Primary Care Program Advisory Committee

Meeting 2

May 4, 2023

Faulkner CONSULTING GROUP

Agenda

Topic	Timing
Opening Remarks	10 Minutes
Committee Member Introductions - Continued	5 Minutes
Care Delivery Redesign Straw Proposal	15 Minutes
Discussion	15 Minutes
Detailed Design Questions	15 Minutes
Discussion	15 Minutes
Closing Discussion: Scope and Evidence	15 Minutes

Committee Member Introductions

Follow-up from last meeting

We would like to offer each committee member an opportunity to introduce themself and provide some context for their perspective, for example:

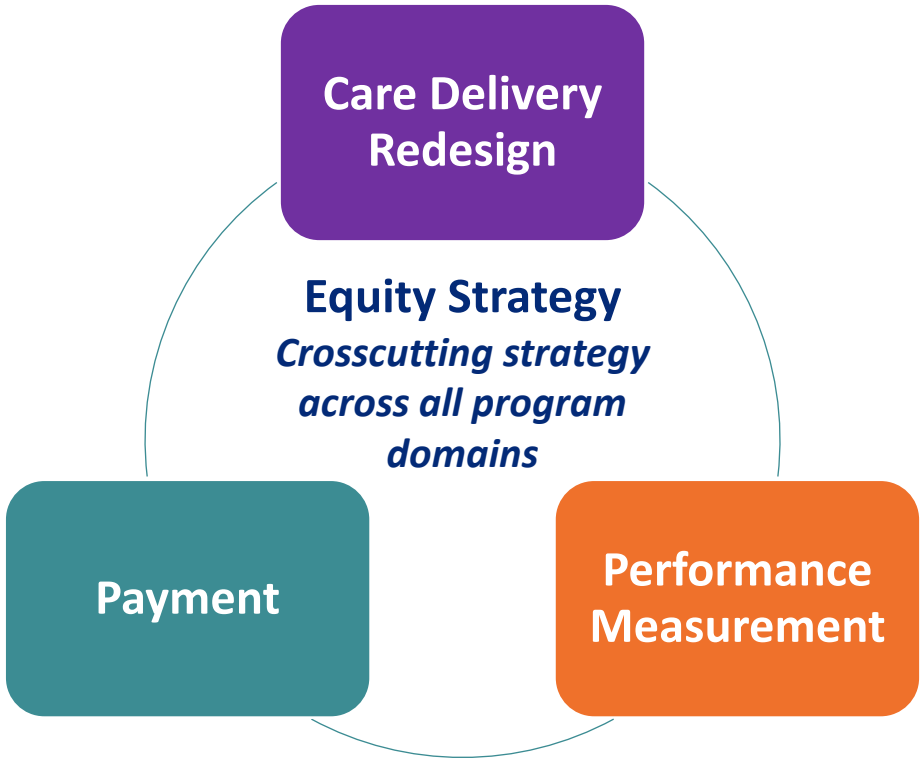
- Who do you represent?
- What are your priorities for this work?

Committee Member	Organization
Robyn Anderson	Ministers Health Fellowship Advocacy Coalition
Ellen Andrews	CT Health Policy Project
James Cardon	Hartford Healthcare
Stephanye Clarke	Health Improvement Collaborative of Southeastern Connecticut
Tiffany Donelson	Connecticut Health Foundation
Alice Forrester	Clifford Beers Community Health Partners
Paul Grady	Alera Group
Angela Harris	Phillips Health Ministry
Josh Herbert	Stamford Health Medical Group

Committee Member	Organization
Mark Masselli	Community Health Center, Inc.
David Krol	Connecticut Children's Care Network
Nichelle Mullins	Charter Oak Health Center, Inc. & Community Health Center Association of CT (CHCACT)
Doug Olson	Optimus Health Care
Joseph Quaranta	Community Medical Group
Mark Schaefer	Connecticut Hospital Association
Karen Siegel	Health Equity Solutions
Kelly Sinko	CT Office of Health Strategy
Polly Vanderwoude	Yale New Haven Health System
Josh Wojcik	Office of the State Comptroller

Today's Topic: Care Delivery Redesign Priorities

Each meeting of the Primary Care Program Advisory Committee will focus on defining a component of the program.



Month	Agenda Topic
April	Background & Introductions
May	Care Delivery Redesign Priorities
June	Primary Care Base Payment
July	Primary Care Performance Based Payment
August	Quality Measurement and Data Sharing
September	*Technical Design*: Primary Care Base Payment
October	*Technical Design*: Primary Care Performance Based Payment
November	Practice Recognition and Provider Technical Assistance
December	Equity Strategy Review*
January	*Technical Design*: Quality Measurement

EQUITY STRATEGY

**Note that equity considerations will be addressed throughout each meeting topic; the Equity Strategy Review is intended to provide an opportunity to assess the crosscutting equity strategy*

Starting Point: Primary Care Program Recommendations

★ Today's Discussion

The primary care program assessment established a set of program design recommendations and key program components responsive to identified goals and opportunities.

	Primary Care Program Recommendations	*Key Program Components*
Develop a **cross-cutting equity strategy** with the goal of reducing inequities and racial disparities		
Care Delivery Redesign	**Provide support for practices to achieve and demonstrate core practice functions foundational** to the delivery of high-quality primary care – with a focus on **expanded care teams, enhanced care coordination, and technology-enabled care modalities** that support easy and timely access to care, behavioral health integration, identifying and addressing health related social needs, and promoting equity.	**Care Coordination** ★ **Care Transformation Infrastructure** ★ **HRSN Supports** ★ **Practice Recognition** **Technical Assistance**
Performance Measurement	Establish a **performance measurement program that drives accountability and improvement**, with an enhanced **focus on measuring and addressing disparities in care**. Ensure performance data is available to support provider performance improvement, and ongoing program monitoring.	**Quality Measurement** **Data Sharing**
Payment	Provide sufficient payment to **enable and integrate** care delivery redesign and performance measurement opportunities and ensure that payment adequately **supports and advances biopsychosocial health** and **drives accountability** for outcomes.	**Funding for Care Delivery Redesign** **Funding for Performance** **Aligned Incentives**

*Pursue **multi-payer alignment** on select design features*

Care Delivery Redesign: Goals for Today

Care Delivery Redesign

- **Care Coordination**
- **Care Transformation Infrastructure**
- **HRSN Supports**

	Goals for Today	Key Design Questions
Straw Proposal	***Review the care delivery redesign straw proposal and collect your feedback***	(1) What are the **core elements** of the envisioned approach to care delivery redesign? (2) What role are primary care providers envisioned to play in **addressing health related social needs**? (3) How will care delivery redesign activities and infrastructure be **funded**?
Detailed Design	***Discuss key design questions and review a range of examples to inform more detailed design***	(4) How **prescriptive vs. flexible** should care delivery redesign requirements be? (5) How should providers be **held accountable** for the use of care delivery redesign funds?

Care Delivery Redesign: Target Impact

Care delivery redesign aims to improve member outcomes and experience.

Case Study (John)

John is a 62-year-old man with end stage renal disease (ESRD). John is **housing insecure and does not have reliable access to transportation**. John is **unable to find transportation** to his dialysis appointment and ends up missing the appointment. For the next two days he **forgets to take his blood pressure medication.**

What can primary care payment reform do for John?

John is screened for health-related social needs when he sees his primary care doctor.

A care coordinator on John's care team helps arrange a ride to John's dialysis appointment.

John's care coordinator or CHW calls to check in on him regularly to make sure he is doing ok, check on his ability to take his medications, follow up on possible housing supports, and make it to his appointments.

John begins experiencing chest pain and goes to the emergency room.

John's care team is aware of his needs and provides support to help him manage his condition and avoid a trip to the ER.

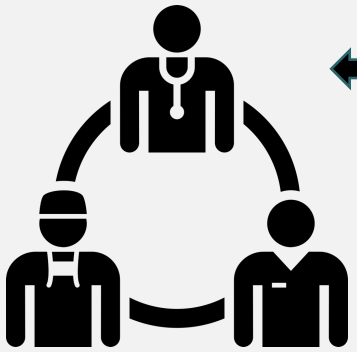
Approach to Care Delivery Redesign

Design Question #1: What are the core elements of the envisioned approach to care delivery redesign?

Straw Proposal: *Primary care program design envisions support for expanded care teams and infrastructure to enable and support care coordination, inclusive of behavioral health and health-related social needs.*

1 Primary Care Practice Teams

Expanded care teams inclusive of clinical care management personnel and non-clinical care coordination personnel (i.e., community and peer-based health workers) coordinate care for members between visits and across the continuum of care



Specialty Care

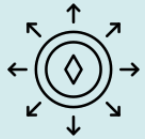
Behavioral Health Care

Health Related Social Services

2 Care Transformation Infrastructure

Infrastructure to enable identification of behavioral health and health related social needs and support care coordination, e.g.:

Screening Tools for Behavioral Health and Health Related Social Needs



Referral Process and Tools

Data Collection and Analysis

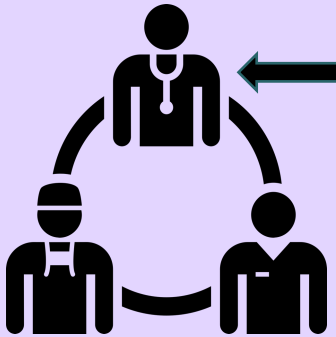
Approach to Addressing Health Related Social Needs (HRSN)

Design Question #2: What role are primary care providers envisioned to play in addressing health related social needs?

Straw Proposal: *Primary care program design envisions providing the tools, supports, and flexibilities to enable primary care providers to address members' health related social needs through referral and coordination.*

Role of the Primary Care Practice Team in HRSN Screening and Referral

Expanded care team personnel screen members for HRSNs, refer members to HRSN providers, and help to coordinate care for HRSNs.



HRSN Screening
Implement a tool and process to screen members for HRSNs

HRSN Referral
Refer members with identified needs to a HRSN provider or referral hub

HRSN Service Provider
Delivers service

HRSN Coordination
Assist with coordinating services to meet HRSN needs

Scope of Primary Care HRSN Strategy

DSS envisions pursuing a referral and coordination based HRSN strategy as part of the initial primary care program design. A more comprehensive strategy incorporating reimbursement for HRSN services may be considered in the future.

Care Delivery Redesign Funding

Design Question #3: How will care delivery redesign activities and infrastructure be funded?

Straw Proposal: *DSS intends to sustain existing funding and seek additive funding for care delivery redesign activities and infrastructure through the state budget process.**

Many primary care programs incorporate additive funding for care coordination activities and infrastructure.
Funding is typically paid out prospectively, on a per member basis, with adjustments made for case mix/patient complexity.

PROGRAM EXAMPLES		Care Delivery Redesign Funding Model	Amount
Current CT Programs	DSS PCMH+	**PMPM** payment for FQHCs	$5 PMPM
	State Employee Health Plan	**PMPM** payment, risk adjusted	$12 PMPM (additive to existing $1.50 PMPM)
Other State Medicaid Programs	MassHealth Primary Care ACO	**PMPM** payment, tied to tiered practice capabilities and member characteristics (pediatric, adult)	$4 - $13 PMPM
	RI Medicaid AE	**PMPM** care transformation payment	$8 PMPM, declining over time
	Minnesota IHP	**Quarterly per member** payment, risk adjusted (clinical and social)	$1 - $30 PMPM
	Maine PCPlus	**PMPM** payment, tied to tiered practice capabilities and case mix	$3 - $16 PMPM
CMMI Multi-Payer	CPC+	**PMPM** payment, tied to practice track and case mix	$9 - $100 PMPM

**Note that this strategy is dependent on the inclusion of additional funding in the state budget – DSS intends to pursue additive funding for care delivery redesign activities but can not guarantee that funds will be authorized.*

Straw Proposal Discussion

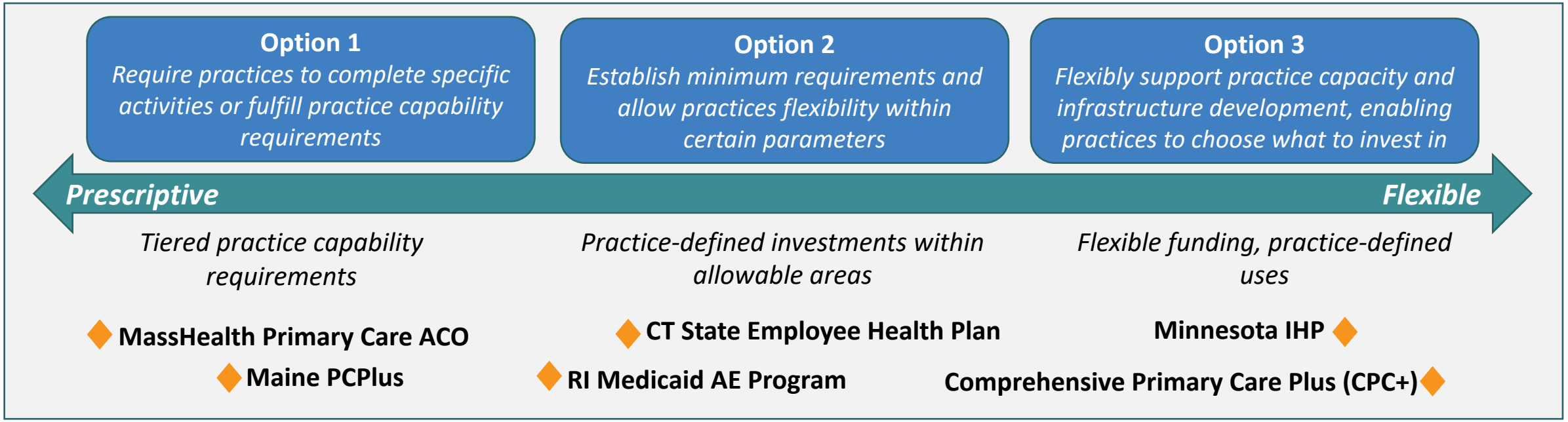
Design Question #1: What are the core elements of the envisioned approach to care delivery redesign?	***Straw Proposal:*** *Primary care program design envisions support for expanded care teams and infrastructure to enable and support care coordination, inclusive of behavioral health and health-related social needs.*
Design Question #2: What role are primary care providers envisioned to play in addressing health related social needs?	***Straw Proposal:*** *Primary care program design envisions providing the tools, supports, and flexibilities to enable primary care providers to address members' health related social needs through referral and coordination.*
Design Question #3: How will care delivery redesign activities and infrastructure be funded?	***Straw Proposal:*** *DSS intends to sustain existing funding and seek additive funding for care delivery redesign activities and infrastructure through the state budget process.*

For Discussion:

- Questions, comments, feedback on this straw proposal?
- Any other priority elements that are not included that should be?

Care Delivery Redesign Requirements

Design Question #4: How prescriptive vs. flexible should care delivery redesign requirements be?

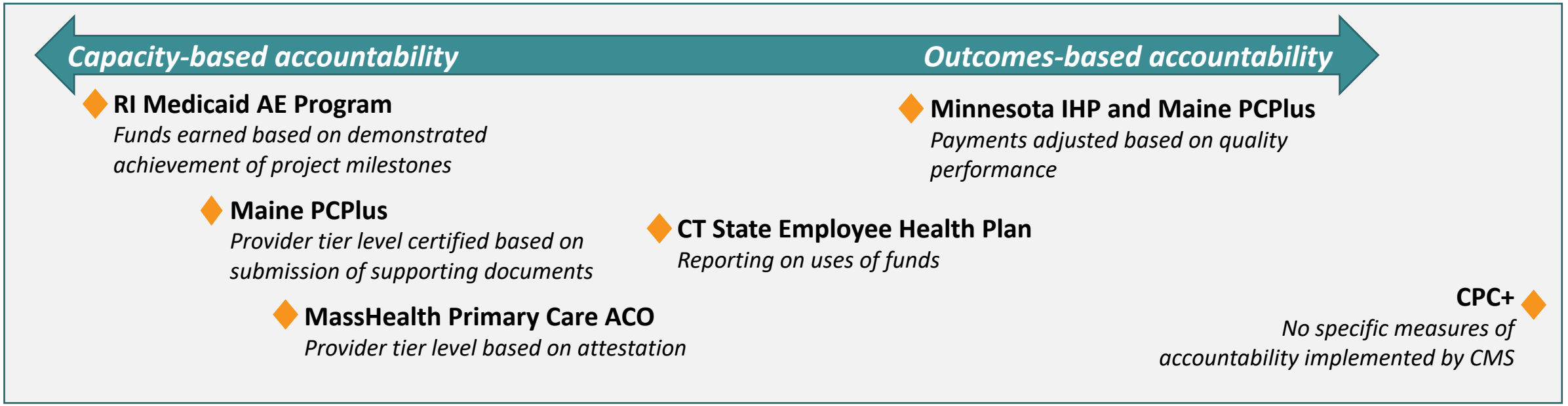


For Discussion:

- Is the goal to create accountability for a **specific set of activities or outcomes**? Or is the goal to support a **more flexible model of capacity and infrastructure development** under which practices choose what to invest in?
- Are **care team roles, responsibilities, and qualifications** prescribed or practice-defined?
- Do practices need to meet **minimum infrastructure or capability standards**? Are there any **common tools or processes** that practices should be required to implement? (e.g., standardized HRSN or BH screening and referral tools)
- Are there particular areas in which **more standardization or more flexibility** is of value?

Care Delivery Redesign Requirements

Design Question #5: How should providers be held accountable for the use of care delivery redesign funds?



For Discussion:

- Are care delivery redesign payments **adjusted based on quality performance** or other outcomes?
- Are practices **required to report** on the use of care delivery redesign funds?
- How is **compliance with program requirements monitored**? Submission of supporting documentation, attestation, other reporting?

Appendix

- **Care Coordination/Management Evidence Base**
- **Care Delivery Redesign Program Examples**
- **State Approaches to Addressing Health Related Social Needs**

Care Coordination/Management Evidence Base: Systematic Reviews

Evaluations of the effectiveness of care coordination/ management interventions have shown mixed results. Effectiveness varies by type of intervention, target population, and the outcome measured.

Source	Focus Area	Key Findings/ Lessons Learned
Agency for Healthcare Research and Quality. "Designing and Implementing Medicaid Disease and Care Management Programs, Section 8: The Care Management Evidence Base."	Effectiveness of care management interventions for individuals with chronic conditions (including diabetes, asthma, CHF, COPD, and CAD)	• ***In general, the impact of different interventions varied widely depending on the disease and type of measure.*** • ***In-person care management was the most effective intervention across all five diseases.*** *Although it can be more difficult and expensive to implement, in-person care management is the best intervention to use to generate cost savings and improve clinical outcomes.* • *Across all diseases, the literature found examples of successful care management programs in terms of intervention outcomes.* • *Although interventions ideally would prove equally effective for all diseases, the literature review found that they might vary among diseases in terms of their overall efficacy and, in particular, which outcomes they impact.* • *As expected, provider interventions exerted the greatest impact on measures that target provider processes such as HbA1c screening or medication use.*
Duan-Porter, W., Ullman, K., Majeski, B. et al. "Care Coordination Models and Tools—Systematic Review and Key Informant Interviews," Journal of General Internal Medicine, 2021.	Effectiveness of care coordination	• ***CC [care coordination] interventions have inconsistent effects on reducing hospitalizations and ED visits.*** • *Effective interventions were implemented in multiple settings, including rural community hospitals, academic medical centers (in urban settings), and public hospitals serving largely poor, uninsured populations.* • *Two SR highlighted selection for specific risk factors as important for effectiveness; one of these also indicated high intensity (e.g., more patient contacts) and/or multidisciplinary plans were key.*
Joo, J.Y., et. al. "Case management effectiveness in reducing hospital use: a systematic review," International Nursing Review, 2016.	Effectiveness of case management in reducing hospital use by individuals with chronic conditions	• ***There was strong evidence of significant reductions in hospital use with case management as an intervention.*** • *Other results about the effectiveness of case management remain mixed; more rigorously designed studies with case management interventions are needed.*

Care Delivery Redesign: Program Examples

		Payment Model	Amount	Requirements	Accountability
Current CT Programs	**DSS PCMH+**	PMPM payment for FQHCs	$5 PMPM	Specific staffing, training, screening, and care planning requirements	Submission of documentation and site visits to evaluate compliance
	State Employee Health Plan	PMPM payment, risk adjusted	$12 PMPM (additive to existing $1.50)	Invest in some or all of the 11 core areas identified in the OHS Roadmap	Report annually on how funds were spent to improve competencies
Other State Medicaid Programs	**MassHealth Primary Care ACO**	PMPM payment, tied to tiered practice capabilities and member characteristics (pediatric, adult)	$4 - $13 PMPM	Detailed practice capability requirements in 3 areas: • Care delivery • Structure and staffing • Population-specific	Self-attestation used to select tier; monitoring and oversight through MCO/ACO structure
	RI Medicaid AE	PMPM care transformation payment	$8 PMPM, declining over time	AEs develop project plans to invest in 3 core areas: • Readiness • IT Infrastructure • System Transformation	Funds earned based on demonstrated achievement of project milestones and outcome measure performance
	Minnesota IHP	Quarterly per member payment, risk adjusted (clinical and social)	$1 - $30 PMPM	Flexible funding	Payments adjusted based on quality performance
	Maine PCPlus	PMPM payment, tied to tiered practice capabilities and case mix	$3 - $16 PMPM	Tiered practice capability requirements	Payments adjusted based on quality performance Initial tier certification w/ submission of supporting documents; re-certification by attestation
CMMI Multi-Payer	**CPC+**	PMPM payment, tied to practice track and case mix	$9 - $100 PMPM	Flexible funding - intended to support augmented staffing and historically non-billable services such as care coordination	CMS and most other aligned payers did not implement accountability measures. A third of aligned payers adjusted the payment based on practice performance on cost, utilization, or quality

MassHealth Primary Care ACO: Practice Capability Requirements

	Tier 1	Tier 2	Tier 3
Care Delivery Requirements	• Traditional primary care • Referral to specialty care • Oral health screening and referral • Behavioral health (BH) and substance use disorder screening • BH medication management • Health-Related Social Needs (HRSN) screening • Care coordination • Clinical Advice and Support Line • Postpartum depression screening • Use of Prescription Monitoring Program • Long-Acting Reversible Contraception (LARC) provision, referral option	• Brief intervention for BH conditions • Telehealth-capable BH referral partner	• Clinical pharmacist visits • Group visits • Designated Educational Liaison for pediatric patients
Structure and Staffing Requirements	• Same-day urgent care capacity • Video telehealth capability • No reduction in hours • Access to Translation and Interpreter Services	• E-consults available in at least three (3) specialties • After-hours or weekend session • Team-based staff role • Maintain a consulting independent BH clinician	• E-consults available in at least five (5) specialties • After-hours or weekend session • Three team-based staff roles • Maintain a consulting BH clinician with prescribing capability
Population-Specific Requirements	• EPSDT required screenings and assessments • Screen for SNAP and WIC eligibility • Children's Behavioral Health Initiative (CBHI) • Coordination with MCPAP • Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M) • Fluoride varnish • Buprenorphine Waivered Practitioner Requirement	• On-site staff with children, youth, and family-specific expertise • SNAP/WIC application assistance • Buprenorphine Waivered Practitioner Requirement • LARC provision, at least one option • Active Buprenorphine Availability • Active Alcohol Use Disorder (AUD) Treatment Availability	• Full-time, on-site staff with children, youth, and family-specific expertise • LARC provision, at least one (1) option • Active Buprenorphine Availability • LARC provision, multiple options • Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up

Maine PCPlus: Practice Capability Requirements

Base Tier	Intermediate Tier	Advanced Tier
• Has 24/7 coverage • Has a certified EHR • Participates in technical assistance • Assesses and addresses behavioral and physical health integration • Educate members about primary care vs. urgent care vs. ED use	**Base AND** • PCMH accreditation or participating in Primary Care First • HealthInfoNet connection (bidirectional/HL7) • Collects and track social health needs • Holds a practice agreement with at least one Behavioral Health Home • Refers to a Community Care Team (CCT) • Offers telehealth • Offers Medications for Opioid Use Disorder (MOUD) or has a cooperative referral and co-management process with an MOUD provider • Includes MaineCare members and/or their families in practice improvement efforts • Offers community-based community health worker services directly or through partnerships (e.g., CBOs) – April 2024	**Intermediate AND** • HIN connection includes data elements that support clinical quality measurement • Participates in MaineCare's Accountable Communities (AC) program • Has a Joint Care Management and Population Health Strategy with AC and any contracted CCT

CT DSS PCMH: Care Coordination Requirements

The PCMH program care coordination requirements are based on the care coordination requirements for NCQA PCMH recognition.

There are five core requirements that all practices must achieve and maintain for their NCQA recognition based on the NCQA Standards.	There are sixteen additional criteria. These criteria are elective. Practices can choose any of them for credit towards recognition. They are not required but illustrate the practice's enhanced care coordination activities. The criteria are summarized as follows:
1. Lab and Imaging Test Management: The practice has processes in place to manage lab and imaging tests by: a. Tracking lab tests until results received. Having a process for follow up for results. b. Tracking imaging tests until results received. Having a process for follow up for results. c. Flagging all abnormal test results, alerting the clinician. d. Notifying patients/families of normal and abnormal results. 2. Referral Management: The practice manages referral by: a. Providing the specialist/consultant with information regarding the clinical issue, patient demographics, clinical information, any test results and the care plan. b. Continued tracking of referrals until the report is available. 3. Identifying Unplanned hospital and ED Visits: The practice has a process for: a. Monitoring unplanned admissions and ED visits. b. Receiving timely notification of patient visits 4. Sharing Clinical Information: Clinical information is shared with hospitals and emergency departments. 5. Post Hospital/ED Visit Follow-Up: The practice contacts patients/families for follow-up, within an appropriate period following the admission or emergency department visit.	1. Newborn Screenings – obtaining hearing and blood screening results from hospital. 2. Uses clinical protocols to determine necessity of labs and imaging. 3. Uses clinical protocols to determine necessity of specialist referrals. 4. Identifies specialist most used by the practices. 5. Considers referral specialist performance information when making referrals. 6. Works with frequently used non-behavioral health specialist to determine process for sharing information and patient care. 7. Works with frequently used behavioral health specialists to determine process for sharing information and patient care. 8. Integrates behavioral health providers into the practice site. 9. Monitors timeliness and quality of referral response. 10. Documents co-management of patients who see specialists regularly in medical record. 11. Connects patients to financial resources. 12. Process for acute care coordination after hours 13. Exchanges patient information with the hospital during hospitalization 14. Process for consistently obtaining patient discharge summaries from hospitals and other facilities. 15. Develops a written care plan for practice transitions in collaboration with patients/families (i.e., pediatric to adult care) 16. Process for electronic exchange of information

CT DSS PCMH+: Care Coordination Requirements

Enhanced care coordination activities are required of both FQHCs and ANs participating in PCMH+. Additional care coordination activities are required of FQHCs receiving care coordination add-on payments.

Enhanced care coordination requirements include detailed requirements in the following categories:	Care coordination add-on activities required of FQHCs include:
• Behavioral Health/Physical Health Integration • Culturally Competent Services • Care Coordinator Staff Requirements • Children and Youth with Special Healthcare Needs • Competencies in Care of Individuals with Disabilities	• Employ a care coordinator with behavioral health experience who serves as a member of the interdisciplinary team and has the responsibility for tracking patients, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed. • Develop WRAPs or other behavioral health recovery planning tools in collaboration with the member and family. • Develop and implement care plans for TAY (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY). • Use an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position, and that has the capacity to fully integrate across the entire organization to facility member care. • Physical and behavioral health integration, conduct interdisciplinary team case review meetings at least monthly, promote shared appointments and develop a comprehensive care plan outlining coordination of physical and behavioral health care needs.

State Approaches to Addressing HRSN (1115 Waiver)

As of Fall 2022, CMS approved four 1115 waivers (AR, AZ, MA, and OR) that authorize evidence-based HRSN services for specific high-need populations. CMS also approved eighteen 1115 waivers with SDOH-related provisions (8 states had pending SDOH requests).

State	**AZ** Whole Person Care Initiative	**MA** ACO Program	**OR** Health Plan	**NC** Health Opportunities Pilots
Program Overview	AZ implemented a statewide **closed loop referral system** (technology platform), to address social determinants of health (SDOH) needs in Arizona. The H2O program provides specified evidence-based **housing supports** and **case management** services to targeted populations.	ACOs can pay for **traditionally non-reimbursed flexible services** to address HRSNs, and Community Partners (CPs) provide care management and navigational services. MA may provide **infrastructure/capacity building funding** directly to social service organizations.	HRSN services will be provided both through the **fee-for-services system** and through OR's **Coordinated Care Organization** (CCO) network. OR may opt to incorporate the HRSN services into **risk-based capitation rates** for CCOs or to pay for HRSN services via a **non-risk payment to CCOs**.	"Network Leads" develop, contract, and manage a **network of CBOs** that **deliver pilot services**. Health plans manage the pilot budget, determine enrollee eligibility, and authorize the delivery of pilot services.
Service Focus	Case Management, Housing	Case Management, Housing, Food, Transportation	Case Management, Housing, Food	Case Management, Housing, Food, Transportation, Interpersonal Violence (IPV)
Target Populations	- H2O program: Members who are **homeless** or at risk of becoming homeless and who meet at least one **clinical and social risk criteria** (e.g., high- cost high needs chronic health conditions or co-morbidities, or enrolled in AZ's Long Term Care System)	- Flexible Services Program: Medicaid-only, ACO-enrolled members who meet at least one **health needs-based criteria** and one risk factor. - Specialized Community Supports Program: Members who meet criteria related to **behavioral health needs** and meet other risk factors (e.g., homeless or justice-involved individuals)	Populations eligible for HRSN services are **experiencing major life transitions**. (e.g., youth with special health care needs; justice-involved adults and youth, youth involved in child welfare system; transitioning to dual eligibility status; at risk or experiencing homeless; and individuals with high-risk clinical needs in regions experiencing extreme weather events.)	Managed Care members must have at least one **physical or behavioral health risk factor** (e.g., two+ chronic condition, high risk pregnancy) *and* at least one **social risk factor** (e.g., housing/food insecurity, IPV exposure)

Health-Related Social Needs (HRSN) Screening – Design Decisions

Decision Decision	Option A	Option B	State Examples
Standardized screening tool?	Mandate use of existing or newly created screening tool	Let practices choose existing tool or create own tool	• NC – Created statewide, standardized tool • MA, RI – Specified screening domains and let the screening entity choose/develop its tool (with approval of tool)
Screening requirements?	Mandatory	Optional	• MA – Mandatory • NC, NY – Optional
Who to screen?	All members	Select populations (e.g., high-cost, high-needs members)	• MA – All ACO-attributed members
Where should screenings occur?	Clinical setting only	Clinical/nonclinical settings	• NC, MA, RI – Clinical and nonclinical settings
Frequency of screening?	Annually	Upon enrollment	• MA – Annually for all ACO-attributed members • RI – Annually for members with primary care visits
Who is responsible for screening?	Providers or CHWs	MCOs/ACOs (can delegate this responsibility to providers and independent entities)	• NC, MA, RI, NYC – MCOs/ACOs

HRSN Screening – State Examples

Massachusetts	North Carolina	Rhode Island	New York
• Screening is **required** • Screening is required for **housing, utilities, transportation, and food** • In addition to the required domains, at least **one optional domain must be included**. Optional domains include employment, training or education; experience of violence; and social supports • ACOs can **select their own screening tool**, which must be approved by the state	• Screening is strongly encouraged but is **not required** • Screening is conducted through a **standardized, NC-specific screening tool** that focuses on four priority domains: Food insecurity, Housing instability, Lack of transportation, Interpersonal violence • MCO may add supplemental questions • NC also built a **statewide resource platform** to connect those with an identified need to community resources.	• **Screening is strongly recommended** before members are connected to an intervention • Interventions must align with the domains of: Economic stability; Education; Health & health care; Neighborhood & environment; Social, family, and community context • **MCOs choose their screening tool** • MCOs **in risk arrangements** with providers are required to **implement an intervention** that addresses one of the priority domains	• **Screening is required** • Screening must include the domains of: Food, Housing, Safety, Transportation, Utilities • **MCOs are responsible for completing the screen**, with approval of their tool required

HRSN Screening Tools

Tool Name	About the Tool	Core Domains	Created By
AHC HRSN *Accountable Health Communities Health-Related Social Needs*	10-question screening tool designed for the Accountable Health Communities Model	Housing, Food, Transportation, Utilities, Interpersonal safety	CMS & CCMI
PRAPARE *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences*	Screening tool with 7 core domains; been translated into 26 languages and comes with a companion implementation toolkit	Housing, Food, Transportation, Economic stability, Education, Employment, Social support Supplemental domains on incarceration and safety	National Association of Community Health Centers
Health Leads' Social Needs Screening Tool	10-question screening tool with 5 core domains; Available in English and Spanish	Housing, Food, Transportation, Transportation, Economic stability, Interpersonal safety Supplemental domains on Education, Employment, & Social support	Health Leads
IHELP Questionnaire *Income, Housing, Education, Legal Status, Personal Safety*	IHELP has 14-24 questions assessing needs across 5 domains	Economic stability, education, social & community context, neighborhood & physical environment, and food.	Dr. Jeffery Colvin, CMH physician and Associate Professor of Pediatrics at UMKC
WE CARE Survey *Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education*	WE CARE is designed to: (1) identify unmet social needs (e.g., childcare, employment, and housing) by self report and (2) using a family-centered approach, determine whether parents would like assistance with any of their unmet needs.	Economic stability, education, neighborhood & physical environment, and food.	Boston Medical Center
North Carolina *Health Opportunity Screening Questions*	Created standardized tool with stakeholder feedback; MCO may add supplemental questions	Housing / Utilities, Food, Transportation, Interpersonal Safety	North Carolina

Accountability for HRSN Screening

State Medicaid agencies can assess performance on social risk factor screening by implementing a social risk factor screening measure

- Some state Medicaid agencies have developed "homegrown" screening measures for contractual incentive application (RI, MA, OR).

State	Measure Name	Purpose	Use in Value-Based Payment
MA	Health-Related Social Needs Screening	2018: measure used for performance measurement 2021: measure moved to pay-for-performance	Part of a group of measures used to determine attribution of shared savings and shared losses to Medicaid ACOs
OR	Social Determinants of Health Screening	2021: recommendations for measure design 2023: target year for contract incentive measure	Part of a group of measures used to determine CCO (MCO) withhold return
RI	Social Determinants of Health Screening	2017: measure used for performance reporting 2020: measure modified; used as pay-for-reporting 2021: measure moved from pay-for-reporting to pay-for-performance	Part of a group of measures used to determine attribution of shared savings and shared losses to Medicaid ACOs
IA	The 2022 MCO RFP requires MCO social risk factor screening, to be assessed with a social risk factor screening measure, and places 10% of a 2% withhold at risk for MCO submission of screening data to the state.		

Note: NCQA recently developed and added the Social Need Screening and Intervention (SNS-E) HEDIS measure for measurement year 2023.