Primary Care Program Advisory Committee

March 7, 2024

Agenda

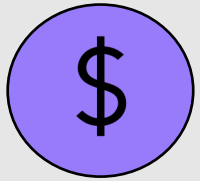
Topic	Time
Opening Remarks and Welcome	5 Minutes
Recap and Goals for Today	10 Minutes
Equity Strategy: Review & Discussion	35 Minutes
HRSN & Community Supports: Review & Discussion	35 Minutes
Wrap Up & Next Steps	5 Minutes

Goals for Today

1. Review and discuss the program's **crosscutting equity strategy**, taking stock of the different components we've discussed throughout this process and identifying any additions or modifications

2. Revisit the **HRSN screening & community supports** discussion, reviewing the committee's feedback to date and discussing next steps

Primary Care Program Design Status

Care Delivery 	*What are the key things that primary care should be doing differently or better to improve member health and well being?* **Oct 26th Meeting**	Chronic Condition, BH & Targeted Care Management → Accessibility of Care → HRSN Screening & Community Supports → Data Infrastructure & Data Sharing → Team Based Care
Performance Measurement 	*What is the definition of success? How should this be measured?* **Nov 14th Meeting** **Dec 7th Meeting**	Each domain is associated with a definition of success – and select **measures** that will be used to drive progress towards success.
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?* **Jan 18th Meeting** **Feb 8th Meeting**	The primary care payment model includes **base and performance-based payments** that advance care delivery and performance measurement priorities.

Crosscutting Equity Strategy: *How do we address inequities and racial disparities?* **TODAY**

Topic 1: Equity Strategy Review

Goal

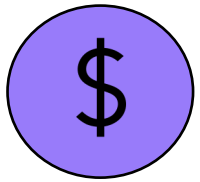
Review and discuss the program's **crosscutting equity strategy**, taking stock of the different components we've discussed throughout this process and identifying any additions or modifications

Approach

- **Review a starting point** based on previous discussions
- **Discuss** any additions or modifications

Equity Strategy Review

Cross Cutting Equity Strategy: *How do we address inequities and racial disparities?*

		Equity Strategy Components
Care Delivery 	*What are the key things that primary care should be doing differently or better to improve member health and well being?*	• Integration of community health workers (CHWs) • HRSN screening and referral • Use of HRSN/SDOH data to implement interventions and prioritize needed community resources • Requirements for competencies in care of individuals with disabilities and/or ADA training for care team members • Adherence to National Standards for Culturally and Linguistically Appropriate Services (CLAS)
Performance Measurement 	*What is the definition of success? How should this be measured?*	• Collection of race, ethnicity, language and disability (RELD) data and performance measure segmentation to identify and track reduction of disparities in quality of care and member outcomes, at the program and provider level • Use of patient reported experience measures • Use of process measures related to screening for and addressing health-related social needs
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?*	• Performance-based payment tied to collection of RELD data and/or performance on population-segmented measures • Base payment that provides care delivery flexibility and funding to support care delivery and performance measurement priorities • Medical and social risk adjustment that accounts for patient needs • Multi-track program that enables broad-based provider participation

For Discussion – Equity Strategy

Are there other components that should be considered as part of the program's crosscutting equity strategy?

Topic 2: HRSN Screening & Community Supports

Goal

Revisit the **HRSN screening & community supports** discussion, reviewing the committee's feedback to date and discussing next steps

Approach

- Provide a **quick recap** of discussions on this topic to date
- Summarize **key committee feedback**
- Propose **next steps** based on committee feedback

Quick Recap of Discussions to Date

Throughout this process, this committee has discussed and provided valuable feedback on strategies to address HRSN, both within and beyond the primary care system.

Meeting	Recap

Jul 13th*	• DSS reviewed a **framework for addressing HRSN** and provided an overview of:
	  • **Initiatives already underway**, such as the CHW Assessment and Referral program
	  • **1115 wavier strategies** used in other states to enable Medicaid to pay for HRSN services
	• Committee members participated in a **listening session**, sharing feedback on opportunities to address HRSN

Aug 3rd*	• DSS summarized **key learnings from the HRSN listening session** • DSS shared examples of state and federal **primary care programs that have integrated strategies** to identify and address HRSN
Oct 26th*	• Committee members discussed primary care capabilities/care delivery priorities and **voted HRSN Screening & Community Supports their third highest priority** (out of 10) • Committee members discussed what role primary care practices should play in addressing HRSN; **85% voted** that *primary care practices are expected to perform* ***certain functions related to screening, referral, and/or coordination***
Dec 7th*	• Committee members reviewed and provided feedback on potential **measures and requirements** that could be used to drive progress in the HRSN Screening & Community Supports domain
Jan 18th	• Committee members raised the **importance of community investment strategies** to support HRSN screening and referral strategies
Feb 8th	• Committee members suggested DSS explore **broader financial accountability structures** that ensure a portion of any savings generated are reinvested in community or BH providers

**Meeting materials available in the appendix*

Key Committee Feedback

(1) Primary care should play a role in addressing HRSN

- Committee members see **HRSN Screening & Community Supports as a top priority** primary care capability
- The majority of committee members (85%) say **primary care practices should be expected to perform certain functions related to screening, referral, and/or coordination for HRSN**
- Committee members see **value in integrating CHWs into care teams** and **building the capacity for primary care to partner with CBOs**

(2) Concurrent investments in community supports are critical

- **Without concurrent investments in community capacity, there is a risk** that Medicaid members will be referred to waitlists, diminishing the value of screen and refer strategies
- DSS should **consider how to develop a financing and accountability mechanism** that enables participation of a broad range of actors in the community and healthcare system who are critical in addressing HRSN

(3) DSS can not shoulder this work alone and should partner with other agencies as part of broader statewide efforts

- DSS cannot and should not shoulder SDOH/HRSN work alone; **this work requires multi-agency partnerships and collaboration**

Proposed Next Steps

(1) Move forward with a primary care program design that enables providers to address HRSN, integrate CHWs, and partner with community providers

- Support primary care practices with the tools and funding to enable practices to screen, refer, and coordinate to address HRSN
- Encourage integration of CHWs and partnership with CBOs

(2) Participate in broader statewide efforts underway to invest in communities

- Engage in broader multi-agency efforts to develop the organizational structures and integrated financing mechanisms to support community investment
- CT is exploring the possibility of applying for the AHEAD Model; if the state proceeds with an application and is selected to participate, there will be opportunities to pursue statewide strategies as part of the development of the AHEAD health equity strategy

AHEAD Model Opportunities

DSS anticipates that participation in the AHEAD model would provide a forum for a broader, multi-agency effort to develop community-driven strategies to improve population health.

The AHEAD model governance structure and Statewide Health Equity Plan components are directly responsive to the guidance this committee has provided around the collaboration and partnership needed to develop broader community investment strategies.

- States are required to establish a **model governance structure:** States are required to form **a multi-sector model governance structure** to guide implementation of the model. The structure must include various stakeholders, including providers, payers, CBOs and patients to ensure diverse perspectives are incorporated into the **design of statewide initiatives that improve population health.**
- States are required to develop a **Statewide Health Equity Plan (HEP):** States are required to develop HEPs to define **cross-sector and community-driven strategies aimed at reducing disparities and improving population health**. Participating hospitals are also required to create **hospital health equity plans** that align with statewide priorities and activities.

Source: States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

For Discussion – HRSN & Community Support Strategies

DSS recognizes that a multi-phased, multi-pronged approach will be needed to support a more comprehensive community investment approach.

As DSS moves forward with primary care program design, what program features will be most important to enable integration with broader efforts?

Next Steps

		Primary Care Program Advisory Committee Meeting Topics
Phase 1	**April 6**	Background & Introductions
	May 4	Primary Care Goals and Strategies
	June 1	Scope of Primary Care Design and Prior Work
	July 13	Listening Session: Strategies for Addressing Community Needs
	August 3	Review of Primary Care Program Examples and Discussion of Supplementary Data
	August 24	Supplementary Data Review Meeting
Phase 2	**October 5**	Process Check In and Review of Program Examples
	October 26	In Person Meeting: Care Delivery Redesign
	November 14	Primary Care Capabilities and Measurement – Part 1
	December 7	Primary Care Capabilities and Measurement – Part 2
	January 18	In Person Meeting: Payment Model – Part 1
	February 8	Payment Model – Part 2
	March 7	Equity Strategy Review
	April 4	In Person Meeting: Phase 2 Review

Appendix: HRSN Screening & Community Supports

This appendix includes materials reviewed and discussed during previous meetings.

Meeting	Recap

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Dec 7th	• Committee members reviewed and provided feedback on potential **measures and requirements** that could be used to drive progress in the HRSN Screening & Community Supports domain

Inform: Topic 1 – Starting Point (DSS Initiatives Underway)

July Meeting

Starting Point DSS Initiatives Underway	**This Committee's Work** Primary Care Payment Reform	**Broader Strategies** Under Consideration
DSS has a range of targeted initiatives aimed at addressing HRSN currently underway, including:	***Primary care payment reform will build on this by giving primary care providers the flexibility and incentives to:***	***DSS is exploring* a Section 1115 waiver to provide HRSN services to Medicaid members, including:***
• CHESS • Integrated Care for Kids (InCK) • Violence Prevention Professional Coverage • SUPPORT Grants • Community Options • ASO CHW Assessment and Referral • SUD 1115 Waiver • Family Bridge Pilot Program	• Identify members' health related social needs • Refer members to providers who can help address these needs • Assist members in arranging for and obtaining HRSN services	• Housing and nutrition supports for specified populations *Additional Executive and Legislative branch approval is required to pursue the waiver and has not yet been received

Connecticut Department of Social Services
Making a Difference

HUSKY HEALTH CONNECTICUT

July Meeting

DSS Initiatives Underway

Below is additional information on DSS' current, targeted initiatives aimed at addressing health-related social

DSS Initiatives	Program Description	Resources
Connecticut Housing Engagement and Support Services (CHESS)	CHESS provides **supportive housing benefits** under HUSKY Health (Medicaid), coordinated with Medicaid services and non-Medicaid housing subsidies to individuals with mental health, substance use and other serious health conditions.	CHESS Webpage
Integrated Care for Kids (InCK)	DSS selected a local lead organization, Clifford Beers Inc., to implement and test InCK (a child-centered local service delivery and state payment model) in New Haven. This model aims to reduce expenditures and **improve the quality of care for children** through prevention, early identification, and **treatment of behavioral and physical health needs**.	InCK Webpage
Violence Prevention Professional Coverage	HUSKY Health covers and reimburses **community violence prevention services** when performed by a qualified certified violence prevention professional (VPP).	Provider Bulletin
Substance Use Disorder Prevention that Promotes Opioid Recovery & Treatment (SUPPORT) Grant	SUPPORT is a Section 1003 Demonstration Project planning grant that Connecticut received to evaluate and recommend improvements for the substance use disorder (SUD) treatment system. DSS, in collaboration with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children Families (DCF), has been working to **assess access and provider capacity for SUD services** in Medicaid.	SUPPORT Progress Report
Community Options	HUSKY Health offers Community Options **Assisted Living services**, a combination of supportive services, personalized assistance and health care, to help eligible individuals who need support to live at home or to return to community living.	Community Options Info Page
Section 1115 Demonstration Waiver for Substance Use Disorder (SUD) Treatment	DSS implemented a **Substance Use Disorder Demonstration** to ensure a complete American Society of Addiction Medicine (ASAM) levels of care (LOCs) service array is available as part of an essential continuum of care for Medicaid enrolled individuals with opioid use disorder (OUD) and other SUDs.	SUD 1115 Waiver Webpage
Universal Nurse Home Visiting: Community Health Worker RFP	Five state agencies (the Office of Early Childhood (OEC), DSS, DCF, the Office of Health Strategy (OHS), and Department of Public Health (DPH)) released an RFP in 2022 to pilot the evidence-based Universal Nurse Home Visiting (UNHV) model in Greater Bridgeport. The model will support UNHV registered nurses in the provision of 1-3 **home visits to newborn families**. Families with additional needs will be connected to a CHW who will **link families with local resources**.	UNHV Webpage

DSS Initiatives Underway: CHW Assessment and Referral

July Meeting

Today, we will highlight the **CHNCT, Inc. CHW Assessment and Referral program**, and review data on the prevalence of SDOH/HRSN needs from that program.

- **When was this program started?** The CHW program began in 2014 under the Intensive Care Management (ICM) program. In February 2020, the CHWs were combined with the Community Engagement Team to enhance CHNCT, Inc.'s ability to help members access their HUSKY benefits and to obtain social determinants of health services. The expansion of the program, to meet DSS's new focus, occurred in July 2022 and a new CHNCT, Inc. Outreach program was established to assist members with finding a primary care provider.
- **Who does the program serve?** The program serves unattributed members with high utilization, who are high cost/high need, or who are referred from an external source.
- **How are members screened?** ICM assessments, Member Engagement Services (MES) representative screens, Health Risk Questionnaires (HRQ's), and reporting from claims and the OB P4P encounter forms.
- **How are members referred?** Members are referred to the CHWs by a Care Management Nurse, members self-refer via HUSKY Health 800 number, Member Engagement Services and HRQ responses.

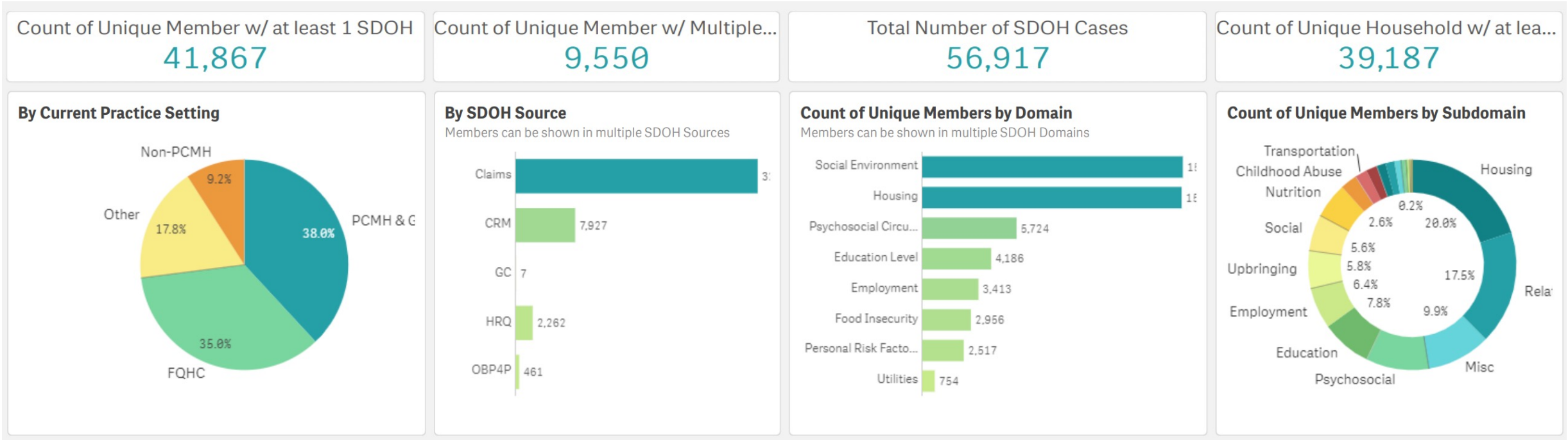
Social Determinant of Health Needs

July Meeting

In a one-year review of data - using a variety of sources, including claims, MES or ICM assessments - there were **41,867 uniq members** with at least one SDOH need in 2022. Following the DSS Domain Bulletin 2021-38, the top three domains were:

1. **Social Environment** – 38%
2. **Housing** – 37%
3. **Psychosocial Circumstances** – 14%

HUSKY Health SDOH Needs



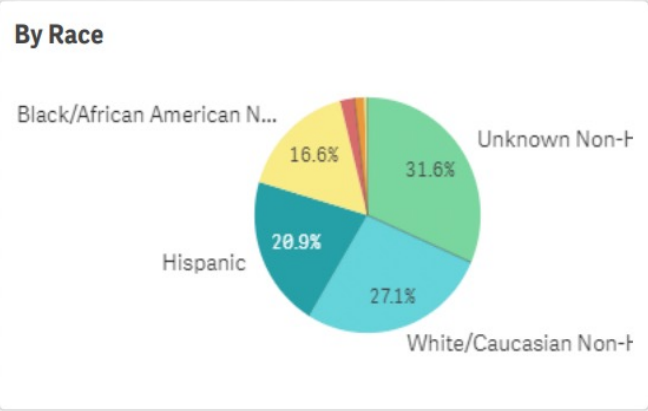
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

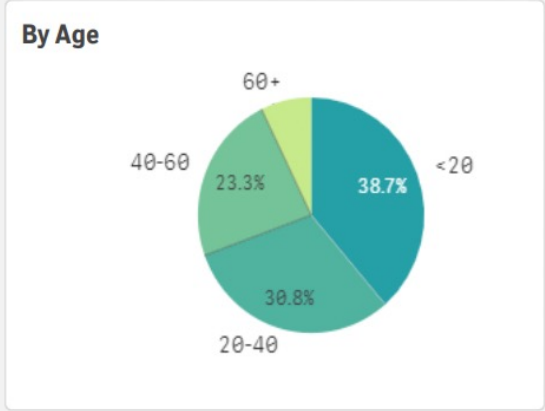
Community Health Network of Connecticut, Inc.

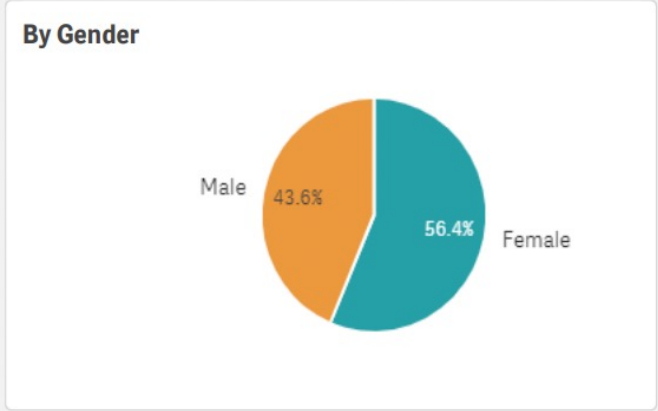
Social Determinant of Health Needs

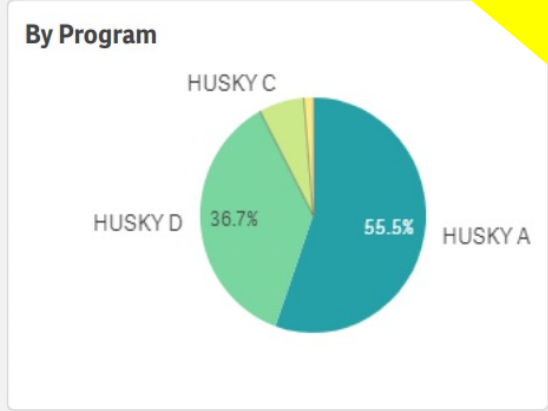
July Meeting

Member Demographics

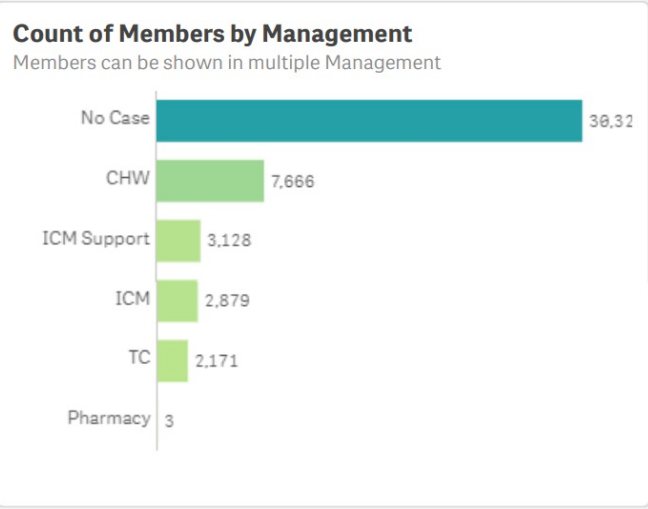


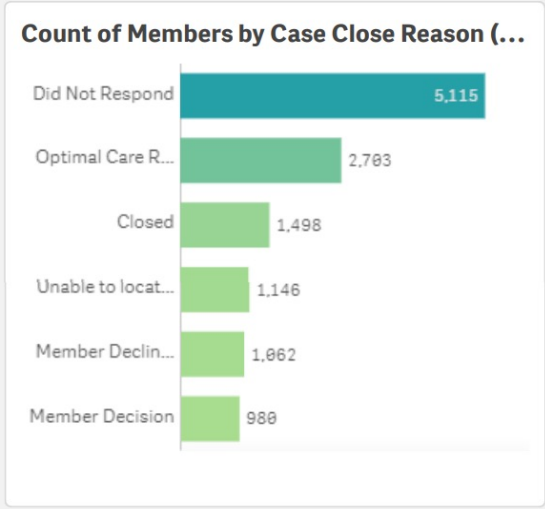


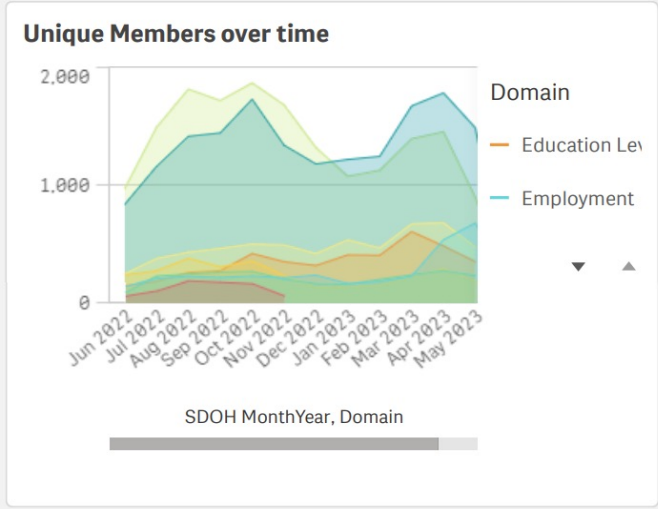


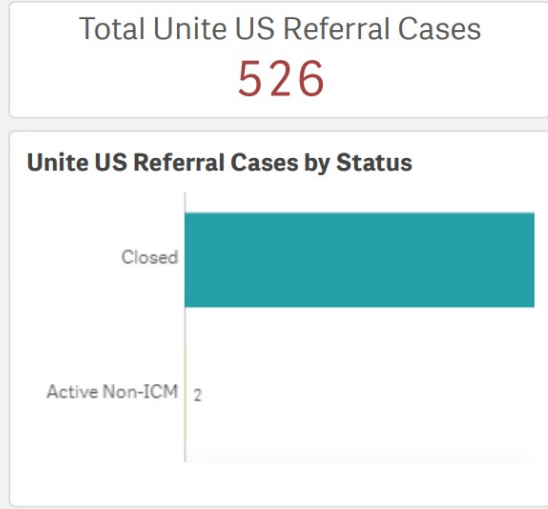


SDOH Case Management









Source: CHNCT, Inc. SDOH Dashboard (Member Level)

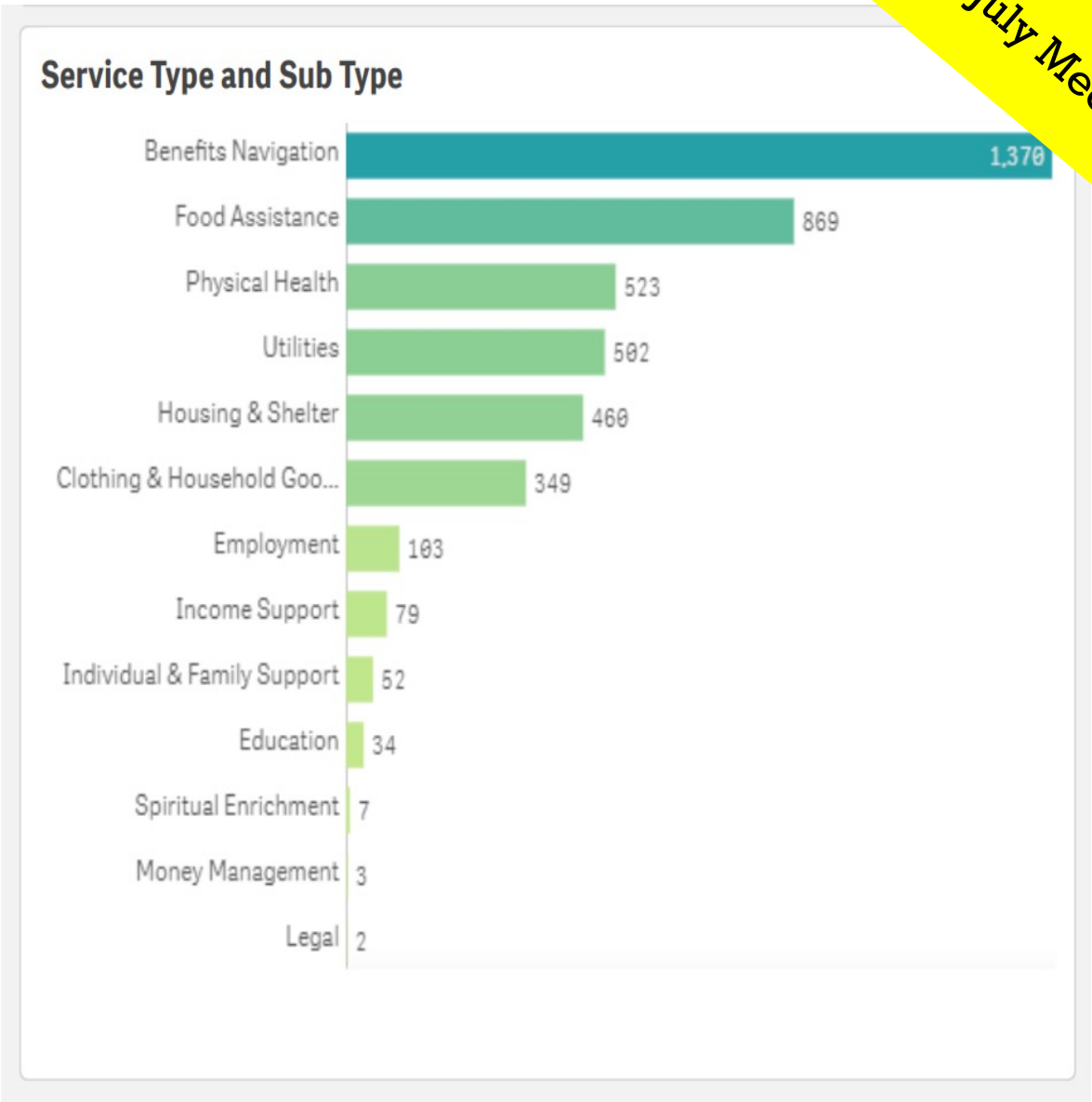
Community Health Network of Connecticut, Inc.

SDOH Referral Dashboard

July Meeting

Over 2,864 members were referred to Unite Us for SDOH support in 2022 of which:

- 36% of referrals were for **Benefit Navigation** (SNAP, Food and Cash Assistance Programs)
- 20% were for **Food Assistance**
- 14% were for **Housing/Shelter**



Source: CHNCT, Inc. UniteUs Dashboard

Community Health Network of Connecticut, Inc.

Inform: Topic 2 – Broader Strategies (1115 Waivers)

July Meeting

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July Meeting

Background & Context: Federal Guardrails

Federal guardrails place significant limitations around using federal funds to pay for non-medical services.

- Outside of Medicaid home and community-based services (HCBS) authority, **states have limited ability to use federal Medicaid funds to pay the direct costs of non-medical services** like housing and food
- **Section 1115 Waivers** give states additional flexibility and have been used by a number of states to address the health-related social needs of Medicaid enrollees.

In Fall 2022, CMS **approved four new 1115 Waivers** (AR, AZ, MA, OR) and outlined a **new method for waiver approval.**

Key Changes

Authorized Services

CMS authorized evidence-based HRSN services to address food insecurity and/or housing instability for specific high-need populations, including:

- **Housing supports** (e.g., six months of rent payments, pre-tenancy/ tenancy sustaining services, one-time moving costs, utility support)
- **Nutrition supports** (e.g., medically tailored meals, produce prescriptions, nutrition counseling/education, necessary cooking supplies)
- **HRSN case management** (and other services, case-by-case basis)

Financing

CMS made changes to the "budget neutrality" requirements associated with 1115 waivers, providing **more flexibility to spend on HRSN services** by:

- Specifying that HRSN spending does not require offsetting savings (which are typically required)
- Allowing states to spend **up to 3% of total annual Medicaid spend** on HRSN services, if other maintenance of effort/ provider payment guardrails are met

Source: Kaiser Family Foundation, 1115 Waiver Tracker
A Look at Recent Medicaid Guidance to Address Social Determinants of Health and Health-Related Social Needs (KFF, Febrary 2023)

July Meeting

States Using 1115 Waivers to Address SDOH

As of June 2023, 19 states have approved 1115 Waivers with SDOH related provisions.

States Approved in Fall 2022:

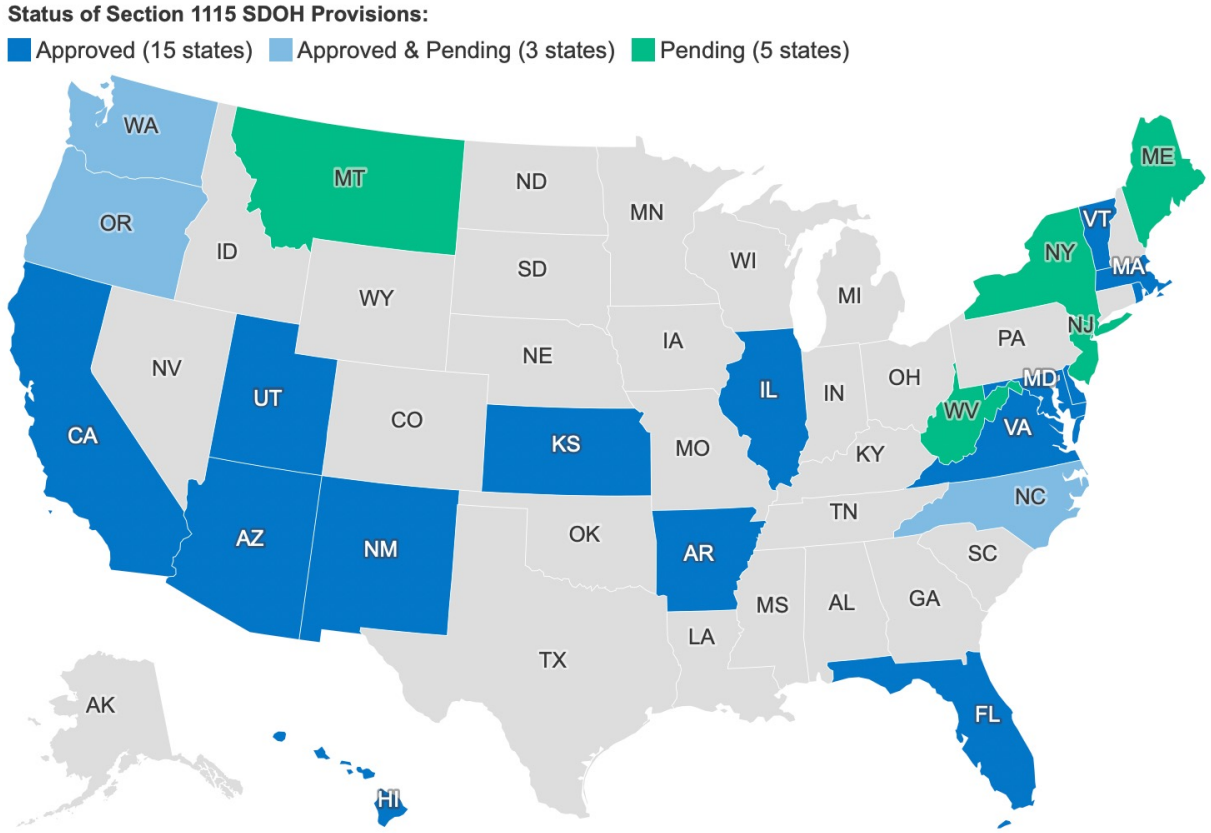
- Arizona
- Arkansas
- Massachusetts
- Oregon

Additional Approvals since Fall 2022:

- New Jersey

The remaining states had 1115 Waivers with SDOH related provisions approved prior to the release of CMS' new guidance in Fall 2022.

Section 1115 Waivers with Provisions Related to Social Determinants of Health (SDOH), as of 11/2/2022

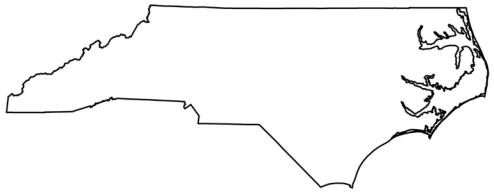


Source: Kaiser Family Foundation, 1115 Waiver Tracker

State Approaches: Prior 1115 Waiver Approvals

July Meeting

North Carolina and Washington had 1115 Waivers with SDOH related provisions approved prior to 2022.



North Carolina Healthy Opportunities Pilots

First of its kind program approved by CMS in 2018, allowing Medicaid funds to be used to pay for non-medical interventions that target SDOH

- Focuses on housing instability, transportation insecurity, interpersonal violence, and toxic stress
- Limited to high-need managed care enrollees who meet health and social risk factors
- Regionally based "Network Leads" develop, contract, and manage a network of CBOs that deliver pilot services. MCOs manage the pilot budget, determine enrollee eligibility, and authorize the delivery of pilot services (29 distinctly defined and priced services).

Washington Accountable Communities of Health

Regional ACHs are designed to serve as a convener, coordinating body, investor, and connection point between the health care delivery system and local communities

- Regionally based "Accountable Communities of Health" coordinate specific health care and social needs-related projects and activities
- CMS authorized funding for ACH performance-based incentive payments earned based on completion of activities, improvements in outcomes for beneficiaries residing in the ACH, and adoption of value-based payment methods

Kaiser Family Foundation, *A First Look at North Carolina's Section 1115 Medicaid Waiver's Healthy Opportunities Pilots,* May 15, 2019
Kaiser Family Foundation, *Section 1115 Waiver Watch: Approvals to Address Health-Related Social Needs,* Nov 15, 2022
State program webpages and program guidance/requirements documents

State Approaches: Recent 1115 Waiver Approvals

July Meeting

The four 1115 Waivers approved in Fall 2022 authorized the provision of HRSN services to specified high-need popu

	Arizona H2O Program	**Arkansas** Health and Opportunity for Me (ARHOME)	**Massachusetts** Flexible Services and Specialized CSPs	**Oregon** Health Plan
Expenditure Authorized	✓ **Housing Supports** ❑ Nutrition Supports ✓ **Case Management** ❑ Transportation to HRSN ✓ **HRSN Infrastructure**	✓ **Housing Supports** ✓ **Nutrition Supports** ✓ **Case Management** ❑ Transportation to HRSN ✓ **HRSN Infrastructure**	✓ **Housing Supports** ✓ **Nutrition Supports** ✓ **Case Management** ✓ **Transportation to HRSN** ✓ **HRSN Infrastructure**	✓ **Housing Supports** ✓ **Nutrition Supports** ✓ **Case Management** ❑ Transportation to HRSN ✓ **HRSN Infrastructure**
Target Populations	Members who are **homeless or at risk of becoming homeless** and who meet at least one clinical and social risk criteria	**Life360 HOMEs** are hospital-based entities providing intensive care coordination and HRSN services for three focus populations: • Individuals **with BH needs in rural areas** • Individuals **with high-risk pregnancies** • Young adults **at high risk for long-term poverty**	Members who are **participating in:** • **Flexible Services Program**: ACO-enrolled members who meet at least one health needs-based criteria and one risk factor • **Specialized CSPs**: Members who meet criteria related to behavioral health needs and are homeless, justice-involved, or facing eviction	Members **experiencing major life transitions**. (e.g., youth with special health care needs; justice-involved adults and youth, youth involved in child welfare system)

Kaiser Family Foundation, *Section 1115 Waiver Watch: Approvals to Address Health-Related Social Needs,* Nov 15, 2022
Kaiser Family Foundation, 1115 Waiver Tracker

HRSN Listening Session: Key Themes

August Meeting

Key Themes

Developing and Expanding SDOH/HRSN Initiatives

- **Encourage statewide, multi-agency partnerships:** Addressing SDOH requires cross-agency collaboration. DSS cannot and should not shoulder SDOH/HRSN work alone.
- **Integrate statewide resources:** Acknowledging that this is a work in progress, DSS should be cognizant of connecting HUSKY members to all Medicaid benefits (e.g., Veo – a free transportation benefit) and safety net programs/resources (e.g., SNAP, WIC, 211 line) that they are eligible for.
- **Expand pilot programs when successful:** It is important to both pilot SDOH/HRSN initiatives and pursue statewide coverage when initiatives are successful.

SDOH/HRSN Screening, Referral, and Outreach

- **Build capacity of CHWs and CBOs:** Given the large volume of HUSKY members with HRSN, there is a critical need and opportunity to expand use, access, and capacity of community health workers (CHWs) and community-based organizations (CBOs).
- **Increase community representation:** CHWs should have community-based connections and be representative of the HUSKY population served. Effective care coordination and case management requires developing trusting relationships.
- **Integrate CHWs into care teams:** CHWs are more likely to be trusted messengers than healthcare providers and staff. CHWs should partner with primary care providers to help HUSKY members navigate their care and benefits.

August Meeting

HRSN Listening Session: Key Themes

Key Themes

Delivery System

- **Pursue community-based HRSN strategies:** SDOH/HRSN are broader structural and public health issues which require community-based strategies beyond the scope of primary care.
- **Consider utilizing regional hubs:** Regional entities can provide more flexibility than centralized delivery systems (e.g., they can offer better tailored community-informed interventions and support).
- **Encourage upstream prevention**: This work should apply a public health approach aimed at upstream prevention, in contrast to the medical system's downstream focus.

Financing and Accountability

- **Support existing community-based collaboratives**: To improve infrastructure and overall capacity, fund and build off existing CBOs and faith-based organizations that already operate programs aimed at streamlining HRSN referrals for high need members.
- **Promote a whole person financing and accountability model:** Create financing and accountability structures that enable participation of a broad range of actors in the community and healthcare system who are critical in addressing HRSN.

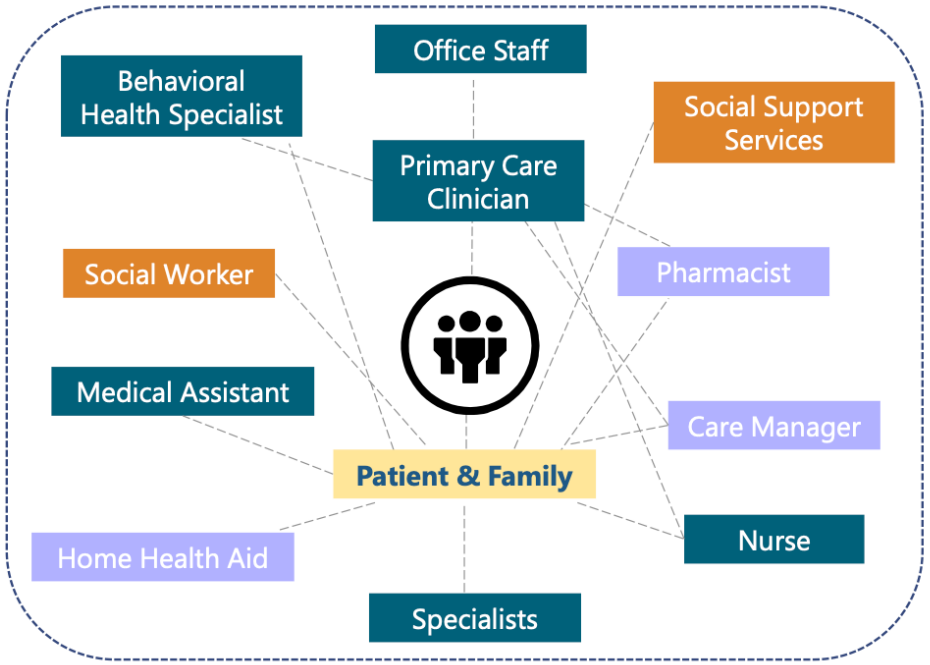
CMS Innovation Center Primary Care Programs and HRSN

August Meeting

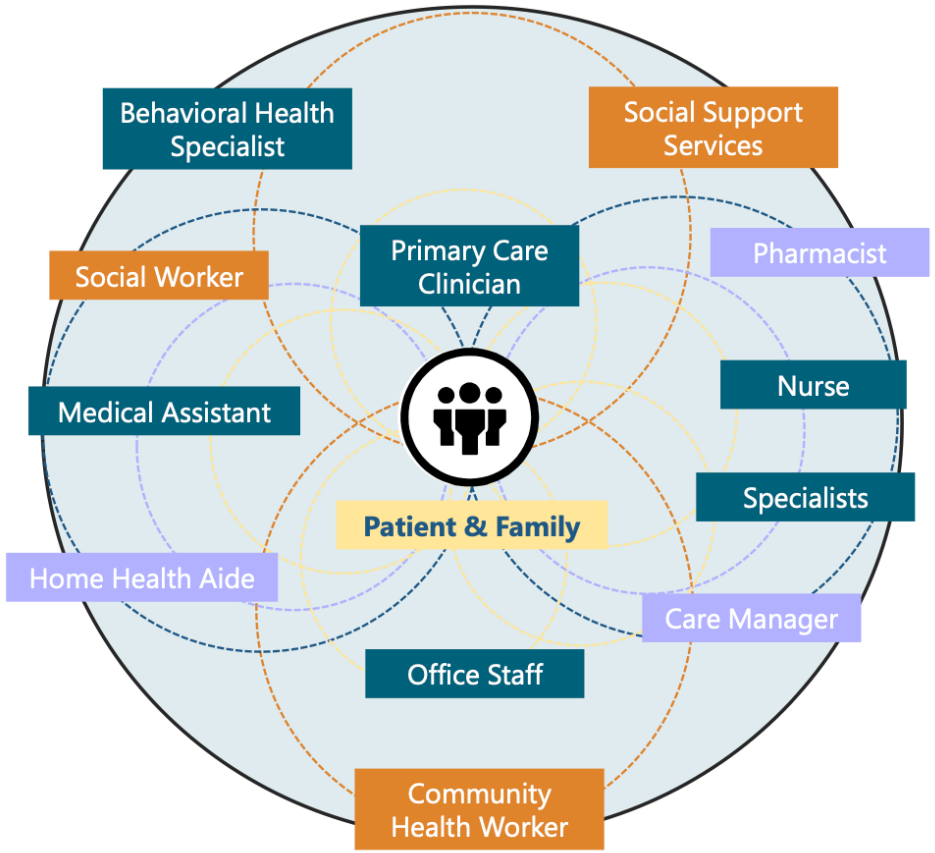
Making Care Primary aims to encourage care coordination and reduce patient challenges navigating their health ca

In this model, primary care is envisioned to play an important role in integrating a patient's system o care, inclusive of social support services.

Current State:
A Disjoined System



Desired Future State:
Integrated, High-Quality Primary Care



CMS Innovation Center Primary Care Programs and HRSN

August Meeting

The CMMI primary care programs envision a role for primary care in screening for health-related social needs and connecting patients to community supports and services.

		CPC+	PCF	MCP
HRSN Care Delivery Requirements	Screen for HRSN	✓	✓	✓
	Maintain an inventory of services and supports in the community	✓	✓	
	Develop and implement referral workflows			✓
	Partner with social service providers	✓		✓
	Utilize CHW or equivalent professional with shared lived experience to deliver services to higher need patients			✓

CMS Innovation Center Primary Care Programs and HRSN

August Meeting

HRSN related care delivery expectations are supported by the program's payment model and performance measu
standards.

		CPC+	PCF	MCP
HRSN Payment Model	Additive funding for care management to support augmented staffing and historically nonbillable services	✓	✓	✓
	Population-based payment structure to provide greater flexibility in care delivery	✓	✓	✓
HRSN Performance Measurement	HRSN screening performance incentive measure			✓
	HRSN data collection to evaluate health disparities			✓

Medicaid Primary Care Programs and HRSN: MassHealth Ex[illegible]

August Meeting

Some state Medicaid programs have taken a similar approach to defining the role of primary care in addressing HR[illegible]

	MassHealth Primary Care Accountable Care Organization HRSN Strategy
HRSN Care Delivery Requirements	**Screen:** Conduct a universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool
	Refer: Provide a regularly-updated inventory of relevant community-based resources to those with positive HRSN screens
	Coordinate: Participate in formalized practice-driven and/or ACO-driven care coordination that includes connection to community-based services, state agencies, federal programs (e.g., SNAP or WIC), and/or other supports
	Integrate Team-Based Staff: At least 1 CHW, Peer, Social Worker, or Nurse Care Manager dedicated to the primary care site (to qualify for Tier 2 or 3 payment)
HRSN Payment Model	**Tiered add-on payment:** Additive funding to support new care delivery requirements
	Primary Care Sub-Capitation Payment: Per member per month payments for primary care services are structured to increase flexibility for providers and enable the integration of team-based staff
HRSN Performance Measurement	**HRSN Screening Measure:** Included in the ACO Quality Performance Score
	Health Equity Score: ACO Health Equity Incentive payments can be earned based on collection of member-level social risk factor data, reporting on quality measures stratified by social risk factors, and reduction of identified disparities in performance

Medicaid Primary Care Programs and HRSN: Additional Exa

August Meeting

State Medicaid primary care programs have adopted a variety of other design elements as part of their HRSN strate

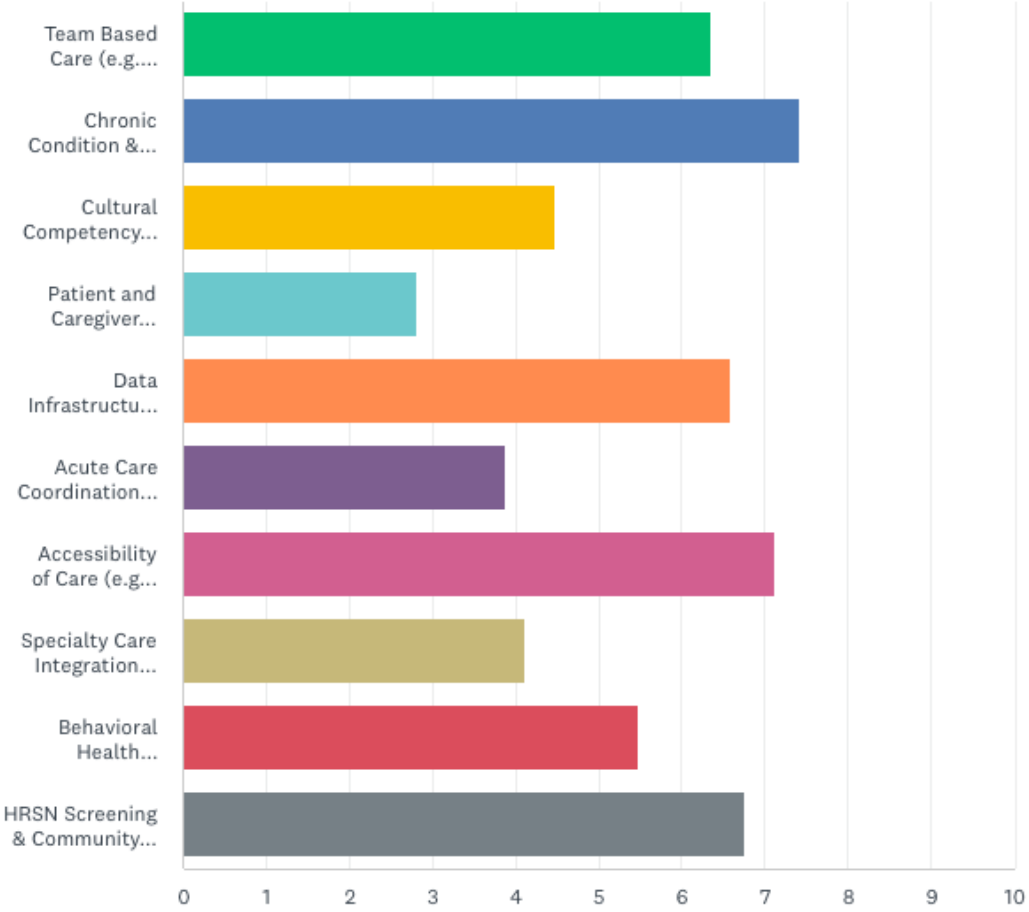
	Other Notable Features of Medicaid Primary Care Program HRSN Strategies	
HRSN Care Delivery Requirements	Statewide Referral Systems	• **Arizona:** CommunityCares statewide closed-loop referral system integrated with existing EHRs, patient portals, and care management systems • **North Carolina, Rhode Island:** statewide referral systems that can be leveraged to connect members with identified needs to community resources
	Standardized HRSN Screening Tools	• **North Carolina:** standardized screening tool focused on four priority domains; MCOs can add supplemental questions
	Approval of HRSN Screening Tools	• **Massachusetts, New York:** HRSN screening tool can be selected, with approval by the state
	CBO Partnership Requirements	• **Rhode Island:** Medicaid Accountable Entities required to establish partnerships with CBOs as part of infrastructure building
HRSN Payment Model	Infrastructure Funding for CBO Partners	• **Rhode Island:** Medicaid Accountable Entities required to allocate 10% of infrastructure funding to CBO partners as part of infrastructure building
HRSN Performance Measurement	HRSN Screening Performance Measures	• **Massachusetts, Rhode Island:** Pay-for-performance measure associated with HRSN screening; tied to ACO shared savings/loss calculations

October Meeting

Survey 1 – Primary Care Capabilities

Question: What are the key things that primary care should be doing differently or better to improve member health and well-being?

Please rank the below domains in order of importance (#1 being the most important)



Top 5 Rank Ordered:

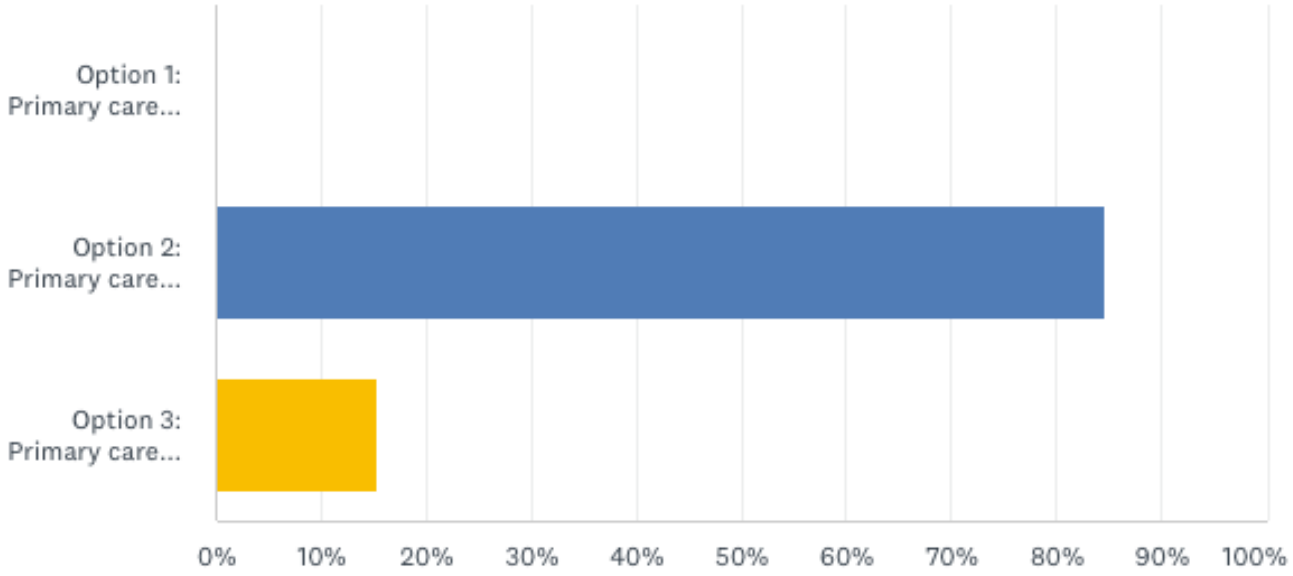
1. Chronic Condition & Targeted Care Management
2. Accessibility of Care
3. HRSN Screening & Community Supports
4. Data Infrastructure & Data Sharing
5. Team Based Care

Survey 2 – Health Related Social Needs

October Meeting

Question: What role should primary care practices play in addressing health related social needs (HR

At this point, which of these options do you think is best?



- **Option 1** - *Primary care practices have no responsibility for identifying or addressing HRSN*: **0%**
- **Option 2** - *Primary care practices are expected to perform certain functions related to screening, referral, and/or coordination*: **85%**
- **Option 3** - *Primary care practices are expected to deliver select HRSN services:* **15%**

HRSN Screening & Community Supports

December Meeting

Goal

Acknowledge the role that social determinants of health play in member health and well-being and better identify and address health related social needs.

Ideal State

The practice team identifies social risk factors affecting its patients and is knowledgeable about community resources that can address social needs (OHS).

December Meeting

HSRN & Community Supports: Example Measures and Requirements

Example Measures (Program, Steward)		**Example Requirements** (Program)
Process	❑ Social Determinants of Health Screening (OHS/MassHealth/RI Medicaid/CPC+/Primary Care First/Making Care Primary*) **This measure has been used in many programs, and is typically defined/stewarded by the state/program*	*Use SDOH data to implement interventions and prioritize needed community resources* ❑ Monitor social determinants of health at the population level and implement care interventions based on these data (PCMH) ❑ Use information on the population served to identify and prioritize needed community resources (e.g., food banks, support groups) (PCMH) *Maintain an inventory of community supports and refer, coordinate or partner with social service providers* ❑ Maintain an inventory of services and supports in the community (CPC+, Primary Care First, MassHealth) ❑ Develop and implement referral and/or coordination workflows (Making Care Primary, MassHealth) ❑ Partner with social service providers (CPC+, Making Care Primary, RI Medicaid) *Integrate community health workers (CHWs)* ❑ Specific program examples included in the Team Based Care domain
Outcome	*Hospitalization* ❑ Plan All-cause Readmission (OHS, NCQA) ❑ Avoidable ED (PCMH+, 3M; RI Medicaid, NYU/JHU Algorithm) ❑ Avoidable Hospitalization (PCMH+, 3M); Hospitalization for Potentially Preventable Complications (Medicare, NCQA)	
Equity Strategy	❑ Segment measures by REL and IDD demographic information to measure disparities	❑ Report on identified needs by REL and IDD demographic information to measure disparities