1990	- State Medicaid managed care begins, - National Health Care for the Homeless program begins, - Low-Income Home Energy Assistance program begins
1990-2000	- Temporary Assistance for Needy Families (TANF) replaces Aid to Families with Dependent Children, - Personal Responsibility and Work Opportunity Reconciliation Act enacted (welfare reform begins), - Children's Health Insurance Program (CHIP) created,
2000-2010	- Medicare Part D enacted
2010- present	- Affordable Care Act (ACA) and Medicaid expansion implemented

Note. Based on text material in National Association of Public Hospitals and Health Systems (2006), Swartz (2009), Fisher and Elnitsky (2012), Social Security Administration (2016), Virginia Commonwealth University (2011).

In further comparing the common elements between how the two systems have traditionally approached rendering services to low-income enrollees, clients, and patients at the front-line, both systems have the following features:

- Navigation: Led the most at-risk populations to models of self-navigation for seeking and enrolling in supportive social services despite the clear need for integrated guiding and direction, even when incorporating the case management services provided,
- Affordability: Offered no-cost and low-cost services in line with necessary out-of-pocket cost minimization for low-income populations,
- Intake/ Enrollment: Presented challenges in insurance coverage enrollment and social service referral and wait-list processes that present substantial barriers and disruptions to readily accessing such services and to remaining covered,
- Continuity: Lacked a lifespan view of the complex needs of vulnerable populations, and have not offered comprehensive delivery systems that may prevent some from becoming high-need, high-cost patients and clients,
- Privatization: Relied on some means of privatization of the administrative functions of core services (e.g., MCOs administering Medicaid services and privately operated electronic benefit transfer (EBT) systems).

At a more macro-level, an outcome of the contemporary history continues to be the relatively low level of national social welfare spending overall in the U.S., as compared to the 34 other Organization for Economic Cooperation and Development (OECD) nations worldwide (Bradley & Taylor, 2013; Bradley et al., 2016). In light of increasing rates of

both socio-economic inequality and health inequality in the country, such underspending is especially concerning in areas related to educational attainment, supportive housing, employment opportunities, and food security for the poor (Zheng, 2009). Bradley and Taylor (2013) noted the following in their watershed comparative global study on the "American paradox," which highlighted suboptimal U.S. spending on health and social services:

> On average in the OECD countries other than the US, for every dollar spent on health care, an additional two dollars was spent on social services. Yet in the US, for every dollar spent on healthcare, less than sixty cents was spent on social services. Most important, we found that less spending on social services relative to spending on health services was statistically associated with poorer health outcomes in key measures, such as infant mortality and life expectancy and this result held even when the US was removed from the analysis. (p. 17)

Thus, it is imperative to further examine the negative health effects of current national spending on the nonmedical social determinants (Adler et al., 2016; Bradley et al., 2011). The lack of funding for the U.S. social service safety net system has consequently compounded pressure on the Medicaid program, resulting in poorer health outcomes at higher costs (Bachrach et al., 2016). The health system's outcomes point to the uneven distribution of ill health, persistent health disparities for the most vulnerable, and the areas where there are Medicaid programs and services needed to address broader factors that influence health (Heiman & Artiga, 2015).

The current model of health and social service benefit design is built on separate funding, delivery, and coordination (or lack thereof) for low-income populations receiving

federal, state, and local government benefits, and community-based in-kind safety net benefits. This system is poorly integrated and there is a lack of blended, or even intersected, payment structures for federally funded programs that are similarly targeting low-income populations (see Figure 2). The tapestry of poorly connected, yet interrelated, safety net benefits includes, among others, Medicaid, the Children's Health Insurance Program (CHIP), the Special Supplemental Nutrition Assistance Program (SNAP), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Indeed, despite the complex needs faced by these populations spanning a number of social service areas, the separate delivery systems put forward to serve them are haphazardly linked and lack needed consistency and critical connections (Wilson, 2016). At both national administrative levels and local programmatic levels, centralized administration and comprehensive, formal linkages between the two sectors are lacking (Fisher & Elnitsky, 2012). Rosenbaum et al. (2017) notes that "system transformation, quality improvement and payment reform" are needed to enable coordination and alignment between Medicaid and other low-income assistance benefit programs. Wilson (2016) noted a pressing need for an overall national standard of care to treat the "condition of poverty," and that such a care standard necessitates "verifiable and accountable coordination among human services, healthcare, education, and government programs." Wilson further argued that by categorically treating poverty as a distinct condition, the unique challenges experienced by impoverished communities can be comprehensively addressed (Wilson, 2016).

Based on the national and state health reforms underway, including ACA and Medicaid waiver implementation, the policy window has widened to tilt the balance and

redefine the boundaries between social and human services, public health, and healthcare. This window of opportunity has the potential to remove structural level barriers presented by federal policies while improving access to available social services. It also offers the possibility of scaling lesser known disruptions and transformations that are centered on implementing interventions at the many other levels that change is needed. Various public health frameworks, for example, indicate that to truly impact the social determinants of health that adversely affect populations, there must be policy change made at the institutional, community, and household levels (Solar & Irwin, 2007). This notion holds true in the case of Medicaid populations, in that in order to improve the critical coordination and availability of wrap-around and supportive social services for these populations, change must be driven at all levels along the hierarchy of the provision of social services and healthcare services. In particular, a large focus should be placed closer to communities, at the state and local levels, where action is building to foster more coordination and integration.

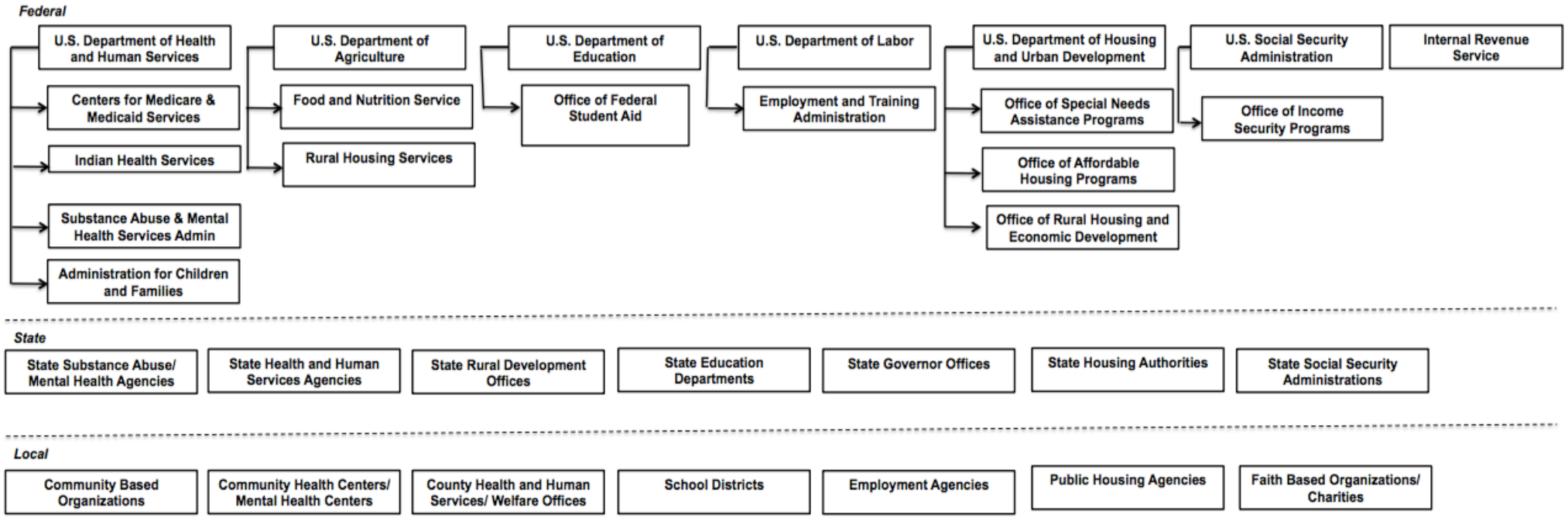

Figure 2. Administrative division of federal, state and local health and social services.

Rationale for Focusing on Medicaid Managed Care Organizations

Given the current U.S. healthcare landscape and growing penetration of risk-bearing managed care arrangements between states and healthcare payers, Medicaid managed care organizations (MCOs) in particular can play a critical role in social service integration. These entities are accountable for directly managing the costs and health outcomes of Medicaid populations, and are largely incentivized to and capable of addressing the bifurcation between health and social services that exists for Medicaid populations. They are now better positioned than ever to improve access to quality healthcare through amending their health plan offerings. Moreover, they can and have created innovative, community-based partnerships and interventions specifically targeting the upstream social determinants of health (SDoH) (Silow-Carroll & Rodin, 2013). In many ways, MCO interventions that have focused on the broader social determinants are being fostered as states are increasingly turning to managed care to leverage their Medicaid investments. To date, the vast majority of the 73 million Medicaid beneficiaries currently receive coverage from a Medicaid MCO, with 39 states opting to pursue a Medicaid MCO financial arrangement of some kind (Smith et al., 2016).

Under the Centers for Medicare & Medicaid Services (CMS) federal authorities allowing for state plan amendments and waivers, including Section 1932(a); Section 1915(a) and (b); and Section 1115 of the Social Security Act, over the last 34 years, Medicaid MCOs have gradually assumed increasing risk and responsibility for Medicaid populations. This evolution has been based on their contractual selection by state Medicaid agencies to directly provide key administrative services on the state's behalf. The specified contracted services include benefit structure, marketing, actuarial evaluation, network contracting and

assessment, claims adjudication and processing, medical management, and care management, and are tied to the upside and downside risk that Medicaid MCOs face (Mayzell, 2015).

In line with these outlined duties, Medicaid MCOs pay contracted healthcare providers directly, after being funded by states according to a per member per month (PMPM) basis. They are contractually obligated to meet the various needs of state Medicaid agencies while being incentivized to keep their membership healthy under these predetermined capitated payment structures. Correspondingly, the network of Medicaid MCOs across the United States varies based on organizational financial status (i.e., not-for-profit versus for-profit health plans), size (i.e., local versus multistate health plans), and scope (i.e., specialized health plans covering solely Medicaid populations, and those covering other insured populations). With respect to the expectation that they address Medicaid enrollee's core care coordination needs, a key requirement for state-based Medicaid MCO arrangements is centered on financing more effective, higher quality healthcare for Medicaid populations while achieving greater administrative efficiency, as compared to traditional fee-for-service Medicaid payment arrangements.

Consequently, MCOs have prioritized quality enhancing initiatives and the provision of care management services as they have acted as contracted intermediaries in reimbursing Medicaid providers and in experimenting with the design of insurance benefit packages (Smith et al., 2016). Out of this prioritization and the broader attention being placed on the social determinants of health at the global, national, and local levels, some MCOs have evolved to provide more of a focus on these determinants through the provision of wrap-around and supportive social services. They have shown that they are experienced in member intake and coordination, and continue to build core competencies that position them

well to alter member benefits and provider payments, and to robustly evaluate data in order to address the social determinants of health.

Weaknesses and Strengths of Medicaid MCOs

One weakness to the argument that Medicaid MCOs should adopt more responsibility for social services integration is that the literature on the results of Medicaid managed care financial performance and administrative efficiency is mixed (Caswell et al., 2015; Keast et al., 2016; Sparer, 2012). However, over time these payer types have increasingly been chosen to administer Medicaid programs by states and have moved to pay for noncovered services and supports on an exception basis in doing so. MCO services have expanded as several state Medicaid agencies have begun to direct MCOs to fund more nonmedical social service supports through patient-centered Medicaid homes (PCMH) and Medicaid accountable care organizations (ACOs). These efforts are similarly centered on shifting financial incentives through shared savings, global payments, and enhanced PMPM payment models that encourage the use of such services to bring down total costs of care. States have also directly pushed Medicaid MCOs to address the SDoH, with many states requiring MCOs to perform health needs and risk assessments. Twenty-six states specifically required or encouraged MCOs to "screen for social needs and provide referrals to other services" in fiscal year 2016, and four states reported an intention to do so in fiscal year 2017 (Smith et al., 2016).

When examining the breadth of options that state Medicaid agencies have taken to fund social service integration at more local levels for Medicaid populations, it can be noted that states have set out to find creative solutions to this challenge. They have offered social service care coordination payments, bundled payments, direct payments to social service entities, payments tied to social service metrics through shared savings or quality withholds,

and global community health budgets (Crawford & Houston, 2015). Indeed, the array of federally allowable health-promoting services, under CMS demonstration authorities and broader payment rules, have helped expand the scope of covered social services that can be offered through Medicaid. This policy change is occurring as state Medicaid directors collectively identified "improving population health and addressing the social determinants of health" as one of their overarching priorities for fiscal year 2016 and beyond (Smith et al., 2015).

And yet, at present, local MCOs face several barriers to expanding and streamlining their SDoH programs and services. Too often they lack adequate clarity and policy guidance from CMS and state Medicaid agencies on the scope of fully allowable and reimbursable SDoH services, given federal regulatory limits on Medicaid dollars being spent on nonclinical services (Centers for Medicare & Medicaid Services, 2017). Despite these challenges, they continue to adopt different strategies to implement new programs to meet the social service needs of their membership in providing "flexible" services. There is, however, variability in how closely or loosely coupled those services are to traditional health benefits across health plans. Gottlieb et al. (2017) noted the following from interviews with 52 Medicaid MCO senior leaders from across the country on their challenges and barriers experienced in creating innovative programs to address the social and economic needs of their members:

1. Variability in individual states' regulatory climates.
2. Absence of designated CMS and state funding mechanisms to support SDoH interventions.
3. Lack of convening and advocacy support from state Medicaid agencies.

4. Lack of evaluation of SDoH-related interventions.
5. Presence of state premium rate determination policies that exclude noncovered services and that potentially reduce health plan revenues in future periods.

CMMI Accountable Health Communities Model

These and other policy developments continue to affect the widening policy window that has emerged for MCOs in particular to address gaps in access to needed social services among Medicaid populations. One such notable development was the January 2016 announcement of the first federal demonstration program aimed at funding and evaluating social determinants of health interventions for Medicaid and Medicare beneficiaries (Centers for Medicare & Medicaid Services, 2016c). Under the CMS Center for Medicare and Medicaid Innovation (CMMI), authorized and appropriated by Section 3021 of the ACA, CMS introduced the accountable health communities (AHC) model with the goal to determine whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts health care quality, utilization, and costs in addition to beneficiary and provider experiences.

This model, if found to be successful among the 44 national grant awardees to be announced in 2017, has the potential to transform the long-term financial viability and national scaling of this work through a federal investment of over $157 million. Gottlieb et al. (2016b) predict that "if expanded by complementary and synergistic research, [the model has] the potential to transition previously scattered and understudied programs to address SDH into sustainable key components of the health care delivery system." Once the evaluated results are assessed, the CMMI AHC model will be considered a prototype for "bridge organizations" across the United States that are seeking to systematically address the

social determinants for vulnerable populations. CMMI broadly defines bridge organizations as entities that have "the capacity to develop and maintain relationships with clinical delivery sites and community service providers." The center will allow the following types of entities to act as bridge organizations: community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit or non-for-profit local and national entities (Centers for Medicare & Medicaid Services, 2016c).

Furthermore, it will likely set a national precedent around incorporating the following model attributes that are detailed in the model's Funding Opportunity Announcement requirements: (a) systematic screening for social needs; (b) tailored, streamlined referral and navigation services provided by community health workers (CHWs); (c) community-level partner organization alignment; and (d) continuous quality improvement and gap analysis (Centers for Medicare & Medicaid Services, 2016c). Though CMS grant funds cannot pay directly for the provision of social services, in line with current CMS regulation, they will fund "systems change interventions" that aim to connect Medicare and Medicaid beneficiaries to needed social services. The CMMI model creates a significant potential opportunity to involve Medicaid managed care organizations in better addressing the health-related social needs of Medicaid populations. Many Medicaid MCOs will likely be incentivized to evolve to serve as bridge organizations within the communities that they serve if this model is proven successful in the eyes of CMS and state Medicaid agencies. Overall, the AHC demonstration program reflects a "growing emphasis on population health in CMS payment policy" (Alley et al., 2016). It also serves as a signal for where CMS social service integration funding may be going, though the role of bridge organizations, at times

also known as “backbone,” “macro-integrator,” or “quarterback” organizations, is not a new concept in US healthcare delivery (McCarthy & Klein, 2010).

Social Service Integration Opportunities Moving Forward for Medicaid MCOs

Some healthcare and social services actors alike might doubt the intentions and capabilities of Medicaid MCOs as they seek greater involvement in the coordination and management of social services delivery. However, their interest in the financial returns associated with continued membership growth and positive market positioning in increasingly competitive state contract bidding environments can serve as an accelerant to their action. Both factors are likely to affect MCOs’ speed-to-market to implement and evaluate sound SDoH interventions in years to come. Accenture (2016) estimated that more than $5.6 billion in Medicaid dollars are currently being spent on “community-based” investments for the Medicaid managed care population, including Navigator programs, community health worker services, high-utilizer “frequent-flyer” programs, transitional care services, provider-community collaborations, community services, and community-based directories. And, given their interest in offering cost-effective healthcare coordination, Medicaid MCOs have found it necessary to build integrated approaches that involve state governments, healthcare providers, communities, and care recipients (HHS, 2015). As MCOs consider the ultimate social and financial value proposition of this involvement in the long-term, they will likely weigh the following factors: federal and state political receptivity, administrative feasibility, and the collective evidence behind previous social services innovations implemented at the Medicaid MCO level.

Doctoral Engagement in Leadership and Translation for Action (DELTA) Project Strategy

In line with the previously defined background and context, following is a detailed description of the DELTA project strategy that I carried out (see Table 2):

Aims/ Hypotheses

Overall, the thesis project aimed to uncover and inform the following:

1. The extent to which Medicaid managed care organizations in recent years have approached integrating the healthcare coverage and access needs of Medicaid populations, and their access to other social services influencing their health status, including their housing, transportation, employment, education, financial stability, and other needs.
2. The varying type, intensity, and outcomes of such approaches, based on their overall levels of resource, effort, and formal partnership at the organizational, local, state, and national level.
3. A set of emerging practices based on the collective evidence of previously implemented interventions' success, and an analysis of gaps in the published literature and current practice that can inform future action among MCOs.

Table 2. DELTA Project Strategy Work Plan

Inputs	Activities	Outputs	Outcomes (short-term)	Impact (long-term)
Systematic review protocol/search strategy Formal advisement from DELTA project committee and host organization supervisor Informal, background interviews with healthcare and public health experts	Conduct systematic review and analysis (September 2016 - January 2017) Immersion into role at host organization, Medicaid MCO (July 2016-March 2017) Hold informal, background interviews with healthcare and public health experts (September 2016-January 2017)	Comparative analysis of current and past Medicaid MCO SDoH interventions' operational models and outcomes achieved according to the Triple Aim (Berwick et al., 2008)	Deeper understanding of emerging practices and gaps in the published literature on Medicaid MCO SDoH interventions' operational models and outcomes achieved according to the Triple Aim (Berwick et al., 2008)	Translation and application of core learnings from emerging practices and gaps in the published literature to real-time, field-based implementation, evaluation and scaling of local MCO SDoH pilots and tests

The central hypotheses on the outcomes of the thesis project were that there would be vast differences in the number, types, and collective knowledge of social determinants of health programs and services offered to Medicaid populations in settings across the country based on variability in the following:

1. Preexisting levels of partnership and alignment (e.g., close versus disparate integration) among social service agencies/programs, Medicaid providers and plans, and other relevant cross-sector stakeholders.

2. Combinations of infrastructural and workforce inputs, including integrative data systems, community health workers, healthcare providers, and social service professionals.
3. Differing payment models, funding sources, and structures.
4. Plan-level factors (e.g., executive leadership's interest, and organizational history and commitment to SDoH, community health, health equity, etc.).
5. Terms of state contractual agreements governing MCO functions.

In conducting the systematic literature review, relevant papers from academic peer-reviewed publications and grey literature were sourced from the following public health, health policy, healthcare trade group, and government sources (see Table 3) in accordance with the predetermined search strategy framework (see Exhibit 1):

Table 3. Systematic Literature Review Sources

Grey literature sources	Academic literature sources
Academy Health	PubMed/ MEDLINE
Accenture	Lexis Nexis Academic
America's Health Insurance Plans	Google Scholar
American Public Health Association	
Alliance of Community Health Plans	
Association for Community Affiliated Health Plans	
Center for Healthcare Strategies	
Commonwealth Foundation	
Deloitte	
Families USA	
Google web	
Grey Literature Report	
Institute for Healthcare Improvement	
Institute for Alternative Futures	
Institute for Medicaid Innovation	
Kaiser Family Foundation	
Manatt Health Solutions	
Mathematica	
Medicaid Health Plans of America	
Milbank Fund	
National Academy for State Health Policy	
National Association of Medicaid Directors	
ReThink Health	
Robert Wood Johnson Foundation	
The Advisory Board	
U.S. Department of Health and Human Services, Agency for Healthcare Research & Quality Innovations Exchange	
U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation	

Inclusion Criteria

Papers that included key search terms in their titles, abstracts, or descriptions and that met the following inclusion criteria were retrieved and included for full text review:

- *Date of paper publication:* January 1996–December 2016

- *Type of papers:* Any peer reviewed journal articles; government documents; think tank and industry publications; white papers; reports; working papers; briefings; case studies; annual reports, press releases, and so forth.
- *Type of data:* Qualitative and quantitative.
- *Language:* English.
- *Population:* Medicaid managed care beneficiaries.

Exclusion Criteria

Papers were excluded from review if they did not address interventions involving Medicaid managed care organizations or the Medicaid managed care population. Additionally, literature was excluded that described (a) programs led by entities other than Medicaid MCOs, and (b) programs and activities that were not substantive.

Analysis

After applying these strict criteria, 68 MCO-led interventions were uncovered. The majority of the sources reviewed for inclusion were not found in the scholarly literature; the grey literature provided more sources of central importance. Relevance was ultimately determined based on descriptions made of the Medicaid MCO programs and interventions.

I aimed to conduct content analysis on all papers and publications reviewed, with a focus on high-level abstraction. When possible, I critically evaluated the overall strength of the research design and assessed the findings associated with each paper reviewed. A narrative synthesis was then produced based on the detailed description of the interventions discussed within the literature.

In addition, I applied an industry-informed lens to my DELTA thesis analysis based on the following:

1. Conducting informal informational interviews with relevant managed care, delivery system reform, health policy, and public health leaders from across the United States to inform my framing (see Exhibit 2).
2. Reflecting on my experience of first person observation during my professional immersion at a large Medicaid MCO endeavoring to launch new SDoH programs in cities across the country. The immersion experience included:
    - completing organizational orientation and training, and a series of meetings with executive leadership regarding the MCO's state and national operations, mission, vision, values, culture, and approach to social services integration;
    - holding "ride-along" and shadow sessions with in-field social workers and community health workers leading outreach to particularly vulnerable health plan members;
    - applying the CMMI AHC model attributes to new MCO program launches, including the model's staffing, navigation outreach, technology, data sharing, evaluation, and community partnership requirements;
    - studying the vast literature on SDoH, Medicaid delivery system reform, and Medicaid managed care;
    - working closely with the MCO's governmental policy and external affairs leaders;
    - developing and leading a steering committee of the MCO's SDoH innovation team; and

- co-leading the design of a research study aimed at robustly measuring the outcomes of the MCO's SDoH programs.

Statement of Results

Approaches Taken by Medicaid MCOs

In my DELTA thesis project I synthesized various dimensions of MCO-led SDoH interventions based on my seeking evidence from the literature and applying my practice-based field knowledge. I assessed the interventions to understand their design and implementation features, and what accommodations, partnerships, policies, and funding streams are being used currently or are needed to take these efforts further. At the highest level, my overall findings were that (a) over the last 2 decades momentum has been building; and (b) in order to develop deeper success in improving the quality of life for underserved Medicaid populations, a clear framework for funding, designing, implementing, and evaluating innovations at the health plan level is critical. Findings from the analysis further indicate that a breadth of approaches have been taken by health plans to address the socioeconomic challenges faced by Medicaid populations in recent years.

Relying on the academic and grey literature uncovered in the public domain and a 9-month field based professional experience within an MCO, I found a total of 68 interventions (see Exhibit 3). The interventions were then analyzed according to the following 12 attributes:

1. MCO type (i.e., overall membership size, geographic reach, and corporation status of the health plan).
2. Geographic location (i.e., city, county, or state of intervention implementation).
3. Launch timing (i.e., year and/or month of intervention implementation).

4. Funding source and arrangement (i.e., basis of the most direct funding source for the intervention and method of payments made to and from entities involved).
5. Partner organizations and partnership structure (i.e., named partners involved and the partnership model employed to implement the intervention).
6. Intervention model (i.e., specific settings and activities related to the intervention).
7. Targeted population (i.e., segmented membership groups of interest for the intervention).
8. SDoH domains addressed (i.e., types of social services attended to in the intervention).
9. Workforce composition (i.e., staff employed to deliver the intervention).
10. Measures of success (i.e., outcomes sought by implementing the intervention).
11. Outcomes achieved (i.e., results the intervention produced).
12. Integration level (i.e., intensity of services offered through the intervention).

MCO types, intervention locations, and timing. The resulting analyses indicated that the types of Medicaid MCOs that have been involved in leading SDoH interventions over the last 20 years do not follow a clear discernable pattern, and have ranged from large, multistate, for-profit Medicaid health plans to relatively small, county-based, not-for-profit Medicaid health plans. The interventions that I uncovered have been scattered and launched in urban and rural locations across the United States in various periods from 1996–2016. Although several dozen interventions were found in locales spanning the country, this

analysis only included a subset of the 290 Medicaid MCOs operating in cities, counties, and states across the country (see Figure 3).

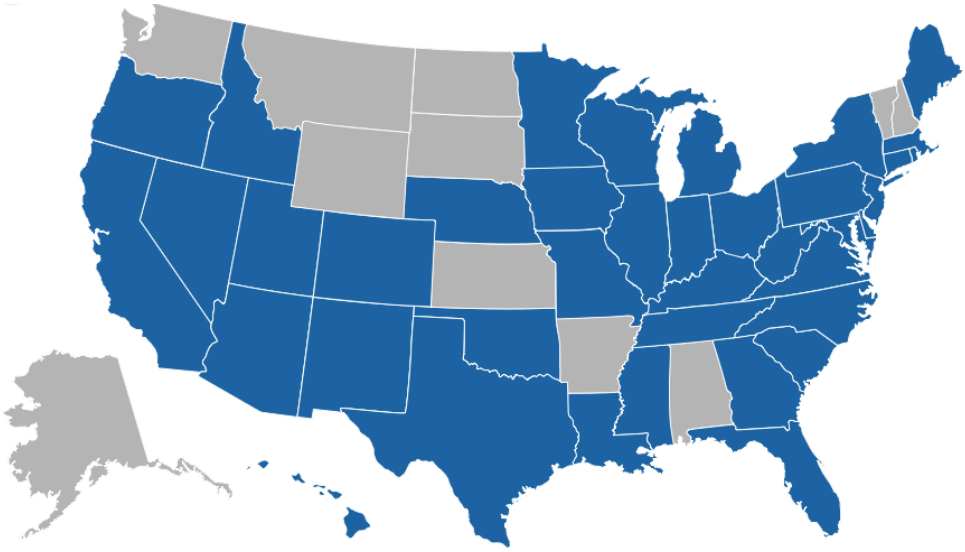

Figure 3. Geographic distribution of Medicaid MCO interventions

Note. Blue states indicate that one or more interventions were found in that state.

Furthermore, while some programs are beginning to permeate the once hard and fixed boundaries between social services and healthcare services, others are testing and exploring the long-term sustainability of putting forward new SDoH interventions to create optimal synergies for Medicaid members. Several health plans appear to be advancing sustainable offerings in this space, while others are just getting started. For example, the earliest launched intervention that was uncovered was the "Social Care Management" program that has been offered since 1998 to all newly covered Medicaid members by the Neighborhood Health Plan (2017), a not-for-profit plan based in Massachusetts. This program continues to date in addressing the following needs of screened members: financial services, housing, health behaviors, food, utilities, transportation, family and social support, and clothing support.

Funding sources and arrangements. Some interventions represent substantial financial investments by the health plans, while a select few were funded by the government (e.g., CMS Innovation Center) or private foundations. Detailed funding descriptions were noticeably lacking (see Table 4). Without better understanding of the interventions' financing mechanisms and sources, it is difficult to know where exactly intervention funding came from and how it was disbursed among health and social services providers involved in the interventions. There is still much to be learned about how Medicaid MCOs are approaching financing these types of initiatives, as many services are deemed "non-billable," "non-encounterable," and "non-covered" services as currently regulated by CMS and state Medicaid agencies.

Table 4. Funding Sources Used for Medicaid MCO Interventions

Funding source	Number of interventions
Health Plan	60
Private Foundations (e.g., through the Annie E. Casey Foundation, Duke Endowment, Bill & Melinda Gates Foundation, etc.)	8
CMS (e.g., through CMMI grant awards and other CMS demonstration programs)	6
State and Local Government Agencies (e.g., through state government entities other than state Medicaid agencies such as the departments of child services, public health departments, etc.)	2

Note. Several interventions were financed by more than one entity.

Partner organizations, structure, and intervention models. The majority of interventions that I uncovered were associated with a broad range of named partners, though the exact terms of their partnership structures and relationships are largely unknown. Common partners included federally qualified health centers (FQHCs) and other clinical providers, and local and state government entities spanning social services, family and child services, and behavioral health services. Many different nonprofit social services agencies operating at the local level were chosen by health plans as viable partners (see Table 5). However, there is still much to understand regarding the most effective modes of collaboration, contracting, and governance between health plans and their community-based partner organizations. The majority of health plans operated as "bridge" organizations, and they employed various forms of partner selection and methods for insourcing and outsourcing referrals and service requests among partners. Several interventions used internal and external community resource directories and databases to help facilitate member referrals to social service partners.

Table 5. Partners Associated with Medicaid MCO Interventions

Partner type	Number of interventions
Nonprofit Community Based Organizations (e.g. Goodwill, shelters, food banks, YMCA, United Way, faith based organizations, etc.)	30
State and Local Government Agencies (e.g. housing authorities, transportation authorities, public health departments, Sheriff's offices, etc.)	21
FQHCs and other Clinical Providers (e.g. behavioral health centers, hospitals, rehabilitation centers, nursing facilities, etc.)	20
Unknown	20
For-Profit Companies (e.g., wireless phone service providers, grocery stores, financial services companies, etc.)	5
Primary and Secondary Schools	4
Universities	2
None	2

Note. Nearly all interventions involved multiple types of partners.

Interventions that have been led by Medicaid MCOs, with the assistance of their selected partners, have taken various approaches to engaging managed care populations across multiple settings (see Figure 4). They have also been centered on a diverse set of activities and models across those settings.

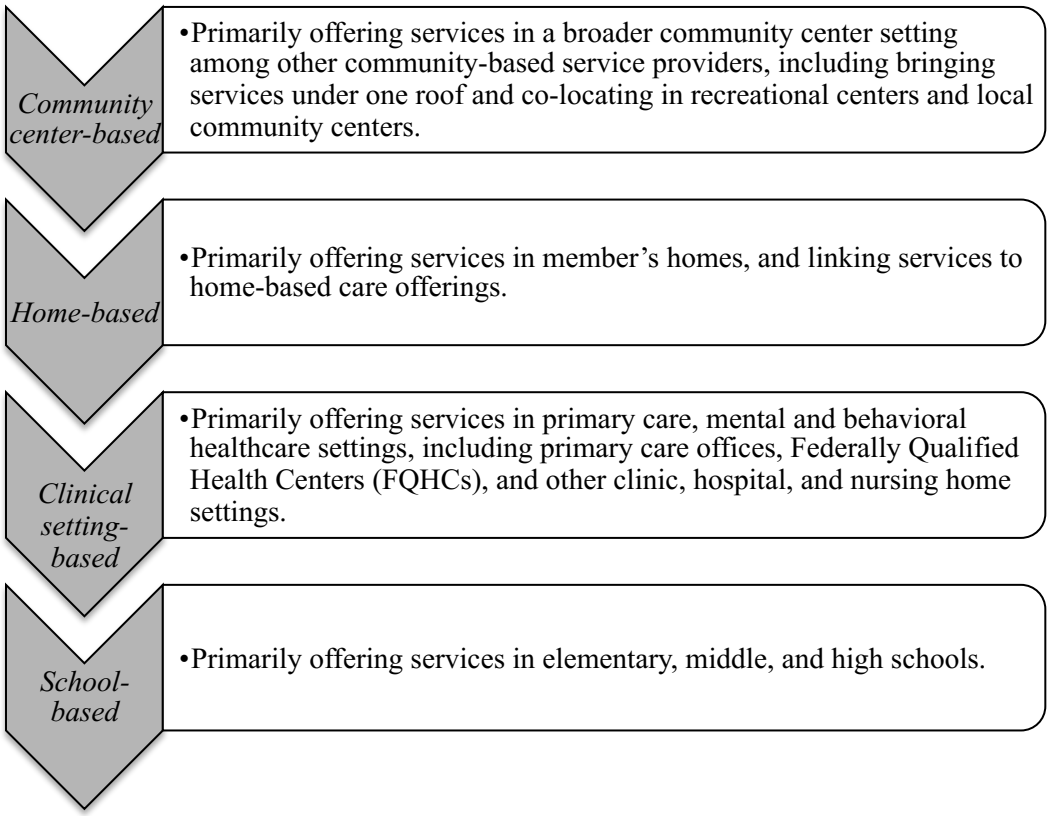

Figure 4. Settings of Medicaid MCO interventions.

Targeted populations. The Medicaid MCO interventions appeared to target populations they considered to be the most complex, highest risk, or highest cost when taking into account healthcare expenditures and utilization and overall social vulnerability. Though classified in various ways that are difficult to precisely quantify, targeted member groups included the following:

1. Members living with multiple chronic disease co-morbidities and/or serious mental illness.
2. Youth in foster care.
3. Homeless members.
4. Members discharged from acute inpatient settings.

5. Members living with physical disabilities.
6. Members with histories of frequent, yet avoidable, hospitalizations, and readmissions.
7. Pregnant members.
8. Newborns with serious health conditions.
9. Members with substance use disorders.
10. Members lacking a high school diploma.
11. Members dually enrolled in Medicaid and Medicare coverage, for example.

Several MCOs routinely screened newly enrolled members for social needs as part of their standard intake processes. Others elected to assess the needs of certain higher need segments of their membership according to analyses of member claims and other health record data (e.g., manual review, geo-mapping, and "hot-spotting"). Still, many of the populations of interest were especially fragile, hard-to-reach, and in need of assistance with multiple health-related social services.

Domains addressed. In all, the collective set of MCO-led interventions that were found addressed more than 18 broad SDoH domains (see Table 6).

Table 6. SDoH Domains Addressed by Medicaid MCO Interventions

Domain	Number of Interventions
Housing	31
Food	29
Family/ social supports	26
Health behaviors	23
Clinical services	19
Transportation	19
Utilities	15
Education	14
Employment	12
Mental health services	11
Financial services	10
Clothing	6
Home remediation/repairs	6
Child care	3
Interpersonal violence	3
Legal services	3
Substance abuse services	2
Juvenile justice	1

Note. Nearly all interventions addressed more than one health-related social need.

In defining the scope of each SDoH domain, I aimed to be as specific as possible in parsing out the services rendered to health plan members. For example, “home remediation

and home repairs" were distinguished from "housing" services. The housing category strictly included the offering of physical housing and shelter units and housing counseling services, while home remediation and repairs included services associated with improving housing quality.

Specific Medicaid MCO activities included:

1. Leasing housing units to homeless members.
2. Providing members with mobile phones and monthly phone call and text message service plans.
3. Locating and identifying homeless members.
4. Offering employment at the health plan to unemployed members.
5. Providing members with graduate and undergraduate scholarships.
6. Embedding staff within member's clinical and behavioral provider settings and in hospital emergency departments.
7. Referring and connecting members to a broad range of health and social services and appointments.
8. Providing members with a multidisciplinary care coordination team.
9. Providing members with one-on-one life coaches.
10. Conducting home visits.
11. Operating community centers in neighborhoods where members live.
12. Developing coordinated care plans across the member's health and social needs.

13. Paying for members lacking high school diplomas to complete General Educational Development (GED) exams and the High School Equivalency Test (HiSET).
14. Sponsoring food banks and farmer's markets and offering food vouchers and grocery shopping assistance to members.
15. Hosting book clubs for members.
16. Holding peer-support groups for members.
17. Offering members small cash grants for personal items, for example.

Workforce composition. I examined the staff who were employed by the health plans and their selected partners to implement the interventions. Nearly all interventions included multidisciplinary teams of professional and lay staff. Common staff roles included community health workers, social workers, registered nurses, care coordinators, case managers, behavioral health specialists, and patient navigators.

Integration levels. I examined the interventions' overall integration level to understand whether there were low, moderate or high-level "touches" made as part of the interventions (see Table 7). The vast majority of interventions were "low touch," meaning that they focused on one or more avenues of providing basic access to (a) referrals to internal and external sources, (b) care coordination services, and (c) system navigation services. A small number of interventions were categorized as "moderate touch" in that they endeavored to be more sophisticated in their approach to provide expanded teams of service providers and to offer integrated care delivery processes. Few interventions were deemed "high touch," in aiming to redesign and ultimately create new entities to carry out the integrated services needed, as first noted by Crawford and Houston (2015a).

Table 7. Integration Level of Medicaid MCO Interventions

Integration level	Number of interventions
Low touch	41
Moderate touch	20
High touch	7

Measures of success. In accordance with this broad reach of social service domains and health and social service-focused staff, the interventions uncovered can be roughly categorized into three broad measures of success:

1. Improved health and social service care coordination.
2. Lowered healthcare utilization and costs.
3. Increased access to needed health and social services.

The overarching goals of these interventions appear to be harmonious with and to draw on the Triple Aim goals of reducing costs, improving care, and improving health—a key hypothesis that was presented before beginning both the systematic literature review and the 9-month professional immersion. Several intervention descriptions lacked measures of success. Thus, the long- and short-term outcomes sought by those MCOs are unknown.

Outcomes achieved. Robust, formal evaluation of intervention outcomes and overall efficacy and efficiency targets being met was also minimally described. Sixty-nine percent of the interventions (n=47), had outcomes data included in their descriptions, though detailing of rigorous program evaluation was rare. This factor made it especially difficult to gauge the comparative improvement of health and/ or the resulting impact on cost-avoidance that the interventions were associated with. It can be assumed, however, that given the need for

financial solvency, the ultimate impact on the health plan's bottom line and financial return-on-investment were considered in launching the initiatives to begin with.

Overall, the lack of outcomes data presented was a major gap in the systematic analysis. Of note, the majority of interventions were found via grey literature sources and not from scholarly academic, peer-reviewed literature sources. By definition, these grey literature sources tended to have a different scope of focus, audience, and purpose as compared to peer-reviewed publications that are reliant on empirical research.

Emerging Practices

To apply my core DELTA project learning to practice, I identified a set of emerging practices that are both experience-based and literature informed and that aim to frame useful approaches that Medicaid health plans can adopt and apply to new and ongoing implementation and thinking in this space. Although many practices offered are practical and straightforward, they are focused on distilling the critically important factors for supplying much-needed social supports to Medicaid managed care populations that I have observed and analyzed. The original goal of the literature review was to extract promising practices based on the interventions uncovered, relying on the strict typology used to classify public health interventions by level of scientific evidence developed by Brownson et al. (2009). However, based on my review I came to understand that nearly all of the interventions and their associated evaluative approaches could only speak to emerging practices, and not promising ones. (see Table 8). This realization is important, as Medicaid MCOs are likely most interested in guidance on evidence-based and effective interventions as they proceed to build

out their services and programs in this space, though interventions meeting this rigorous threshold appear to be lacking.

Table 8. Typology for Classifying Public Heath Interventions

Category	How established	Considerations for the level of scientific evidence	Data source examples
Evidence-based	Peer review via systematic or narrative review	-Based on study design and execution - External validity - Potential side benefits or harms - Costs and cost-effectiveness	- *Community Guide* - Cochrane reviews - Narrative reviews based on published literature
Effective	Peer review	-Based on study design and execution - External validity - Potential side benefits or harms - Costs and cost-effectiveness	- Articles published in the scientific literature -Research tested intervention programs -Technical reports with peer review
Promising	Written program evaluation without formal peer review	-Summative evidence of effectiveness -Formative evaluation data - Theory- consistent, plausible, potentially high-reach, low-cost, replicable	- State or federal government reports - Conference presentations
Emerging	Ongoing work, practice-based summaries, or evaluation works in progress	-Formative evaluation data - Theory- consistent, plausible, potentially high-reach, low-cost, replicable - Face validity	-Evaluability assessments -Pilot studies - NIH CRISP database - Projects funded by health foundations

Note. Based on Brownson et al. (2009)

At the highest level, the emerging practices that I have identified are framed by decisions about the following key program dimensions that Medicaid MCOs must choose:

1. Targeted Medicaid populations (*who and where?*).
2. SDoH domain scope (*what and why?).*
3. Time investment (*when and for how long?*).
4. Intervention workforces, data systems, and processes (*in what way*?).
5. Governance/ partnership structures and evaluation plans (*how?*).

Based on my understanding of these core distinguishing elements, the following six emerging practices and three gaps in current literature and practice have surfaced. They are each based on my DELTA thesis research and analysis, and by my professional field immersion. They are intended to inform future practice among MCOs.

1. **Committing to the time span required.** Given the time that it takes to develop and implement robust community-based interventions and based on how hard it might be to address local contexts while "treating poverty" (Wilson, 2016), devoting enough time to implementing and evaluating these interventions is critically important. For Medicaid MCOs to deliver high-touch and even low-touch services effectively, they must understand the particular community-level needs, the social services partners that exist in communities, and broader community dynamics (e.g., assets, mistrust, transparency, etc.). They must also recognize the complexities of intergenerational cycles of poverty and the broader culture of poverty that might affect the Medicaid populations covered by their health plans. In doing so, MCOs should consider balancing being time bound with allowing enough time to lapse before evaluating intervention outcomes and considering the intervention a success or failure.

   For example, the CeltiCare Health Plan of Massachusetts noted that the creation of its "Opioids 360" program in 2014 was a "long-term investment in members" and that they focused on building "trust and respect between [health plan] staff and members." The program is focused on helping members overcome and recover from opioid addiction through "expanding access to community-based services by creating housing-first and peer-support initiatives,

and expanding the availability of critically valuable services beyond state-sponsored efforts" (Institute for Medicaid Innovation, 2016). The program also included offering overdose rescue training to the significant others of the targeted members.

Another example of this approach is the CHW care coordination program created by the Empire Blue Cross Blue Shield HealthPlus plan in 2015. The program aimed to help "hard-to-reach" members with their management of chronic health conditions, including asthma, diabetes, hypertension, and chronic heart failure and with gaining connections to local social service supports. It was created after the health plan conducted geo-mapping of where best to place CHWs in the community and after the health plan established that traditional methods of care coordination and telephonic outreach were ineffective for the plan's highest risk members. The program was similarly focused on "engaging members by building a relationship and maintaining trust" (Institute for Medicaid Innovation, 2016).

2. **Building more integrative data systems.** Such data systems allow for the widespread collection and tracking of SDoH needs, eligibility information, claims and referral-based data, and for the culmination of data sharing among various providers and sectors. In the era of "big data" in healthcare, Medicaid MCOs are beginning to use more integrative data systems to centralize and share data and to paint more holistic pictures of the interrelated health and social services needs of their members. Some are using these systems to create personalized, coordinated care plans that span sectors and provider types. For

example, the Hennepin Health model launched in 2012 required an initial investment of approximately $1.6 million to “fund expanded staffing and data infrastructure" for the new model of care. Data analytics professionals of various backgrounds are considered core staff members and “ serve as a bridge between the technical world of data and the operational world of providing health care, sorting through complexities in the data, putting data together, and looking for patterns to help improve the care process” (Sandberg et al., 2014).

3. **Developing strong cross-functional, multidisciplinary teams.** Medicaid MCOs are increasingly focused on hiring professional and lay workforces that include teams of physicians, nurses, community health workers, navigators, *promotoras de salud*, registered nurses, health coaches, and licensed clinical social workers (LCSWs). These teams often function as community care teams. Community health workers, who are in higher demand than ever, were at the center of many of the SDoH interventions found, and they were employed to act as central care coordinators and connectors, with titles ranging from care coordinators to navigators to care managers and care connectors.

Several MCOs are venturing to create new roles and responsibilities for the staff that function as community care teams. These staff are tasked with assisting their highest need members who may be difficult to reach and remain in touch with and who may face extreme difficulty with remaining compliant with care plans, service referrals, and appointment schedules. In fostering care team support redesign, some health plans have created new staff outreach and navigation trainings, workflows and pathways for the newly structured teams.

For example, the AmeriHealth Caritas health plan uses community care connectors who are:

> Familiar with the local resources and can interact well with members, these connectors are knowledgeable about locally available social services, share language and life experiences of the members served, and help members sort through complex and competing needs, many of which are not just medical. Community care connectors are provided internal training on care coordination and health-related competencies and also work closely with the care coordinator to ensure that the member is getting the services he/she needs (Department of Health and Human Services, 2015).

4. **Determining the most strategic multisectorial and interorganizational governance and partnership models.** Medicaid MCOs have begun establishing various partnership structures to support the collective goals of the interventions identified, and many are acting as bridge organizations. Health plans are continually identifying and targeting appropriate social service partners to connect and collaborate with who operate at the national (for large, multistate health plans), state, and local levels. Plans will increasingly need to describe and define partnership expectations, accountability measures, methods of mutual support, and resource and data sharing agreements, along with other administrative items, with selected partners. In outlining terms of partnership, some may be relying on contracts and memorandums of understanding (MOUs) across partner entities and providers. Others might be utilizing business

associate agreements or other more formal forms of affiliation agreements. As such, Medicaid MCOs must find providers and programs that represent unconventional partnerships and that allow Medicaid MCOs to truly integrate social services as needed. In the case of the San Mateo Health Plan "Community Care Settings" pilot program launched in April 2014, the health plan solicited and selected partners through a formal request for proposal (RFP) process that allowed them to cast a wide net to attract the attention of community-based organizations and leaders.

5. **Establishing very clear intervention domains among the many social determinants of health that can be addressed.** Based on the needs of their targeted members, Medicaid MCOs have sought to address various combinations of social determinants and health-related social needs. They have accomplished this by determining common gaps in care and the social needs most closely linked to those gaps in care. They have identified these needs based on various forms of member and community-level data, including community health needs assessments, Healthcare Effectiveness Data and Information Set (HEDIS) measures, self reported Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, health plan claims, and other population health data. Health plans must also decide which social domains are most addressable and in which Medicaid populations, and whether they will direct their attention and resources to one single need or to a collective set of needs present in members' lives.

For example, the Amerigroup Coaching And Comprehensive Health Supports (COACHES) program, launched in 2014, aims to address the comprehensive set of needs that high-risk foster youth may be facing as they transition into adulthood. The COACHES program combines three different programs into one, to be a "one stop shop" resource for foster youth while "integrating behavioral and physical health needs, incorporating trauma-informed care, and providing peer support (Institute for Medicaid Innovation, 2016). Conversely, since 2013 the Molina Health Plan of Utah has opted to solely focus their efforts on providing free cell phones and mobile health services to members lacking such channels of communication (Voxiva, 2013). The mobile phones offered allow the members to make free phone calls to the health plan's member services department.

6. **Developing deep partnerships with state Medicaid agencies.** Medicaid agencies have a critical role in overseeing and regulating Medicaid programs at the state level. Thus, Medicaid MCOs are seeking the political and administrative support of these government entities as they develop and grow new social determinants-based programs. The Molina Health Plan of New Mexico, for example, negotiated with the New Mexico Medical Assistance Division, the state Medicaid agency, in 2005 to create a billing code for their CHW navigation program to directly reimburse CHWs who were deemed "Client Support Assistants" (Johnson et al., 2012). The Hennepin Health model is also another example of this approach as the state Medicaid agency has been elevated as one of the state and county government entities that directs and

coordinates the model's operations, in addition to the Minneapolis Public Housing Authority, the Hennepin County Department of Community Corrections, the Hennepin County Sheriff's Office, and the Hennepin County Human Services and Public Health Department (Sandberg et al., 2014).

Gaps in Current Practice

1. **Promoting population health improvement and health equity.** As Medicaid MCOs move to expand their action in the SDoH space, they must expressly operationalize the tenets of population health and health equity. Though it can be surmised that advancing these two key areas are a possible foundational premise of Medicaid MCO social service efforts, for many health plans they may not be. In those cases, they cannot simply be viewed as a bonus outcome and must be intentionally focused on, as addressing the health inequities present within the U.S. health system is becoming more of a national priority. In seeking to advance health equity among racial and ethnic minority Medicaid populations, in particular, health plans must demonstrate an understanding of the diverse cultural and linguistic needs of Medicaid populations so as not to direct funding to ineffective services and staff. They must also create teams that are multicultural and multilingual. Furthermore, in responding to the social needs of Medicaid populations, population health improvement must be a priority within the new services and systems of care put forward in order to truly be inclusive of the social determinants of health.
2. **Planning robust evaluation strategies and incorporating quality improvement strategies.** It is evident that without more intentional focus on

objective evaluation and quality improvement, many Medicaid MCOs risk failing at what it takes to be successful in integrating social services for Medicaid populations. In this failure to rigorously assess the observable outcomes achieved and the resulting opportunities for strengthening intervention components, MCOs risk scaling and overly investing in ineffectual interventions and models that can lead the health system further away from better addressing the social determinants of health. Clear definitions and frameworks for isolating the effects of various program inputs should be put forward, along with implementation strategies that adapt and improve the overall quality of services and programs provided based on data collected and analyzed on members' health status, use of services, and so forth.

3. **Building learning systems to share success and developments across health plans.** There appears to be a lack of purposeful design of learning systems and learning collaboratives that allow Medicaid MCOs and the network of other related social services and healthcare actors to share and learn of successes and failures in this space. Medicaid MCO associations, such as the Association for Community Affiliated Health Plans (ACAP) and the Medicaid Health Plans of America, could likely play a major role in filling this gap. If established, such systems might serve as a means of offering critical mutual awareness and support among like-minded partners and even competitors, which can lead to the creation of more sustainable social service programs and services for Medicaid managed care populations. The proprietary nature of emerging innovations created by MCOs will likely have large implications for how widely

the interventions and their evaluated outcomes are made known publicly, and will have to be considered.

Conclusion

Broad Implications of This Work for Medicaid MCOs

Overall, there appears to be no single Medicaid MCO leader in the SDoH space, nor best practices for specific targeted populations and intervention models. However, intervention launches appear to have ramped up in recent years, and preliminary results of new and existing models may soon emerge, as the majority of initiatives identified appeared to be operating at smaller, pilot-like scales. Whether focused on the health-related social needs of foster youth with complex needs or Medicaid populations facing chronic homelessness, the most common social needs addressed by Medicaid MCOs appear to be homelessness, food insecurity, and family and social supports, which are reflective of the gaps in access to material needs that many Medicaid populations experience and that have been identified as causally important for health. On the whole, my research indicates that the Medicaid health plans that have entered into this space are demonstrating cautious experimentation in addressing the complex social needs present among their members. A subset of plans noted that they view expanded social services as a means of fostering self-sufficiency and stability and improving the quality of life of their members. The vast majority of interventions uncovered, however, only serve relatively small numbers of the health plan's total covered membership and have not yet moved to robustly monitor SDoH measures and outcomes in the long-term.

As I have further reflected on where state and federal Medicaid delivery reform and managed care policy is going, the uncertainty is abundant, though the dramatic overhaul of Medicaid that has been initially proposed legislatively does not appear to be imminent. However, as Governors and state Medicaid directors across the United States continue to consider reforming their financing and coverage mechanisms under new national leadership, they will be confronted with how best to restructure their Medicaid MCO contractual arrangements. This period of change is both an opportunity and a challenge for Medicaid MCOs. The new state and federal political climate may result in a push for maintaining the momentum of previous reform efforts, such as the ACA's Medicaid expansion provision, or it may move state Medicaid agencies further away from the gains made in expanding eligibility and in implementing the broader payment and service delivery transformations that are underway.

With the Congressional ACA repeal policy debates that have taken place, and potential resurgence of interest in the implementation of alternative funding structures for state Medicaid programs, state and federal officials appear to be posturing to weigh policy options that can bluntly drive down Medicaid spending via various means, including administrative policy, waiver authority, and executive orders. Because converting Medicaid into a block grant program would not allow for increased funding in the event of future increases to state healthcare costs and beneficiary enrollment, such a change could be quite unfavorable for some states, newly eligible populations, and for payers and providers. However, policy discussions of block-grant arrangements have been tied to the expansion of state flexibility with regard to Medicaid benefit design.

This shift could mean that despite receiving less federal funding, states will soon be granted a newfound ability to allow Medicaid MCOs to experiment further and to more directly use Medicaid funding to coordinate social services. Such an outcome would be promising, as state Medicaid agencies and Medicaid health plans must be better enabled and incentivized to invest in social determinants of health interventions through policy and regulatory guidance that allows flexible spending and blended payment structures. Alternatively, block grants could stifle research and experimentation on social services interventions because MCOs and states alike might become more focused on programs with quicker return on investment. They could also cause states to implement new measures that could increase beneficiary cost-sharing and reduce other critical benefits. The current policy alternatives will certainly produce sizeable effects for Medicaid MCOs and the accountability that they will continue to hold for improving the health and social well being of managed care populations. No matter the regulatory outcome, innovative financing mechanisms will be required and states will be pushed to continue serving as incubators and laboratories for Medicaid innovation and reform.

Discussion of Organizational Context and Practical Learnings

As I worked to complete my DELTA project and thesis, my analytical platform knowledge shifted in one meaningful way once I further examined the health policy and healthcare delivery contexts that affected my topic and the breath of interventions that my thesis could cover. I realized that I had to think as practically as possible regarding two important components of the thesis project: (a) how comprehensive of an understanding I needed to hold on historical, current, and emerging health and social service policy developments; and (b) how to best frame my analysis. I ultimately faced a dilemma in

assessing the process that I should use and the time limits that I should provide myself to work under to ensure my analysis went beyond a cursory review. I knew I had to work pragmatically to ensure that I met established timelines and to quickly carry over my learning into my immersion experience at the host organization. Thus, I decided that I had to adapt my thinking and action and focus on synthesizing my work to meet my academic and professional needs.

Since the conceptualization of my project, I sought advice from my DELTA project committee and host organization supervisor, and I aimed to use the guiding measure of overall professional relevance to evaluate my actions and how best to meet my project strategy. I saw, for example, that many of the programs that I needed to include in my thesis lacked publicly available sources of information on their financial, operational, and evaluation outcomes. As such, I worked to distill what information I could access in making my analysis useful. A major assumption that I made at the onset of my project was that it would be a straightforward process to locate and conduct an in-depth assessment of the published literature. I found, however, that it was not easy to either find or translate empirical research evidence into practical promising practices. In the end, my project helped me to generate new ideas and questions regarding the relative action and inaction among Medicaid MCOs and the advocacy platform that exists for them to address the social determinants. I will use these new insights to directly inform my work within my host organization moving forward.

Throughout the DELTA project process, I have also been pushed to think through what I have been learning and experiencing and how to best apply my learning to my host organization's context. As a large, influential commercial health insurer, this entity has a

different set of political, financial, and reputational considerations to make when establishing partnerships and expanding services to members, as compared to other small, not-for-profit Medicaid MCOs, for example. Still, my host organization likely shares some general operational challenges associated with boldly innovating and experimenting in the SDoH space with the hundreds of other Medicaid MCOs across the country. These challenges include the difficult decision-making associated with the prioritization of which social services are

1. effective and sustainable to offer to members (*i.e., what will have a long-term positive impact on health outcomes and financial return on investments?*);
2. within the scope of reasonable influence of the health plan (*i.e., how far is too far upstream?*); and
3. revenue generating (*i.e., which services are likely to be fully reimbursed by state Medicaid agencies as allowable expenses in the near-term?*).

As I have reflected on the decision making I have seen in my host organization, these practical matters are being assessed at various levels of leadership. They involve the many teams responsible for the health plan's network provider adequacy, membership growth, external and governmental affairs, clinical quality, finance, marketing, operations, and innovation. Given the enterprise-wide implications that social service integration has for the organization, the decision to build new programs and services has been years in the making. And priorities will likely continue to shift in meaningful ways over the years to come as newly launched SDoH programs are scaled and evaluated.

With respect to my immediate goal of contributing to the work that my team and host organization lead, I have begun applying what I have learned from my DELTA project to the

overall operations and formal evaluation strategy being created by my team to more rigorously determine the results of our pilot and test programs. I have also incorporated my learning into an SDoH workgroup being formed at my host organization to share SDoH strategies across business segments. The recommendations that I have carried over have stemmed directly from the emerging practices and gaps in current practice that I discovered from my DELTA project. Thus far, the suggestions that I have put forward based on my analysis have been well received.

I anticipate that in the months to come, as our strategy and leadership structure are refined further, that I will be able to apply even more of my learning as we look much deeper into the critical success factors for local partner engagement, staff hiring and training, workflows and processes used, and technology adopted to truly innovate in this space. I expect that the Medicaid MCO that I have been immersed within will continue to fine-tune and build out its model of hiring local Community Health Workers to serve as cross-functional assisters and navigators that can help health plan members and broader community members with seeking referrals for external social services and that can insource certain services where possible and appropriate. For example, the current set of CHWs hired by the health plan hold expertise in various areas of local social services delivery, including housing counseling, transportation and mobility services, and workforce training and development. These critical staff work to streamline access to services for members experiencing hardship in the social service domains prioritized by the MCO, and will be key enablers of the MCO's success as they seek to more comprehensively address members' social wellbeing.

And, as I reflect overall on what experimentation has taken place in the last twenty years, it is my hope that there will be even more speed-to-market to foster more meaningful

connections to much needed social supports for the most complex Medicaid beneficiaries across the U.S. Based on my experience over the last 9 months, I foresee that impending state and federal Medicaid coverage and funding policy changes will directly shape this outcome, and that there will be dramatic shifts in the social services integration strategies adopted by my host organization and by many other Medicaid MCOs to determine the strongest models to put forward. I also suspect that Medicaid MCOs will soon consider being much more public regarding the approaches they are taking to elevate the collective health and social wellbeing of covered members under forthcoming reforms to Medicaid financing and coverage mechanisms.

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Exhibit 1: Systematic Literature Review Search Strategy Framework

Population	Context- Social determinants of health	Context- Interventions	Outcomes
Medicaid	Social determinants	Assessment	Utilization
Managed care programs	Social services	Integration	Alignment
Medicare-Medicaid dual eligible beneficiaries	Social needs	Screening	Partnership
Health plans	Social welfare	Referral	Costs
Health maintenance organizations	Social work	Navigation	Expenditures
Managed long-term care	Socioeconomic factors	Assistance	Health status
	Community services	Innovations	Health improvement
	Safety net	Programs	Gaps in care
	Human services	Interventions	Access
	Complex care needs	Pilots	Awareness
	Accountable care organizations	Case studies	Satisfaction
	Clinical- community linkages	Community health workers	Quality
	High utilizers	Navigators	Readmissions
		Care managers	Prevention
		Case managers	
		Supportive housing	
		Homeless	
		Housing	
		Education	
		Employment	
		Job training	
		Food security	
		Food access	
		Food assistance	
		Transportation	
		Interpersonal violence	
		Domestic violence	
		Social support	
		Utility assistance	
		Financial services	
		Home repairs and remediation	
		Legal services	
		Health behaviors	
		Mental health services	
		Clinical services	

Exhibit 2: List of Background Interviewees

Name	Role
Regina Davis Moss, PhD, MPH	Associate Executive Director, American Public Health Association
Paula Lantz, PhD, MS	Professor of Public Policy and Associate Dean for Academic Affairs, University of Michigan Ford School of Public Policy
Marsha Lillie Blanton, DrPH	Chief Quality Officer and Director, Division of Quality, Evaluation & Outcomes, Centers for Medicare & Medicaid Services
Myechia Minter Jordan, MD, MBA	President and CEO, The Dimock Center
Tamiko Morgan, MD	Former Chief Medical Officer, Hennepin Health
Janet Page- Reeves, PhD	Research Assistant Professor, Department of Family & Community Medicine, University of New Mexico
LaQuandra Nesbitt MD, MPH	Director, DC Department of Health
Lauren Taylor, MDiv, MPH	PhD Student, Harvard University Health Policy Program & Co-Author, "The American Healthcare Paradox: Why Spending More is Getting Us Less"
Reed Tuckson, MD	Former Executive Vice President & Chief of Medical Affairs, UnitedHealth Group
Marcella Wilson, PhD, MSW	CEO and Founder, Transition to Success
Jean Zotter, JD	Program Manager, Massachusetts Prevention & Wellness Trust Fund, Massachusetts Department of Health

Exhibit 3: Key Features of Social Determinants of Health Interventions Led by Medicaid Managed Care Organizations, 1996-2016

Part 1. Managed Care Organization, Intervention, Location, Population, Funding Source, Partners

Managed Care Organization	Intervention Name/ Source	Geographic Location/ Launch Timing	Targeted Population	Funding Source/ Structure	Partner Organizations/ Structure
1) United Healthcare Community & State (Large, multistate for-profit health plan, covering 5.9 Medicaid members in 25 states) UHC Community Plan of Arizona UHC Community Plan of Michigan UHC Community Plan of New York UHC Community Plan of Ohio UHC Community Plan of Nebraska	myConnections™ myWork Connect™ myHousing Connect™ myMoney Connect™ myRide myCommunity Connect™ myData Connection™ Sources: http://www.unitedhealthgroup.com/Newsroom/Articles/Feed/UnitedHealthcare/2016/0218myCommunityConnectCenter.aspx https://www.camdenhealth.org/wp-content/uploads/2017/01/CamdenPartnershipPressRelease-FINAL.pdf https://www.camdenhealth.org/wp-content/uploads/2017/01/myConnections_TackleBox_Brochure_090816.pdf	Phoenix, AZ (February 2016-present) Detroit, MI (March 2016-present) New York City, NY (April 2016- present) Raleigh, NC (June 2016- present) Dayton, OH (January 2017-present) Lincoln, NE (January 2017-present)	All Medicaid managed care populations covered by the health plans identified Broader low-income community members	United Healthcare Community & State	Structure: - Contractual agreements with partner orgs, - Joint operating committees including all local partner orgs Subset of Partners: UnitedWay Goodwill Local food banks Local housing authorities Local employment agencies Local transportation authorities
2) Hennepin Health	Hennepin Health	Hennepin County, MN	New Medicaid beneficiaries with	Risk-bearing Medicaid Accountable Care	Hennepin County Human Services and Public Health Department

(County health plan, comprehensively covering 9,000 Medicaid members)	Sources: Sandberg, S. F., Erikson, C., Owen, R., Vickery, K. D., Shimotsu, S. T., Linzer, M., DeCubellis, J. (2014). Hennepin Health: a safety-net accountable care organization for the expanded Medicaid population. Health Affairs, 33(11), 1975-1984. http://www.commonwealthfund.org/publications/case-studies/2016/oct/hennepin-health	(January 2012-present)	high medical and social service needs	Organization operating under a braided financing strategy, receiving a fixed PMPM payment for the total cost of Medicaid health services (excluding long-term care) and using grants from the county to cover the cost of some program staff Funded by PMPM fees paid by the Minnesota Department of Human Services for those enrolled in the ACO; to date, these fees have exceeded costs, obviating the need for ACO partners to contribute to program costs. Health plan receives a global capitation payment, providing flexibility to invest in nonmedical services like care coordination and housing units. At year's end, a portion of accrued savings is distributed back to providers, with another portion reinvested in projects to improve patient health and well-being. Initial investment of approximately $1.6 million to fund expanded staffing and data infrastructure	Hennepin County Medical Center Metropolitan Health Plan NorthPoint Health & Wellness Center Homeless shelters Minneapolis Public Housing Authority Hennepin County Department of Community Corrections Hennepin County Sheriff's Office

3) CareSource (Large, multistate non-profit health plan, covering 1.5 Medicaid members in Ohio, Indiana, Kentucky and West Virginia)	Life Services Source: https://www.caresource.com/caresource-life-services/ohio-life-services/ http://www.dispatch.com/content/stories/local/2016/08/07/medicaid-insurer-provides-life-services-to-connect-clients-with-education-jobs.html http://waysandmeans.house.gov/wp-content/uploads/2016/05/20160524FC-Testimony-VanZant.pdf	Ohio counties: Butler, Clark, Darke, Franklin, Greene, Miami, Montgomery, Preble and Warren. Indiana (2014- present)	All Medicaid managed care populations covered by the health plan or parents of a minor child who is covered by the health plan	CareSource	Hundreds of community resource partners, including: -Employment partners -Food pantries -Shelters & housing organizations -Local, county and state government agencies -Faith-based organizations -County-based facilities -Rehabilitation centers -Social service agencies
4) Molina Healthcare of Utah (Large, multistate for-profit health plan, covering 3.3 Medicaid members in 12 states)	TracFone Wireless Program Sources: https://www.voxiva.com/tracfone-wireless-voxiva-partner-molina-healthcare-provide-free-cell-phones-mobile-health-services/	Utah (2013)	Medicaid members	Molina Healthcare of Utah	TracFone Wireless Voxiva
5) Amerigroup Community Care (Amergroup covers ~9,000 foster children in the Georgia Families 360° program. Anthem is a large, multistate for-profit health plan, covering	Coaching and Comprehensive Health Supports (COACHES) program Sources: Institute for Medicaid Innovation Medicaid Managed Care Best	Macon, Georgia Atlanta, Georgia (July 2014- present)	Youths (ages 17-20) transitioning out of foster care as adults, who live in a group or foster home, have been in foster care at least 12 months, and have a behavioral health	CMS Center for Medicare and Medicaid Innovation (CMMI) $5.8 million innovation grant (3 year funding period)	Government and non-profit partners: Families First (non-profit family service agency) Georgia Division of Family and Children Services

5.9 Medicaid members across the US)	Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf http://www.businesswire.com/news/home/20140721005850/en/Amerigroup-Wins-CMS-Innovation-Award-Develop-Care http://www.familiesfirst.org/coaches/		diagnosis		Georgia Department of Community Health Barton Child Law and Policy Clinic Bethany Christian Services Multi-Agency Alliance for Children (MAAC) Georgia Appleseed Center of Law and Justice CHRIS Kids Lutheran Services of Georgia
6) WellCare Health Plan of Kentucky (Large, multistate for-profit health plan, covering 2.4 Medicaid members in 9 states)	Homeless Healthcare program Sources: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	Kentucky	Homeless members aged 18 and older covered by the state health plan	WellCare Health Plan of Kentucky	Hotel Inc. (homeless shelter) WestCare Homeless Shelter Volunteers of America Homeless Shelter
7) Empire Blue Cross Blue Shield HealthPlus (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	Community Health Worker (CHW) Care Coordination program Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Update	New York City, NY (2015)	Hard-to-reach members with chronic health conditions, including asthma, diabetes, hypertension, and chronic heart failure	Empire Blue Cross Blue Shield HealthPlus	Unknown

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8) Anthem Indiana Medicaid (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	Indiana CICOA Care Transitions Program Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	Central Indiana (January- June 2015)	Members discharged from acute inpatient settings with a high risk of inpatient readmissions or emergency department visits Members having complex needs, including physical health and social supports needs	Anthem Indiana Medicaid	Central Indiana Coalition on Aging (CICOA) Area on Aging (AAA)
9) Cardinal Innovations Healthcare (Non- profit health plan operating in 16 counties in North Carolina, covering 850,000 Medicaid members)	Partnering for Excellence Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf http://www.practicenotes.org/v21n3/PFE.htm	Salisbury, NC (July 2013)	Foster children and other youth in the county child welfare system between the ages of 4 and 18	Cardinal Innovations Healthcare Duke Endowment	Rowan County Department of Social Services Benchmarks: An Alliance of Agencies Helping Children, Adults and Families (includes dozens of non-profit and for profit agencies that provide child welfare, behavioral health, juvenile justice, or related services via community-based programs and/or out-of-home care.)
10) Cardinal Innovations Healthcare (Non- profit health plan operating in 16 counties in North Carolina, covering	Transitional Living Services for Youth Sources: Institute for Medicaid Innovation Medicaid Managed Care Best	Salisbury, NC	Youths (ages 16-21) transitioning out of foster care as adults, or who are exiting from juvenile justice custody, and/or mental health	Intervention: Cardinal Innovations Healthcare Evaluation: Edna McConnell Clark Foundation	Youth Villages Rowan County Department of Social Services

850,000 Medicaid members)	Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf Manno, M., Jacobs, E., Alson, J., & Skemer, M. (2014). Moving into Adulthood: Implementation Findings from the Youth Villages Transitional Living evaluation. New York, NY: MDRC. http://www.mdrc.org/sites/default/files/Youth%20Villages_Full%20Report.pdf Valetine, E. J., Skemer, M., & Courtney, M. E. (2015). Becoming Adults: One-Year Impact Findings from the Youth Villages Transitional Living Evaluation. New York, NY: MDRC.		systems	Annie E. Casey Foundation Bill & Melinda Gates Foundation	
11) UnitedHealthcare Community & State UnitedHealthcare Community Plan (AZ, FL, LA, MS, NE, NY, TN, WI) (Large, multistate for-profit health plan, covering 5.9 Medicaid members in 25 states)	Food Smart Families Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	(AZ, FL, LA, MS, NE, NY, TN, WI) (2015- present)	Children attending public schools where at least 50% of students are in free and reduced lunch programs	UnitedHealthcare Community & State ConAgra Foods Foundation	Local elementary schools National 4-H Council 163 partnerships with local community-based organizations

12) CareOregon (A Portland, Oregon-based non-profit Medicaid health plan)	CareSupport Source: Transforming the Roles of a Medicaid Health Plan from Payer to Partner. http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2010/Jul/Triple%20Aim%20v2/1423_McCarthy_CareOregon_triple_aim_case_study_v2.pdf	Portland (2004)	Members with multiple co-morbid conditions who account for a high percentage of the plan's total spending	CareOregon Performance Incentive Payments made to six primary care renewal pilot sites in 2009	Virginia Garcia Memorial Health Center Central City Concern (FQHC) Oregon Health and Science University Providence Health Services Health Share Adventist Health Legacy Health Multnomah County Health Department
13) UPMC Health Plan (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	Community Team Program Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	Allegheny (Pittsburgh) and other western Pennsylvania counties (2015-present)	High-risk, high-cost, and complex high-need Medicaid, Medicare Advantage and commercially insured members (age 18 and older) who have a web of physical and behavioral health conditions, and/or severe psychosocial issues.	UPMC Health Plan	Community Care Behavioral Health Broader community team advisory board comprised of local CBOs
14) Amerigroup Georgia (Anthem, Inc.) (Anthem is a large, multistate	Pathways to Permanency (PTP) Source: Institute for Medicaid	Georgia	Foster care youth with complex behavioral health and physical health care needs	Amerigroup Georgia (Anthem, Inc.)	Multi Agency Alliance for Children Chris Kids Youth Villages

for-profit health plan, covering 5.9 Medicaid members across the US)	Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf				
15) Illinicare Health (Non-profit health plan serving 200,000 Medicaid members in Illinois)	Boulevard Pilot Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	Chicago, IL	Members over 18 years of age who are homeless, with medical or mental health issues, that are exacerbated due to their lack of housing	Illinicare Health	The Boulevard
16) Anthem California (Anthem, Inc.) (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	End Stage Renal Disease (ESRD) pilot Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	San Francisco, CA	Members with End Stage Renal Disease (ESRD)	Anthem California (Anthem, Inc.)	Unknown
17) Keystone First (Formerly Keystone Mercy Health Plan) (Non-profit health plan serving 400,000 Medicaid	Community Health Worker Embedded in Primary Care Practice for High-Risk Asthma Pediatric Members	Philadelphia, PA (early 2015- present)	High-risk asthma pediatric members (ages 2-21)	Keystone First	St. Christopher's Hospital for Children Sisters of Mercy Healthy Homes in the Philadelphia Department Public Health

members in Pennsylvania)	Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2015- 2016 http://www.medicaidinnovation.org/_images/content/IMI-best_practices__2015-2016.PDF				
18) Simply HealthCare and Better Health Care Plans (Non-profit health plan serving 84,000 Medicaid members in Florida)	Pediatric and Medically Complex Children Care Coordination Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2015- 2016 http://www.medicaidinnovation.org/_images/content/IMI-best_practices__2015-2016.PDF	Florida (2014- present)	Children with complex conditions and high healthcare utilization	Simply HealthCare and Better Health Care Plans	Unknown
19) IlliniCare (Non-profit health plan serving 200,000 Medicaid members in Illinois)	7/30-Day Follow-Up Post-Hospitalization Pilot Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium	Chicago	Populations with serious mental illness (SMI) covered by plan	IlliniCare	Thresholds Cenpatico

	2015- 2016 http://www.medicaidinnovation.org/_images/content/IMI-best_practices__2015-2016.PDF				
20) Optima Health	Partners in Pregnancy Source: 2005 AHIP Innovations in Medicaid Managed Care Report: http://docplayer.net/8477099-Innovations-in-medicaid-managed-care-health-plan-programs-to-improve-the-health-and-well-being-of-medicaid-beneficiaries.html	Virginia (2002)	Pregnant Medicaid and commercial members	Optima Health Received grant from the Center for Health Care Strategies in 2004 to measure the long-range outcomes from May 2004 through October 2007 and to calculate the return on investment for the program Received grant from March of Dimes to educate and develop service coordination documents and standards between CHIP of Virginia and the Optima program	Comprehensive Health Investment Project (CHIP), an organization offering support and education to at-risk families throughout the state Virginia Department of Health and Social Services Resource Mothers Healthy Families Community Services Boards Regional Development Services
21) Amerigroup Maryland (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	Coordinating Care for Members with Chronic Disease Source: 2005 AHIP Innovations in Medicaid Managed Care Report: http://docplayer.net/8477099-Innovations-in-medicaid-managed-care-health-plan-programs-to-improve-the-health-and-well-being-of-medicaid-	Maryland (2002)	Members with past hospitalizations related to asthma, diabetes, heart failure, sickle cell disease, end-stage renal disease, HIV/AIDS, and substance abuse	Amerigroup Maryland	Unknown

	beneficiaries.html				
22) BlueCross BlueShield of Minnesota (Non-profit health plan serving 292,000 Medicaid members in Minnesota)	Closing the Loop program Source: 2005 AHIP Innovations in Medicaid Managed Care Report: http://docplayer.net/8477099-Innovations-in-medicaid-managed-care-health-plan-programs-to-improve-the-health-and-well-being-of-medicaid-beneficiaries.html	Four Minnesota counties (Kandiyohi, Swift, Chippewa, and Yellow Medicine) (January 2004)	In its initial phase, the project focused on elderly dual-eligible members with diabetes Eventually, the scope expanded to include individuals with other chronic conditions	Community Service/Service Development grant from the State of Minnesota	Two regional Area Agencies on Aging Volunteers of America
23) Medica Health Plan (Non-profit health plan serving 294,000 Medicaid members in Minnesota)	Minnesota Source: 2005 AHIP Innovations in Medicaid Managed Care Report: http://docplayer.net/8477099-Innovations-in-medicaid-managed-care-health-plan-programs-to-improve-the-health-and-well-being-of-medicaid-beneficiaries.html	Ramsey and Hennepin counties, Minnesota (2001)	Initially, the program focused on English-speaking families in Hennepin County with two or more children ages 0 through 9 who had not had a well-child checkup for more than a year The project subsequently expanded to focus on all children over age 2, regardless of primary language, living in the western portions of Ramsey and Hennepin Counties		

24) Neighborhood Health Plan (nonprofit health plan serving 294,000 Medicaid members in Massachusetts) Sources Neighborhood Health Plan Social Care Management Program (2017). Retrieved from https:/www.nhp.org/provider/clinics/programs/Pages/Social-Care-Management.aspx 2005 AHIP Innovators in Medicaid Managed Care Report: http://docplayer.net/8477099-Innovations-in-medicaid-managed-care-health-plan-programs-to-improve-the-health-and-well-being-of-medicaid-beneficiaries.html	Management Program	Massachusetts (1998-present)	All new Medicaid and commercial members	Neighborhood health plan	Unknown
25) Passport Health Plan (Non-profit health plan serving 283,000 Medicaid members in Massachusetts)	Tiny Tot Transition Program Source: 2005 AHIP Innovations in Medicaid Managed Care Report: http://docplayer.net/8477099-Innovations-in-medicaid-managed-care-health-plan-programs-to-improve-the-health-and-well-being-of-medicaid-beneficiaries.html	Kentucky (2001)	Newborns with serious health conditions	Passport Health Plan	Unknown

26) Magellan Healthcare of Nebraska (Magellan Health)	Magellan Mobile Connect Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	Nebraska (2014)	High-utilizer members with serious and persistent mental illness (SPMI) and substance abuse populations that were very high cost and repeatedly had poor engagement in treatment and difficulty attaining success in the community	Magellan Healthcare of Nebraska	Unknown
27) Keystone First (Formerly Keystone Mercy Health Plan) (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	Community Care Management Team: Philadelphia and Chester Hubs for Superutilizers Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-best_practices__Updated_10-05.pdf	Chester and Philadelphia, PA (2013)	Members with complex comorbidities including uncontrolled chronic illness and behavioral health-related needs	Keystone First	Unknown
28) CeltiCare Health Plan of Massachusetts (Centene is a large, multistate for-profit health plan, covering 5.7 Medicaid members in 17 states)	Opioids 360: From Prescribing to Recovery Source: Institute for Medicaid Innovation Medicaid Managed Care Best Practices Compendium 2016-2017 http://www.medicaidplans.org/_docs/IMI-	Massachusetts (2014- present)	Members with substance use disorders (SUD) and those in need of more effective management of prescribed opioids	CeltiCare Health Plan of Massachusetts	Unknown

	best_practices__Updated_10-05.pdf				
29) Volunteer State Health Plan (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	SelectKids Unit Source: 2013 AHIP Innovations in Medicaid Managed Care: Highlights of Health Plans' Programs to Improve the Health and Well-Being of Medicaid Beneficiaries.	Tennessee (2001- present)	Children and youth in foster care	Volunteer State Health Plan	Tennessee Department of Children's Services
30) Aetna Better Health (Large, multistate for-profit health plan, covering 2.3 Medicaid members in 12 states)	Integrated Care Management program Sources: 2013 AHIP Innovations in Medicaid Managed Care: Highlights of Health Plans' Programs to Improve the Health and Well-Being of Medicaid Beneficiaries. http://www.dhhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Care%20Coordination%20Work%20Group/Meeting%20Materials/20160425/GI-Aetna-Medicaid-Care-Management-April-2016.pdf	AZ, DE, IL, TX, and VA (2012- present) MD, FL, CA, MO, OH (2013- present)	Chronically ill members	Aetna Better Health	Unknown

31) CareSource (Large, multistate non-profit health plan, covering 1.5 Medicaid members in Ohio, Indiana, Kentucky and West Virginia)	Supporting Families through High-Risk Pregnancies and Beyond Source: 2013 AHIP Innovations in Medicaid Managed Care: Highlights of Health Plans' Programs to Improve the Health and Well-Being of Medicaid Beneficiaries.	Unknown	Members with high-risk pregnancies	CareSource	YMCA UnitedWay
32) UCare (Non-profit health plan serving 42,000 Medicaid members in Minnesota)	Minnesota Senior Care Plus (Medicaid Managed Care for Seniors) Sources: 2013 AHIP Innovations in Medicaid Managed Care: Highlights of Health Plans' Programs to Improve the Health and Well-Being of Medicaid Beneficiaries. https://innovations.ahrq.gov/profiles/state-federal-program-provides-capitated-payments-plans-serving-those-eligible-medicare-and	Minnesota (2005)	Minnesota's Senior Health Options (MSHO) program for dual eligibles	The Robert Wood Johnson Foundation funded a planning grant from 1991 to 1995 CMS funded the demonstration project from 1995 to 2005 Since 2006, the program has been funded by the state Medicaid program through capitated payments made to participating plans	Unknown
33) Molina Healthcare of New Mexico (Large, multistate for-profit health plan, covering 3.3 Medicaid members	CHW program Source: Johnson, D., Saavedra, P., Sun, E., Stageman, A., Grovet, D., Alfero, C.,	11 New Mexico counties (May 2005- present)	Members who were high users of the ED, who had high consumption of controlled substances, who had poorly controlled	Molina negotiated a contract with the New Mexico state Medicaid agency to begin an initial capitated payment structure of $256 per member per	Salvation Army Commodities New Mexico St. Vincent de Paul New Mexico Department of

in 12 states)	Kaufman, A. (2012). Community health workers and Medicaid managed care in New Mexico. Journal of community health, 37(3), 563-571.		chronic diseases such as diabetes, cardiovascular disease, asthma, and who exhibited high use of disease management referrals, family or provider referrals, and high use of care coordination referrals MHNM used predictive modeling using a proprietary data analysis program	month of service, raised to $306 in 2007 and $321 in 2009	Children, Youth and Families Local public schools University of New Mexico Health Sciences Center Community Access to Resources and Education in New Mexico (CARE NM)
34) UPMC Health Plan (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	Shelter Plus Care program Source: Association for Community Affiliated Plans. “Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way”	Pennsylvania	Homeless members covered by the plan	UPMC pays Metro Family Practice for the health care services provided, plus a care coordination fee and reimbursement for a registered nurse’s salary HUD provides a rental subsidy UPMC also pays for case management provided by CHS	Metro Family Practice (primary care practice) Local housing authority Community Human Services (HUD-funded housing support agency)
35) Health Plan of San Mateo* *Plan is a Health Insuring Organization (HIO), a member plan in California's	Community Care Settings Pilot Sources: Association for Community Affiliated	San Mateo County, CA (April 2014- present)	Members transitioning out of skilled nursing facilities and other institutions and back to living	In 2014, was awarded a contract to participate in the CMS Dual Eligibles Demonstration program	Brilliant Corners The Institute on Aging San Mateo County Department of Housing

County Organized Health Systems (COHS). (Non-profit health plan serving 112,000 Medicaid members in San Mateo County)	Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way" http://www.calduals.org/wp-content/uploads/2016/02/CCSP-HPSM-slides-2.18.16.pdf		independently in the community; and members living in the community, or in acute care settings, that are at imminent risk of institutionalization		San Mateo County Health System
36) Central California Alliance for Health* *Plan is a Health Insuring Organization (HIO), a member plan in California's County Organized Health Systems (COHS). (Non- profit health plan serving 350,000 Medicaid members in Santa Cruz, Monterey and Merced counties)	Project Connect Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"	Santa Cruz, Monterey and Merced counties, CA	Medically fragile members experiencing homelessness	Central California Alliance for Health	Project Connect (case management organization)
37) Amida Care (Non- profit New York City-based health plan focused on people living with HIV, serving 6,100 Medicaid members)	Employment of Enrollees as Outreach Staff Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"	New York City, NY	Unemployed members	Amida Care	None

38) Community Health Choice (Non-profit health plan serving 240,000 Medicaid members in Texas)	Internship program Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"	Metro Houston, TX	Young adults and local high school students	Community Health Choice	Genesys Works Cristo Rey High School
39) Family Health Network (Non-profit health plan serving 252,000 Medicaid members in Illinois)	Book Club Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"	Chicago, IL	Child members, aged 5- 16 years old	Family Health Network	None
40) AlohaCare (Non-profit health plan serving 67,000 Medicaid members in Hawaii)	The AlohaCare Believes in Me Scholarship Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"	Hawaii Statewide (2003- present)	Health plan members and other students studying at a University of Hawaii community college or university campus and majoring in health care or a health-related field for undergraduate or graduate studies	AlohaCare University of Hawaii Foundation	University of Hawaii
41) Health Services for Children with Special Needs, Inc.	Individualized Family Service Plan Involvement Source: Association for Community Affiliated	Washington, DC	Children with special needs and disabilities	Health Services for Children with Special Needs, Inc.	DC Office of the State Superintendent of Education (OSSE)

	Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"				
42) Health Plan of San Joaquin (Non-profit health plan serving 337,000 Medicaid members in California)	Improving Access to Healthy Foods Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"	Central Valley of California	Families in need of food assistance	Health Plan of San Joaquin	Stockton Farmer's Market Local shelters Boggs Tract Community Farm
43) CareSource (Large, multistate non-profit health plan, covering 1.5 Medicaid members in Ohio, Indiana, Kentucky and West Virginia)	Diabetic Food Pack Program Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way"	Ohio (2012- present)	High risk members with diabetes	Funded as a two-year pilot program through a grant of $140,000 to The Foodbank from the CareSource Foundation	The Foodbank American Diabetes Association
44) CareOregon "Prescription Veggies? CareOregon pilot program helps patients eat healthier food." Portland Business Journal, May 30, 2014, written by Elizabeth Hayes.	Food Rx Program Source: Association for Community Affiliated Plans. "Positively Impacting Social Determinants of Health: How Safety Net Health	Oregon	Members who are food insecure and/or who have chronic health issues related to diet	CareOregon	3 FQHCs Area grocers

	Plans Lead the Way"				
45) Health Services for Children with Special Needs, Inc.	Male Caregivers Support Group	Washington, DC (2004)	Male caregivers of children with special needs and disabilities	Health Services for Children with Special Needs, Inc.	Unknown
46) L.A. Care Health Plan (Non-profit health plan serving 1.3 Medicaid members in California)	Family Resource Centers Source: Silow-Carroll, S. & Rodin, D. (2013). Forging community partnerships to improve health care: the experience of four Medicaid managed care organizations. Issue Brief (Commonwealth Fund), 19, 1-17.	Los Angeles, CA (2007- present)	Populations covered by the health plan Broader low-income community members	L.A. Care Health Plan	Northeast Community Clinic Women Alive Coalition Great Beginnings for Black Babies Weight Watchers Women Alive Coalition Uplifting our Future Black Women for Wellness A Plus Nursing Network
47) Commonwealth Care Alliance Senior Care Options Plan (Initiative continues under the auspices of CMS Medicare Advantage as a Special Needs Plan, with a separate contractual arrangement with the state Medicaid program)	Senior Care Options program Source: https://innovations.ahrq.gov/profiles/plan-funded-team-coordinates-enhanced-primary-care-and-support-services-risk-seniors Master RJ. Massachusetts Medicaid	Boston, MA (2004)	At-risk, medically complex dual eligible members	Commonwealth Care Alliance	Urban Medical Group Upham's Corner Community Health Center Boston University Geriatrics Health Care for All Boston Center for Independent Living

	and the Community Medical Alliance: a new approach to contracting and care delivery for Medicaid-eligible populations with AIDS and severe disability. American Journal of Managed Care. 1998;4 Suppl:SP90-8. [PubMed] http://humanservices.vermont.gov/dual-eligibles-project/person-centered-materials/commonwealth-case-study-elderly-and-disabled-care-12-9-11/view Meyer H. A new care paradigm slashes hospital use and nursing home stays for the elderly and the physically and mentally disabled. Health Affairs (Millwood). 2011;30(3):412-415. doi: 10.1377/hlthaff.2011.0113.				
48) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid members in Massachusetts)	Brightwood demonstration project Source: https://innovations.ahrq.gov/profiles/health-plan-financed-nurse-led-care-coordination-improves-quality-care-and-reduces-costs	Springfield, MA (2000-2009)	Disabled, chronically ill members	Neighborhood Health Plan reallocated capitation payment funds to pay for enhanced health-center based outpatient services	Brightwood Health Center

49) Superior Health Plan (STAR)	STAR Health (State of Texas Access Reform) Sources: https://innovations.ahrq.gov/profiles/statewide-managed-care-plan-foster-care-children-features-care-coordination-and-central http://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/STAR_Health_Quick_Guide_to_Program_Enhancements.pdf STAR Health—a guide to medical services at CPS. Texas Department of Family and Protective Services. Available at: http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp	Texas (Statewide) (2008- present)	Children and young adults in foster care, and young adults who have aged out of the foster care system.	Superior Health Plan (STAR) The State of Texas received a $4 million grant from the U.S. Department of Health and Human Services to build the Health Passport system. HHSC pays a capitated monthly rate per enrollee to Superior Health Plan to cover the cost of program-related services.	Unknown
50) Priority Health Plan	Children's Healthcare Access (CHAP) program Sources: http://www.uwmich.org/michap/ https://innovations.ahrq.gov/profiles/community-partners-offer-financial-incentives-and-support-primary-care-practices-improving	Genesee County, Kent County, Macomb County, Northwest Michigan, Wayne County, Ingham County, Kalamazoo County, Saginaw County, Michigan	Children covered by health plan	Major funders included the Douglas & Maria DeVos Foundation, Early Childhood Investment Corporation, Frey Foundation, Heart of West Michigan United Way, PNC Grow Up Great initiative, Sebastian Foundation, Steelcase Foundation, and Mike and Sue Jandernoa.	Molina Asthma Network of West Michigan Michigan Association of United Ways

51) Molina Healthcare (Large, multistate for-profit health plan, covering 3.3 Medicaid members in 12 states)	Pathways[SM] Source: Molina Healthcare 2015 Annual Report http://www.molinahealthcare.com/members/common/en-US/abtmolina/compinfo/investors/reports/Pages/finreports.aspx http://www.pathways.com	National (November 2016- present) Arizona California Colorado Delaware Florida Georgia Idaho Illinois Indiana Louisiana Maine Massachusetts Nevada North Carolina Ohio Oklahoma Oregon Pennsylvania Tennessee Texas Virginia Washington Washington, DC West Virginia	Adults and youth seeking behavioral and mental health services	Molina Healthcare	Subset of Partners: Salvation Army Food banks Western Arizona Council of Governments Campsinos sin Fronteras
52) Health Net (Non-profit health plan serving 1.5 Medicaid members in California)	Community Solutions Center Source: https://www.healthnet.com/portal/shopping/content/iwc/shopping/shp/community_solutions_centers.action	Los Angeles, CA (2014- present)	All Medicaid managed care populations covered by the health plan Broader low-income community members	Health Net	Planned Parenthood Monterey Park Hospital Mexican Consulate Los Angeles County Department of Public Social Services Los Angeles County Department of Mental Health East Los Angeles Women's Center Alzheimer's Association

					Santa Rosa Clinic Children's Hospital Los Angeles
53) WellCare (Large, multistate for-profit health plan, covering 2.4 Medicaid members in 9 states)	High School Equivalency Benefit Program	(2013- present) Florida Georgia Hawaii Illinois Kentucky Missouri New Jersey New York South Carolina	All Medicaid managed care populations covered by the health plan	WellCare	Unknown
54) WellCare (Large, multistate for-profit health plan, covering 2.4 Medicaid members in 9 states)	Welcome Rooms http://flbusinessdaily.com/stories/510735427-wellcare-launches-latest-welcome-center-in-miami-gardens http://www.prweb.com/releases/2015/06/prweb12779151.htm	Florida (16 locations) New York Hawaii Texas Connecticut Nebraska (4 locations) Kentucky	All Medicaid managed care populations covered by the health plan	WellCare	Girls Scouts Boys Scouts Local daycare centers
55) EmblemHealth (Non-profit health plan serving 263,000 Medicaid members in New York)	Neighborhood Care program Sources: http://www.emblemhealth.com/~/media/Files/PDF/EHNC_Provider_Brochure_Cambria1.pdf http://www.ehnc.com/Locations/Chinatown.aspx#calendar-of-events http://www.emblemhealth.com/~/media/Files/PDF/EmblemHealth_FactSheet_Final.pdf	January 2013-present Chinatown, Manhattan	All Medicaid managed care populations covered by the health plan Broader low-income community members	EmblemHealth	World Financial Group Hamilton Grange Library Tender Touch for All™ Park Farmer's Market East Harlem Farmer's Market

56) Gateway Health Plan (Non-profit health plan serving 312,000 Medicaid members in Pennsylvania)	Asthma Home Teaching program Source: Catov JM, Marsh GM, Youk AO, Huffman VY. Asthma home teaching: two evaluation approaches. Disease Management. 2005;8(3):178-187.	Southwest and Western Pennsylvania (1998)	At risk asthma patients	Gateway Health Plan	Unknown
57) Commonwealth Care Alliance	Disability Care Program Source: Meyer H. A new care paradigm slashes hospital use and nursing home stays for the elderly and the physically and mentally disabled. Health Affairs (Millwood). 2011;30(3):412-415. doi: 10.1377/hlthaff.2011.0113.	Boston, MA	Members with severe physical disabilities—including congenital anomalies, neuromuscular disorders, and spinal cord injuries	Health plan has a risk-adjusted capitated contract with the state Medicaid agency and the Neighborhood Health Plan	Contracts with a preferred network of medical specialists and vendors experienced in serving disabled people
58) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid members in Massachusetts)	Massachusetts Mental Health Services Program for Youth (MHSPY) Source: Grimes KE, Mullin B. MHSPY: A children's health initiative for	Massachusetts	Child members between the ages of 3 and 18	Neighborhood Health Plan	Unknown

	maintaining at-risk youth in the community. Journal of Behavioral Health Services Research. 2006;33(2):196-212.				
59) CareOregon (A Portland, Oregon-based non-profit Medicaid health plan)	Health Resilience Program http://www.achp.org/wp-content/uploads//ACHP-Mental-Health-Profile-11.12.14-LONG.pdf	Portland, Oregon	Individuals with severe mental illness	CareOregon	Unknown
60) Capital District Physicians Health Plan (Non-profit health plan serving 90,000 Medicaid members in New York)	Behavioral health case management Source: http://www.achp.org/wp-content/uploads//ACHP-Mental-Health-Profile-11.12.14-LONG.pdf	Albany, NY	Individuals with severe mental illness and substance use disorders	Capital District Physicians Health Plan	Unknown
61) Gold Coast Health Plan* *The plan is a Health Insuring Organization (HIO), a member plan in California's County Organized Health Systems (COHS). (Non-profit health plan serving 206,000 Medicaid members in California)	Health Navigator Program Source: http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP-Reducing_Avoidable_ER_Utilization.pdf	Ventura County, CA (2013)	Members who are high ED utilizers	Gold Coast Health Plan	Unknown

62) UPMC Health Plan (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	Connected Care (2009- present) Sources: http://www.chcs.org/media/Mathematica-RCP-FinalReport-2012.pdf https://www.upmchealthplan.com/about/community/myhealth-community/improving-health-outcomes.aspx	Southwest Pennsylvania	Members with serious mental illness	UPMC Health Plan	Community Care Behavioral Health (CCBH) Allegheny County Department of Human Services, Office of Behavioral Health
63) Keystone Mercy Health Plan (Formerly Keystone Mercy Health Plan) (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	HealthChoices HealthConnections Sources: http://magellanofpa.com/media/156916/hchc%20consumer%20fact%20sheet.pdf	Southeast Pennsylvania	Members with serious mental illness	Keystone Mercy Health Plan	Pennsylvania Department of Public Welfare Bucks County Behavioral Health System Delaware County Office of Behavioral Health Montgomery County Department of Behavioral Health and Developmental Disabilities Magellan Behavioral Health of Pennsylvania
64) Gateway Health Plan (Non-profit health plan serving 312,000 Medicaid members in Pennsylvania)	Prospective Care Management model Source: Silow-Carroll, S. & Rodin, D. (2013). Forging community partnerships to improve health care: the experience of four Medicaid managed care organizations. Issue	Pennsylvania (2012- present)	High risk members who have eight chronic conditions or those who have experienced at least two inpatient admissions within the prior 12 months	Gateway Health Plan	University of Pittsburgh Center for Health Equity Businesses owned and operated by African Americans in targeted regions FQHCs Primary care providers

	Brief (Commonwealth Fund), 19, 1-17.				
65) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid members in Massachusetts)	Management of high blood pressure and diabetes Source: Silow-Carroll, S. & Rodin, D. (2013). Forging community partnerships to improve health care: the experience of four Medicaid managed care organizations. Issue Brief (Commonwealth Fund), 19, 1-17.	Massachusetts	African American residents of targeted neighborhoods, including both plan members and nonmembers	Neighborhood Health Plan	Local grocery stores Local pharmacies Local FQHCs American Heart Association American Stroke Association
66) HealthPartners (Non-profit health plan serving 83,000 Medicaid members in Minnesota)	Geriatric teams in community nursing facilities Source: Silow-Carroll, S. & Rodin, D. (2013). Forging community partnerships to improve health care: the experience of four Medicaid managed care organizations. Issue Brief (Commonwealth Fund), 19, 1-17.	Minnesota	Frail seniors in nursing facilities that are “hotspots” for complex medical and social cases	Health Partners offers an incentive payment program that rewards nursing facilities and housing partners for better managing care for their residents	Nursing facilities Assisted-living residences Presbyterian Homes Housing partners
67) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid	Postpartum and early well-child visits Source:	Lawrence, Massachusetts	Latinas residing in the Lawrence region	Received funding from Culture InSight (Harvard Pilgrim Health Care Foundation)	Greater Lawrence Family Health Center Food for the World

members in Massachusetts)	Silow-Carroll, S. & Rodin, D. (2013). Forging community partnerships to improve health care: the experience of four Medicaid managed care organizations. Issue Brief (Commonwealth Fund), 19, 1-17.				Harvard Pilgrim Health Care Foundation
68) Oregon Coordinated Care Organizations ** Counted Oregon CCOs because they receive state premium payments on behalf of enrolled Medicaid beneficiaries.	Sources: http://www.chcs.org/media/Medicaid_-Soc-Service-Financing_022515_2_Final.pdf McConnell, K. J., Chang, A. M., Cohen, D. J., Wallace, N., Chernew, M. E., Kautz, G., Smith, J. (2014, September). Oregon's Medicaid transformation: An innovative approach to holding a health system accountable for spending growth. In Healthcare (Vol. 2, No. 3, pp. 163-167). Elsevier.	16 communities throughout Oregon (2012- present)	Managed care populations throughout state	CMS 1115 waiver pays for the total cost of Medicaid beneficiaries' physical, mental, and oral health care under a global budget Allows the state to include "flexible" or non-State Plan services in the CCO capitation payment, to fund health-related social services	CCOs are governed by a partnership among: Health care providers Community members Stakeholders in the health system that have financial responsibility and risk.

Part 2. Managed Care Organization, Domains, Integration Level, Workforce, Measures of Success, Outcomes

Managed Care Organization	Domains Addressed	Integration Level/ Intervention Model	Workforce Composition	Measures of Success	Outcomes Achieved
1) United Healthcare Community & State (Large, multistate for-profit health plan, covering 5.7 Medicaid members in 25 states) UHC Community Plan of Arizona UHC Community Plan of Michigan UHC Community Plan of New York UHC Community Plan of Ohio UHC Community Plan of Nebraska	- Transportation - Housing - Employment - Financial services - Food - Clinical Services - Family and social supports - Education - Clothing	High touch services: Health plan acts as a bridge organization and operates physical locations of varying formats (community centers, pop up facilities/ co-locating with partners, mobile vans, etc.) that serve as the central channel for consumers to get connected to a range of social support services Bridge organization also houses a centralized IT platform and network of service providers that can enable information sharing across health and social services	- Navigators - CHWs - Site Directors - Site Managers - CBO Network Developers	Process Outcomes: - Increased assessment and referrals for SDOH needs - Improved transportation supports - Improved housing stability - Improved food security - Improved financial security Health Outcomes: -Reduced Emergency Department visits - Reduced hospital lengths of stay - Reduced hospital readmissions within 30 days - Reduced urgent care visits -Increased preventive care visits -Increased convenience care visits	Increased Member Satisfaction

				-Reduced total medical costs -Improved HEDIS measures	
2) Hennepin Health (County health plan, comprehensively covering 9,000 Medicaid members)	- Housing - Employment - Mental health services - Food security - Education - Legal services - Clinical services - Mental health services	High touch services: Operates as a county-level safety net ACO and is one of the state's Integrated Health Partnerships (IHPs). Members receive care from a multidisciplinary care coordination team. Other features include a common electronic health record, and tiered care that is based upon a member's identified needs. Members are verbally administered a comprehensive lifestyle survey, the Member Lifestyle Assessment, to document enrollees' needs. Community health workers located in participating clinics often serve as the primary point of contact for members and coordinate needed health and social services. The care coordination team (generally starting with the community health worker) contacts the member, conducts the first patient visit and the	- Care coordinators (registered nurses) - Community Health Workers - Clinical social workers - Pharmacists - Dentists, dental hygienists, dental assistants - Behavioral health "in-reach" staff - Housing or social service navigators - Vocational services counselor - Emergency medical services (EMS) staff - Data analytics staff	- Increased outpatient clinic visits -Decreased Emergency Department visits - Decreased inpatient admissions	Emergency department visits decreased 9.1 percent between 2012 and 2013, while outpatient visits increased 3.3 percent. An increasing percentage of patients have received diabetes, vascular, and asthma care at optimal levels. Hennepin Health has realized savings and reinvested them in future improvements.

		initial care need assessment, and develops a coordinated care plan when appropriate. Hennepin Health coordinates with local service providers Health plan is leasing public housing units to 112 homeless patients with complex medical conditions in an effort to reduce unnecessary hospitalizations and emergency department visits.			
3) CareSource (Large, multistate non-profit health plan, covering 1.5 Medicaid members in Ohio, Indiana, Kentucky and West Virginia)	- Employment - Education - Childcare - Transportation - Financial services - Family and social supports - Food - Housing - Utilities - Substance abuse services	Moderate touch services: Members are assigned a Life Coach who will continue to work with them for 24 months as they work toward their goals. The support provided by the Life Coach varies based on what each member wants and needs. Life Coaches help members build a personal plan for success. Seek to help members grow, acquire skills, and expand their horizons so they can achieve a fuller quality of life. Has established relationships with 30 employers who currently have 1,500+ openings	-Life Coaches -Placement Specialists -Advocates - Community Partner Specialists - Employer Partner Specialists - Case managers	-Improved wellbeing - Improved job retainment -Improved transportation supports - Improved housing stability - Improved food security - Improved financial security	96% of members have retained employment

		that range from $10-$15 per hour, full-time with benefits.			
4) Molina Healthcare of Utah (Large, multistate for-profit health plan, covering 3.3 Medicaid members in 12 states)	- Utilities - Health behaviors	Low touch services: Provide free cell phones and mobile health services Phones have 250 free monthly minutes, unlimited texting and toll free calls to Molina's member services Participants may also subscribe to Voxiva's suite of mobile health programs (text4baby, text4kids and txt4health), which provide families with timely information and alerts that encourage them to follow recommended guidelines such as physical exams, preventative screenings, flu shots and vaccinations.	Unknown	Unknown	Unknown
5) Amerigroup Community Care (Amergroup covers ~9,000 foster children in the Georgia Families 360° program. Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	- Employment - Educational attainment - Family/ social supports - Housing - Financial services	High touch services: Youth/ young adults receive one-on-one coaching, clinical care, case management, education and social supports Aim to "form the comprehensive network of health and social supports to which the	-Coaches - Support team	-Increased access to primary and preventive care - Increased access to behavioral healthcare -Reduced emergency department visits - Reduced utilization of inpatient/residential	Health Outcomes: - 64 percent decrease in total medical spending - Psychotropic medication spending decreased by 28 percent - Oral contraceptive fills increased - Overall, inpatient

		participants will be connected" Combined with targeted payment incentives First-of its-kind partnership with the state's sole Care Management Organization- Georgia Families 360° program		treatment -Improvements in employment -Improvements in educational attainment -Reduced unintended pregnancy - Decreased early pregnancy related issues	behavioral health claims have declined by 99 percent COACHES program exceeded target enrollment projections and cost savings while operating under budget
6) WellCare Health Plan of Kentucky (Large, multistate for-profit health plan, covering 2.4 Medicaid members in 9 states)	- Housing	Low touch services: Health plan case managers help locate and identify homeless members, and connect them to housing and healthcare services needed	- Case managers	-Improved health outcomes -Increased access to housing and social services	Cost savings not yet calculated for this initiative - Referred 122 homeless members into case management and helped 76 members secure housing - 561 health assessments conducted -139 copay vouchers distributed for: medical provider (32), pharmacy (21), dental (14), vision (2), and transportation (70) expenses
7) Empire Blue Cross Blue Shield HealthPlus (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	- Health behaviors	Moderate touch services: Employed a team of field-based staff to engage, educate, and facilitate care coordination of members by connecting them to health plan services, providers, and community resources	- Community Health Workers - Health plan medical management team - Health plan quality team -Health plan operations team	- Reduced gaps in care - Reduced ED visits -Reduced inpatient admissions - Improved member experience - Improved member	Forty-eight of the 219 members with diabetes who had repeat lab tests have improved control demonstrated by HgbA1C. Five of seven Quality Assurance Reporting Requirements (QARR) measures resulted in higher rates in the target population

		Used Empire's proprietary predictive modeling algorithms Geo-mapping was used to align CHWs to members in their communities, based on location and language needs Staff attended cultural competency training to develop empathy and understanding of issues, such as poverty training, to better enable them to connect with members on an empathetic level. Health literacy and appropriate reading levels were used to reduce barriers to care.		satisfaction	compared to rates for the same group in the previous year. The program has raised member retention rates in the targeted population: 93 percent for reached members compared to 77 percent for general membership. Clinician Outcomes: With the program, 107 members engaged in medical care coordination; seven received nutritionist referrals; 50 members have attended health education classes; 406 were referred to community resources or social services. The program offers providers a care coordination model to support providers in caring for their patients, improving adherence with treatment plans, and achieving improved disease outcomes. Members actively engaged in the CHW program had 39 percent fewer inpatient admissions compared with a control group. Members actively engaged in the CHW program had 34 percent lower ED usage than members in the control group. Five of seven QARR measures resulted in higher rates in the target population compared to rates for the same group in the previous year.

8) Anthem Indiana Medicaid (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	- Health behaviors - Transportation - Home remediation/repairs	Moderate touch services: Provided in-home care coordination to members identified as being at high risk of readmission using predictive modeling or assessment by utilization management staff.	- Care coordinators - Discharge planners - CICOA managed care outreach coordinators (MCOCs) -Behavioral health care managers - Social service care managers	- Improved health literacy - Increased discharge planning adherence - Increased medication adherence - Improved home environment supports - Improved transportation assistance	Cost savings resulted from a readmission rate that decreased by 31.2 percent. Quality Improvement Efforts: Based on the outcomes of the pilot, Anthem expanded the program statewide, in partnership with the Indiana Aging Alliance (I2A), and has now reached 809 members. Data analysis on this program expansion is pending.
9) Cardinal Innovations Healthcare (Non- profit health plan operating in 16 counties in North Carolina, covering 850,000 Medicaid members)	- Interpersonal violence - Mental health services - Family and social supports - Juvenile justice	Moderate touch services: Increase screening and referral for children and youth in need of mental health services and support. After the screening, the youth receive a timely, trauma-informed comprehensive clinical assessment (TiCCA) from a clinician and an Integrated Child Plan is created.	- Social workers -Behavioral health peer-support specialists - Mental health providers	- Increased access to behavioral healthcare -Decreased entry into the juvenile justice system - Reduced use of intensive residential treatment services - Reduced total healthcare costs	Increase in the percentage of young people diagnosed with ADHD and conduct disorder, while the number diagnosed with PTSD has increased. Cleveland County Department of Social Services and its MCO, Partners Behavioral Healthcare, have started implementing the PFE model, and the project will likely add at least one more county .More children are being assessed and more are receiving outpatient therapies.
10) Cardinal Innovations Healthcare	- Housing - Education	High touch services: 9 month intensive	- Transitional Living Clinical Supervisors	- Improved job placement	Independent evaluation of the program showed that 99

(Non- profit health plan operating in 16 counties in North Carolina, covering 850,000 Medicaid members)	- Employment - Interpersonal violence - Financial services - Healthy behaviors (substance use, sexual health, physical and mental health, healthy relationships) - Family and social supports	counseling program aimed at helping the youth to navigate independent living, including education, employment, natural supports, and effective crisis planning Program included: treatment planning, systematic assessment, home visits, and delivery of evidence-informed practices within a highly structured supervisory system. Services are individualized according to each youth's strengths, interests, skills, and goals and are included on an individualized transition plan (i.e. Waiver Plan of Care). It is expected that Transition Living Skills activities take place in the community on an individual basis because the diagnoses of the children make this service inappropriate in a group setting.	- Educational Coordinators - Vocational Coordinators - Assessors - Transitional Living Specialists	- Improved job earnings - Improved housing stability - Improved economic stability - Decreased drug and alcohol use - Increased condom use - Decreased interpersonal violence - Decreased partner violence	percent of youth enrolled in the program participated in at least one session and about half participated for at least nine months (the expected average length of the program). The evaluation showed significant positive impacts in the areas of housing stability, economic security, earnings, mental health, and exposure to domestic violence 88.3 percent of youth received at least 60 days of service. Also, 7.3 percent of youth reenter the program within two years. Among youth who completed a satisfaction survey, 90 percent reported satisfaction with the services they received. At one-year post-discharge, 88 percent of youth are living independently or with family, 82 percent report no trouble with the law and 85 percent are in school, have graduated, or are employed.
11) UnitedHealthcare Community & State UnitedHealthcare Community	- Food - Health behaviors	Low touch services: Partner with public elementary schools and provide youth with 10 hours of programming	- Teen Healthy Living Ambassadors	- Improved healthy food choices among youth - Improved food	The 2014 program pilot found that 87 percent of participating families purchased healthier foods, 86 percent prepared

Plan (AZ, FL, LA, MS, NE, NY, TN, WI) (Large, multistate for-profit health plan, covering 5.9 Medicaid members in 25 states)		on nutrition, food budgeting, and preparation Families receive referrals for and information about government food benefits, such as the Supplemental Nutritional Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to support families to more sustainably access healthy food. Trains Teen Healthy Living Ambassadors to teach and serve as community role models for participating youth.		security through increased access to public food benefits - Increased physical activity among children and parents	healthier foods, 86 percent ate fruit for a snack, 82 percent prepared meals together, 78 percent ate breakfast, and 77 percent were physically active most days. Program has educated more than 26,000 youth and their families, improved health choices among participants, provided more than14,000 referrals to nutrition resources, and distributed more than 9,000 bags of food.
12) CareOregon (A Portland, Oregon-based non-profit Medicaid health plan)	- Housing - Food - Transportation - Clinical services - Healthy behaviors	Moderate touch services: Health plan provides a multidisciplinary case management service and care coordination services Helps members find critical community-based resources, resolve difficult behavioral issues and self-management problems, and improve their ability to follow a treatment plan. Uses a predictive	- Health Resilience Specialists (social workers) - Registered nurse case managers - Behavioral health case managers (social workers) - Health care guides	- Reduced avoidable ED visits -Improved health status and health risk assessment scores - Improved HEDIS measures across a number of dimensions - Improved CAHPS satisfaction measures - Reduced total cost of care -Reduced average cost of inpatient care	3.4% increase in the proportion of female patients screened for cervical cancer (pap test within three years) among five clinics 12.2% increase in the proportion of young children who were up-to-date on immunizations at one clinic More than threefold increase in the proportion of patients screened for depression within one year 10.8% increase in the proportion of diabetic patients receiving HbA1c

		modeling technique (using the Ambulatory Care Groups case-mix system developed at Johns Hopkins University) to identify high-risk patients Health Resilience Specialists (Master's level Social Workers) are embedded within primary health homes and specialty practices to enhance the practices' ability to provide community-oriented individualized 'high touch' support to high risk/high cost patients		-Reduced average cost of ED visits	testing to measure their blood sugar control 7.6% increase in the proportion of diabetic patients with blood sugar under control (HbA1c)
13) UPMC Health Plan (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	- Health behaviors - Clinical services - Transportation - Housing	Low touch services: Face-to-face home visit 48–72 hours post discharge, which includes a medication reconciliation. Assessment and interventions explore and support the complex social and environmental factors interfering with optimal health and recovery.	- Clinical nurse care managers - Mobile social service clinical case managers - Community Health Workers -Pharmacist - Certified Registered Nurse Practitioner (CRNP)	- Reduced healthcare costs - Reduced hospital readmissions within 30 days	- 71% of members engaged had a medication reconciliation completed within 30 days of discharge. -79% of members had coordination of care between the CT staff and primary care provider (PCP) within 30 days of discharge. Cost savings not yet calculated for this initiative. However, early results suggest a reduction in 30-day readmission rates.
14) Amerigroup Georgia (Anthem, Inc.)	- Housing - Mental health services - Family and social supports	Low touch services: Provide enhanced services to youth with significant behavioral	- Youth & Family Coordinators	- Reduced utilization of inpatient/residential treatment	5 percent of youth are in compliance with their annual health and dental check.

(Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)		health challenges The Multi Agency Alliance for Children receives the referral for the program, assigns it to one of two pathways, and maintains records and evaluation of each member and their outcomes. One pathway is for children identified as having a potential adoption. This pilot partner works to support the adoption process and help maintain stability in their new home. The other pathway is for youth who are not identified for adoption; it works to maintain their stability in a group home or foster home.		- Increased housing placement stability - Increased access to primary care and mental health services	Additionally, 96 percent have received a follow-up visit to a behavioral health professional within 7 days of entering a placement and 80 percent have maintained their placement stability.
15) Illinicare Health (Non-profit health plan serving 200,000 Medicaid members in Illinois)	- Housing - Utilities	Low touch services: Health plan pays the respite care facility to house 8 members per month using the Impact Pro predictive modeling program to determine member appropriateness for the program as well as to assist in determining future risk and cost. All program participants undergo comparative utilization measurements before and after program completion.	- Care Coordinators	- Increased housing stability - Reduction in inpatient and emergency room utilization - Increased medication adherence - Improved health outcomes - Decreased health care costs - Reduced Healthcare	- Unknown

		When the member is reached, he or she is provided a phone either through the government Safelink or Illinicare's Connections Plus program.		Effectiveness Data and Information Set (HEDIS) gaps in care	
16) Anthem California (Anthem, Inc.) (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	- Food - Clinical services - Health behaviors	Moderate touch services: Service coordination, including facilitating transportation, navigating and maximizing health plan benefits, and connecting members to additional services available such as meal services, were included in case management Case managers collaborate with local dialysis centers to expedite authorizations, coordinate care, and promote adherence with diet, medications, and visits.	- Case managers - Nurses - Social workers - Care extenders	- Decreased inpatient admissions - Decreased avoidable emergency department (ED) visits - Improved adherence to dialysis visits, diet, and medication	Decrease in inpatient and emergency room admissions, along with an increase in use of professional services and the pharmacy. Anthem expects positive outcomes associated with members' compliance with dialysis treatments. Participants decreased average per-member-per-month (PMPM) expenses by $718 (10 percent). Additionally, pharmacy PMPM expenses increased by 33 percent, demonstrating improved medication adherence, and scripts per 1,000 members increased by 2 percent. Inpatient admissions per 1,000 decreased by 44 percent and inpatient PMPM costs dropped by approximately 43 percent. Outpatient admissions per 1,000 decreased by 3 percent.

17) Keystone First (Formerly Keystone Mercy Health Plan) (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	- Housing - Legal services - Child care - Education - Interpersonal violence - Transportation - Home remediation - Utilities - Food - Clothes - Family and social supports	Moderate touch services: Embedded CHWs serve as an extension of the practice and health plan care management by providing face-to-face care coordination, home assessments, and asthma-related education for pediatric members and their families while addressing the social determinants affecting member health.	- Community health workers - Community care managers - Social workers	-Improved access and health outcomes -Promotion of patient-centered care through engagement and shared decision-making. - Reduced of per capita cost of care - Reduced disparities in care of racial and ethnic minorities.	Unknown
18) Simply HealthCare and Better Health Care Plans (Non-profit health plan serving 84,000 Medicaid members in Florida)	- Transportation - Family and social supports	Moderate touch services: Members are targeted for intervention based on predictive modeling and analytics. Monthly utilization and pharmacy reports and HRA responses have also been used, as well as internal referrals from medical management teams, member services, providers, and member caregivers. Intervention includes: - in-home/ telephonic comprehensive assessment - home evaluation - medication reconciliation and discrepancy identification - comprehensive care planning, including	- Bilingual case managers - Bilingual case coordinators - Complex case managers	-Improved access and health outcomes -Promotion of patient-centered care through engagement and shared decision-making -Reduced per capita cost of care - Reduced disparities in care of racial and ethnic minorities	Reduction or elimination of malnutrition diagnosis Increased coordination of DME and home health needs (incorporating member and caregiver cultural values and beliefs) Increased coordination of dental care and waiver program inclusion Increased coordinated pharmaceuticals, eliminating dangerous drug interactions

		medical, behavioral, and service needs of the member - development of personal health record, including member and providers in creation of the record; - development of self-management/ monitoring plan - health education sessions (disease, signs, and symptoms); - coordination of outpatient appointments, including transportation -coordination of DME and home health needs and visiting physicians - identification and coordination of community resource needs and caregiver support needs			
19) IlliniCare (Non-profit health plan serving 200,000 Medicaid members in Illinois)	- Housing - Food security - Mental health services	Low touch services: Face-to-face case management approach by the health plan's provider partner to ensure that health plan members had successful follow-up appointments at 7 days and/or 30 days post-discharge from inpatient psychiatric hospitalization. The pilot involved high-volume inpatient hospitals, was located on-site, and engaged with members face-to-face during the hospital stay to assess their post-discharge	- Case managers - Outreach workers	-Improved access and health outcomes -Reduced per capita cost of care	Increased HEDIS rates for the health plan were a positive outcome, meeting state pay-for-performance goals Decreased readmission and emergency department usage rates helped to get members connected to the appropriate services to meet their needs and also to address the social determinants, such as housing and food. The pilot also helped to increase access to services at one of the largest community mental health centers

		needs. Staff accompanied the member to his or her home environment post-discharge and supplied the follow-up appointment as well as case management and linkage services, as needed, until the member could be connected with the ongoing treatment provider.			(CMHC) in greater Chicago.
20) Optima Health	- Food - Family and social supports - Transportation - Interpersonal violence - Utilities	Low touch services: Analyzes claims data to identify pregnant members and determine which members are at highest risk for pregnancy complications. Nurse case manager remains in contact with high-risk members throughout their pregnancies; communicates with their doctors when appropriate; and helps them access community resources such as WIC Support high-risk pregnant women and their families by offering nursing assessments and support with medical follow-up, acting as clinical “eyes and ears” for the OB/GYN physician, and providing	- Nurse case manager - Outreach workers	Unknown	Optima estimates that nearly 3,000 days in the neonatal intensive care unit have been avoided since 2002, and for every dollar spent on the program, $2.80 was saved.

		social and emotional support and coordination with local service organizations.			
21) Amerigroup Maryland (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	- Housing - Transportation	Low touch services: Patients identified at point of enrollment and with hospitalizations related to asthma, diabetes, heart failure, sickle cell disease, end-stage renal disease, HIV/AIDS, and substance abuse. In 2004, Health plan's nurses and social workers began visiting hospitals and individuals' homes to find members who could benefit from the program. Create action plans and they remain in close contact with the member's treating physician and health plan's medical director to ensure that treatment issues are addressed in a timely manner.	- Nurses - Social workers - Care coordinators	Unknown	Hospital admissions for the SSI population decreased slightly (by less than 5%).
22) BlueCross BlueShield of Minnesota (Non-profit health plan serving 292,000 Medicaid members in	Unknown	Low touch services: Create one-page information sheet called "Closing the Loop." On this sheet, county case managers write	- County case managers - Social workers	Unknown	The 14 physicians participating in the project reported that "Closing the Loop" is effective in providing them with insight into their patients' needs.

Minnesota)		comments relevant to the patient's care and information about his or her medications, and they record clinical and lifestyle goals that they have helped patients develop Case managers fax the information to the beneficiary's primary care clinic before scheduled appointments so that the clinic has the information at the point of care.			Dually eligible Blue Plus members participating in the program indicate that the information sheets help them better articulate their needs and concerns. The State of Minnesota extended the grant through 2005 in the four participating counties. In addition, the state is expanding the "Closing the Loop" process into three counties not in the pilot and is initiating a similar project to coordinate care for dually eligible beneficiaries in four additional counties.
23) Medica Health Plan (Non-profit health plan serving 294,000 Medicaid members in Minnesota)	- Food - Housing - Utilities - Family and social supports	Low touch services: Nurse calls to schedule an in-home visit for a Child and Teen Checkup (Minnesota's version of the EPDST program). During the visit, the nurse works with the parent or guardian to identify a primary care clinic to serve as their regular source of care. In addition, the nurse emphasizes the importance of routine preventive health visits for children and provides information on resources available in the community (e.g., sources for free or	- Public health nurses - Health plan customer service staff	Unknown	Number of well-child visits among Medica's public program members has increased substantially each year.

		reduced- price food, assistance with housing and utility payments). The nurse also describes other Medica programs and services that could be helpful to the family			
24) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid members in Massachusetts) Sources: Neighborhood Health Plan. Social Care. Management Program. (2017). Retrieved from https://www.nhp.org/provider/clinical/programs/Pages/Social-Care-Management.aspx 2005 AHIP Innovations in Medicaid Managed Care Report: http://docplayer.net/8477099-Innovations-in-medicaid-managed-care-health-plan-programs-to-improve-the-health-and-well-being-of-medicaid-beneficiaries.html	- Financial services - Housing - Health behaviors - Food - Utilities - Transportation - Family and social supports - Clothes	Low touch services: Identifies members who could benefit from the program through needs assessments conducted with new members, referrals from the plan's staff and participating health care practitioners, and through member self-referrals. Social Care Managers conduct a Health Needs Assessment that gathers information about members' medical, behavioral, and psychosocial needs, and then they collaborate with other care managers to help meet the members' through placing calls, helping with applications and writing referrals	- Social Care Managers (SCM) - Behavioral care managers - Medical care managers	Unknown	Unknown
25) Passport Health Plan (Non-profit health plan serving 283,000 Medicaid members in	- Housing - Utilities - Family and social support	Low touch services: Identifies Medicaid beneficiaries for the program based on administrative data	- Program Coordinators	Unknown	In 2002, 411 babies were served by the program, and in 2003, 461 babies were served.

Massachusetts)		and contacts parents while they are still in the hospital. Educating new mothers about infant care and the importance of creating a healthy home environment program coordinators are responsible for discharge planning and working with the family for at least 30 days following discharge while acting as liaisons among the family, the doctors and hospital, and any home care agencies working with the family.			From 2002 through 2003, the average length of stay for newborns in the program fell by 12%. Emergency room visits after discharge declined from 7% in 2002 to 4.5% in 2003.
26) Magellan Healthcare of Nebraska (Magellan Health)	- Utilities - Substance abuse services	Low touch services: Distributed 219 Samsung Galaxy SII smartphones to adult members with serious mental illnesses and clinically complex profiles, providing the opportunity to open channels for reliable access to care coordination and relevant health-related services. Health plan allows unlimited phone calls, texting, voice mail, 9-1-1 access, and nearly unlimited data. The health plan provides the	-Recovery care managers - Peer specialists	- Increased connection to healthcare providers and support systems - Reduced higher levels of care while ensuring members are engaged in treatment - Reduced cost of care	Initiative has led to significantly lower costs, improved community tenure, better appointment attendance, and better medication adherence Improved member-provider connections, appointment adherence, medication adherence, member-community connections, member digital literacy, provider satisfaction, member satisfaction, self-advocacy, and hope.

		phone and covers the monthly cost. The phone is delivered to the member preloaded with contact information for Magellan, service providers, and other community supports. Magellan also includes various health and wellness applications to promote self-management and self-advocacy. At the completion of the program, the member owns the phone and can choose to assume the cost of the plan. Phones were programmed to access interpreter services for non-English speaking.			
27) Keystone First (Formerly Keystone Mercy Health Plan) (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	- Food - Employment - Utilities - Housing - Education	Moderate touch services: Teams are divided into two regional hubs, one per county and work to: (1) identify actual or potential superutilizers with unmet needs by referrals from population data mining, telephonic case managers, hospital discharge planners, or primary care physicians; (2) find and engage these members in the communities where they live; (3) assess and	- Community care connectors - Social workers -Nurses - Community Health Workers -Telephonic care managers	Unknown	6-month pre/post engagement data showed a double-digit reduction in total costs per member per month, the majority of which can be attributed to avoided inpatient admissions. Program evaluation will continue to monitor for up to 18 months of pre/post engagement data where available.

		address immediate medical, behavioral, and social need(s) using a trauma- informed, strength-based approach; (4) establish a connection to the medical and behavioral health neighborhood and social services; (5) monitor and support execution of a common plan of care by addressing barriers and closing care gaps; and (6) promote self-management by coaching members to develop problem-solving and self-advocacy skills. Staff also coordinated with behavioral health services, supported vitals monitoring and health coaching, and managed open social services pathways of active members.			
28) CeltiCare Health Plan of Massachusetts (Centene is a large, multistate for-profit health plan, covering 5.7 Medicaid members in 17 states)	- Housing - Clinical services - Substance abuse services	Low touch services: Health plan's management of all aspects of opioid use, addressing prescriber behavior, inappropriate member utilization, and the treatment of opioid addiction (leading to recovery). CeltiCare expanded access to community-based services by creating housing-first	- Care managers	-Increased adherence to treatment and recovery programs -Improved access and health outcomes - Increased promotion of patient-centered care through engagement and shared decision-making - Reduced per capita	Emergency department use (and costs) has dropped in the health plan's overall population.

		and peer-support initiatives, expanding the availability of these critically valuable services beyond state-sponsored efforts.		cost of care	
29) Volunteer State Health Plan (Anthem is a large, multistate for-profit health plan, covering 5.9 Medicaid members across the US)	- Family and social supports	Low touch services: Created a Rapid Response Team for Children in Foster Care. Fostered strong collaboration with the Department of Children's Services; early contact with foster parents and ongoing support; medical homes for children; timely preventive, primary, and specialty care; comprehensive care management for children with chronic medical conditions and/or behavioral health needs; support for children aging out of foster care; and the ability to respond on a moment's notice to the full range of often unexpected needs at any hour of the day or night. VSHP worked with Shared Health, Tennessee's largest public/private information exchange, to increase the use of electronic health records (EHRs) that the exchange had created	- Care managers - Nurses - Licensed behavioral health clinicians	Unknown	For the past four years, VSHP's three health plans have far exceeded the federal standard for well-child screening. Two VSHP plans achieved 100 percent scores in 2011. In 2011, VSHP's TennCare Select health plan received the highest score possible on an assessment of patients' care experiences—the "Best Overall CAHPS Award"12—from the Bureau of TennCare's Quality Oversight Division.

		for each child. VSHP's care managers lead conference calls including social service staff, health care practitioners, and caregivers to discuss complex care issues on a regular basis.			
30) Aetna Better Health (Large, multistate for-profit health plan, covering 2.3 Medicaid members in 12 states)	- Transportation - Child care - Health behaviors - Employment - Family/ social support	Moderate touch services: When Medicaid members join Aetna, the health plan reviews their health histories and past use of hospital and emergency room care. Conduct in-depth interviews Care managers serve as Medicaid members' single point of contact to all of the health care, social services, and behavioral health care they need and can guide people to a broad range of resources in their communities, All assessments include medical, behavioral and social components and evidence based practices	- Care managers (nurses and social workers) - Primary care doctors - Psychiatrists - Nutritionists - Pharmacists	Unknown	Unknown

31) CareSource (Large, multistate non-profit health plan, covering 1.5 Medicaid members in Ohio, Indiana, Kentucky and West Virginia)	- Food - Housing - Clinical services	Low touch services: As soon as CareSource learns of a Medicaid member with a high-risk pregnancy, a prenatal nurse case manager gets in touch to help her find a pediatrician. Nurses then coordinate with pharmacists, social workers, and others on CareSource's case management team to help women access all of the treatments and services they need. Nurse case managers follow up with families six months to a year later and may stay in touch for many years.	- Prenatal nurse case manager	Unknown	From 2011-2012, the number of NICU readmissions among CareSource's Medicaid members fell by 10%, and the rate of readmissions per thousand dropped by 2%
32) UCare (Non-profit health plan serving 42,000 Medicaid members in Minnesota)	- Food - Transportation - Financial services - Utilities	Low touch services: Health plan assigns a trained care coordinator to each member who takes charge of administering the uniform assessment and working with beneficiaries and their families to develop and execute the customized care plan	- Care coordinators - Nurses - Social workers - Pharmacists - Home care workers	- Enhanced access to care - Fewer hospitalizations -Reduced nursing home lengths of stay - Reduced nursing home admissions - Increased satisfaction among healthcare providers - Increased satisfaction among beneficiaries	From 2005- 2009, the monthly nursing home admission rate for people in MSHO and UCare's Minnesota Senior Care Plus (Medicaid Managed Care for Seniors) consistently was about 50 percent lower than for beneficiaries in Medicare's fee-for-service (FFS) program. The average nursing home length of stay among MSHO and Minnesota Senior Care Plus members was between 2 and 10 percent lower than among those with Medicare FFS coverage. From 2007-2011, the proportion of MSHO and Minnesota Senior Care Plus

					members age 65-84 with heart disease and/or diabetes who took aspirin every day as recommended rose from 25.9 percent to 41.8 percent.
33) Molina Healthcare of New Mexico (Large, multistate for-profit health plan, covering 3.3 Medicaid members in 12 states)	- Food - Utilities - Home remediation/ repairs - Family/ social support - Transportation - Clinical services - Financial services	Low touch services: CHWs provided patients education, advocacy and social support for a period up to 6 months	- Client Support Assistants (Community Health Workers) - Medical director - Health services director (registered nurse) - Care coordinators	- Decreased Emergency Department utilization and costs -Decreased inpatient utilization and costs - Increased management of chronic diseases	Decreased utilization and reduced costs associated with: Emergency Department use, inpatient care, non -narcotics prescriptions, and narcotics prescriptions
34) UPMC Health Plan (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	- Housing	Low touch services: Health plan leads a housing support initiative to secure stable housing for members Primary care practice provides care coordination and health services. Housing subsidies provided by HUD	- Registered nurse - Case managers	- Reduced Per-member-per- month (PMPM) claims costs associated with utilization patterns.	For this initial population, the program has yielded numerous favorable results, including: A 23% reduction in overall per-member-per-month (PMPM) claims costs. Before entering the program, enrollees averaged PMPM costs of roughly $4,100 versus PMPM costs of roughly $3,200 while in the program PMPM cost reductions occurred in all medical service categories except prescription drugs, where a slight increase occurred The vast majority of enrollees remained stably housed

35) Health Plan of San Mateo* *Plan is a Health Insuring Organization (HIO), a member plan in California's County Organized Health Systems (COHS). (Non-profit health plan serving 112,000 Medicaid members in San Mateo County)	- Housing	Low touch services: Health plan leveraged affordable housing partnerships, identified supplemental funding, gathered information from a wide range of alternative housing providers and service organizations In the future, the health plan will identify those at high risk for institutionalization and, when appropriate, work to "intercept" their institutionalization such that they can lead healthier, more productive lives in the community.	- Case managers (licensed social workers) - Clinical supervisor - Intake specialist - Project manager	- Reduced cost of care (HPSM must achieve sufficient reductions in costly institutional services to procure and maintain housing and service alternatives.)	Early results of the program show decreased cost and overall improvement in the system – including better outcomes for their patients.
36) Central California Alliance for Health* *Plan is a Health Insuring Organization (HIO), a member plan in California's County Organized Health Systems (COHS). (Non- profit health plan serving 350,000 Medicaid members in Santa Cruz, Monterey and Merced counties)	- Housing	Low touch services: Contracts with Project Connect to provide case management for up to 20 medically needy Alliance members Working with multiple agencies to provide housing, case management and recuperative care for homeless individuals	Unknown	Unknown	Unknown
37) Amida Care (Non- profit New York City-	- Employment	Moderate touch services: Health plan employs its enrollees to serve in a	-Health plan staff	- Increase access to employment	Health plan to date has hired, trained and employed more than 250 of its enrollees to serve in a

based health plan focused on people living with HIV, serving 6,100 Medicaid members)		variety of community-support roles. Affords members experience that can lead to the attainment of full-time employment. Roles include: Peer Specialists: Amida Care enlists people to provide peer coaching that includes sharing personal experiences to help motivate enrollees who are facing similar challenges. The engagement is for a six-month cycle and participants are paid a modest stipend. Community Health Outreach Workers (CHOWs): Amida Care employs CHOWs to canvass the community and help the health plan re-engage with enrollees who have dropped out of care. Health Navigators: Amida Care employs full-time health navigators to conduct peer coaching, escort enrollees to/from care, and provide other navigation support. Health navigators typically work 35 hours per week. Member Advisory Council (MAC): MAC participants attend 6-8			variety of community-support roles.

		meetings per year, serving as advisors to health plan management on consumer feedback and ways to improve health care delivery and increase satisfaction.			
38) Community Health Choice (Non-profit health plan serving 240,000 Medicaid members in Texas)	- Employment	Low touch services: Health plan provides career counseling and workforce training to underprivileged high school students and young adults. Community hires interns from local schools and educates them about health care and provides them work experience within the day-to-day operations of the health plan. Programs expose participants to the work environment in their preferred field, providing internships with local companies.	Unknown	-Increase access to employment	Unknown
39) Family Health Network (Non-profit health plan serving 252,000 Medicaid members in Illinois)	- Education	Low touch services: Established book club that provides free books & rewards students for completing academic work and improving their reading skills Members can initially enroll in the Children's Book Club by submitting three book reports	Unknown	- Increased reading literacy	Unknown

		accompanied by a registration form. In return they receive a club book bag, a new book, reading certificate and a $10 Target gift card. After the first submission, members continue to receive the reading certificate, new book and gift card for every quarter they continue to participate by submitting three book reports.			
40) AlohaCare (Non-profit health plan serving 67,000 Medicaid members in Hawaii)	- Education	Low touch services: Undergraduate scholarship program offering up to $2,500 a year To help address the health care shortage in rural areas, preferences will be given to students from a neighbor island (other than Oahu) and/or graduates from a neighbor island high school.	Unknown	- Increased college attainment	Scholarship has helped more than 300 students across all 10 University of Hawaii campuses reach their higher education goals.
41) Health Services for Children with Special Needs, Inc.	- Education - Family/ social supports	Low touch services: When invited by the child's primary caregiver, the HSCSN Care Manager attends meetings held between the child's speech therapist, physical therapist, occupational therapist, and the DC Office of the State Superintendent of	- Care managers	Unknown	Unknown

		Education (OSSE) to discuss the child's Early Intervention and Individualized Family Service Plan (IFSP)			
42) Health Plan of San Joaquin (Non-profit health plan serving 337,000 Medicaid members in California)	- Food	Low touch services: Health plan leads the following: 1) sponsors the downtown Stockton Farmer's Market, which brings fresh produce, nutritional education classes, and meal preparation instructions (including cooking demonstrations) to low-income communities, 2) supports an urban community farm in a low-income, food desert area, 3) provided financial support for the purchase of a refrigerated truck shared by a coalition of shelters and organizations to distribute food to those in need	Unknown	- Increased access to food	From 2011 to 2012, approximately 2,000 community members indirectly benefitted from the program by volunteering on the farm, attending educational workshops, and/or receiving affordable organic produce from the farm. While the programs are available to individuals throughout the community, HPSJ staff indicate that at least 80 percent of program participants receive Medi-Cal. Surveys of the persons receiving food and educational support through the Mobile Farmers Market yielded encouraging findings
43) CareSource (Large, multistate non-profit health plan, covering 1.5 Medicaid members in Ohio, Indiana, Kentucky and West Virginia)	- Food - Health behaviors	Low touch services: Deployed more than 60 Patient Navigators to the homes of more than 8,000 high-risk members Distribute portable, diabetic-friendly food packs at quarterly meetings	- Case Manager - Diabetes Disease Management Nurses - Patient Navigators	- Increased patient satisfaction	Preliminary descriptive survey data results of 80 patients were reported. 88% of participants were satisfied or extremely satisfied with diabetic food pack; 65% of participants were satisfied or extremely satisfied with education given in conjunction with food pack; 72% of participants were satisfied or extremely satisfied with variety of food

					provided; and 64% were satisfied or extremely satisfied with the quality of food provided. CareSource recently announced that it is expanding this initiative beyond Diabetic Food Packs. CareSource will donate $100,000 to five Ohio food banks to help them distribute backpacks of food to the under-privileged, many of them school children. This funding is intended to provide food backpacks to 25,000 low-income Ohioans.
44) CareOregon "Prescription Veggies? CareOregon pilot program helps patients eat healthier food." Portland Business Journal, May 30, 2014, written by Elizabeth Hayes.	- Food	Low touch services: Teamed with three of its network clinics to provide $15 food vouchers, which the physicians deliver to enrollees during patient visits similar to offering prescriptions Physicians provide education around shopping for and preparing nutritious food Each $15 "prescription" comes with two refills, for a total of $45 that can be spent on organic food at an area grocer (which operates trolleys parked outside the participating clinics)	- Physicians	- Increase healthy dietary habits	Unknown

45) Health Services for Children with Special Needs, Inc.	- Family and social support	Low touch services: Plan recognized the need for an outlet and support group specifically tailored to male caregivers so they could discuss the needs of their children with others in similar situations. Meetings are held at the plan's community outreach offices, close to where many members reside. HSCSN provides transportation for those who need it.	Unknown	Unknown	Over the 10-year life of the male caregivers support program, several hundred male caregivers support group meetings have occurred
46) L.A. Care Health Plan (Non-profit health plan serving 1.3 Medicaid members in California)	- Health behaviors - Food - Education - Family and social supports	High touch services: Plan operates 4 centers across the Los Angeles area in predominantly African American and Latino neighborhoods: Boyle Heights, Inglewood, Lynwood, and Pacoima. Center activities focus on: - Health education classes (e.g., healthy cooking, managing asthma, diabetes or weight.) - Exercise classes (e.g., Zumba, yoga, Pilates, Tai Chi, aerobics) - Help finding a doctor - Health screenings (e.g. blood pressure, weight and vision)	-Registered dieticians - Fitness class instructors - Member service representatives - Enrollment assisters	Unknown	Unknown

		-Medicaid enrollment assistance - Child care A Department of Public Social Services (DPSS) Staff at the center help with applications for WIC, Medi-Cal, Healthy Families and Healthy Kids programs.			
47) Commonwealth Care Alliance Senior Care Options Plan (Initiative continues under the auspices of CMS Medicare Advantage as a Special Needs Plan, with a separate contractual arrangement with the state Medicaid program) Source: https://innovations.ahrq.gov/profiles/plan-funded-team-coordinates-enhanced-primary-care-and-support-services-risk-seniors	- Transportation - Family and social supports - Food	Moderate touch services: The team ensures that at-risk, medically complex individuals receive needed medical care and social services, with the goal of keeping them healthy and allowing them to remain in their homes for as long as possible (enabling independent living). Plan manages a selectively chosen network of providers who have made a commitment to providing the level of service needed by plan members. Enrollees receive 1) Assignment to a primary care site 2) Development of a care plan 3) Ongoing care and care coordination, assessment, and monitoring from primary care team	-Physicians - Nurse practitioners - Geriatric support services coordinator (social workers)	-Reduced hospitalizations - Reduced nursing home placements	Unpublished data for Senior Care Options from 2007 found the number of hospital days per 1000 members as equal to 55% of the number hospital days for comparable patients cared for in fee- for-service payment environments. Senior Care Options also reported the rate of nursing home placements as 30% the rate of comparable seniors in Medicaid fee-for-service environments from 2005-2009. Total medical spending in Senior Care Options for seniors eligible for nursing home placements from 2004-2009, as well as ambulatory seniors from 2006-2009, grew by a much lower annual rate than fee-for-service growth rates.

48) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid members in Massachusetts)	- Family and social supports - Transportation - Health behaviors - Clinical services	Moderate touch services: Designed as an alternative structure of care, including: - A multidisciplinary clinical and nonclinical team - Behavioral health and physical health integration - Home visits - Intensive case management - 24 hour call system - Support groups - Health promotion	- Nurses - Nurse practitioners - Mental health and addiction counselors - Medical assistants	- Reduced disparities - Reduced total cost of care - Reduced emergency room visits and costs - Reduced inpatient hospital stays and costs - Increased primary care services, care coordination, outpatient mental health services and substance abuse treatment - Improved access - Improved health	Saw increased primary care costs
49) Superior Health Plan (STAR)	- Family and social supports - Clinical services - Clothing/ personal care - Health behaviors	Moderate touch services: Offers care coordination services, facilitates connections to community-based services, performs psychotropic drug utilization review, and trains caseworkers and foster parents on the impact of trauma on children in the system. Health plan staff conduct an assessment to identify specific needs and then assign	- Service manager (registered nurses or social workers) - Service coordinators (vocational nurses) - Caseworkers - Well-being specialists - Residential providers - Court-appointed special advocates	Unknown	The program has resulted in improved access to care, higher follow up rates after hospitalization for mental illness than national averages, and reduced use of psychotropic drugs among children in foster care.

		enrollees to one of three service categories based on intensity of need (e.g., service management, service coordination, low need) Health Passport online database, including: includes demographic data, a list of medical contacts/providers, health history, insurance claims, immunization records, prescriptions, laboratory test results, State-required assessment forms, the health care service plan (for children receiving service management), and results of psychotropic utilization reviews. Enhanced program: Case-by-Case Services (available upon approval) include support services such as trauma-informed peer support for caregivers, practice visits for gynecology and dental appointments and services to assist when a child with primary medical needs moves. Small cash grants for items like art supplies, clothing or other personal items. a2A CentAccount® Rewards Program offering rewards dollars			

		for members who complete wellness visits, dental checkups and other health screenings for members ages 18 through 21 years old. Boys and Girls Club Membership for members ages 6 through 18 years old. In addition to online training opportunities STAR Health Members will have access to www.mystrength.com online resources to improve mental health and overall wellbeing available for members, caregiver, and caseworkers. Mobile access offered to Health Passport account Statewide access to specialized foster care clinics that have expertise in child welfare and Trauma Informed Care.			
50) Priority Health Plan	- Transportation - Clinical services	Low touch services: Together the Local Multidisciplinary Teams and Virtual CHAP provide, education, care coordination, community resource referral, transportation and other necessary services to address social determinants of health and barriers to medical	- Program manager - Pediatric nurses - Resource coordinators - Social workers - Community Health Workers (bilingual-English and Spanish)	Unknown	Unknown

		access for children on Medicaid.	- Asthma educators		
51) Molina Healthcare (Large, multistate for-profit health plan, covering 3.3 Medicaid members in 12 states)	- Clinical services - Mental health services - Employment - Food - Utilities - Housing - Education - Clothing - Health behaviors - Family and social supports	Moderate touch services: Provide counseling and support services in home- and community-based settings	- Therapists - Service coordinators - Nurses - Psychiatrists -Substance abuse specialists - Housing specialists - Education/ employment specialists - Benefits specialists - Peer mentors - Recovery coaches -Family aids - Family support partners	Unknown	Unknown
52) Health Net (Non-profit health plan serving 1.5 Medicaid members in California)	- Health behaviors - Food - Family and social supports	High touch services: Operates a community resource center that offers: -Referrals to public services -Health and wellness classes for all ages based on community needs - Nutrition and health education classes	- Fitness Instructors - Resource Center Representatives	Unknown	Unknown

		- "One-Stop" shop to learn about coverage options - Enrollment advice (how to enroll in a health plan) -Meeting space available for community use			
53) WellCare (Large, multistate for-profit health plan, covering 2.4 Medicaid members in 9 states)	- Education	Low touch services: Covers testing and coursework for GED® or HiSET® exams.Members must: -Be at least 18 years old -Not have graduated from an accredited high school or received a high school equivalency certificate or diploma, -Not be currently enrolled in a high school	Unknown	-Increased access to educational attainment	Unknown
54) WellCare (Large, multistate for-profit health plan, covering 2.4 Medicaid members in 9 states)	- Health behaviors - Clinical services	Moderate touch services: Neighborhood health information, education and activity centers. Events range from exercise and nutrition classes to preventive health, safety and disease management education. Past events WellCare Welcome Rooms have hosted are: meetings for community partners like the Girl and Boy Scouts and local day care centers; monthly art and craft days; Mobile	Unknown	Unknown	Unknown

		mammography screenings; Zumba and yoga classes; ealth classes on smoking cessation, autism, and more.			
55) EmblemHealth (Non-profit health plan serving 263,000 Medicaid members in New York)	- Health behaviors - Family and social supports - Clinical services - Mental health services - Financial services - Food	Moderate touch services: Staff support EmblemHealth members and the community with connections to information and solutions to traditional and non-traditional issues. -Offer support and personal attention -Provide BMI screening -Offer the following classes: - Care for the Family Caregiver -Diabetes self-management - Nutrition - Tai Chi - Wii Fitness -Yoga - Financial planning	- Health Care Solutions Specialists - Case Managers (Social Workers) - Community Liaisons -Registered Nurses - Pharmacists	Unknown	Unknown
56) Gateway Health Plan (Non-profit health plan serving 312,000 Medicaid members in Pennsylvania)	- Housing - Health behaviors	Low touch services: Patient education and provider coordination was provided to all patients with asthma, and a more intensive home-based teaching	-Respiratory therapists	- Decreased ED visits	Two quasi-experimental studies reported mixed findings. One group pre/posttest design on enrolled members found significant reductions in ED visits and hospital

		program was implemented for those who had multiple ED visits or who had been hospitalized with asthma			admissions (*P* <.001). An additional treatment-control group comparison was conducted.
57) Commonwealth Care Alliance	- Transportation - Family and social support - Food - Housing	Moderate touch services: Teams provide assessments; care planning; 24/7 staff availability; and intensive medical, behavioral health, palliative care, and social support services in the home and community Plan manages a selectively chosen network of providers who have made a commitment to providing the level of service needed by plan members. Enrollees receive: 1) Assignment to a primary care site 2) Development of a care plan 3) Ongoing care and care coordination, assessment, and monitoring from a care team.	-Physicians - Nurse practitioners - Geriatric support services coordinator (social workers)	-Reduced costs of care	Unpublished data show that total monthly costs were $3,601 in 2008, compared with $5,210 for Medicaid fee-for-service patients with conditions of similar severity.
58) Neighborhood Health Plan	Unknown	Low touch services: Case management includes home visits, the	-Family coordinator - Care manager	- Reduced utilization - Reduced costs	Observational and descriptive data showed a 50% reduction in MHSPY

(Non-profit health plan serving 294,000 Medicaid members in Massachusetts)		identification of social needs and natural supports such as teachers, neighbors, state agency staff who are linked into the care team		- Increased member satisfaction	enrollee days spent in placements not covered under the MHSPY benefit (including foster care, residential, group home, detention, jail, pre-independent living, assessment, secure treatment, or boot camp). Enrollee expenses averaged 50%-60% less than similar youth in more restrictive settings. Approximately 81% of the graduating youth and 68% of other MHSPY youth remain in their homes after leaving the MHSPY program. High levels of satisfaction were reported by parents and youth enrolled in the program.
59) CareOregon (A Portland, Oregon-based non-profit Medicaid health plan)	- Housing - Food - Family and social supports	Low touch services: CareOregon uses claims data to identify members who are receiving an unusually high volume of care, and the plan's providers meet with those members to decide whether they would benefit from the program. Health Resilience Specialists visit participants in their homes and communities to help them work toward wellness and stability in their lives, and play an important role in developing a highly individualized	- Health Resilience Specialists (social workers)	- Reduced inpatient admissions - Reduced ED visits	After one year of work with a Health Resilience Specialist, participants had reduced inpatientadmissions of more than 30 percent and half the number of emergency department (ED) visits. Prior to being identified as candidates for the program, they averaged 3.1 hospital inpatient admissions and 13.1 ED visits each year. One year after the initial intervention, enrollees averaged one hospital inpatient admission and 5.8 ED visits per year.

		approach to address each person's unique set of challenges. These range from traditional medical assistance — such as accompanying individuals to their appointment with a mental health practitioner — to non-traditional meetings and interactions, such as helping them move out of a destructive home environment, or meeting in a park, restaurant or other place the person is particularly comfortable.			
60) Capital District Physicians Health Plan (Non-profit health plan serving 90,000 Medicaid members in New York)	- Housing - Mental health services	Low touch services: Embeds a behavioral health case manager into primary care offices. Through their collaboration with the PCP, the care manager monitors medication compliance and effectiveness, and assists primary care physicians with the referral process to outpatient behavioral health providers, including facilitating communication and ensuring there is a consistent care plan among all providers. The case manager has two core responsibilities:	- Behavioral health case manager	-Reduced inpatient admissions -Reduced ED visits -Decreased cost of care	Following intervention, 83 percent of individuals seen by a case manager did not have another hospital admission in the next year, and 76 percent had a reduction in ED visits; almost half of participants had no ED visits in the following year. These reductions led to an average cost savings of $1,154 per person in the program. Out of 180 program referrals in 2012, 101 individuals engaged in treatment with a behavioral health provider. Of those 101, 65 remained committed to and engaged in their treatment more than a year later.

		working with physicians to help coordinate care, and working with patients to engage them in their care. Once a CDPHP provider identifies a person as a potential beneficiary of the program, he or she is referred to in-office case management. The case manager spends two days per week working directly in a primary care office, and assists in treatment and care coordination among primary care physicians (PCP), mental health providers and the patient and his or her family.			
61) Gold Coast Health Plan* *The plan is a Health Insuring Organization (HIO), a member plan in California's County Organized Health Systems (COHS). (Non-profit health plan serving 206,000 Medicaid members in Callifornia)	Unknown	Low touch services: After an ED visit by one of the plan's members, a Health Navigator contacts the member to help renew the connection to his or her primary care provider. Health Navigators assist members with appointment scheduling and other social service needs, and educate beneficiaries about the importance of establishing and maintaining a relationship with their	-Health Navigators -Care coordinators	Unknown	Unknown

		primary care provider Care coordinators, assist ED high utilizers in accessing primary care services and other social service needs			
62) UPMC Health Plan (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	- Housing - Transportation - Employment - Mental health services	Low touch services: Aims to strengthen the collaboration between physical and behavioral health care providers	- Navigators - Care Managers	Unknown	During its first two years, Connected Care resulted in 12 percent fewer hospital readmissions among the targeted population. Data from the pilot led to improved communication and member access to resources. The program continues, and modifications are being evaluated to extend it to other populations with multiple chronic conditions.
63) Keystone Mercy Health Plan (Formerly Keystone Mercy Health Plan) (Non-profit health plan serving 400,000 Medicaid members in Pennsylvania)	- Mental health services - Health behaviors - Clinical services	Low touch services: Navigators work with members and their health care providers to share information, better coordinate care, and design a personal plan for members.	- Navigators	Unknown	Unknown
64) Gateway Health Plan (Non-profit health plan serving 312,000 Medicaid members in Pennsylvania)	- Health behaviors - Food - Housing - Clothes - Substance abuse - Financial services - Mental health services	Moderate touch services: Identifies members at high risk for hospitalization, conducts a comprehensive needs assessment using its	- Care managers - Member services staff - Utilization management staff	-Reduced avoidable admissions	Staff attribute the 9% decline in the plan's inpatient admission rate from 2009 to 2012 to the combination of PCM/community initiatives

	- Employment - Home remediation/ repairs - Legal assistance - Family/ social support - Clinical services - Transportation - Utilities	BEEMSS tool (which evaluates behavioral, environmental, economic, medical, social and spiritual needs), and develops and implements a care plan that includes finding and linking members to a wide range of community resources Gateway developed a database of 3,000 community resources that care management and member services staff use to refer patients. Health plan staff members continually update the database through local meetings and personal relationships with organizations and through member feedback. 40% of care management cases rely on the repository. Community meetings and events to network with local health and social service providers are also scheduled.	- Preventive health specialist		
65) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid members in Massachusetts)	- Food - Clinical services - Health behaviors	Low touch services: NHP partners with local grocery stores and pharmacies to address high blood pressure and diabetes among African	- Supermarket outreach workers	- Improved blood pressure control	Unknown

		Americans. The MCO places a facilitator in local grocery stores to survey consumers and help raise awareness of good nutrition and healthy eating, and mails coupons and vouchers for fresh produce to members. The health plan also provides diabetes education and glucose and blood pressure screenings at health fairs at local pharmacies, and reimburses members for blood pressure cuffs			
66) HealthPartners (Non-profit health plan serving 83,000 Medicaid members in Minnesota)	-Housing -Clinical services	Moderated touch services: Teams are placed in public housing, nursing facilities, assisted-living residences, and adult day centers and provide primary and urgent care, social services, and develop care plans, and facilitate transitions. Electronic health records are shared with partner hospitals .	- Nurse practitioners -Geriatricians - Case managers - Home care staff	- Reduced hospital admissions	Hospital readmission rates at nursing facilities and low-income housing facilities with teams dropped nearly 30 percent and 50 percent, respectively
67) Neighborhood Health Plan (Non-profit health plan serving 294,000 Medicaid members in Massachusetts)	- Education - Childcare - Food - Clinical services	Low touch services: Health plan partners with local organizations to provide or refer members to education, childcare, health, food-related and other services; hosts new mom health and	Unknown	- Reduced disparities in postpartum complications	Postpartum visits increased by almost 3 percent among the Latina population in the first year. Well child visits increased by almost 9.5 percent for Latino children (during the first fifteen months of life) in

		wellness events; distributes health information in Spanish; hosts a new mom's support group			the first year of the program.
68) Oregon Coordinated Care Organizations ** Counted Oregon CCOs because they receive state premium payments on behalf of enrolled Medicaid beneficiaries.	-Family and social supports - Home repairs - Transportation - Housing - Food -Health behaviors	High touch services: CCOs are accountable for population health outcomes of the population they serve and use non- traditional health providers, who help patients address non- medical factors impacting health. One CCO pays for social workers to be staffed in emergency departments and to identify frequent visitors, connecting them with a primary care provider. Another CCO has expanded nurse coordination with post-partum women and complex pediatric patients	-Community health workers - Patient navigators -Health resilience specialists - Social workers	- Reduce the Medicaid spending growth rate to 3.4% by 2015 - Improved care coordination -Implementation of alternative payment methodologies -Integration of physical, behavioral, and oral health -Increased efficiency through administrative simplification -Use of flexible services to improve care. - Spreading effective innovations and best practices	- Compared with a 2011 baseline, the Oregon Health Authority reported that per-member per-month spending for inpatient care had decreased in 2014 by 14.8% - Per-member per-month spending on outpatient care was also lower, by 2.4%. - 19.2% increase in spending on primary care services