Primary Care Program Advisory Committee

Meeting 4

July 13, 2023

Agenda

Topic	Timing
Opening Remarks and Welcome	5 Minutes
Update on Data Requests	5 Minutes
Goals for Today	5 Minutes
Inform: Topic 1 – Starting Point (DSS Initiatives Underway)	15 Minutes
Inform: Topic 2 – Broader Strategies (1115 Waivers)	15 Minutes
Listening Session	45 Minutes

Meeting Schedule

	Primary Care Program Advisory Committee Meeting Topics
April	Background & Introductions
May	Primary Care Goals and Strategies
June	Scope of Primary Care Design and Prior Work
July	**Listening Session: Strategies for Addressing Community Needs**
August	Discussion of Supplementary Data and Review of Primary Care Program Examples
September	In Person Meeting: Key Design Decisions

Update on Data Requests

At the last meeting, Committee members made requests for additional data and information.

- The table below shows what requests can be fulfilled with available data, and where to find the data.
- As part of today's discussion, we will review available data on the prevalence of health-related social needs.
- The August meeting will include a review of the other data provided in advance of this meeting – we will also schedule an optional meeting to review the additional data if Committee members would like.

Data Request	Data Available?	Where to Find
Prevalence of Health-Related Social Needs (HSRN)	Yes	**(1) PCPAC Meeting 4 Deck**
Unattributed Member Data	Yes	**(2) Data Compendium** (Excel)
Pediatric Data: Cost and Utilization	Yes	**(2) Data Compendium** (Excel)
Pediatric Data: Quality and Outcomes	Yes	**(2) Data Compendium** (Excel)
Member Experience Metrics	Yes	**(3) Member Experience Metrics** (PDF)
Measures of Access: By Different Geographical Areas in the State	Yes	**(4) Measures of Primary Care Access** (PDF)
Measures of Access: By Practice Setting	Yes	**(4) Measures of Primary Care Access** (PDF)
Utilization and Cost by Practice Setting	Yes	**(5) Utilization, Cost, and Prevalence** (PDF)
Prevalence of Chronic Conditions	Yes	**(5) Utilization, Cost, and Prevalence** (PDF)
Measures of Access: By Subpopulations (DD, noncitizens)	No	
Measures of Access: By Member Preferences for Providers	No	

Goals for Today's Meeting

1. Be responsive to this Committee's request to have more conversation about strategies to address health-related social needs (HRSNs)

2. Inform Committee about DSS' starting point and potential pathways for broader HRSN initiatives

3. Gather and share ideas to inform primary care payment reform or the development of broader HRSN initiatives

Note on Terminology

The terms SDOH and HRSN are used throughout these materials.

Definitions:

- **Social Determinants of Health (SDOH):** The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[1]

- **Health-Related Social Needs (HRSN):** An individual's unmet, adverse social conditions that contribute to poor health. These needs – including food insecurity, housing instability, unemployment, and/or lack of reliable transportation – can drive health disparities across demographic groups.[2]

Note on Usage:
CMS has used the term **Health-Related Social Needs** in recent Section 1115 Waiver approvals, new sub-regulatory guidance, and other CMS materials. CMS notes that an individual's HRSN are a result of their community's underlying SDOH.

For the sake of today's discussion, we are using these terms interchangeably.

1. "Presidential COVID-19 Health Equity Task Force Final Report and Recommendations." U.S. Department of Health and Human Services, October 2021. https://www.minorityhealth.hhs.gov/assets/pdf/HETF_Report_508_102821_9am_508Team%20WIP11-compressed.pdf
2. "Addressing Health-Related Social Needs in Section 1115 Demonstrations." CMS, December 6, 2022. https://www.medicaid.gov/medicaid/downloads/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf

Strategy for Addressing Health Related Social Needs (HRSN)

DSS is pursuing other strategies outside of this work to address health related social needs.

Starting Point
DSS Initiatives Underway

DSS has a range of targeted initiatives aimed at addressing HRSN currently underway, 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

This Committee's Work
Primary Care Payment Reform

Primary care payment reform will build on this by giving primary care providers the flexibility and incentives to:

- 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

Broader Strategies
Under Consideration

DSS is exploring* a Section 1115 waiver to provide HRSN services to Medicaid members, including:

- 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

*Broader strategies for addressing HRSN are outside of the scope of this process – however, DSS appreciates this committee's interest in this topic and intends to use **today's meeting** to collect feedback to inform this effort*

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

Starting Point
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DSS Initiatives Underway

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

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

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.

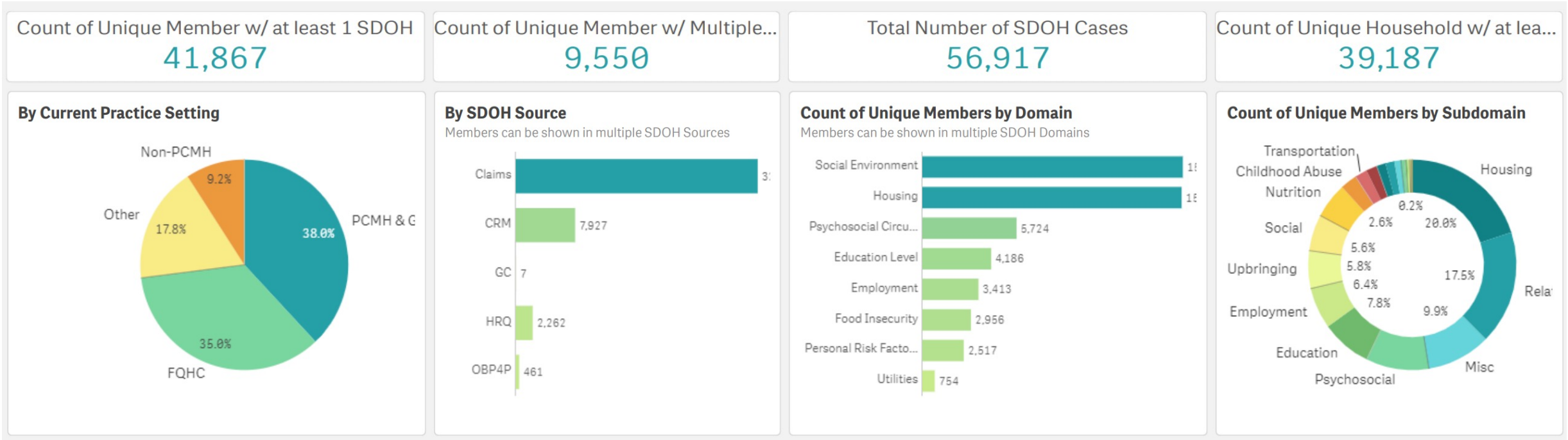
- **When was this program started?** The CHW program began in 2014 under the Intensive Care Management (ICM) program. In February 2020, the CHWs were combined with the Community Engagement Team to enhance CHNCT, Inc.'s ability to help members access their HUSKY benefits and to obtain social determinants 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, MES representative screens, 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

In a one-year review of data - using a variety of sources, including claims, MES or ICM assessments - there were **41,867 unique 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%

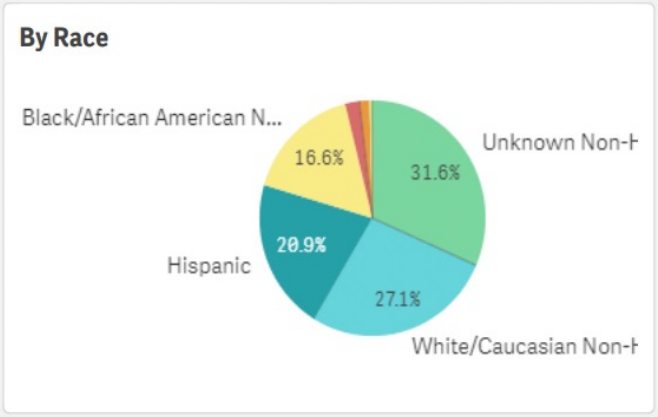
HUSKY Health SDOH Needs

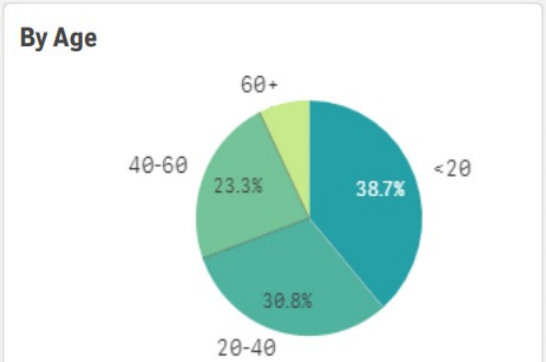


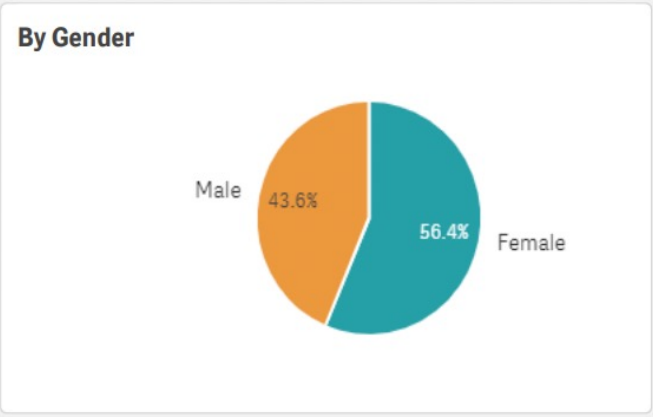
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

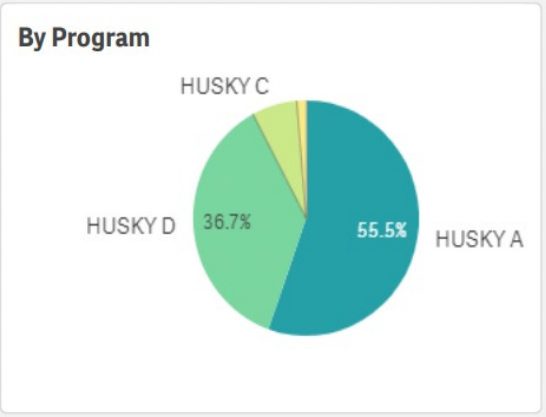
Social Determinant of Health Needs

Member Demographics

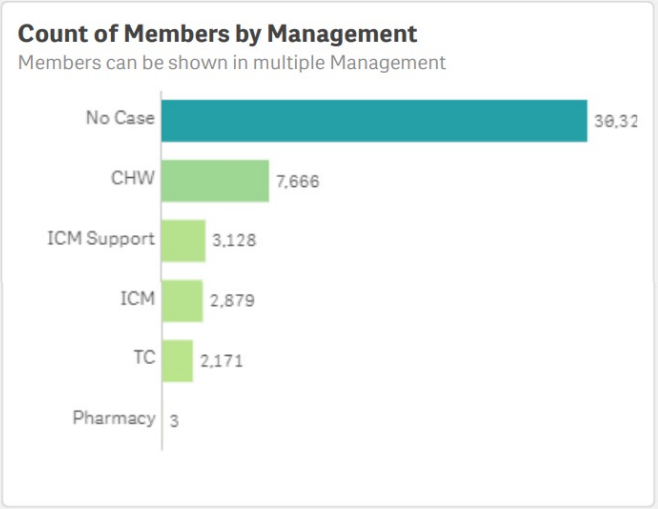


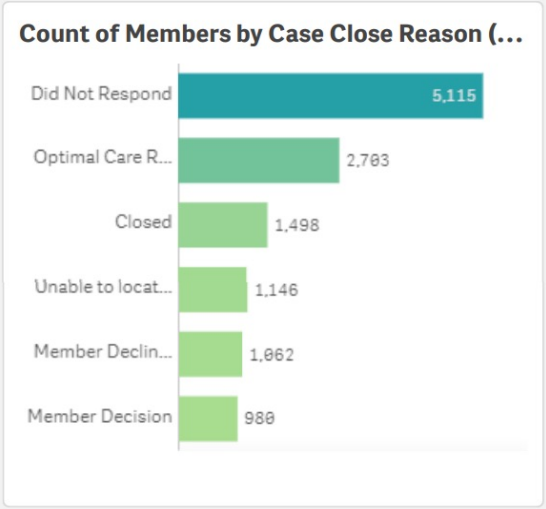


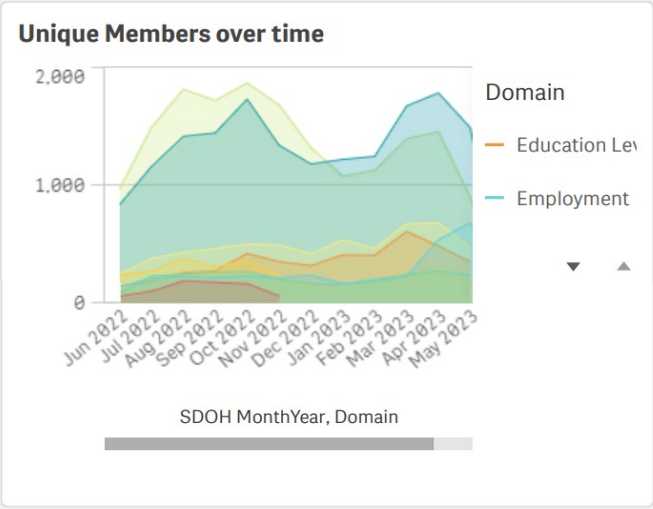


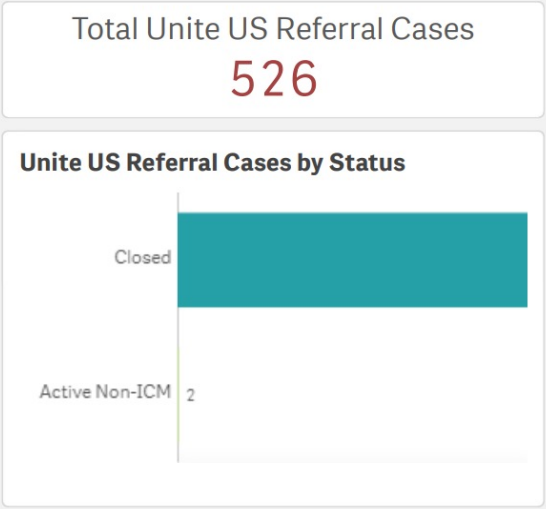


SDOH Case Management







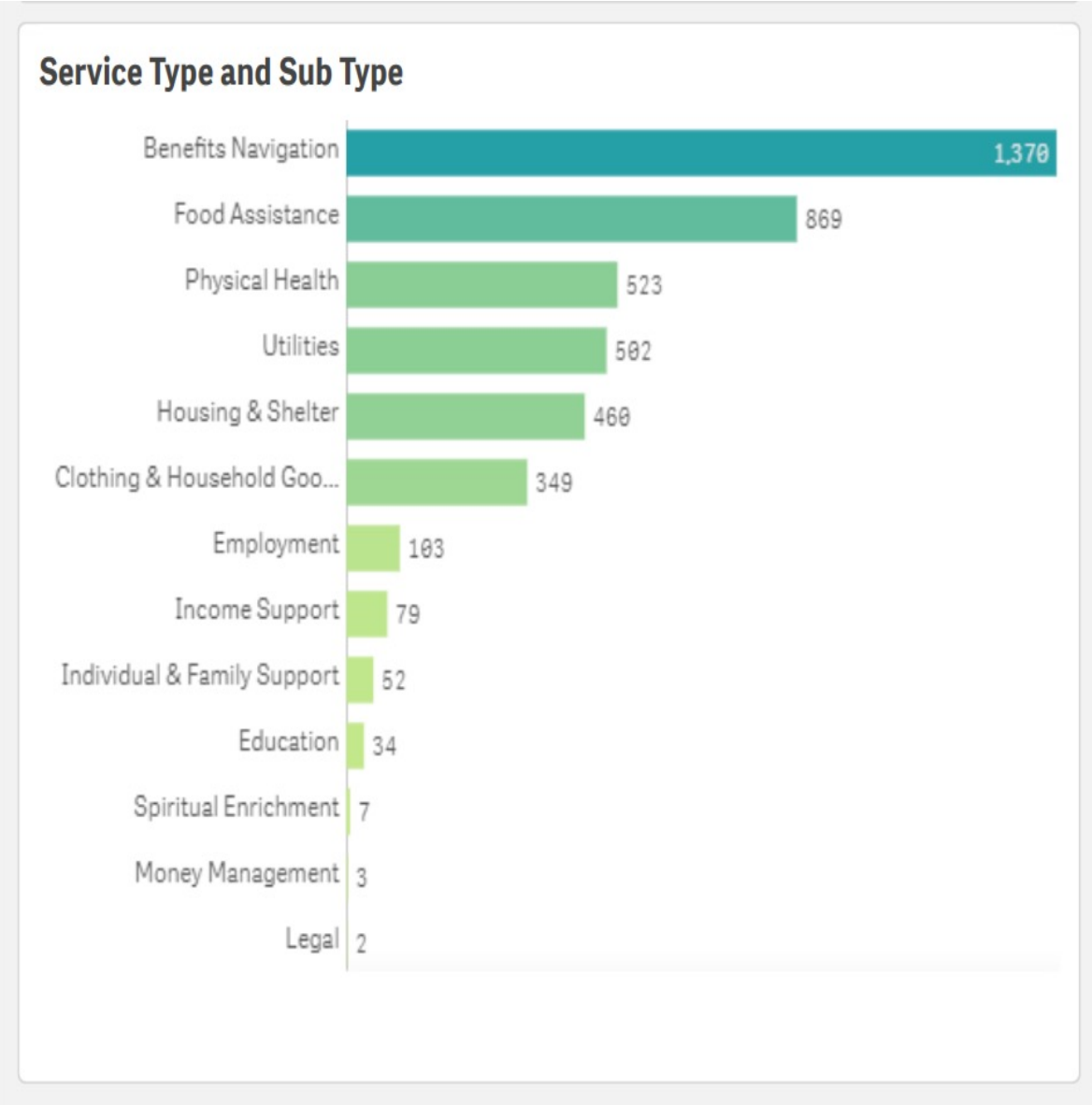


Source: CHNCT, Inc. SDOH Dashboard (Member Level)

SDOH Referral Dashboard

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)

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

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)

States Using 1115 Waivers to Address SDOH

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

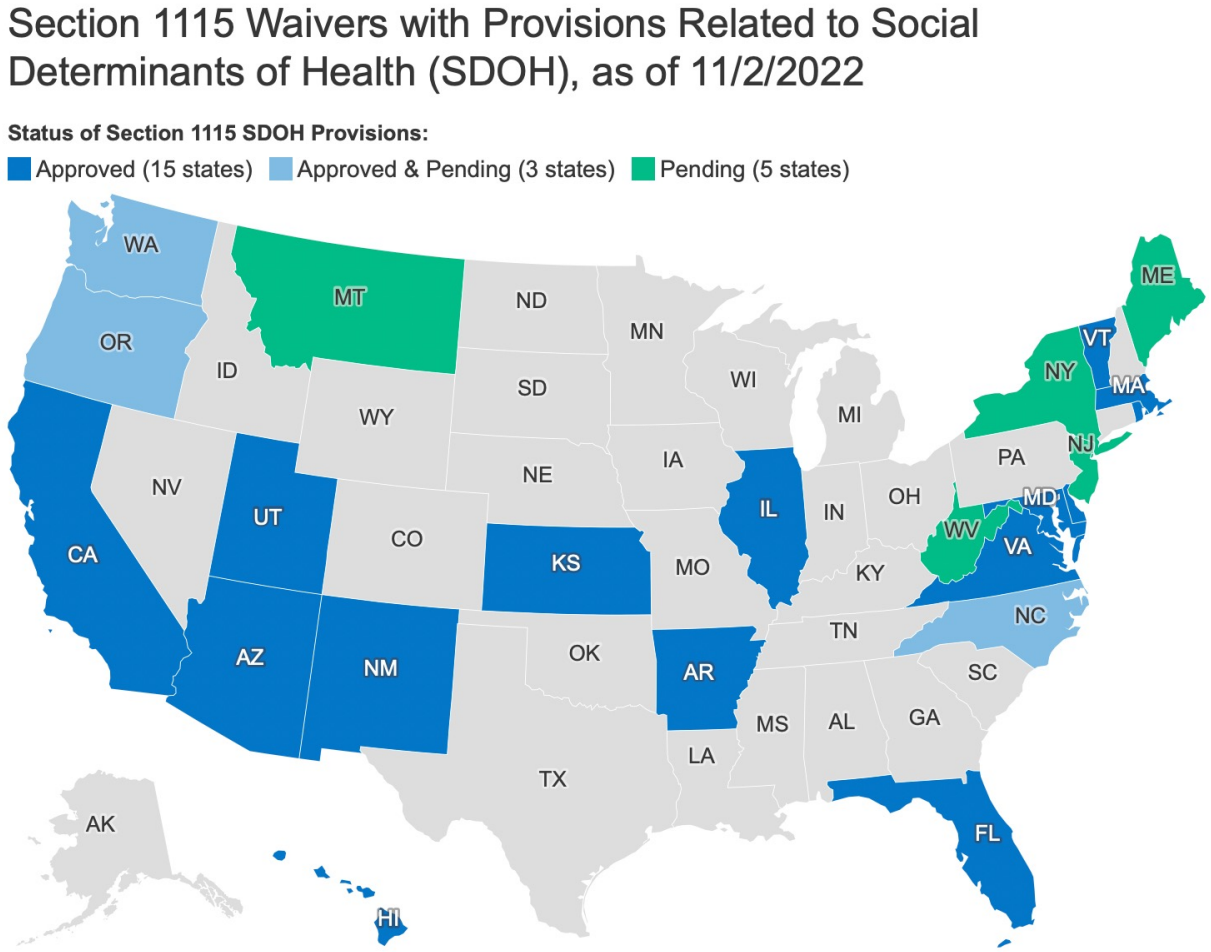
States Approved in Fall 2022:

- Arizona
- Arkansas
- Massachusetts
- Oregon

Additional Approvals since Fall 2022:

- New Jersey

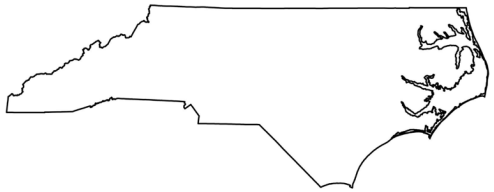
The remaining states had 1115 Waivers with SDOH related provisions approved prior to the release of CMS' new guidance in Fall 2022.



Source: Kaiser Family Foundation, 1115 Waiver Tracker

State Approaches: Prior 1115 Waiver Approvals

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

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

	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

Listening Session Goals

Goal for Today's Session: Gather and share ideas that could inform primary care payment reform or the development of broader HRSN initiatives

After today's listening session, DSS will review and catalog feedback received, using three categories to organize feedback.

Categories for Feedback

- Inform primary care program design
- Inform broader HRSN initiatives
- Outside of DSS scope

Example Feedback: We need to address housing instability by **expanding HSRN screening**, **providing rent supports and one-time moving costs**, and **developing more affordable housing stock**.

HRSN Listening Session Questions

- What do you see as the greatest needs or opportunities for addressing members' health related social needs (HRSN)?

- What role should primary care play in addressing HRSN? How should a primary care program incorporate strategies for addressing HRSN?

HRSN Listening Session

What do you see as the greatest needs or opportunities for addressing members' health related social needs?

Key Themes

HRSN Listening Session

What role should primary care play in addressing HRSN? How should a primary care program incorporate strategies for addressing HRSN?

Key Themes

Appendix

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

Inform: Topic 2 – Broader Strategies (1115 Waivers)

Social Determinant of Health Needs: Social Environment

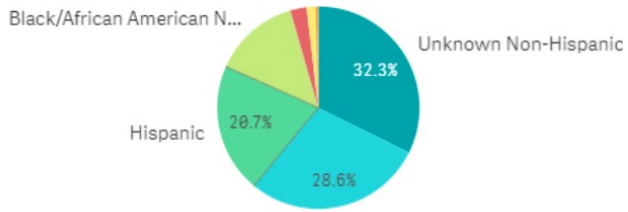
Count of Unique Member w/ at least 1 SDOH
16,039

Count of Unique Member w/ Multiple SD...
1,758

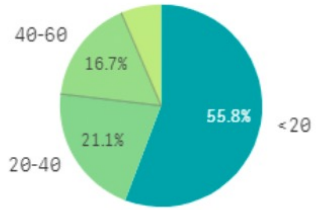
Total Number of SDOH Cases
18,092

Count of Unique Household w/ at least 1 ...
15,012

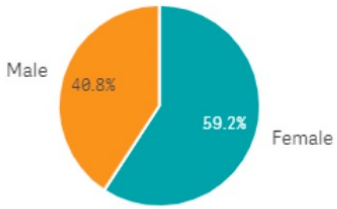
By Race



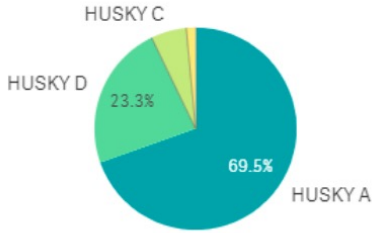
By Age



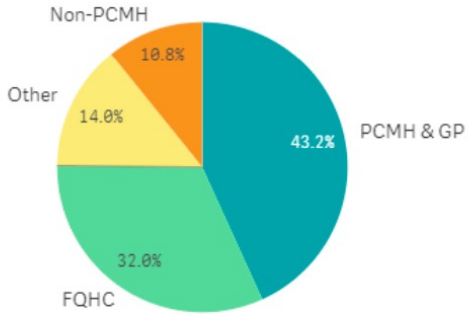
By Gender



By Program

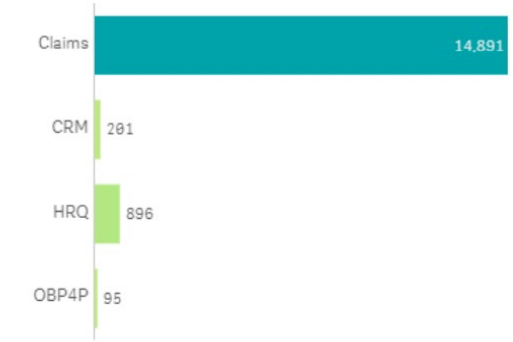


By Current Practice Setting



By SDOH Source

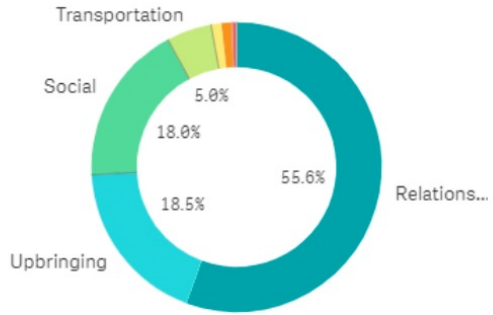
Members can be shown in multiple SDOH Sources



Count of Unique Members by Domain

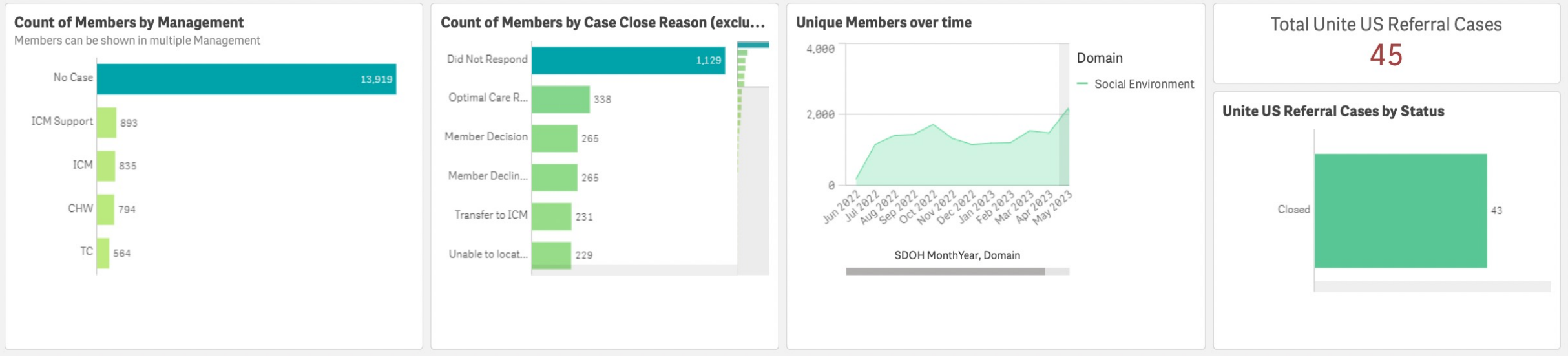
Members can be shown in multiple SDOH Domains

Count of Unique Members by Subdomain



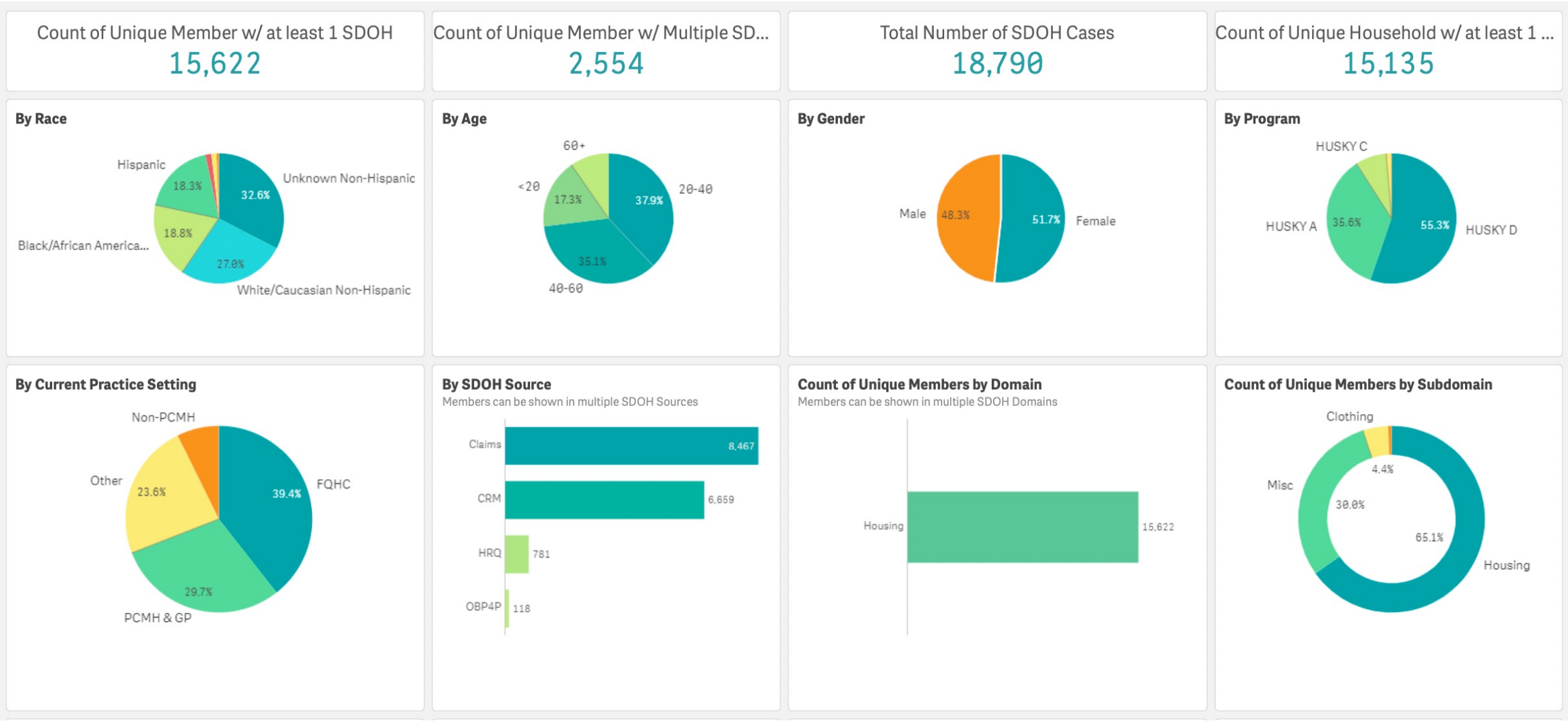
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

Social Determinant of Health Needs: Social Environment



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

Social Determinant of Health Needs: Housing



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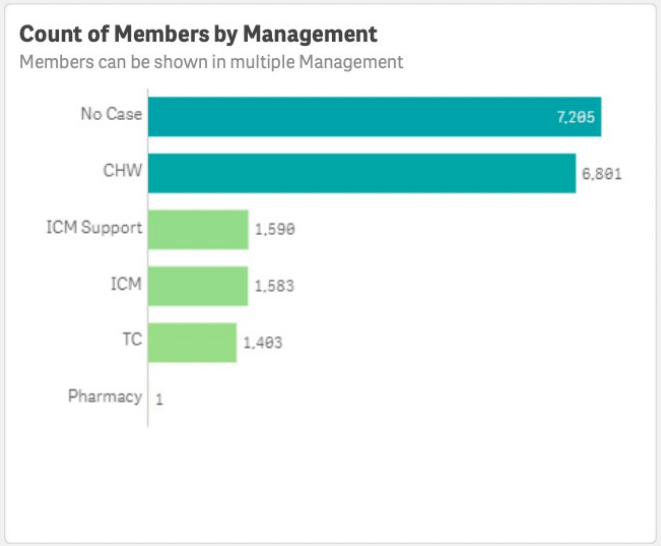
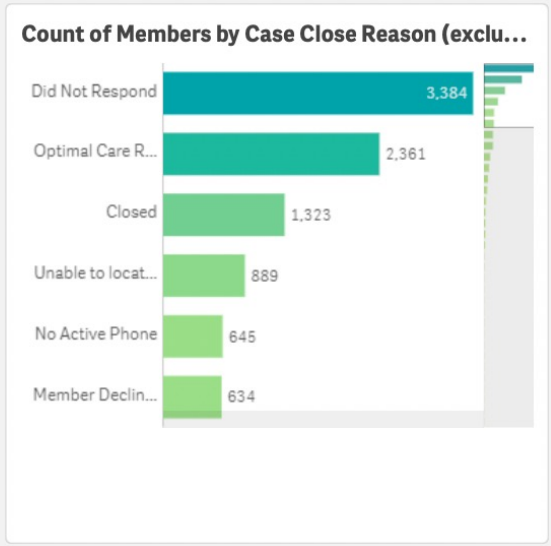
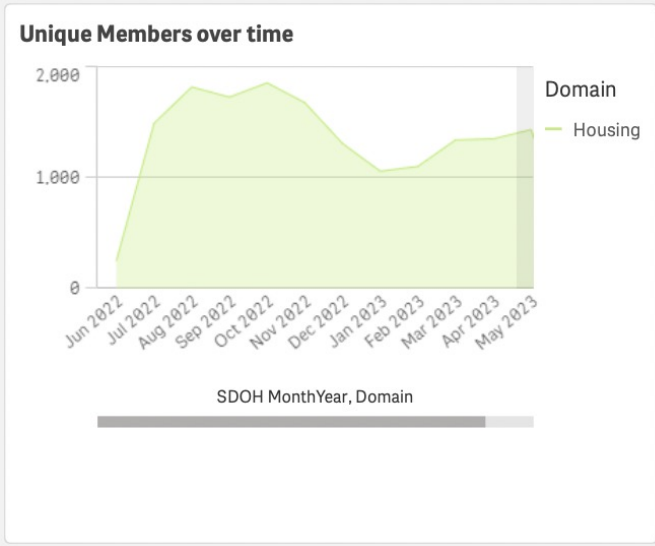
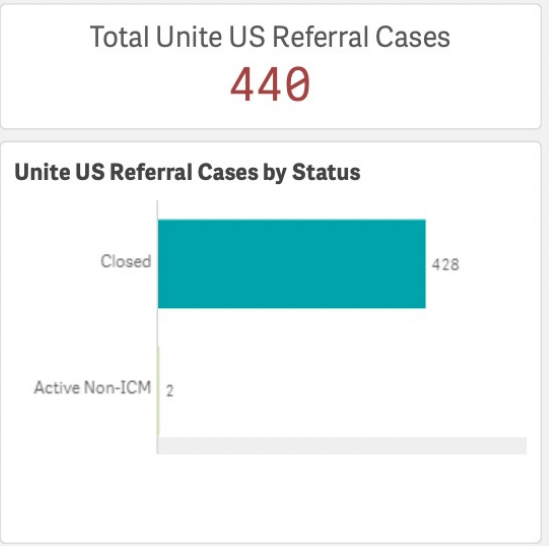
Social Determinant of Health Needs: Housing







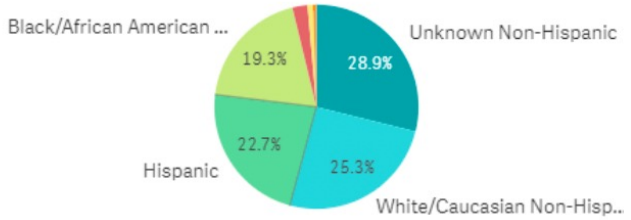


Source: CHNCT, Inc. SDOH Dashboard (Member Level)

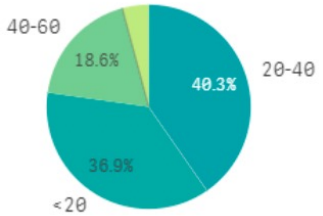
Social Determinant of Health Needs: Psychosocial Circumstance

Count of Unique Member w/ at least 1 SDOH	Count of Unique Member w/ Multiple SD...	Total Number of SDOH Cases	Count of Unique Household w/ at least 1 ...
5,954	155	6,112	5,818

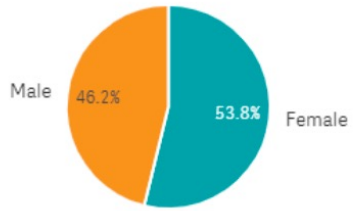
By Race



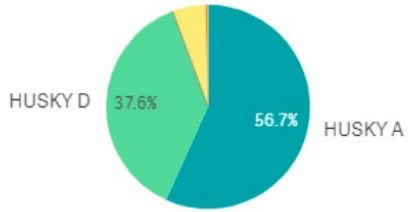
By Age



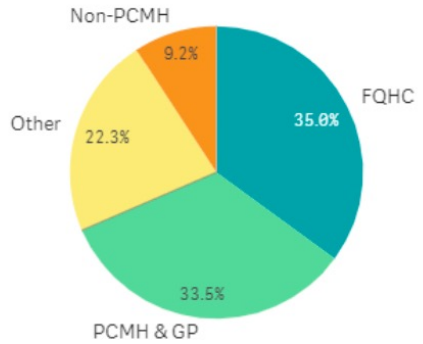
By Gender



By Program

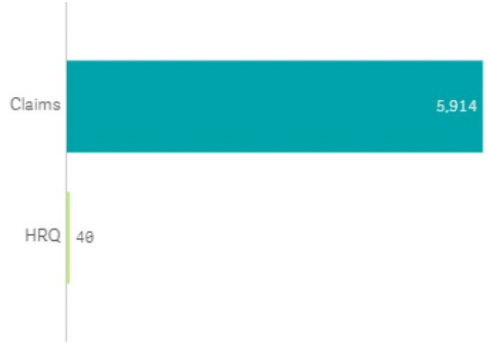


By Current Practice Setting



By SDOH Source

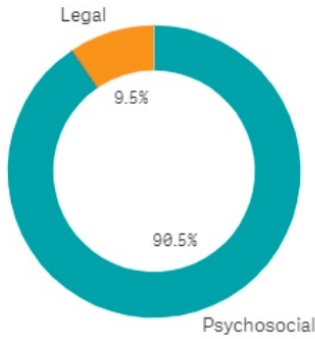
Members can be shown in multiple SDOH Sources



Count of Unique Members by Domain

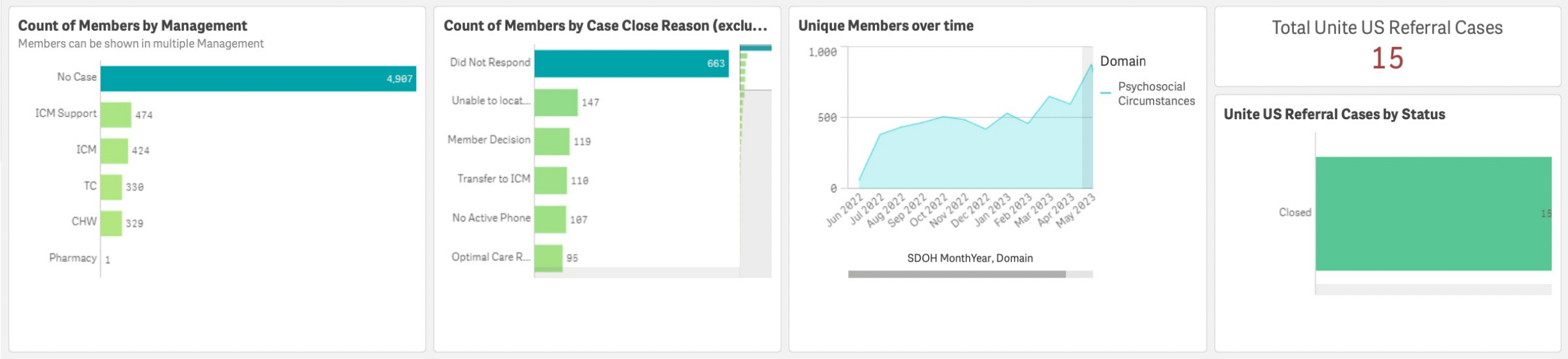
Members can be shown in multiple SDOH Domains

Count of Unique Members by Subdomain



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

Social Determinant of Health Needs: Psychosocial Circumstance

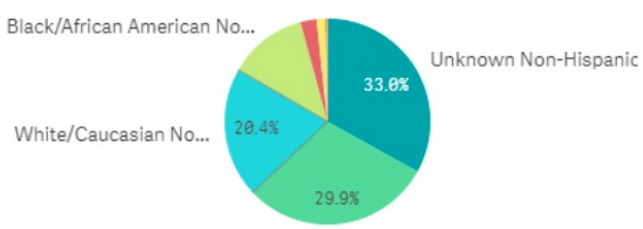


Source: CHNCT, Inc. SDOH Dashboard (Member Level)

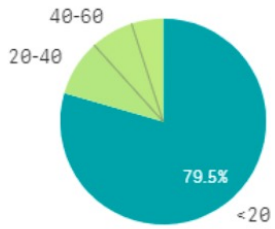
Social Determinant of Health Needs: Education Level

Count of Unique Member w/ at least 1 SDOH	Count of Unique Member w/ Multiple SD...	Total Number of SDOH Cases	Count of Unique Household w/ at least 1 ...
4,373	153	4,531	4,118

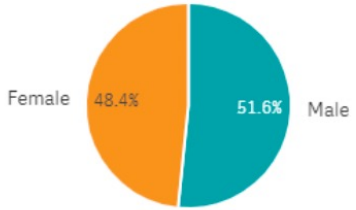
By Race



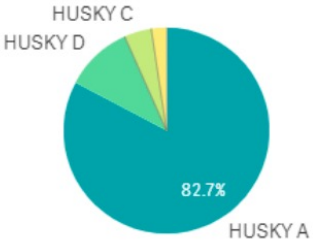
By Age



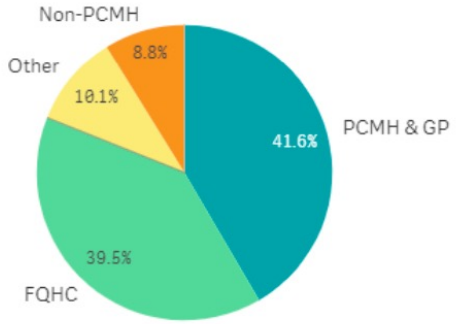
By Gender



By Program

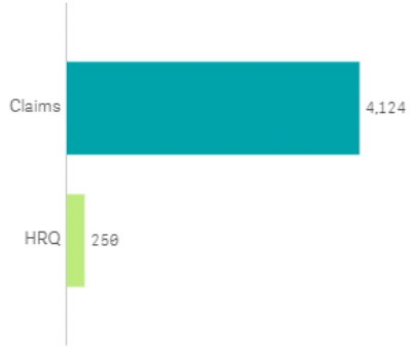


By Current Practice Setting



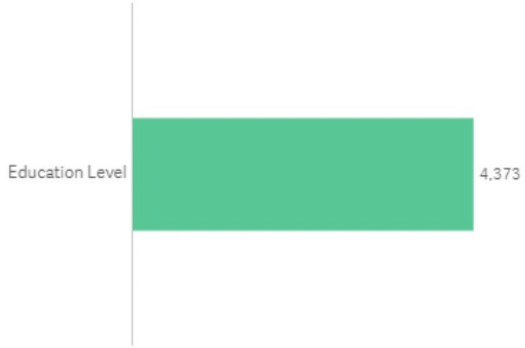
By SDOH Source

Members can be shown in multiple SDOH Sources

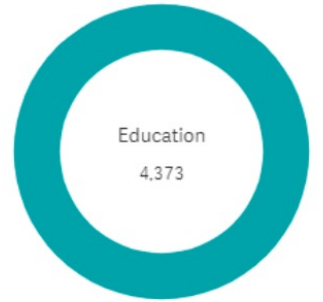


Count of Unique Members by Domain

Members can be shown in multiple SDOH Domains

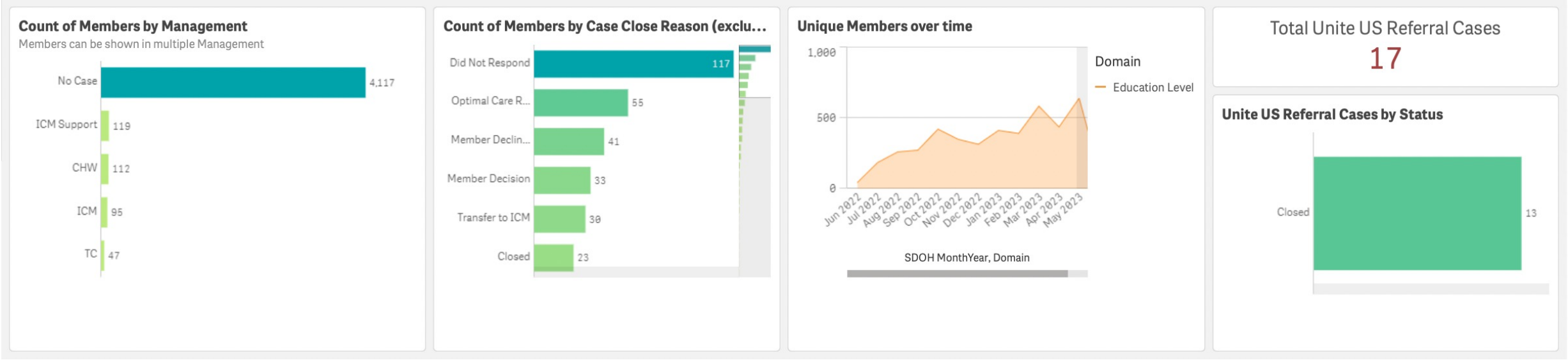


Count of Unique Members by Subdomain



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

Social Determinant of Health Needs: Education Level

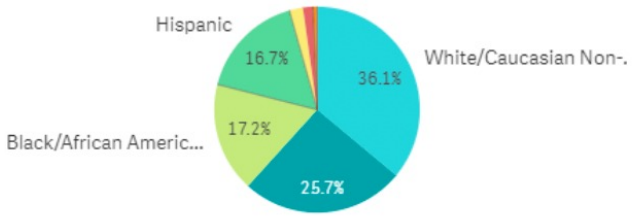


Source: CHNCT, Inc. SDOH Dashboard (Member Level)

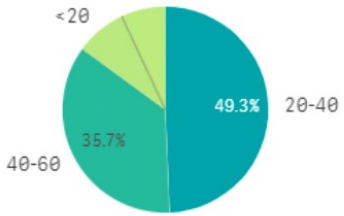
Social Determinant of Health Needs: Employment

Count of Unique Member w/ at least 1 SDOH	Count of Unique Member w/ Multiple SD...	Total Number of SDOH Cases	Count of Unique Household w/ at least 1 ...
3,614	19	3,633	3,605

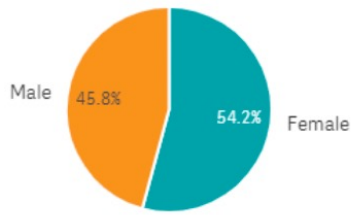
By Race



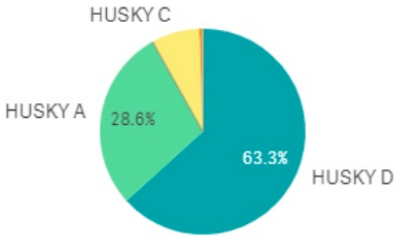
By Age



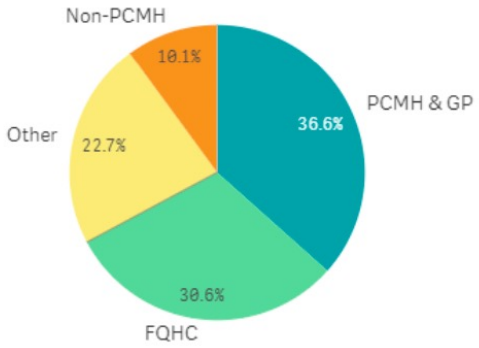
By Gender



By Program

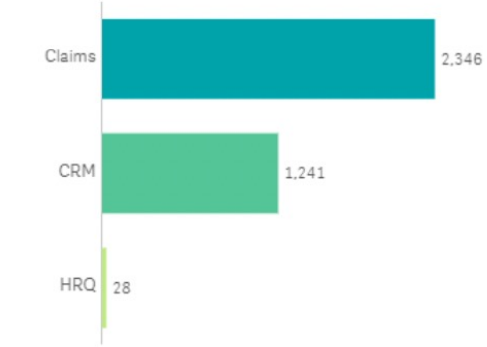


By Current Practice Setting



By SDOH Source

Members can be shown in multiple SDOH Sources



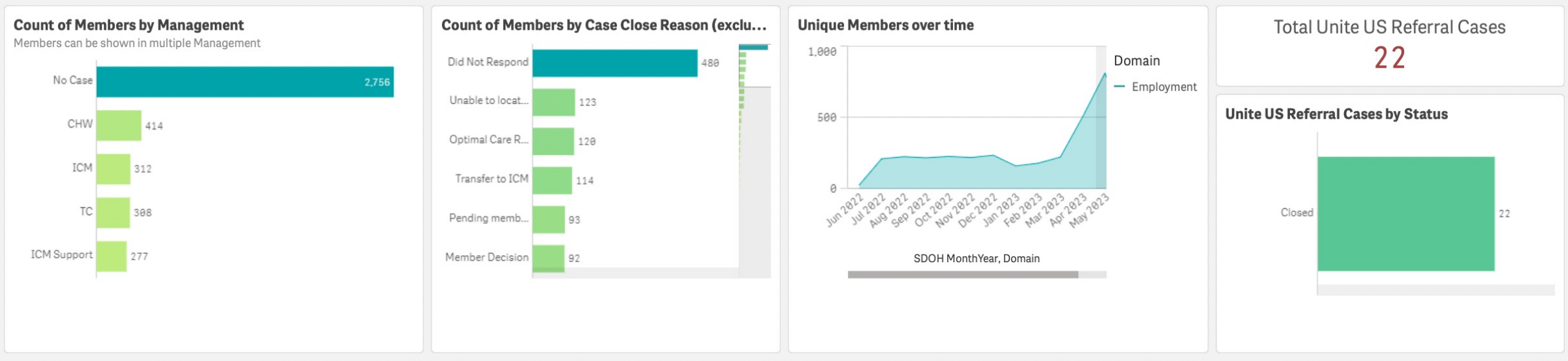
Count of Unique Members by Domain

Members can be shown in multiple SDOH Domains

Count of Unique Members by Subdomain

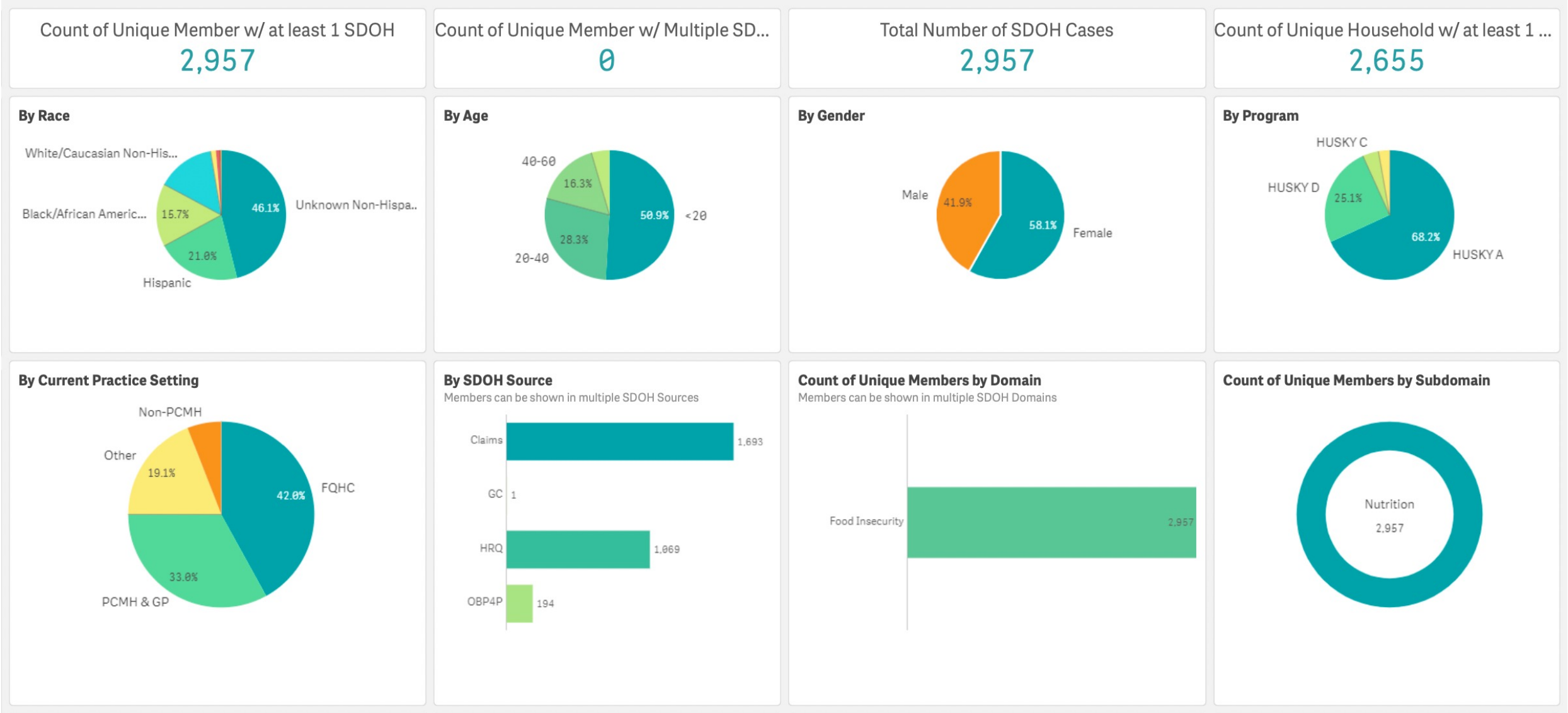
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

Social Determinant of Health Needs: Employment



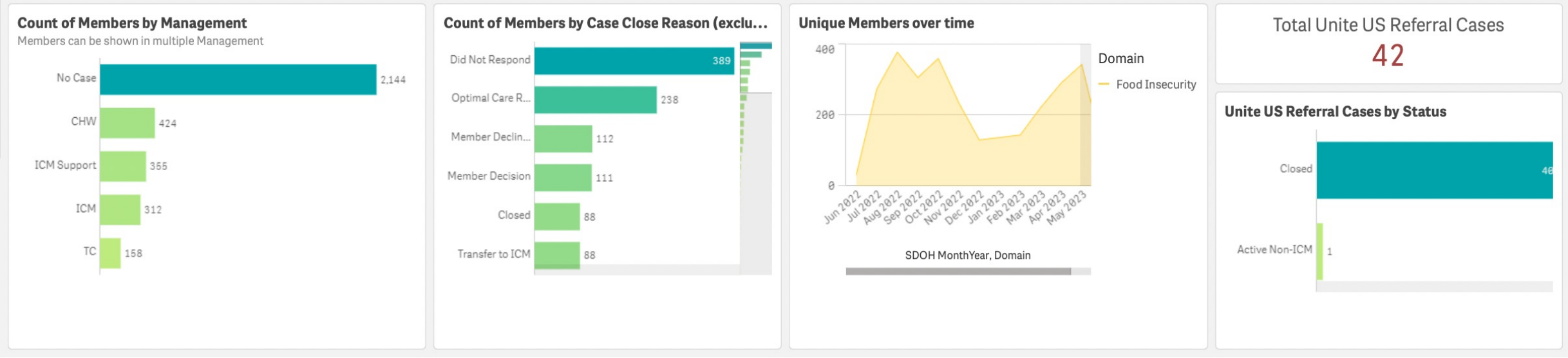
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

Social Determinant of Health Needs: Food Insecurity



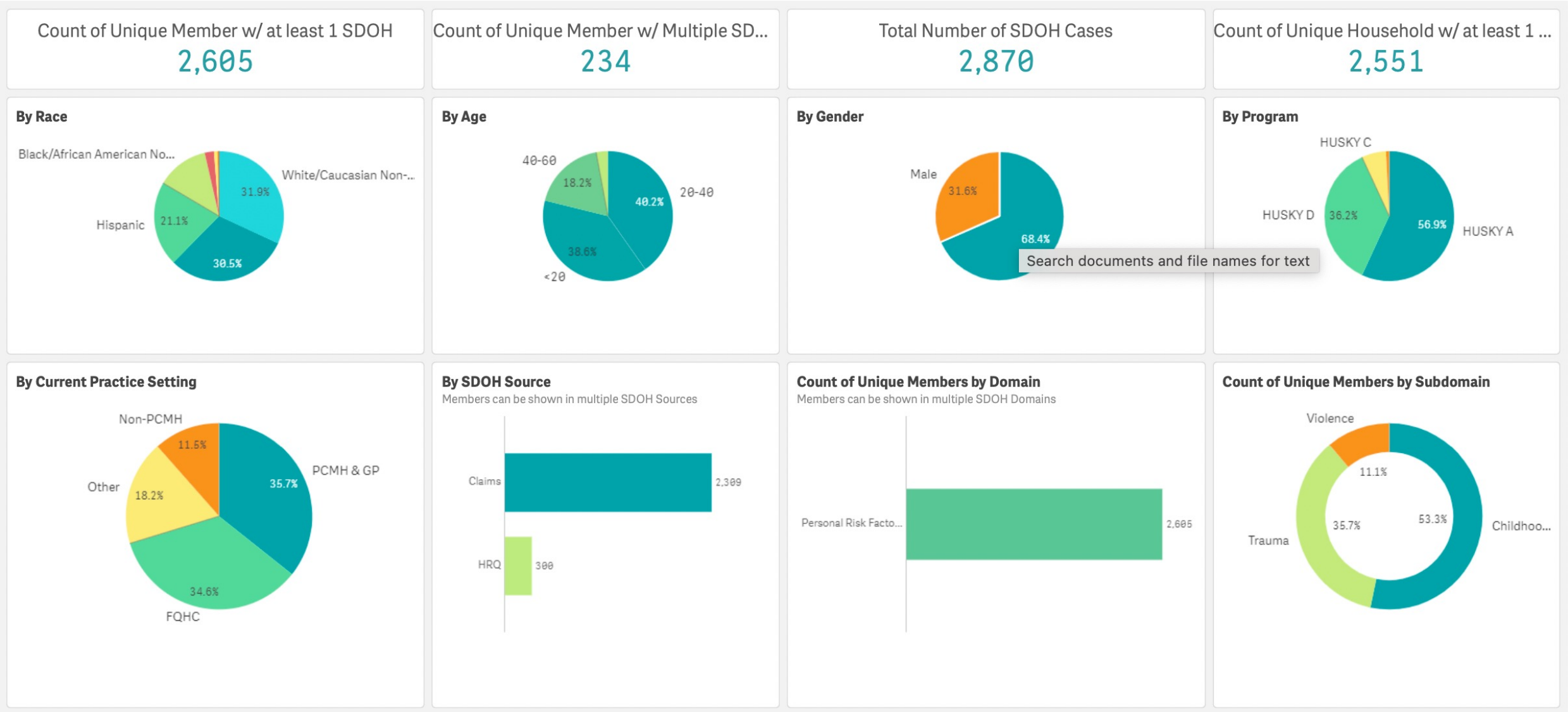
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

Social Determinant of Health Needs: Food Insecurity



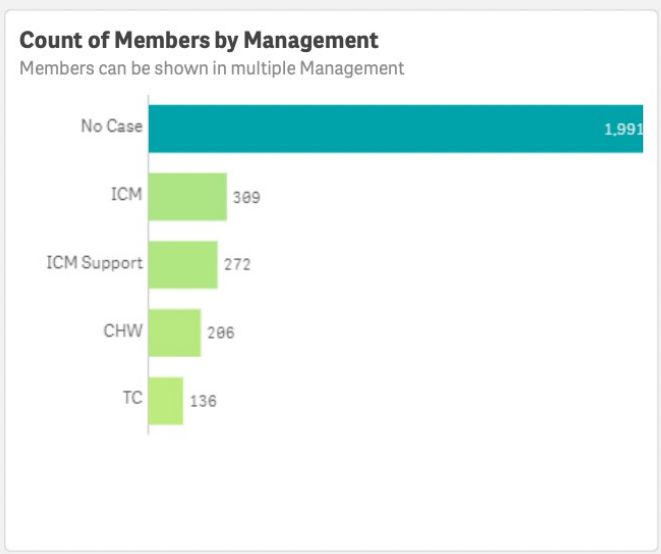
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

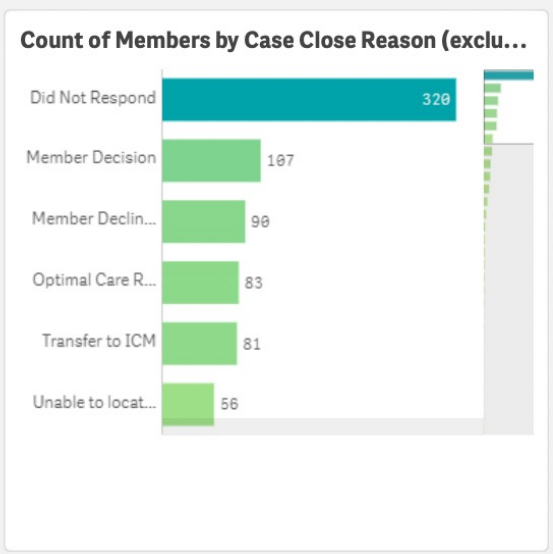
Social Determinant of Health Needs: Personal Risk Factor

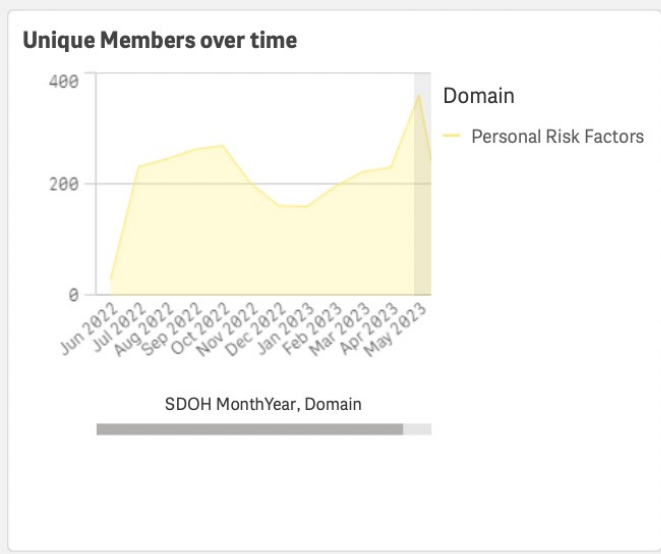


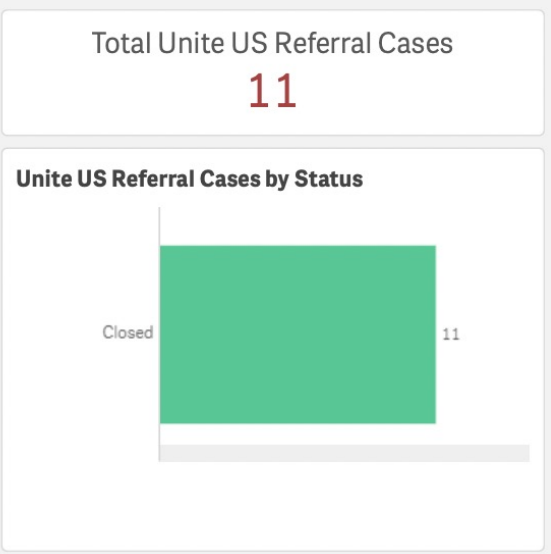
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

Social Determinant of Health Needs: Personal Risk Factor



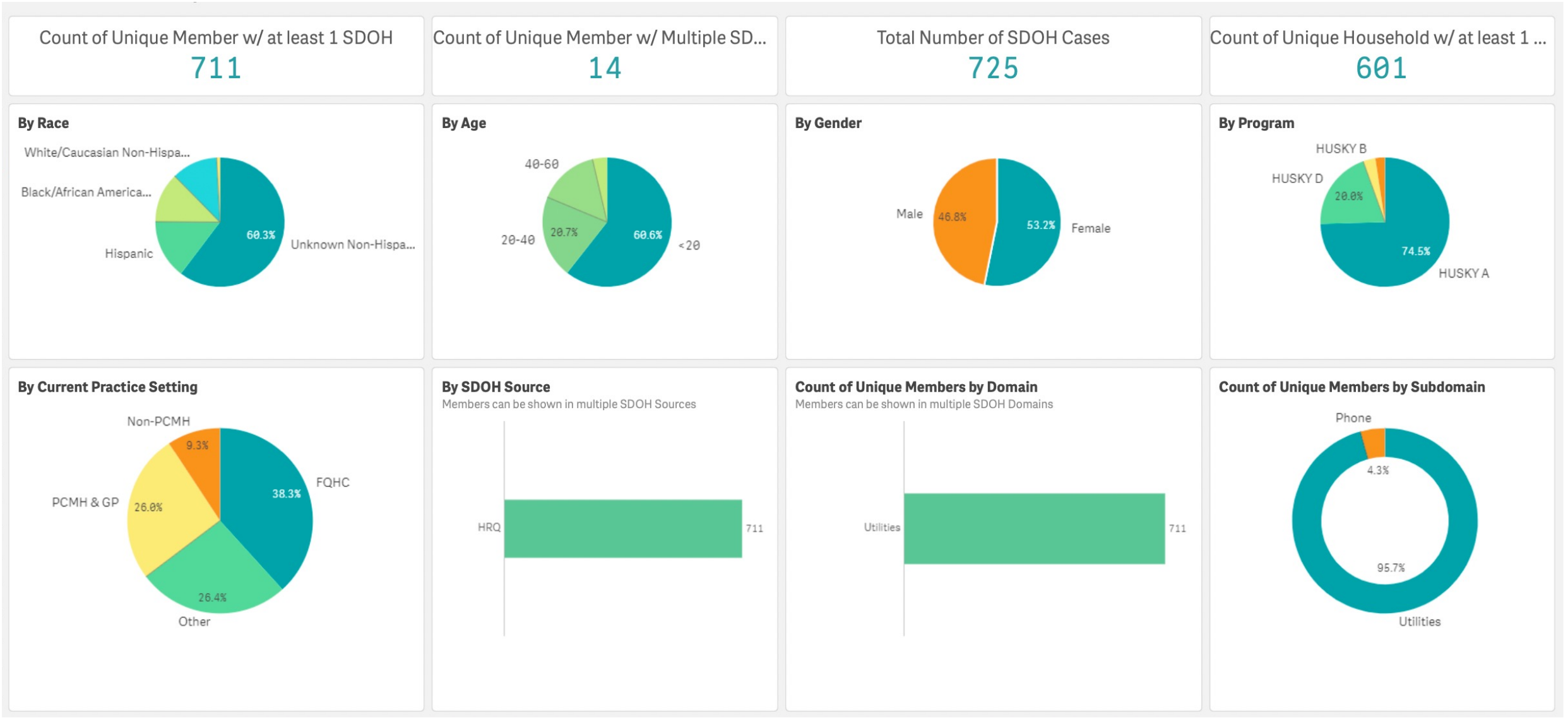






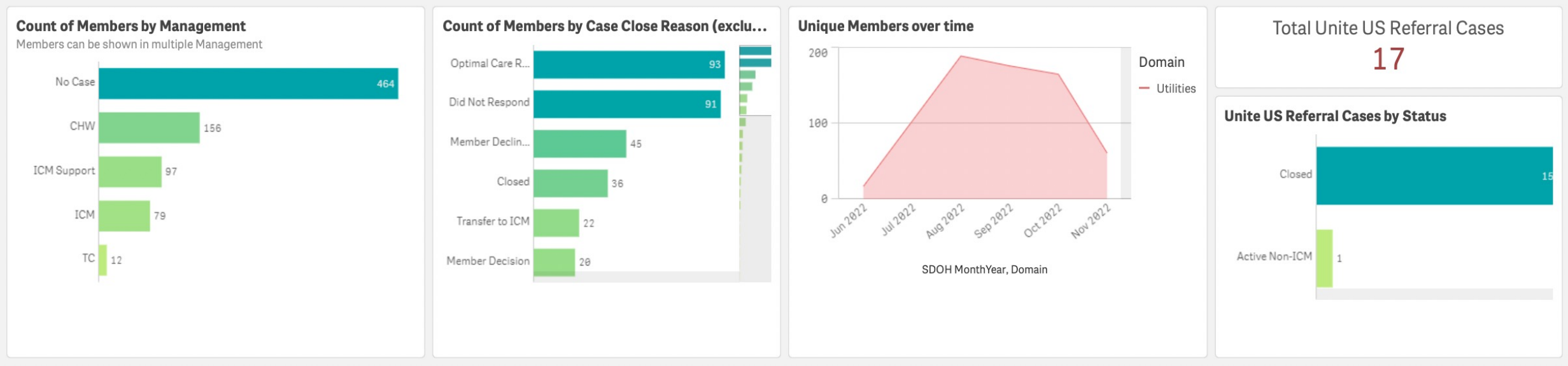
Source: CHNCT, Inc. SDOH Dashboard (Member Level)

Social Determinant of Health Needs: Utilities



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

Social Determinant of Health Needs: Utilities



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

Appendix

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

Inform: Topic 2 – Broader Strategies (1115 Waivers)

Prior 1115 Waiver Approvals: Outcomes

North Carolina Healthy Opportunities Pilots	A formal evaluation will be conducted, but is not yet available – **the program is currently reporting process measures**: • Number of Enrollees: 10,234 • Percent of Service Authorizations Approved: 98% • Percent of Invoices Accepted, Paid, or In Progress: 89% • Number of Invoices Submitted: 88,292 • Number of Services Delivered: 76,582 • Amount Paid for Service Delivery: $10,368,734 Data as of May 31, 2023 (service delivery began in March 2022)
Washington Accountable Communities of Health	**ACH Successes:** • Advancing MTP goals and assisting with transforming the health care delivery system. • Connecting people to social supports that will foster better health. • Identifying strategies to address gaps in health equity, HRSN, and workforce. • Providing innovation and partnering with the state. **Lessons Learned:** • More statewide direction for collective action and alignment is needed to coordinate care and resources. • Focus on achieving a balance of community/regional innovation and statewide approaches. • Continued need for medical and social services and supports for the impacted and marginalized communities, emphasizing early interventions to address social needs and health disparities.

Recent 1115 Waiver Approvals: HRSN Service Detail

Below are examples of HRSN services approved in recent 1115 waiver approvals.

	Authorized Service Examples
Housing Supports	Post-transition rent/temporary housing (up to 6 months), utility costs, pre-tenancy and tenancy sustaining services, housing transition navigation services, one-time transition and moving costs, housing deposits, and medically necessary home accessibility modifications and remediation services
Nutrition Supports	Nutrition counseling and education, meals delivered to the home (for up to 6 months), medically-tailored food prescriptions (for up to 6 months), cooking supplies, meal or pantry stocking
Case Management	Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
Transportation to HRSN	Transportation to HRSN services for tenancy supports and nutrition supports
HRSN Infrastructure	Infrastructure investments to support the implementation and delivery of HRSN services, including technology; development of business or operational practices; workforce development; and outreach, education and stakeholder convening

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

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

Accountability for HRSN Screening: State Examples

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.

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