



## **Addressing Health-Related Social Needs Through Medicaid Managed Care**

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## I. Executive Summary

Social determinants of health (SDOH) are the daily context in which people live, work, play, pray, and age and that affect health. SDOH encompass multiple levels of experience from socioeconomic status, education, and employment to structural and environmental factors (such as structural racism and poverty created by economic, political, and social policies).<sup>1</sup> SDOH influence health and well-being, either by conferring health benefits or contributing to health risks. For example, increased education is associated with better health outcomes while limited education is associated with lower earning potential and poor health outcomes. Social risk factors are defined as “specific adverse social conditions that are associated with poor health, like social isolation, lack of transportation access, utility insecurity, or housing instability.”<sup>2</sup>

The Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, health plans, advocates, and other stakeholders are examining and addressing SDOH needs to promote health equity, reduce medical expenses, and improve Medicaid enrollees’ health, well-being, and quality of care.<sup>3</sup> States are using a variety of approaches to measure and incentivize Medicaid managed care (MMC) entities to address unmet social needs that can contribute to poor health outcomes, lower quality care, and higher medical expenditures.<sup>4</sup> Most of these efforts intervene at the individual level, for example, identifying and mitigating individual social risk factors and needs. A national survey of state Medicaid officials indicated that by 2021, almost half of responding state Medicaid agencies that contract with Managed Care Organizations (MCOs) had incorporated health-related social needs screening provisions into their contracts. More than half of responding states reported the COVID-19 pandemic prompted them to address health-related social needs for Medicaid enrollees, especially the need for stable housing.<sup>5</sup> In addition to efforts at the enrollee level, a few state Medicaid agencies are adopting policies designed to address social risk factors at the population level by encouraging investment in communities.

This toolkit identifies examples of approaches states are taking through their MMC programs to address health-related social needs. Federal rules prohibit states from using Medicaid funds to pay for housing or food, but states can leverage existing authorities to support individuals with housing- and food-related needs. In early 2021, CMS issued a letter to states describing how Medicaid agencies can utilize managed care authorities, State Plan authority, Home and Community-Based Services (HCBS) options and/or Section 1115 waiver authority to address SDOH needs of enrollees.<sup>6</sup>

State Medicaid agencies utilize different terms and definitions related to SDOH, often characterizing SDOH broadly to include interventions that focus on individuals’ social risk factors and health needs. States interested in implementing specific strategies related to SDOH can use this toolkit to develop managed care procurements or update and operationalize key contract provisions. For example, a state may decide to utilize a procurement question similar to one in [Appendix A](#) to assess respondents’ experience and capabilities related to SDOH. A state may also expedite development of their MMC scope of work and contract language by reviewing [Appendix B](#) to see how peer states incorporate SDOH policies into their contract language.

The primary focus is on SDOH options that fall within Medicaid state plan and general managed care authorities. Most Medicaid initiatives to address members’ SDOH needs are focused on MCOs. However, states can modify and apply approaches other states use with managed behavioral health organizations (MBHOs), accountable care organizations (ACOs), and managed long-term services and supports (MLTSS) programs for use in Medicaid MCO procurements and contracts. **Table 1** identifies seven different types of state approaches to address SDOH in MMC.

Table 1: State MMC Approaches to Address Members' SDOH Needs
A. Identifying and addressing SDOH within MCO care coordination/care management requirements
B. Requiring and/or encouraging MCO use of ICD-10 Z codes
C. Encouraging MCO use of SDOH-related value-added services
D. Encouraging MCOs to offer SDOH-related in lieu of services
E. Directing or encouraging MCOs to engage providers in SDOH activities
F. Encouraging SDOH-related activities and approaches with financial or other incentives
G. Accounting for social risk factors in managed care payment methodologies

States may target certain SDOH interventions based on the strength of the evidence and the return on investment. For example, the research base is strong for housing and nutrition interventions and care management programs with demonstrated savings from investments. Non-emergency transportation for individuals with low incomes also produces a return on investment.<sup>7</sup> California cited research showing the impact of medically-tailored meals/medically-supportive food on reductions in emergency department (ED) visits, hospitalizations, and readmissions, and improved outcomes. The state used the information to demonstrate to CMS that nutritional services should be considered medically-appropriate and cost-effective in lieu of services for certain Medicaid managed care populations.<sup>8</sup> States may design and implement special SDOH initiatives targeting a specific MMC subpopulation (e.g., children in foster care, individuals transitioning from the hospital to the community, from the nursing facility to the community, or from incarceration to the community) or a specific SDOH domain(s) (e.g., housing, food security, employment). This resource is focused on states' use of broad SDOH initiatives in MMC. While a number of state Medicaid agencies may have specific pilot programs for certain populations or SDOH domains, those types of pilots are beyond the scope of this resource.

State examples profiled in [Section II](#) are presented in alphabetical order by state and refer to MMC contracts and procurements, including a few contracts related to ACOs, MBHOs, and MLTSS programs.

- [Appendix A](#) contains specific questions states incorporated into MMC procurements to both signal that SDOH is a priority area of focus for the state and to better understand respondent preparedness to support SDOH-related activities and interventions. In addition, Appendix A identifies specific evaluation questions and rating factors in the February 2022 Medi-Cal request for proposals (RFP) related to SDOH.
- [Appendix B](#) includes the specific language states are using in their MMC contracts pertaining to the SDOH approaches identified in this document. In some cases, this contract language is part of model contracts and scopes of work released with recent MMC procurements and not yet implemented.
- [Appendix C](#) includes links to MMC contracts referenced in this document.

This resource does not include all state MMC procurement questions or contract language related to addressing enrollees' SDOH needs, but instead represents a curated list of specific examples from 16 profiled states (see [Table 2](#) for a summary of states and approaches). In some cases, the relevant MMC contract language was excluded from this resource due to length, because it was similar to contract language already cited in [Appendix B](#), or specific to state 1115 waivers. For example, Oregon has a 22-page Exhibit K as part of its managed care contracts describing Medicaid requirements related to social determinants of health and equity. The full MMC contracts (or model contract and procurement scope of work) are available at the website links provided in [Appendix C](#).

## II. State MMC Approaches to Address Members' SDOH Needs

Terminology used to reference SDOH varies across states and MMC programs. Instead of, or in addition to “social determinants of health,” some states refer to: social drivers of health, social needs, health-related social needs, health-related resource needs, non-clinical needs, non-medical needs, social risk factors, and non-medical risk factors. SDOH typically refers to domains, such as food, housing, and transportation. In contrast, social or non-medical risk factors may be defined as food insecurity, housing instability, and lack of reliable transportation including beyond medical appointments.

A first step to address SDOH is to promote screening of MMC members to identify enrollees' social risk factors. Some state MMC contracts specifically direct MCOs and/or ACO and provider entities to conduct SDOH screening as part of health needs assessments and within care coordination/care management. Certain MMC contracts may go further and require or incentivize managed care entities to implement mitigation strategies to address identified social risk factors. MCO mitigation strategies can be incorporated within care coordination and care management requirements, require use of community resource referral platforms to connect individual members with community-based organizations (CBOs), and may extend to MCO financial incentives to partner with CBOs and invest in communities to improve SDOH.

The Social Interventions Research & Evaluation Network (SIREN) has summarized and compared several widely used SDOH screening tools such as: the Accountable Health Communities Health-Related Social Needs (AHC-HRSN) Screening Tool and PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences), including information about the number of questions in each tool, available languages, social health domains covered, and domain-specific measures used. In addition, SIREN's publications offer states, plans, and providers resources to better understand the current state of SDOH screening, patient perspectives, and how to act on screening results using the National Academy of Sciences, Engineering and Medicine (NASSEM) framework. This framework places efforts to identify patients' social risks and assets (i.e., “awareness”) at the center of multiple action strategies that states, MCOs and provider entities can take to mitigate the “impacts of social adversity with the intention of improving individual and population health.”<sup>9</sup>

While some states require Medicaid MCOs to screen for SDOH or at least for certain domains such as housing stability, until just recently, there has been no standardized SDOH measure currently available to assess MCO performance. In August 2022, the National Committee for Quality Assurance (NCQA) adopted a new Social Need Screening and Intervention (SNS-E) measure at the MCO level for use in calendar year 2023.<sup>10</sup> The SNS-E measure requires MCOs to report the percentage of members who were screened using prespecified instruments at least once during a measurement year and received an intervention for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. In addition, a few states have been developing their own SDOH screening and intervention measures, as discussed under Approach F related to encouraging SDOH-related activities and approaches with incentives.

State agencies may focus MMC strategies on certain SDOH domains and interventions or on initiatives targeting a specific subpopulation (e.g., children in foster care or individuals transitioning from the hospital to the community). Medicaid agencies may work with their executive leaders, actuaries, contracted MCOs, providers, members, and CMS to identify and refine SDOH approaches based on priorities, resources, the prevalence of the social risk factors and the potential to improve health and reduce medical expenses.

Table 2 provides more detail on how the 16 Medicaid programs included in this resource utilize one or more of the identified approaches to identify and address SDOH needs for managed care enrollees.<sup>11</sup> The SDOH-related procurement and contract examples cited in Table 2 are intended to be illustrative of the state's approaches,

not an exhaustive record of all its approaches to address members’ SDOH needs. Similarly, the MMC contract language in Appendix B does not include contract language from all states or all MMC programs identified.

Many states have multiple MMC programs (e.g., CA, MA, MN, RI, TX, VA). The information summarized in Table 2 may represent the state’s approaches in one or more of its managed care programs. For example, in Texas the specific approaches cited are related to the state’s recent MLTSS (STAR+PLUS) procurement and in Rhode Island and Massachusetts, some of the approaches are within Medicaid ACO contract provisions. Appendix C provides website links to Medicaid managed care contracts and procurements referenced in this resource.

Table 2: Overview of State MMC Approaches to Addressing SDOH Needs of MMC Enrollees

Approach	AZ	CA	HI	IA	LA	MA	MN	MS	NV	NC	OH	OR	PA	RI	TX	VA
A. Identifying and addressing SDOH within MCO care coordination/care management requirements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
B. Requiring and/or encouraging MCO use of ICD-10 Z codes	Y	Y	Y		Y	Y	Y				Y		Y	Y	Y	
C. Encouraging MCO use of SDOH-related value-added services			Y		Y			Y				Y				Y
D. Encouraging MCOs to offer SDOH-related In lieu of services		Y										Y				
E. Directing or encouraging MCOs to engage providers in SDOH activities		Y	Y			Y			Y	Y	Y	Y	Y	Y		
F. Encouraging SDOH-related activities and approaches with financial or other incentives	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y		Y	Y	
G. Accounting for social risk factors in managed care payment methodologies						Y	Y									

The remainder of this section summarizes each of the SDOH approaches (A through G) using state examples.

**A. Identifying and Addressing SDOH Within MCO Care Coordination/Care Management Requirements**

All 16 states profiled in this resource direct Medicaid MCOs to screen for social needs, largely within care management assessment and/or address social needs within care management interventions. Some states require managed care entities to screen for unmet SDOH needs as part of initial health needs assessments that are required for new enrollees under federal regulations. In addition, many of these states include requirements for MCOs to mitigate identified unmet needs, including by making referrals to community-based resources and by checking to see if an identified member’s need was met. Select examples of different approaches across the profiled states are summarized below. (See [Table 3 in Appendix B](#) for specific language some of these states are using in their MMC contracts related to SDOH care coordination and care management provisions.)

- **Arizona’s** AHCCCS Complete Care (ACC) managed care contract includes a focus on housing interventions within care management. MCOs are required to employ a housing specialist whose responsibilities include supporting case managers by providing education and training on evidence-based housing interventions and identifying and referring members with housing needs to the appropriate services.
- **California** has extensive new MMC care management requirements which the state incorporated into the 2022 Medi-Cal procurement. The new provisions will require Medi-Cal MCO care managers to screen for SDOH, refer individuals to community health workers or community-based services to

address identified needs, and track referrals to ensure fulfillment. In addition, members who are experiencing homelessness or who are transitioning from incarceration are eligible for enhanced care management. Enhanced care management “will meet beneficiaries wherever they are – on the street, in a shelter, in their doctor's office, or at home.” In addition, “beneficiaries will have a single Lead Care Manager who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for them to get the right care at the right time.”<sup>12</sup>

- **Hawaii, Iowa, Louisiana, Mississippi, North Carolina, and Virginia** require MCOs to screen for SDOH and use the information to inform interventions (Hawaii) and identify individuals for care management support (Hawaii, Louisiana, Mississippi, North Carolina, and Virginia). Hawaii, Iowa, and North Carolina will determine the final SDOH questions to be used in the MCOs’ screening tool.
- **Massachusetts’** new Medicaid ACO model contract requires entities to screen for health-related social needs, evaluate identified needs, provide information about available supports, and refer individuals to social service organization(s) for follow up. Those requirements are components of broader care coordination and care delivery requirements.
- **Mississippi’s** new model contract outlines requirements for MCOs to provide closed-loop referrals, which means that MCOs will connect individuals directly to entities receiving referrals. Virginia will require MCOs to annually report on policies and procedures related to (1) programs and partnerships established to address SDOH and (2) identifying, addressing, and tracking SDOH related to employment, food security, and housing stability.
- **Nevada’s** MMC contracts require MCOs to submit to the state a Care Management Program Description of care coordination and case management processes, including those used to identify and address SDOH and to refer members to community resources. Nevada’s MMC contracts also require MCOs to: 1) screen for SDOH needs as part of a broader health needs assessment, 2) consider member SDOH needs as part of MCO risk stratification models to identify members for care coordination and/or case management services, and 3) report annually to the state regarding SDOH issues identified and addressed within the MCO’s member population. In addition, Nevada considers “homeless/transient status” a priority condition for which MCOs must provide case management services.
- **Ohio’s** new MMC agreement expected to be effective by December 2022 includes requirements for MCOs to use risk stratification to assess population-level and member-level risk levels. Risk stratification criteria and thresholds must include SDOH, among other factors. MCOs must use risk stratification, in coordination with other data sources, to assist in targeting interventions aimed at identifying and providing for SDOH-related needs of members.
- **Pennsylvania’s** HealthChoices Physical Health MCO contracts require MCOs to address SDOH within care coordination requirements for the state’s Home Visiting Program for maternal and infant care. Home Visiting Program activities focus on increasing screenings and referrals to community resources for SDOH, which include food insecurity, healthcare access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, and financial strain. The MCO contracts also specify case management standards for the MCO’s Special Needs Unit, to include SDOH as part of a broader health needs assessment.
- **Texas’s** STAR+PLUS 2022 procurement scope of work requires MCOs to use an evidence-based screening tool for health-related social needs, coordinate and track referrals to community organizations for community-based resources, and provide social needs resources to network providers to address members’ needs. In addition, requirements for service coordination, a specialized care management service, also identify and address SDOH.

Refer to [Appendix C](#) for links to MMC contracts referenced in this section.

## B. Requiring and/or Encouraging MCO Use of ICD-10 Z Codes<sup>13</sup>

ICD-10 Z codes provide a standardized way to document SDOH, allowing for SDOH prevalence to be tracked, data to be aggregated, and trends identified. Z codes are a subset of ICD-10-CM codes related to circumstances (other than a disease, injury, or diagnosis) that influence an individual's health status. Use of Z codes enables social needs data to be extracted from electronic health records. Data can then be used for clinical, operational, reporting, or other usages. States that require Medicaid MCO use of Z codes include Arizona, Hawaii, Louisiana, Massachusetts, Ohio, and Pennsylvania. (See [Table 4](#) in **Appendix B** for specific language some of these states are using in their MMC contracts related to the use of ICD-10 Z codes.)

- **Arizona's** ACC Whole Person Care Initiative requires MCOs to promote and educate providers on the use of SDOH ICD-10 codes on claims to support data collection on social risk factors.
- **Hawaii's** Medicaid quality improvement strategy requires MCOs to develop a SDOH work plan that is designed to increase member-level SDOH screening, including through the use of ICD-10 Z codes to document screening results. MCOs are also required to develop plans to increase provider understanding of SDOH.
- **Louisiana's** new MMC model contract requires MCOs to develop a Health Equity Plan, which includes an action plan for reimbursing network providers for screening for SDOH needs and submitting ICD-10 Z codes on claims.
- **Massachusetts'** new Medicaid ACO model contract requires ACOs to ensure providers include relevant ICD-10 codes, including Z codes, on claims when a health-related social need is identified in an encounter.
- **Ohio's** new MMC agreement includes a significant focus on population health and quality, to include improvement strategies that reduce health disparities, address social risk factors, and achieve health equity. MCOs must reimburse providers for ICD-10 Z codes included on the fee schedule to help ensure referral and follow-up related to identified SDOH-related needs.
- **Pennsylvania** requires its physical health MCOs to ensure contracted Patient Centered Medical Home (PCMH) providers screen patients for SDOH and submit ICD-10 Z codes to document screening results. In addition, providers participating in Pennsylvania's maternity care bundled payment program have a financial incentive to screen individuals for SDOH and document results using ICD-10 Z codes.

Refer to [Appendix C](#) for links to MMC contracts referenced in this section.

## C. Encouraging MCO use of SDOH-Related Value-Added Services

Value-added services are additional services or benefits not covered under a Medicaid state plan that MCOs may offer to members. Examples include respite services, health and exercise programs, assessments of asthma triggers in the home, and meal delivery programs. Value-added services do not qualify as a covered service for the purpose of capitation rate setting, but states may permit MCOs to include the cost of value-added services in the numerator of a Medical Loss Ratio (MLR) if they are determined to be part of a quality initiative. Some state Medicaid agencies have encouraged MCO use of value-added services to address SDOH, including Hawaii, Louisiana, Mississippi, and Virginia. (See [Table 5](#) in **Appendix B** for the language some of these states are incorporating into their MMC contracts related to SDOH value-added services.)

- **Hawaii** requires Medicaid MCOs to develop a separate SDOH work plan describing how they will provide SDOH value-added services. The SDOH work plan is a sub-component of the MCOs' Quality Assurance and Performance Improvement program.
- In **Louisiana**, the state identified specific value-added services, including respite care targeting individuals with post-acute medical needs who are experiencing homelessness, in its MMC RFP and asked respondents to indicate if they planned to offer any of the listed value-added services.



- **Mississippi** identified in its 2021 MMC request for qualifications (RFQ) a list of “desired” value-added SDOH benefits such as nutrition assistance, utility payment assistance, pest/bed bug control, education and employment supports, and internet access in the home.
- **Virginia’s** MMC programs encourage MCOs to offer enhanced benefits targeting members’ SDOH needs. The CCC Plus MMC contract includes examples of potential enhanced benefits for the CCC Plus program population, including SDOH. Enhanced benefits provided by MCOs in both MMC programs address food, education, transportation, employment, and housing support for members with identified SDOH needs.

Refer to [Appendix C](#) for links to MMC contracts referenced in this section.

#### D. Encouraging MCOs to Offer SDOH-Related In Lieu of Services

In lieu of services (ILOS) can be used to provide medically appropriate, cost-effective substitutes for covered services to address SDOH. These may be services or settings and could include housing-related services, respite services, or in-home prenatal care, for example. ILOS are considered covered services for the purposes of capitation rate setting so long as the state has determined that the service is medically appropriate and cost-effective. ILOS are accounted for as a medical expense in the MLR numerator. (See [Table 6](#) in **Appendix B** for specific language the following states are using in their contracts related to the use of ILOS.)

- One state with a robust new ILOS program is **California**. Beginning in January 2022, California used MMC ILOS authority to encourage MCOs to offer a menu of twelve “health-related services.”<sup>14</sup> Participating MCOs must develop a network of community-based providers who can provide the ILOS—referred to as “Community Supports” in California—to members and ensure that community-based organizations have capacity to accept referrals, provide social services, and track fulfillment of services.<sup>15</sup> While California initiated this ILOS approach within its existing MMC contracts, the state’s 2022 MMC procurement describes the Medi-Cal current and proposed ILOS approach more fully.
- **Oregon** determined that community transition services, enhanced case management, in-home health hazard remediation programs, and certain other services and settings are medically appropriate and cost-effective substitutes for covered services, and thus permits its Coordinated Care Organizations (CCOs) to offer them as ILOS.

The following ILOS were approved by CMS for CalAIM community supports through managed care/1915(b) authorities:

1. *Housing transition navigation services*
2. *Housing deposits*
3. *Housing tenancy and sustaining services*
4. *Caregiver respite services*
5. *Day habilitation programs*
6. *Nursing facility transition/diversion to assisted living facilities*
7. *Community transition services/nursing facility transition to a home*
8. *Personal care and homemaker services*
9. *Environmental accessibility adaptations*
10. *Medically supportive food/meals/medically-tailored meals*
11. *Sobering centers*
12. *Asthma remediation*

Refer to [Appendix C](#) for links to MMC contracts referenced in this section.

#### E. Directing or Encouraging MCOs to Engage Providers in SDOH Activities

In addition, some states require that MCOs engage and/or incentivize providers to participate in SDOH-related activities for Medicaid members. Some states require MCOs to implement certain alternative payment models that advance SDOH priorities and/or provide technical assistance or support to providers on SDOH activities. (See [Table 7](#) in **Appendix B** for specific language some states are using in their contracts to encourage or direct MCO activities with providers.)

- **Hawaii** requires Medicaid MCOs to support providers in understanding and assessing SDOH and to connect with social services providers to address member SDOH needs as part of broader value-based payment (VBP) transformation requirements.
- **Nevada's** MMC contracts direct MCOs to focus APM contracting strategies on incentivizing providers to address members' SDOH needs, among other strategies. Such strategies must consider provider administrative burden and support providers with data analytics and technical assistance.
- **Massachusetts'** new Medicaid ACO model contract requires ACOs to implement flexible services programs which provide "certain services to address health-related social needs". ACOs must establish at least one flexible services program in each of the tenancy and nutrition SDOH domains. ACOs can provide flexible services to ACO members directly or by connecting members to qualified community-based organizations.
- **North Carolina** requires MMC managed care plans to participate in enhanced case management pilots to address unmet health-related needs. Such participation requires its plans to contract with and make payments to community-based organizations that can deliver evidence-based interventions related to North Carolina's priority SDOH domains (housing, food, transportation, and interpersonal safety).
- **Ohio's** new MMC agreement includes a patient-centered medical home value-based initiative that requires MCOs to play a key role in supporting network comprehensive primary care practices with achieving optimal population health outcomes. MCOs must collaborate with practices to determine their level of support based on the practice's infrastructure, capabilities, and preferences for MCO assistance, including addressing SDOH.
- **Oregon** requires CCOs to offer incentive arrangements with providers, including SDOH providers, for achieving priority outcomes and quality objectives. CCOs must submit plans to the state for how they will distribute earned performance-based incentive dollars to participating providers. CCOs' distribution plans and other contractually required reports are publicly available.
- **Pennsylvania** requires HealthChoices Physical Health MCOs to incorporate community-based providers into VBP arrangements to address SDOH. In addition, these MCOs must form Regional Accountable Health Councils to offer technical assistance (TA) to community-based providers. TA is designed to help these providers improve population health and equity and address SDOH needs of the regions. TA areas include data analytics and measurement, contract management and negotiations, and measuring return on investment.

Refer to [Appendix C](#) for links to MMC contracts referenced in this section.

#### F. Encouraging SDOH-Related Activities and Approaches With Financial or Other Incentives

States employ a variety of incentives (financial and non-financial) to encourage MCOs to implement SDOH-related initiatives or hold MCOs and Medicaid ACOs financially accountable for performance on SDOH performance measures. Some states financially reward or penalize MCOs using performance-based withholds, MLR incentives and/or profit-sharing incentives. Some states stipulate how MCOs can use and distribute any earned incentive dollars. A couple of states incorporate performance on SDOH measures into shared savings and risk arrangements with contracted Medicaid ACOs. Non-financial incentives used by some states include public reporting of managed care SDOH activities, performance on SDOH-related measures, or MCO auto-assignment preference. (See [Table 8](#) in [Appendix B](#) for specific language states are using in their contracts related to the use of financial or non-financial incentives.)

- **Arizona, California, Nevada, Ohio, and Oregon** MMC contracts require MCOs to invest a percentage of profits/net income into the local community. (Some states refer to this as "community reinvestment" strategies.)

- New MCOs participating in **Iowa's** MMC program will have 10% of their annual performance withheld at risk for establishing accurate SDOH data reporting from the MCO to the state. MCOs will be given three months to implement data sharing, and the state will review SDOH data on a monthly basis for the first six months. To earn 100% (of the 10%) of the withhold back, the MCO must correctly implement the SDOH data reporting.
- Screening for SDOH is factored into Medicaid ACO quality performance calculations in **Massachusetts** and **Rhode Island**.<sup>16,17</sup>
- **Mississippi's** new model contract requires MCOs to devote at least 0.5% of capitation payments to SDOH projects and expects that MCOs will use the funds to partner with community-based organizations on SDOH initiatives.
- **North Carolina** employs both financial and non-financial incentives for MCOs to advance SDOH priorities as follows:
  - MCOs that voluntarily contribute to health-related resources that address priority SDOH domains (housing, food, transportation, and interpersonal safety) are permitted to count the contributions towards the numerator of its MLR.
  - The state gives auto-assignment preference to MCOs that voluntarily contribute at least one-tenth percent (0.1%) of annual capitation revenue to health-related resources that address priority SDOH domains.
- **Ohio's** MMC quality withhold program evaluates MCOs on their performance related to quality improvement activities, such as the use of research to develop changes to an MCO's normal processes for addressing health-related social needs, and collaboration with community entities, providers, and other stakeholders for collective impact.
- **Oregon's** CCO contract includes a variety of financial and other incentives for plans to identify, address, and report on SDOH needs of Medicaid managed care members.
  - Recently, Oregon developed a Social Needs Screening and Referral performance measure for inclusion in the 2023 set of CCO quality incentive metrics, for which CCOs are eligible to receive payments based on their performance each year.<sup>18</sup>
  - Oregon permits CCOs to count spending towards health-related services (HRS)—non-covered services intended to improve care delivery and overall member and community health and well-being—as medical expenses in the MLR numerator.<sup>19</sup> The goals of HRS are to “promote the efficient use of resources and address members’ social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being.”<sup>20</sup>
  - The state has also implemented financial incentives for CCOs to provide HRS. Through the Performance Based Reward program, CCOs are paid a variable profit margin based on their investments in HRS as a means of controlling healthcare spending. The state also considers quality and efficiency of care in determining the Performance Based Reward.<sup>21</sup>
- **Rhode Island** requires its accountable entities to execute agreements with SDOH providers in order to be eligible for incentive payments under the state's Medicaid Infrastructure Incentive Program.<sup>22</sup>

Refer to [Appendix C](#) for links to MMC contracts referenced in this section.

### G. Accounting for Social Risk Factors in Managed Care Payment Methodologies

Two states account for social risk factors in the development of MCO capitation rates and/or ACO payment methodologies in an effort to create better alignment between the risk of the population and the managed care payment amount.<sup>23</sup> Both Massachusetts and Minnesota have spent significant time and effort developing methodologies to account for social risk factors. (See [Table 9](#) in [Appendix B](#) for specific language included in Minnesota's contracts related to social risk factor payment adjustments.)

- **Massachusetts** uses social risk factors to adjust per member per month payments to both Medicaid MCOs and ACOs. Its risk adjustment methodology uses a combination of survey data and administrative and claims data to identify social risk factors such as disability status (used as a marker of social risk factors), housing instability, homelessness, and neighborhood stress.<sup>24, 25</sup>
- **Minnesota** uses social risk adjustment in its population-based payment methodology for its Medicaid ACOs. Quarterly population-based payments are adjusted for both clinical and social risk factors, which may include deep poverty, homelessness, serious and persistent mental illness, serious mental illness, substance use disorder, and child protection involvement.

Refer to [Appendix C](#) for links to MMC contracts referenced in this section.

### III. Additional State Authorities to Advance SDOH

Section 1932 of the Social Security Act (SSA) enables states to operate managed care programs using state plan authority. As part of this managed care authority, states have some flexibility to address SDOH needs in ways that are not possible in fee-for-service Medicaid. In addition, states can utilize other federal authorities to address SDOH needs among Medicaid enrollees. In its 2021 letter to states regarding SDOH,<sup>26</sup> CMS provides sub-regulatory guidance on existing authorities and states' abilities to address SDOH needs within these parameters:

- **State Plan Authority:** Optional state plan services under Section 1905(a) of the SSA such as rehabilitative services and targeted case management.
- **HCBS options:** Section 1915(c) HCBS Waiver, Section 1915(i) HCBS State Plan, Section 1915(j) Optional Self-directed Personal Assistance Services, Section 1915(k) Community First Choice State Plan. Services could include case management, peer supports, housing supports, and employment supports.
- **1115 Waivers:** Demonstration programs to test the use of SDOH-related services and supports, which could be in a specific region and/or for a specified population if the state receives a waiver of certain Medicaid rules such as state-wideness.

California, Delaware, Florida, Hawaii, Illinois, Massachusetts, North Carolina, and Rhode Island each have approved 1115 waivers that include SDOH components in MMC.<sup>27</sup> Given the additional rules and federal terms and conditions related to 1115 waivers, these types of SDOH approaches are not highlighted in this resource. However, some components of the MMC procurements and contracts related to these 1115 waivers are summarized. For example, North Carolina's Healthy Opportunity Pilots Program was approved as part of an 1115 waiver to utilize Medicaid managed care funding toward evidence-based interventions to address SDOH interventions related to food, housing, transportation, and interpersonal violence/toxic stress.<sup>28</sup> Appendix C of this resource includes some MMC contract language excerpts that relate to these Health Opportunity Pilots.

Similarly, aspects of California's CalAIM waiver are referenced in the model contract that the state released as part of its February 2022 MMC procurement. Except for California, most of the SDOH components of these 1115 waivers are limited to specific regions, managed care entities and managed care enrollees. In addition, most of these 1115 waiver programs have some component focusing on support for members without stable housing. One example of this type of 1115 waiver program is the housing pilot program that is operating within Florida's Medicaid managed care program and summarized below.

In 2019, **Florida's Medicaid agency obtained 1115 waiver authority to implement a housing pilot in collaboration with health plans operating in designated regions.**<sup>29</sup> Medicaid managed care members eligible to participate in Florida's housing pilot must be:

- over age 21 and living in one of two specified managed care regions,
- homeless or at risk of homelessness, and
- have a diagnosis of Severe Mental Illness (SMI) or Substance Use Disorder (SUD).

In addition to comprehensive MMC services, Florida's housing assistance pilot offers participants transitional housing services, tenancy sustaining services, mobile crisis management, self-help/peer support and one-time payments for moving expenses. Examples of transitional housing services covered by the pilot include:

- Conducting a tenant screening and housing assessment
- Developing an individualized housing support plan
- Assisting with the search for housing and the application process
- Identifying resources to pay for on-going housing expenses such as rent
- Ensure that the living environment is safe and ready for move-in.

Tenancy sustaining services offered to housing pilot participants include:

- Early identification and intervention for behaviors that may jeopardize housing
- Education and training on the roles, rights and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlord/property managers
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction
- Advocacy and linkage with community resources to prevent eviction

MCOs participating in Florida's housing assistance pilot must develop relationships with community partners, including housing assistance providers, community mental health centers, and local managing entities to assist Medicaid housing pilot participants in a collaborative manner.

Florida's overall goal for the housing pilot is to facilitate housing stability and improve health outcomes for up to 4,000 Medicaid enrollees annually. To evaluate the pilot, Florida is measuring the percentage of:

- Participants who achieved housing permanency,
- Participants whose days of homelessness were reduced,
- Participants diagnosed with a SUD receiving medication assisted treatment,
- Participants diagnosed with an SMI who are compliant with medication management requirements, and
- Reduced ED and inpatient hospital use among pilot participants.

## Appendix A: Medicaid Managed Care Procurement Questions Related to SDOH

This Appendix focuses on MMC procurement questions related to SDOH for states with recent MMC procurements—**California, Louisiana, Minnesota, Mississippi, Oregon, Pennsylvania, and Texas**. Relevant procurement questions from **North Carolina’s** 2018 MMC RFP are also included.

Profiled states are presented in alphabetical order. For each state, there is a link to MMC procurement documents (where available), a brief description of the state’s SDOH requirements, and related bidder questions.

### **California (Medi-Cal) Request for Proposals**

[Link](#) to California’s Medi-Cal Commercial MCO RFP released in February 2022. This RFP contains requirements for MCOs to address SDOH through individual and population-level screening, to address SDOH within quality management requirements, to address SDOH within Community Advisory Councils, and to offer SDOH-related in lieu of services within the Community Supports program among additional requirements.

*The Medi-Cal RFP bidder questions related to SDOH are as follows:*

1. The proposer must describe its existing and/or proposed processes and procedures for ensuring the collection, ingestion, and transmission of complete, accurate, reasonable, and timely data necessary to meet or exceed the requirements within Exhibit A, Scope of Work, Attachment III, Operations, Section 2.1 MIS and all subsections. Such processes and procedures include, but are not limited to:
  - a. The editing/validation of claims, encounter, SDOH, and provider data received from Network Providers, Out-of-Network Provider, and Subcontractors;
  - b. The timely correction and resubmission of encounter, provider, program, SDOH, and template data containing errors;
  - c. Successful completion of mandated testing requirements
2. The proposer must describe any experience, investment, knowledge, skills, and abilities that will support the proposer in meeting or exceeding the requirements established in Exhibit A, Scope of Work, Attachment III, Operations, Section 2.1 MIS and all subsections [including having and maintaining a MIS that supports social drivers of health data]...
3. The proposer must describe how it will annually assess its QI and Health Equity activities, including areas of success and needed improvements in services rendered within the QI and Health Equity program, the quality review of all services rendered, the results of required performance measure reporting, and the results of efforts to reduce health disparities. Description must include but is not limited to...
  - a. ...
  - b. Process to develop equity focused interventions to address differences in quality of care and utilization, including addressing underlying factors such as social drivers of health
  - c. ...
4. The proposer must describe processes for meeting requirements and responsibilities to keep Providers informed and updated regarding Medi-Cal policies, procedures, and regulations and include the following:
  - a. ...

Policies regarding the content of the Provider training specifically related to inclusion (sensitivity, diversity, communication skills, and competency), special populations (e.g., Seniors and Persons with Disabilities, Members with intellectual and developmental disabilities), and Social Drivers of Health and disparity impacts.
5. The proposer must describe its experience conducting Population Needs Assessments (or similar Member population-level assessments). The description must include specific examples of the

population-level health and social needs that were discovered through previous assessments and how those findings informed specific person-centered, targeted interventions that were a part of the proposer's population health management, quality improvement and Health Equity programs. Also include specific data and outcome results for the example interventions provided.

6. The proposer must describe its plan and approach to providing Closed Loop Referrals to Community Health Workers, peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports and local community organizations; its process for following-up to determine whether the referral was completed or whether the Member needs further assistance to access the service(s), and if a Member does need assistance, a description what assistance is available and provided to Members. Response should also include how this information will be captured, tracked and monitored to support quality improvement efforts.
7. The proposer must describe its experience and current investments in coordinating health and social services between settings of care and transitions to other MCPs, across delivery systems and programs, with external entities outside of proposer's Provider Network, and with community-based resources, even if they are not Covered Services under this Contract, to address Members' needs, mitigate Social Drivers of Health and provide Members with the appropriate level of care management across the continuum of care.
8. The proposer must describe their previous experience with or plan and approach to proactively identify Members who may benefit from Enhanced Case Management (ECM) and who meet the criteria for ECM Populations of Focus (POF) such as High Utilizers, Homeless, SMI/SUD, transitioning from incarceration, those at risk for institutionalization who are eligible for Long-Term Care services, nursing facility residents transitioning to the community and the ECM Children's POFs.
9. The proposer must describe their prior experience and current investment with areas including, but not limited to, the areas listed within Exhibit A, Scope of Work, Attachment III, Operations, Section 4.5, Community Supports.
10. The proposer must describe their plan and approach towards providing Community Supports in areas including, but not limited to the areas listed within Exhibit A, Scope of Work, Attachment III, Operations, Section 4.5, Community Supports.
11. The proposer must identify which of the Community Supports (ILOS) preapproved by DCHS the proposer will elect to offer in each county, in accordance with requirements of the Contract and all applicable DHCS All Plan Letters.

*In addition to these questions, Attachment 12 of the Medi-Cal RFP includes specific evaluation questions and rating factors associated with the content requirements identified in RFP Main, Proposal Content Requirements and that meet Scope of Work requirements in Exhibit A, Attachments I through III. The evaluation questions related to SDOH are as follows:*

1. To what extent does the Proposer describe and demonstrate, clearly and in detail, similar prior experience; investment; ample knowledge, skills, and abilities through a description of specific examples relevant to the requirements in the Section 2.1 MIS including the requirement to intake and process submissions of Social Drivers of Health data?
2. To what extent does the proposer's policies regarding the content of the Provider training address inclusion (sensitivity, diversity, communication skills, and competency), special populations (e.g., Seniors and Persons with Disabilities, Members with intellectual and developmental disabilities), and Social Drivers of Health and disparity impacts?
3. To what extent does the proposer demonstrate specific examples of its experience and current investments in coordinating health and social services between settings of care and transitions to other Managed Care Plans, across delivery systems and programs, with external entities outside of proposer's

Provider Network, and with community-based resources, even if they are not Covered Services under this Contract, to address Members' needs, mitigate Social Drivers of Health and provide Members with the appropriate level of care management across the continuum of care including how the proposer will monitor its Subcontractors and Downstream Subcontractors?

4. To what extent does the proposer demonstrate understanding and ability, including its administrative ability, of deploying and overseeing a whole-person care management benefit which encompasses all aspects of the Member's health care and social service needs, including social drivers of health?
  - a. The response must include a description of specific, relevant experience or examples of the proposer's ability to meet the holistic and interdisciplinary approach for the delivery of Enhanced Care Management (ECM)...

### **Louisiana's MMC Request for Proposals**

[Link](#) to Louisiana's MMC RFP. These RFP questions are from the Louisiana Department of Health Bureau of Health Services Financing (Medicaid) RFP released in June 2021. The model contract, released with the RFP, requires MCOs to develop and implement a Population Health Strategic Plan that includes addressing SDOH and a Health Equity Plan that requires MCOs to partner with community-based organizations to address SDOH-related needs, including reimbursing network providers for screening for SDOH needs and submitting applicable diagnosis codes (e.g., ICD-10 "Z codes") on claims. MCOs must use a Health Needs Assessment tool developed by the Department that includes questions to identify enrollees' health-related social needs, including housing, food insecurity, physical safety, and transportation. Preferred MCO value-based payment arrangements include those that support the integration of behavioral health, SDOH, and/or populations with special healthcare needs.

*Louisiana's bidder questions related to SDOH:*

1. The proposer should identify whether it proposes to offer any of the following optional value-added benefits to its enrollees: ...Respite care model targeting homeless persons with post-acute medical needs. Model shall address strategies for counseling, nutrition, housing stabilization, transitional care, and other services necessary for successful community reintegration...
2. The proposer should describe its recent experience with utilizing data regarding SDOH to improve health equity and the health status of targeted populations, including the proposer's approach to collecting SDOH data. Include at least one example of how an issue impacted by SDOH was identified, which interventions were developed, how the impacts of the interventions were assessed, and what outcomes were achieved. The proposer should describe how this approach may be applied to a population health and/or health equity priority(ies) named in the Model Contract.
3. The proposer should describe its anticipated approach to meeting the care management requirements of this procurement. Specifically, the proposal should include ... How the proposer will engage enrollees who may potentially benefit from case management in the program, including any specific considerations for the following groups: ... Enrollees with adverse childhood experience; Enrollees with food security; and enrollees without reliable telephone access.
4. The proposer should provide a description of its fully integrated care model, inclusive of experience with care management and delivery models that support the whole-person needs of enrollees. The proposer should include how the following elements will be accomplished in its description: ...Offering incentives and tracking progress for providers to help build greater care coordination, transparency, and communication between primary care and behavioral health providers, based on the level of integration between physical health, behavioral health, and SDOH.



### **Minnesota's MMC Request for Proposals**

[Link](#) to Minnesota's MMC RFP, which was released in January 2022. MCOs will be required to address social needs for specific populations, including adults and children with behavioral health needs and with high emergency department utilization. MCOs will also be required to provide housing stabilization services and non-emergency medical transportation to people with disabilities and seniors experiencing housing instability.

*Minnesota's bidder questions related to SDOH:*

1. Describe your organization's approach to addressing social drivers of health to improve population health and prevention. Describe your organization's work regarding community collaboration efforts, provider and other stakeholder partnerships, and data collection including social drivers of health and analysis. If applicable, provide examples for populations in the various regions of your current or proposed service area covered by this RFP.
2. How are you engaged with communities served by this RFP in co-creation of policies and programs that improve health equity? What social drivers of health have you identified that are unique to these communities who experience the greatest health inequities and how are you planning to address them?

### **Mississippi's MMC Request for Qualifications**

[Link](#) to Mississippi's MMC RFQ, released in November 2021. CCOs will be required to screen members within care management assessments for the following social needs: education, employment, housing, utilities, nutrition, transportation, stress, and violence. CCOs will be required to develop partnerships with state agencies and community-based providers and to make closed loop referrals. Also, as part of the CCO's quality management strategy, Mississippi will require CCOs to devote at least 0.5% of capitation payments received to SDOH projects. It is expected that this expenditure is made through partnerships and initiatives developed with community-based organizations. CCOs will be required to submit SDOH projects to the state for review and approval.

*Mississippi's bidder questions related to SDOH:*

1. Describe how the Offeror will integrate Social Determinants of Health, health equity evaluations, and other non-medical risk factors into the Health Risk Screening and Comprehensive Health Assessment.
2. Describe the Offeror's proposed policies, procedures, and processes to conduct outreach to ensure that Members receive all recommended preventive and medically necessary follow-up treatment and medications. Describe how the Offeror will notify Members and/or Providers when follow up is due. Address the following issues in the response:
  - a. Facilitation and monitoring of Member compliance with treatment plans;
  - b. Partnerships of community-based partnerships and other state agencies; and
  - c. Coordination with other Providers.

The Division requires Contractors to devote at least 0.5 percent of its Capitation Payment to efforts to improve Social Determinants of Health during the next contract cycle. The Offeror must produce a proposed SDOH Strategy that addresses the following questions:

1. Describe the Offeror's approach to and experience with collecting data on non-medical risk factors for targeted Medicaid populations, the types of domains and metrics collected, standardized screening tools that are utilized, and methods used to analyze and act on the data.
2. In the Offeror's view, what are the greatest SDOH challenges facing the MississippiCAN and CHIP populations?
3. What approaches will the Offeror take to address these challenges?
4. How will the Offeror address Health Equity through its SDOH programs?

5. How will the Offeror integrate SDOH evaluation into other programs (i.e., Care Management, Quality Management)?

Additionally, use the Social Determinants of Health: Staffing table in Appendix E, Innovation and Commitment Tables, to provide staffing information for the Offeror's proposed SDOH approaches.

#### *Potential Partnerships*

The Division is requiring consistent, deeply developed partnerships between contractors and local organizations during the next contracting cycle, especially in addressing health equity and Social Determinants of Health... The Offeror must use the Potential Partnership: Summary Chart, included in Appendix E, to name four (4) potential partners. The Offeror should also include potential partnerships to be utilized for Care Management closed-loop referrals and warm hand offs... The Offeror must use the Care Management Potential Partnership: Summary Chart, included in Appendix D, to name four (4) potential referral partners...

#### *Division-Curated Value-Adds for CCO Contract*

The Division compiled a list of desired Value-Adds for this procurement. If an Offeror chooses to include value-added services in its qualification, the Offeror may choose from this list, propose their own original value-added services, or include a combination of both...

1. Nutrition Assistance, including but not limited to additional nutrition resources for Members (even those who receive SNAP and/or WIC benefits) and education and training for Members regarding nutritious foods and food preparation
2. Utility payment assistance
3. Pest Control/Bed Bug home treatment
4. Education and employment supports, including but not limited to paying for GED classes, supporting pregnant minors in pursuit of high school diploma, paying for skills training, and supplying Members with a computer and internet in the home

#### **North Carolina's MMC Request for Proposals**

*North Carolina's Prepaid Health Plan Services RFP was released by the Department of Health and Human Services, Division of Health Benefits in August 2018. North Carolina's SDOH strategies, or strategies to address "unmet health-related needs," are largely embedded in its care management requirements. MCOs are referred to as Prepaid Health Plans (PHPs) and required to use the "NC Resource Platform" to identify community-based resources and connect high-need members to such resources, report on rates of completed screenings for unmet health related social needs, and participate in case management pilots to address unmet health-related needs. In addition, MCOs are encouraged to make contributions to health-related resources that help to address members' and communities' unmet health-related needs and use In Lieu of Services to finance services that improve health through connecting members with resources, social services and other supports. MCOs that voluntarily contribute to health-related resources may count the contributions towards the numerator of its MLR and may receive preference in auto-assignment.*

#### *North Carolina's bidder questions related to SDOH:*

1. The Offeror shall confirm its adherence to and describe its approach to meeting Department's expectations and requirements for the care management continuum as stated in *V.C.6 Care Management*. The response shall include: ...Proposed strategies to use over time to screen Medicaid Managed Care Members for unmet health-related resource needs routinely, in addition to at initial enrollment. ...Provide supporting documentation: Four (4) Care Plan examples, including one (1) care

plan for each of the following: adult, child, individual with LTSS, individual with high unmet resource needs.

2. Describe PHPs adherence and approach to meeting Department's expectations and requirement for care management for populations requiring LTSS in *Section V.C.6 Care Management*. The response shall include: ... Proposed strategies to use over time to screen Medicaid Managed Care Members for unmet health-related resource needs routinely, in addition to at initial enrollment.
3. The Offeror shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for integrating Opportunities for Health into Care Management stated in *Section V.C.6 Care Management*. The response shall include:
  - a. The PHP's methodology for identifying Members with "unmet health-related resource needs" for care management; and
  - b. Planned and historical examples of methods to:
    - i. Partner with Community Based Organizations (CBOs) and state, regional, or private human services agencies to address unmet health-related resource needs of Members;
    - ii. Offer non-medical resource supports for Members;
    - iii. Provider in-person assistance securing health-related services that can improve health and family well-being (i.e., assistance filling out and submitting applications for government assistance programs);
    - iv. Assist individuals in securing and maintaining safe and stable housing; and
    - v. Provide access to medical-legal support for legal issues adversely affecting health.
  - c. Experience and effectiveness in identifying and addressing ACEs and trauma, and how that experience would be applied in North Carolina.
4. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for addressing Members' unmet health-related resource needs as outlined in *Section V.C.8. Opportunities for Health*. Response shall include:
  - a. Experience and success within North Carolina or in other states or regions with addressing unmet health related resource needs for populations similar to those included under this Contract; and
  - b. Experience and success within North Carolina or in other states or regions in collaborating with health and health-related community stakeholders in addressing Members' unmet health-related resource needs, including with:
    - i. Health care providers (e.g., primary care provider, care manager);
    - ii. Local public agencies (e.g., local health departments or departments of social services); and
    - iii. Community-based organizations (e.g., homeless shelters, food banks).
  - c. Strategies the Offeror would employ to address key Opportunities for Health domains (housing, food, transportation and interpersonal safety), and other Opportunities for Health domains identified by the PHP, in each of North Carolina's Regions that the PHP is submitting an offer on, including:
    - i. Specific strategies the Offeror intends to employ in North Carolina to address unmet resource needs for individual Members based on needs documented through Care Needs Screening, Care Management Assessment, or other identification method.
    - ii. Experience in other states to address unmet resource needs in at the community or population-level based on aggregate population needs. Detail types of community-based intervention, rationale behind activities, and health outcomes related to the population interventions.

## **Oregon's MMC Request for Applications**

[Link](#) to Request for Applications (RFA), released in 2019. The following questions come from Attachment 10 of the RFA on Social Determinants of Health and Equity. This RFA required CCOs to invest in services and initiatives to address SDOH, with a focus on housing during the first two contract years. The RFA also requires CCOs to spend a portion of their year-end surplus on SDOH and provides incentive funding for achieving specific SDOH milestones, among additional requirements.

*Oregon's bidder questions related to SDOH:*

1. Does Applicant currently hold any agreements or MOUs with entities that meet the definition of Social Determinants of Health-Health Equity (SDOH-HE) partners, including housing partners? If yes, please describe the agreement.
2. Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.
3. Does Applicant have a current policy in place defining the role of the Community Advisory Council (CAC) in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending.
4. Please describe how Applicant intends to award funding for SDOH-HE projects, including:
  - a. How Applicant will guard against potential conflicts of interest;
  - b. How Applicant will ensure a transparent and equitable process;
  - c. How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.
5. For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.
6. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.
7. Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-HE spending priorities, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process.
8. Please describe how Applicant will track and report SDOH-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection.
9. Applicant will submit a plan for selecting Community SDOH-HE spending priorities in line with existing Community Health Improvement Plan (CHP) priorities and the statewide priority on Housing-Related Services and Supports...
10. Please describe how Health-Related Services (HRS) Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities.
11. Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable)...
12. Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A, describing how it intends to engage key stakeholders, including OHP consumers, Providers, local public health authorities, including local health departments, Tribes, Community-based organizations that address disparities and the social determinants of health, and others, in its work. The Plan should detail the Applicant's strategies for engaging its Community Advisory Council, its process for developing and

conducting a Community Health Assessment, and development of the resultant Community Health Improvement Plan priorities and strategies. The Plan should specify how the Applicant's strategy for health-related services links to the CHP. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities.

### **Pennsylvania MMC Request for Applications**

[Link](#) to 2019 RFA. *Pennsylvania's RFA contains requirements for MCOs selected to participate in the HealthChoices Physical Health (PH) program to collaborate with the state to develop an SDOH assessment tool and assess and assist members with SDOH, including but not limited to housing, food insecurity, health literacy, access to transportation, education, and employment. The RFA also includes additional opportunities for MCOs to participate in community-based care management activities that focus on addressing SDOH.*

*Pennsylvania's bidder questions related to SDOH:*

1. Describe any specific programs that focus on consumers with disabilities or with high acuity levels. Provide outcomes of these programs. Describe how you connect members with the available social and community support services. Describe the programs that will be used and how these programs will improve performance in this area for the HealthChoices PH Program.
2. Describe your organization's philosophy on Community Based Care Management and outline key initiatives of your program. Describe the results of initiatives in demonstrating improved health outcomes for the members that were served. Include any specific initiatives for the perinatal population, those with serious persistent mental illness and those with substance use disorders. Include the number of full time equivalent licensed and non-licensed telephonic and community-based personnel to be involved in these activities.
3. Describe your experience and efforts in identifying and assisting members with social determinants of health including housing, employment, food insecurity, literacy, transportation, and education. Describe any challenges you have experienced in addressing social determinants of health and how you resolved them. Describe how you plan to address social determinants of health, including how you will engage community programs and initiatives aimed at mitigating social determinants of health.
4. Describe specific programs you have and will have in place to address social determinants of health. Include how many or what percentage of your membership participates in the programs. Describe the methodology used to determine whether a program is successful and if so, how it is expanded to incorporate widespread implementation.

### **Texas STAR+PLUS Request for Proposals**

[Link](#) to 2022 RFP. *The Texas STAR+PLUS RFP Scope of Work includes requirements for MCOs to use an evidence-based screening tool for health-related social needs, capture social needs as part of a broader Person-Centered Service Plan, coordinate and track referrals to community organizations for community-based resources, and provide social needs resources to network providers to address members' needs.*

*Texas' bidder questions related to SDOH:*

1. When health and community services are coordinated in a seamless continuum, Persons with Disabilities can more easily live, work, and participate fully in their communities. What Member outcome, data, and other measures does the Respondent track to ensure that Members are receiving the full array of coordinated, effective, and integrated Services (including Acute Care, LTSS, BH, and social supports) they need to meet their goals for independent living, community integration, and health and wellbeing? Provide an example of success in addressing an issue identified through the Respondent's performance monitoring system for a program of similar size and scope.

Appendix B: Medicaid Managed Care Contract<sup>30</sup> Language – State Examples

**Table 3: Approach A: Contract Language Pertaining to SDOH Within MCO Care Coordination/Management**

State	MMC Contract/Procurement Language
Arizona	<p><b>“Whole Person Care Initiative</b></p> <p>The Contractor shall utilize AHCCCS-Approved Statewide Closed-Loop Referral System (CLRS) and actively promote provider network utilization of the CLRS to properly refer members to Community Based Organizations (CBOs) providing services addressing social risk factors of health. Additionally, the Contractor shall partner with the HIE to outreach to CBOs to participate in the CLRS.</p> <p>The Contractor shall actively encourage provider usage of SDOH screening tools available through or compatible with the CLRS to screen members for social risk factors of health based upon the provider’s business needs. Regardless of the screening tool selected, the provider’s tool must screen for the following social risk factors of health at a minimum: 1. Homelessness/Housing instability 2. Transportation Assistance 3. Employment Instability 4. Justice/Legal Involvement 5. Social Isolation/Social Support.</p> <p><b>Additional Required Staff:</b></p> <p>Housing Specialist designated as the subject matter expert(s) on the provision of housing and housing resources to members within the Contractor’s service area. The Contractor shall ensure that it has a designated staff person(s) as a Housing Specialist. The Housing Specialist is required to reside in Arizona within the Contractor’s assigned Geographic Service Area. The Housing Specialist is an expert(s) on housing programs and resources within the Contractor’s service area... While the Contractor shall have at least one designated Housing Specialist, the Contractor shall have sufficient dedicated housing staffing reporting to the Housing Specialist based on the geographic service area size and member enrollment numbers in order to adequately meet contractual and policy housing service requirements.</p> <p>Key duties of the Housing Specialist include:</p> <ol style="list-style-type: none"> <li>1. Assist provider network’s support staff (e.g., case managers) with up to date information designed to aid members in making informed decisions about and accessing their independent living housing options including AHCCCS Non-Title XIX/XXI Housing Subsidy Programs (e.g., scattered site vouchers, Community Living Programs), mainstream housing subsidy programs (e.g., HUD Housing Choice Vouchers, local Public Housing Authority Programs); and market rate housing options, Provide education and training to providers and support staff on housing programs and evidence-based practices related to housing services,</li> <li>3. Supporting provider case managers and network support staff with identifying members with housing needs, making appropriate housing referrals to AHCCCS Housing Subsidy Programs mainstream housing programs and other housing resources for individuals with housing needs,</li> </ol>

State	MMC Contract/Procurement Language
Arizona (continued)	<p>4. Assisting members and provider case managers to support transition or post-transition activities including, but not limited to, requests and referrals, assistance with eligibility documentation and verification, transition wait times, transition barriers and special needs/accommodations, rent amount, monthly income amounts, location of housing options chosen, and counties chosen for transition,</p> <p>5. As specified in the Network Development and Management Plan, the Contractor shall report annually on the status of any affordable housing networking strategies and innovative practices/initiatives it elects to implement,</p> <p>6. Act as the Contractor’s liaison to the quarterly AHCCCS Housing Coordination Meeting led by the AHCCCS Director of Housing Programs as well as other ad hoc AHCCCS Housing Workgroups and initiatives,</p> <p>7. Serve as the Contractor’s liaison to local HUD approved Continuum of Care for the Contractor’s service area. The Housing Specialist or the Housing Specialist’s designee shall attend appropriate CoC meetings, participate in Continuum of Care coordinated entry and HMIS systems, and assist Continuum of Care in identifying, engaging, and securing appropriate housing and services for members experiencing homelessness,</p> <p>8. Advocate, plan, and coordinate with provider supportive services to ensure members in independent, and AHCCCS, and mainstream subsidized housing programs, offer appropriate services to maintain their housing, and</p> <p>9. The Housing Specialist is responsible for identifying housing resources and building relationships with contracted Housing Providers and mainstream public housing authorities for the purposes of developing innovative practices to expand housing options, assisting and coordinating. This may include assisting providers in identifying and applying for AHCCCS SMI Housing Trust Fund projects.”</p>
California	<p><b>“Care Management Programs</b> Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic Population Health Management (PHM). Members receiving care management must have an assigned Care Manager and a Care Management Plan (CMP).</p> <p><b>Care Management Programs</b> Contractor must operate and administer the following care management programs: 1) Enhanced Care Management (ECM) as described in Exhibit A, Attachment III, Section 4.4. 2) Complex Care Management (CCM) a) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium/rising-risk Members through Contractor’s CCM approach. To the extent NCQA’s standards are updated, Contractor must comply with most recent standards.</p>

State	MMC Contract/Procurement Language
California (continued)	<p>Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:.... b) Contractor must assess Members for the need for Community Supports as part of its CCM program and provide Community Supports, if medically appropriate and cost effective. Both ECM and CCM are inclusive of Basic PHM, which the Contractor must provide to all Members. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach. Contractor must identify and assign a Care Manager for every Member receiving CCM. PCPs may be assigned as Care Managers when they are able to meet all the requirements specified in this Subsection.</p> <p>Contractor must ensure that the Care Manager performs the following duties: i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member’s physical, mental health, SUD, developmental, oral health, dementia, palliative care, chronic disease and LTSS needs as well as needs due to SDOH; ii. Complete a CMP for all Members receiving CCM, consistent with the Member’s goals in consultation with the Member.</p> <p>The CMP must: a. Address a Member’s health and social needs, including needs due to SDOH; b. Be reviewed and updated at least annually, upon a change in Member’s condition or level of care, or upon request of the Member; c. Be in an electronic format and a part of the Member’s Medical Record, and document all of the Member’s services and treating Providers; d. Be developed using a person-centered planning process that includes identifying, educating and training the Member’s parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons, as needed; and e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.”</p> <p><b>Contractor’s Responsibilities for Administration of ECM</b></p> <p>A. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus... through systematic coordination of services and comprehensive care management. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.</p> <p>B. Contractor must ensure ECM is available throughout its Service Area.</p> <p>C. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, guardians, authorized representatives, caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the Member’s consent. ....</p> <p>E. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Attachment III, Subsection 4.4.11</p>



State	MMC Contract/Procurement Language
California (continued)	<p>F. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources.</p> <p><b>Review of Utilization Data:</b> Contractor must monitor utilization data to appropriately identify Members eligible for ECM and Community Supports.</p>
Iowa	<p>G.2.11. <i>Health Risk Screening Tool.</i> The Contractor shall obtain Agency approval of a health risk screening tool. At minimum, information collected shall assess the Enrolled Member’s physical, behavioral, social, functional and psychological status and needs. The tool shall determine the need for Care Coordination, Behavioral Health Services, or any other health or community services. The tool shall also comply with NCQA standard for health risk screenings and contain standardized questions that tie to social determinants of health. Contractor tools will be compared against the current approach by the Agency, and a uniform tool is preferred across managed care entities. In addition, the health risk screening shall include the social determinants of health questions as determined by the Agency. The Contractor shall follow the Agency’s approved file exchange format and requirement specification documents to ensure uniform reporting across contractors.</p>
Louisiana	<p><b>“Health Needs Assessment Instrument (HNA)</b>  LDH shall provide the Contractor with the HNA instrument, which shall include the minimum necessary set of questions to identify an Enrollee as potentially requiring case management support. The HNA will aim to identify physical, behavioral and SDOH risk factors. The required HNA may not be modified, but there will be optional screening domains that the MCOs may add, subject to LDH approval.</p> <p>HNA questions shall include:</p> <ul style="list-style-type: none"> <li>• Enrollee demographics, personal health history, including chronic conditions and previous and current treatment for physical and behavioral health care needs, and self-perceived health status;</li> <li>• Questions to identify Enrollees’ needs for culturally and linguistically appropriate services including, but not limited to, hearing and vision impairment and language preference;</li> <li>• Questions to identify the Enrollee’s health concerns and goals;</li> <li>• Questions to identify potential gaps in care; and</li> <li>• Questions to identify Enrollees’ health-related social needs, including housing, food insecurity, physical safety, and transportation.”</li> </ul>
Massachusetts	<p><b>Coordinating Care for Enrollees</b>  The Contractor shall ensure that care for all Enrollees is coordinated.</p> <p>A. Baseline Care Coordination</p> <ol style="list-style-type: none"> <li>1. The Contractor shall perform baseline care coordination supports for all Enrollees. Baseline care coordination supports include but are not limited to: <ol style="list-style-type: none"> <li>a. Assigning Enrollees to a Primary Care Provider and ensuring such provider delivers services in accordance with the requirements described in Section 2.8.C.1;</li> </ol> </li> </ol>

State	MMC Contract/Procurement Language
Massachusetts (continued)	<ul style="list-style-type: none"> <li>b. In accordance with Section 2.5.B, ensuring Enrollees are screened for physical health, Behavioral Health, LTSS, and Health-Related Social Needs;</li> <li>c. Coordinating with service providers, community services organizations, and state agencies to improve integration of Enrollee’s care;</li> </ul> <p>4. For Enrollees with identified Health-Related Social Needs (HRSN), the Contractor shall:</p> <ul style="list-style-type: none"> <li>a. Provide the Enrollee with information about available HRSN-related supports, how to contact such supports, and the accessibility of such supports;</li> <li>b. Ensure such Enrollees are referred to HRSN-related supports provided by the Contractor and a Social Service Organization as applicable; <ul style="list-style-type: none"> <li>1) The Contractor shall refer the Enrollee to a Social Service Organization that has capacity and capability to address the Enrollee’s HRSN and has agreed to receive referrals from the Contractor for the supports the Enrollee needs.</li> <li>2) The Contractor shall ensure the Social Service Organizations, including but not limited to Social Service Organizations with which the Contractor has not previously worked, are capable of providing the supports for which the Contractor has referred the Enrollee. Such actions may include connecting with the Social Service Organization to identify the supports it is able to provide and its capacity to serve new Enrollees.</li> </ul> </li> <li>c. Ensure that its strategy for coordinating HRSN supports is integrated with the Contractor’s overall health equity strategy;</li> <li>d. Establish and maintain at least one relationship with a provider or Social Services Organization that can assist Enrollees in obtaining WIC and SNAP in each of the Contractor’s Service Areas;</li> <li>e. Utilize its Community Resource Database, as described in <b>Section 2.15.E.7</b>, to identify supports; and</li> <li>f. Consider referral to the Flexible Services Program, as set forth in <b>Section 2.22</b>, SNAP, WIC, or related programs to address Enrollee’s needs;</li> </ul> <p><b>Care Delivery</b></p> <p>...</p> <p>Health Related Social Needs Screening</p> <ul style="list-style-type: none"> <li>a. The Contractor shall conduct a Health-Related Social Needs (HRSN) screening for all Enrollees upon enrollment and annually thereafter.</li> <li>b. The HRSN screening may occur as a unique screening, as part of the Care Needs Screening, as part of the Comprehensive Assessment, or through or in combination with any other tool deemed appropriate by the Contractor so long as the HRSN screening conducted fulfills the requirements of this section.</li> <li>c. Health Related Social Needs screenings shall:</li> </ul>

State	MMC Contract/Procurement Language
Massachusetts (continued)	<ol style="list-style-type: none"> <li>1) Be made available to Enrollees in multiple formats including through the internet, print, and telephone;</li> <li>2) Include disclosures to the Enrollee about how information will be used;</li> <li>3) Describe potential services or assistance available to the Enrollee for identified needs;</li> <li>4) Screen all Enrollees for needs in the following domains <ol style="list-style-type: none"> <li>a) Housing insecurity;</li> <li>b) Food insecurity, such as lack of access to healthy, culturally appropriate foods;</li> <li>c) Economic stress, including lack of access to utilities, including heating and internet;</li> <li>d) Lack of access to transportation; and</li> <li>e) Experience of violence</li> </ol> </li> <li>5) In addition to the domains set forth above, the Contractor shall screen Enrollees for at least one of the following domains, as appropriate: <ol style="list-style-type: none"> <li>a) For Enrollees up to the age of 21, needs in school or early childhood education-related services and supports;</li> <li>b) For Enrollees between the age of 21 and 45, needs for employment supports;</li> <li>c) For Enrollees 45 years and older, social isolation.</li> </ol> </li> </ol> <p>d. When the Contractor identifies a HRSN for an Enrollee, whether through the HRSN screening or any other Encounter, the Contractor shall:</p> <ol style="list-style-type: none"> <li>1) Inquire whether the Enrollee would like to receive services or assistance to address identified Health-Related Social Needs, including but not limited to: <ol style="list-style-type: none"> <li>a) Housing supports</li> <li>b) Nutrition supports</li> <li>c) Utility assistance, including heating and access to the internet;</li> <li>d) Transportation services;</li> <li>e) Support for Enrollees who have experienced violence;</li> <li>f) Education supports and services for pediatric Enrollees, including early childhood education-related supports;</li> <li>g) Employment assistance; and</li> <li>h) Support for social isolation;</li> </ol> </li> <li>2) If the Enrollee would like to receive services, provide care coordination for the Enrollee and provide appropriate referrals and follow-up to help the Enrollee address the HRSN in accordance with Section 2.6.A.4;</li> <li>3) Ensure that Providers and their staff include relevant ICD-10 codes (such as “Z codes” included in categories Z55-65 and Z75) on any claims the Enrollee’s Providers submit for the Enrollee related to the Encounter where the HRSN is identified. Such codes shall be used as supplemental diagnosis codes and shall not be used as the admitting or principal diagnosis codes.</li> </ol>

State	MMC Contract/Procurement Language
Massachusetts (continued)	<p>4) Submit to EOHHS aggregate reports of the identified HRSNs of its Enrollees, as well as how those Enrollees were referred to appropriate resources to address those identified HRSNs, in a form, format, and frequency specified by EOHHS.</p> <p>5) Provide a Flexible Services screening and consider referring the Enrollee for Flexible Services as described in <b>Section 2.22</b>, as appropriate and as further specified by EOHHS.</p> <p><b>Care Plans</b>  ...  (e) Care Plans shall include at a minimum, the following:  ...  Identified HRSNs through the HRSN Screening and through any other Encounters, as well as the Contractor’s plan to address the Enrollee’s identified HRSNs.</p>
Mississippi	<p><b>Care Management:</b> The Contractor must provide coordination using appropriate resources, including community-based organizations, to reduce socioeconomic disparities and address Social Determinants of Health, including but not limited to housing, employment, and nutrition programs, as well as closed-loop referrals. The Contractor must also address health equity challenges through Care Management.</p> <p><b>7.4.3.2 Comprehensive Health Assessment</b>  The Contractor will conduct a Comprehensive Health Assessment (CHA) either in person or via telephone to make a determination of the Member’s risk level. The CHA must include both qualitative data reported by the Member and available quantitative data to support appropriate stratification. The CHA must evaluate the Member’s medical condition(s), including physical, behavioral, social, and psychological needs; evaluate Social Determinants of Health, including but not limited to the following topics: education level, employment status, housing status, access to basic utilities, access to nutrition, access to transportation, and other social stressors, such as violence and other adverse factors in the home environment; and any other risk factors that may affect the Member’s health outcomes.</p> <p>The goal of this assessment is to confirm the Member’s need for Care Management, identify the Member’s existing and/or potential health care needs, determine the types of services needed by the Member, including referrals to state agencies, community-based organizations, and partner organizations, and begin the development of the treatment plan.</p>
Nevada	<p><b>Population Health and Care Management: Health Needs Assessment</b>  The Contractor will submit its Health Needs Assessment Screening form and screening-related data for the State upon request. The State reserves the right to standardize the Health Needs Assessment Screening form across Contractors. The Health Needs Assessment tool must, at a minimum, address</p>

State	MMC Contract/Procurement Language
Nevada (continued)	<p>the following: 7.5.5.4.1. Behavioral Health screen, including SUD; 7.5.5.4.2. Medical conditions screen; 7.5.5.4.3. Social determinants of health screen; and 7.5.5.4.4. Pregnancy screen, as applicable.</p> <p><b>Population Health and Care Management: Care Management Program Description</b>  Within ninety (90) Calendar Days of Contract execution and by March 30 annually thereafter, the Contractor must submit a Care Management Program Description to the State for approval that includes all of the requirements within Section 7.5.6. The Contractor must provide an overview of the Contractor’s Care Management Program that includes, at a minimum:  ...  Care Coordination Process  Description of the screening tools and other resources used in the Care Coordination process, including the processes and tools to identify and address social determinants of health;  ...  Process for referrals to community resources and ensuring Members actually access needed resources;  ...  Case Management Process  ...  Processes and tools to identify and address social determinants of health;</p> <p><b>Population Health and Care Management: Member Stratification</b>  The Contractor must utilize predictive modeling tools to stratify Members by risk and identify Members who are appropriate for Care Coordination and/or Case Management supports. The stratification model must consider physical, behavioral, and social determinant of health needs identified through a variety of data sources, including but not limited to, claims, pharmacy, utilization data, laboratory results, health needs assessments and other Contractor screenings and/or assessments, referral information, census or other geographic data, and should include methods to identify racial and ethnic health disparities.</p> <p><b>Population Health and Care Management: Care Coordination Reporting</b>  On a quarterly and annual basis, the Contractor must, at a minimum, report the number of unique identified Members eligible for Care Coordination, outreach attempts, number of Members with an outreach success (reached a Member), number of Members for at least one (1) successful outreach with the Care Coordinator, volume of Members served who have a Behavioral Health condition, and social determinant of health issues identified and addressed within the population. The report template will be provided by the State.</p>

State	MMC Contract/Procurement Language
Nevada (continued)	<p><b>Population Health and Care Management: Case Management Priority Conditions</b></p> <p>The Contractor must, at a minimum, provide Case Management to Members with the following conditions or status. The priority list is not exhaustive and Case Management should be offered to Members whose health conditions warrant Case Management services.</p> <p>...</p> <p>Homeless/Transient Status</p>
North Carolina	<p><b>Care Coordination for All Members</b></p> <p>...For Members with identified unmet health-related resource needs, the PHP shall, as part of care coordination: Coordinate services provided by community and social support providers to address Members’ unmet health-related resource needs; 2. Link Members to local community resources and social supports; and 3. Modify their approaches based on tracking of outcomes, as needed.</p> <p><b>Identification of High-Need Members Needing Care Management</b></p> <p>...The PHP shall include the Department’s standardized Healthy Opportunities screening questions provided in Attachment M. 9. Healthy Opportunities Screening Questions in all Care Needs Screenings, covering four (4) priority domains: i. Housing; ii. Food; iii. Transportation; and iv. Interpersonal Safety.</p> <p><b>Provision of Care Management for High-Need Members</b></p> <p><b>(b) Care Management Services</b></p> <p>...The PHP shall ensure that the care management approach includes help for Members in addressing unmet resource needs. The PHP shall, at a minimum: i. Use the “NC Resource Platform” to identify community-based resources and connect Members to such resources, to the extent the “NC Resource Platform” is available to support such a connection. The Department anticipates this functionality will be ready for PHP use by Contract Year 1. a) The PHP shall use the NC Resource Platform for its community-based organization and social service agency database/directory to identify local community-based resources. b) The PHP shall use the NC Resource Platform for referring Members to the community-based organizations and social service agencies available on the NC Resource Platform and for tracking closed loop referrals once such functionality is ready for PHP use.</p> <p>The PHP may use existing platforms for this capability until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption.</p> <p>ii. Provide in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, at a minimum to: a) Food and Nutrition Services; b) Temporary Assistance for Needy Families; c) Child Care Subsidy; and d) Low Income Energy Assistance Program. iii. Have a housing specialist on staff or on contract who can assist individuals who are homeless in securing housing; and iv. Provide access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers...”</p>

State	MMC Contract/Procurement Language
Ohio	<p><b>Care Coordination: Care Coordination Requirements</b></p> <p>b. Risk Stratification</p> <p>i. In addition to conducting risk stratification for the purposes of population health activities on a population level as described in Appendix C, Population Health and Quality, the MCO must use individual-level risk stratification as one factor when determining the level of care coordination that is appropriate for each member.</p> <p>ii. The MCO must assign a risk tier to each member. The MCO must develop a risk stratification framework as part of its care coordination program that is comprised of three tiers (i.e., from lowest to highest: low risk [Tier 1], moderate risk [Tier 2], and high risk [Tier 3]). The MCO's risk stratification framework must include the criteria and thresholds for each tier to determine member assignments.</p> <p>iii. The MCO's criteria and thresholds must identify the factors the MCO considers when determining a member's risk stratification level.</p> <p>1. At a minimum, the criteria and thresholds must include the following current and historical factors: a. Acuity of chronic conditions, substance use and/or mental health disorders, maternal risk (e.g., prior preterm birth), inpatient or emergency department utilization, SDOH, and safety risk factors; and b. Information from the member's health risk assessment.</p> <p>...</p>
Texas	<p><b>STAR+PLUS Assessments</b></p> <p>The MCO must use an evidence-based screening tool for health-related social needs. Results from the screening may indicate the need for additional assessments, including functional needs assessments and referrals to community organizations for community-based resources. MCOs must track these referrals as part of the systematic process to coordinate and track referrals to community organizations. MCOs must provide to their Network Providers social needs resources, such as education on the screening tool and community-based resources, to address Members' needs. ...</p> <p><b>Service Planning for Members</b></p> <p>The MCO must conduct appropriate assessments and work in collaboration with each Member to develop a Person-Centered Service Plan that meets the requirements of 42 C.F.R. § 438.208(c)(3) and is understandable to the Member and the Member's authorized representatives. The Service Plan is informed by the health needs screening of the Member and any subsequent assessments. ...</p> <p>The MCO must include the following information in the Service Plan and collect such information if it is already documented in the Member's case file:</p> <p>1. The Member's medical and social history; 2. The Member's service delivery preferences; 3. Short and long-term needs, personal preferences, and outcomes for the Member; 4. The Member's informal supports, including caregiver supports; 5. Any training or resource needs of the caregivers that could assist them in caring for the Member. 6. A summary of the Member's current medical and social needs and concerns including: a. BH needs; b.</p>

State	MMC Contract/Procurement Language
Texas (continued)	<p>Physical, occupational, speech, or other specialized therapy service needs; c. DME and medical supplies needs; d. Needed nursing services, including but not limited to, home health skilled nursing and PDN; e. Prescription drugs, including psychotropic medication needs f. Pregnancy and associated needs, including high risk pregnancy due to preeclampsia, high blood pressure, diabetes, mental health or SUDs, previous pre-term birth, or other conditions; g. High-cost catastrophic conditions or high service utilization, such as a high volume of ER or hospital visits; h. Needs associated with a serious ongoing illnesses or Chronic Complex Conditions anticipated to last for a significant period requiring ongoing therapeutic intervention and evaluation (such as COPD, cancer, chronic asthma, cystic fibrosis, diabetes, heart disease, kidney disease, sickle cell disease, HIV, AIDS); i. Transportation needs; and j. Social needs including housing insecurity, substandard housing, social isolation/loneliness, food insecurity, and financial insecurity. 7. A list of Covered Services required, and their frequency, including any existing referrals and PAs; 8. A description of who will provide the Covered Services; and 9. A list of non-Covered Services, community supports, and other resources that the Member already receives or that would be beneficial to the Member. This shall include information on any needed assistance in accessing affordable, integrated housing, and other services from which the Member could benefit or if the Member requests such information. 10. The minimum number of Service Coordination contacts a Member will receive per year and the process for Members to request more or fewer contacts; 11. How Service Coordination will be provided: either in person or by telephone contact; 12. How a Member or Provider can reach a Service Coordinator.</p> <p><b>Referral to Community Organizations</b></p> <p>The MCO must ensure Service Coordinators provide information about and referral to community organizations providing Non-capitated Services that are important to the health and wellbeing of all Members, including referrals related to caregiver supports.</p> <p>The MCO must implement a systematic process to coordinate and track referrals to community organizations and identify service gaps for each Member. The MCO also must make a best effort to establish relationships with State and local programs and community organizations. These organizations include, but are not limited to: 1. State and federal agencies (e.g., those agencies with jurisdiction over aging, public health, SUD, mental health, IDD, rehabilitation, income support, nutritional assistance, family support agencies, etc.); 2. Social service agencies (e.g., area agencies on aging, residential support agencies, independent living centers, supported employment agencies, etc.); 3. City and county agencies (e.g., welfare departments, housing programs, etc.); 4. Civic and religious organizations; 5. Consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.); and 6. Affordable housing programs (e.g. Section 811, local housing authorities, agencies that operate affordable housing, homeless service agencies).</p>



State	MMC Contract/Procurement Language
Virginia	<p>“The Contractor shall provide care coordination efforts that identify and address member access to employment, food security, housing stability, education, social cohesion or resources that support Member connection to social supports, health and health care, as well as environmental needs identified by the member. These social determinants are encompassed under five key areas: Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment.</p> <p>On an annual basis, the Contractor shall complete the following reporting requirements: A) the Contractor shall submit its policies and procedures related to the programs and partnerships established to address SDOH; B) the Contractor shall submit Care Coordination Training Materials for both the Medallion 4.0 non-expansion and Medicaid Expansion Populations; C) the Contractor shall submit its policies and procedures related to identifying, addressing, and tracking the following three (3) determinants belonging to the SDOH areas described as Economic Stability: Employment, Food security, Housing stability.”</p>

**Table 4: Approach B: Contract Language Pertaining to Use of ICD-10 Z Codes**

State	MMC Contract/Procurement Language
Arizona	"The Contractor shall promote and educate provider use of SDOH ICD-10 codes on claims to support data collection on the social risk factors of health experienced by AHCCCS members."
Hawaii	"The Health Plan will develop a SDOH work plan as a component of its QAPI that is informed by the statewide SDOH Transformation Plan. The Health Plan's SDOH work plan shall be submitted as a sub-component of the QAPI plan, and include its own timelines, benchmarks, milestones, and deliverables. The Health Plan's initial SDOH work plan, which will be prepared prior to the completion of the SDOH Transformation Plan, should include: ...Plan for promoting the use of ICD-10 Z codes for SDOH documentation."
Louisiana	"...Partnering with community-based organizations to address SDOH-related needs, including ensuring the active referral to and follow-up on identified needs related to SDOH by: ...Reimbursing Network Providers for screening for SDOH needs and submitting applicable diagnosis codes ("Z codes") on claims including specific reimbursement amounts and frequencies."
Massachusetts	"Ensure that Providers and their staff include relevant ICD-10 codes (such as "Z codes" included in categories Z55-65 and Z75) on any claims the Enrollee's Providers submit for the Enrollee related to the Encounter where the HRSN is identified. Such codes shall be used as supplemental diagnosis codes and shall not be used as the admitting or principal diagnosis codes."
Ohio	"Ensuring the active referral to and follow-up on identified needs related to SDOH such as those outlined above by: ... Reimbursing SDOH codes (Z codes) included in the FFS fee schedule; ... "
Pennsylvania	<p><b>PCMH Screening for SDOH</b>            "The PH-MCO will ensure the PCMH provider meets the following requirements: ...Will complete a Social Determinants of Health assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: food insecurity; health care/medical access/affordability; housing; transportation; childcare; employment; utilities; clothing and financial strain and submit ICD-10 diagnostic codes for all patients with identified needs..."</p> <p><b>Maternity Care Bundled Payment</b>            "The MCO shall use the following quality measures to determine its incentive payments [to participating providers]: a. Social Determinants of Health Screening: Complete at least one Social Determinants of Health screening using a nationally recognized tool, during the episode duration with G9919 or G9920 Procedure Codes. Claims must include appropriate ICD-10 Z-codes when relevant for those determinant areas as defined by Social Determinants Health."</p>

**Table 5: Approach C: Contract Language Pertaining to SDOH-Related Value-Added Services**

State	MMC Contract/Procurement Language
Hawaii	<p>“The Health Plan will develop a SDOH work plan as a component of its QAPI that is informed by the statewide SDOH Transformation Plan. The Health Plan’s SDOH work plan shall be submitted as a sub-component of the QAPI plan, and include its own timelines, benchmarks, milestones, and deliverables. The Health Plan’s initial SDOH work plan, which will be prepared prior to the completion of the SDOH Transformation Plan, should include: ... Plan for incorporating SDOH strategies into the overall QAPI by: a) Linking beneficiaries to identified SDOH needs; and b) Providing relevant SDOH value-added services offerings.</p>
Louisiana	<p>“The proposer should identify whether it proposes to offer any of the following optional value-added benefits to its enrollees: ...Respite care model targeting homeless persons with post-acute medical needs. Model shall address strategies for counseling, nutrition, housing stabilization, transitional care, and other services necessary for successful community reintegration...”</p>
Mississippi	<p>“The Division has compiled a list of desired Value-Adds for this procurement. If an Offeror chooses to include value-added services in its qualification, the Offeror may choose from this list, propose their own original value-added services, or include a combination of both. To the extent that some or all of the desired value-added services may be covered through the offeror’s Care Management strategy, that should be made evident in the Offeror’s Care Management answers in its qualification.</p> <p><b>Social Determinants of Health</b></p> <ul style="list-style-type: none"> <li>Nutrition Assistance, including but not limited to additional nutrition resources for Members (even those who receive SNAP and/or WIC benefits) and education and training for Members regarding nutritious foods and food preparation</li> <li>Utility payment assistance</li> <li>Pest Control/Bed Bug home treatment</li> <li>Education and employment supports, including but not limited to paying for GED classes, supporting pregnant minors in pursuit of high school diploma, paying for skills training, and supplying Members with a computer and internet in the home”</li> </ul>
Virginia	<p>“Examples of potential enhanced benefits for the CCC Plus program population may include, but are not limited to, social determinants of health, chiropractic care, environmental modifications and assistive technology, vision, hearing, and personal care services for individuals who do not meet waiver criteria.”</p>

**Table 6: Approach D: Contract Language Pertaining to SDOH-Related ILOS**

State	MMC Contract/Procurement Language
California	<p><b>Community Supports</b></p> <p><b>DHCS Pre-Approved Community Supports</b></p> <p>A. Contractor may choose to offer Members one or more of the following preapproved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county: 1) Housing Transition Navigation Services; 2) Housing Deposits; 3) Housing Tenancy and Sustaining Services; 4) Short-Term Post-Hospitalization Housing; 5) Recuperative Care (Medical Respite); 6) Respite Services; 7) Day Habilitation Programs; 8) Nursing Facility Transition/Diversion to Assisted Living Facilities; 9) Community Transition Services/Nursing Facility Transition to a Home; 10) Personal Care and Homemaker Services; 11) Environmental Accessibility Adaptations; 12) Medically Tailored Meals/Medically Supportive Food; 13) Sobering Centers; and 14) Asthma Remediation.</p> <p><b>Community Supports Providers</b></p> <p>A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care...</p> <p><b>Community Supports Provider Capacity</b></p> <p>A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports...</p> <p>C. Contractor must ensure its contracted Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.</p> <p><b>Community Supports Model of Care (MOC)</b></p> <p>A. Contractor must develop a Community Supports Model of Care (MOC)... The Community Supports MOC must specify Contractor’s framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.</p> <p><b>Referring Members to Community Supports Providers for Community Supports</b></p> <p>A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor’s policies and procedures must be submitted to DHCS for review and approval prior to its implementation...</p> <p>C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.</p>

State	MMC Contract/Procurement Language
California (continued)	<p><b>Data System Requirements and Data Sharing to Support Community Supports</b></p> <p>A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals to Contractor.</p>
Oregon	<p>“Pursuant to 42 CFR § 438.3(e)(2), Contractor may offer In Lieu of Services to Members. OHA will provide Contractor with a Guidance Document about In Lieu of Services. Such Guidance Document will be located on the CCO Contract Forms Website.</p> <p>The settings or services listed below are determined by OHA to be a Medically Appropriate and Cost Effective substitute for a Covered Service consistent with provisions in OAR 410- 141-3820. Contractor may choose to offer one or more of the following ILOS:</p> <ul style="list-style-type: none"> <li>i. Prevention programs</li> <li>ii. Services provided by Traditional Health Workers</li> <li>iii. Community transition services</li> <li>iv. Enhanced case management</li> <li>v. Post-hospitalization recuperative care</li> <li>vi. Lactation consultations</li> <li>vii. In-home health hazard remediation programs”</li> </ul>

**Table 7: Approach E: Contract Language Pertaining to Directing or Encouraging MCOs to Engage Providers in SDOH Activities**

State	MMC Contract/Procurement Language
Hawaii	<p><b><u>Directing MCOs to Support Providers / CBOs: Health Plan Support for VBP Transformation</u></b></p> <p>The Health Plan will support providers by:... Supporting providers in understanding and assessing SDOH, and connecting with social services providers to address patient SDOH needs...</p>
Nevada	<p><b><u>Directing MCOs to Support Providers: Value-Based Initiatives</u></b></p> <p>“The Contractor must focus its APM contracting strategies to support the Population Health goals and plan as provided in Section 7.5.2.9, in particular, the APM contracting strategies should focus on incentivizing Providers to address the social determinant health needs of Members, improving health equity in access to and delivery of health care services, improvements in maternal and child health outcomes, diversions from emergency rooms, and psychiatric hospital placement into outpatient clinics, when appropriate.</p> <p>The Contractor’s APM contracting strategies must also consider and implement approaches to reduce Provider administrative burden associated with APM contracting and support Providers with data analytics and technical assistance to ensure the successful transition to APM-based reimbursement and progression along the LAN framework.”</p>
North Carolina	<p><b><u>Directing MCOs to Support Providers / CBOs: Enhanced Case Management Pilots to Address Unmet Health-Related Needs</u></b></p> <p>i. Through Enhanced Case Management Pilots, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) priority domains (housing, food, transportation, and interpersonal safety) can be delivered effectively to Medicaid Members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the pilots is to learn which evidence-based interventions and processes are best matched for a specific population to improve health, lower health care costs, and to inform health care delivery statewide.</p> <p>ii. Through a competitive procurement process, the Department will establish Enhanced Case Management pilots in up to four (4) areas of the State to provide a subset of high-need, high-risk, and emerging-risk Medicaid Members with information, services and benefits targeted to measurably improve health and lower costs. The pilots will employ evidence-based interventions addressing Members’ needs in housing, food, transportation, and interpersonal safety. The PHP shall play a key role in executing the pilots in accordance with the roles and responsibilities enumerated below.</p> <p>...</p> <p>iv. Each pilot will have a Lead Pilot Entity (LPE). The LPE’s role is to develop, contract with and manage a network of pilot service providers (e.g., community-based organizations) that can deliver the evidence-based interventions across each of the four (4) priority domains.</p>

State	MMC Contract/Procurement Language
North Carolina (continued)	<p>v. The PHP shall contract with any LPE operating within the PHP’s Region(s). ...</p> <p>xv. The PHP will receive payments from the Department up to a PHP-specific capped allotment to fund pilot services based on the cost and volume of specified services authorized for the PHP’s Members.</p> <p>xvi. The PHP shall make payments to the Lead Pilot Entity to manage the delivery of pilot services.</p>
Ohio	<p><b><u>Directing MCOs to Support Providers: Value-Based Initiatives</u></b> Comprehensive Primary Care Practice Requirements</p> <p>i. The MCO must implement patient centered medical home payments pursuant to OAC rules 5160-19-01 and 5160-19-02.</p> <p>ii. The MCO must play a key role in supporting network Comprehensive Primary Care (CPC) practices with achieving optimal population health outcomes. The MCO must establish a relationship with each network CPC practice and work collaboratively with the CPC to determine the level of support to be provided by the MCO based on the CPC practice’s infrastructure, capabilities, and preferences for MCO assistance (e.g., addressing social determinants of health, data sharing).</p>
Oregon	<p><b><u>Community Reinvestment: 8. Social Determinants of Health and Equity Spending Programs: SDOH-E Partners and SHARE Initiative...</u></b></p> <p>(b) A portion of SHARE Initiative expenditures must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, related to SDOH-E as agreed to by Contractor. Contractor shall enter into a contract, or MOU as applicable, with each SDOH-E Partner that defines the services to be provided and data collection methods as provided in program Guidance Documents posted on the CCO Contract Forms Website.</p> <p>Contractor shall designate a role for the CAC in relation to the SHARE Initiative, as described in OAR 410-141-3735.</p> <p><b><u>Directing MCOs to Support Providers / CBOs: Performance Measure Incentive Payments for Participating Providers</u></b> Contractor shall offer correlative arrangements with Participating Providers (including Social Determinants of Health and Equity partners, public health partners, and other Providers of Health-Related Services as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives. Contractor shall report these arrangements and amounts paid to OHA’s Contract Administrator via Administrative Notice. Such arrangements and amounts paid shall be broken down by quarter and provided in an annual Report in a format determined by OHA (about which OHA shall advise Contractor’s Contract Administrator via Administrative Notice) and sent to OHA in conjunction with the 4<sup>th</sup> Quarter reporting period.</p>

State	MMC Contract/Procurement Language
Oregon (continued)	<p>Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings. (1) The distribution plan must include: (a) An overview of the methodology and/or strategy used to distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Equity and public health partners, that provides information related to Contractor’s process of evaluating the contributions of Participating Providers and connecting those evaluations to distribution of funds; (b) Data on the expenditure of quality incentive pool earnings and whether the distribution considers payments made previously to Participating Providers (such as up front funding to a clinic or non-clinical partner that is intended to help Contractor achieve metrics related to the Quality pool); and (c) Information to help Participating Providers (including SDOH-E and public health partners) understand how they may qualify for payments, how Contractor distributed funds in the most recent year, and how they may distribute funds in future years. (2) The distribution plan, should be provided to OHA, via Administrative Notice, and made publicly available each year within sixty (60) days of Contractor’s receipt of its final Quality Pool distribution.</p>
Pennsylvania	<p><b>Directing MCOs to Support Providers / CBOs:</b> “...MCOs must incorporate CBOs into VBP arrangements with Network Providers to address SDOH as follows:</p> <ol style="list-style-type: none"> <li>1. By March 1, 2021, 25% or more of VBP strategies must include a contract with at least one CBO to address at least one SDOH.</li> <li>2. By June 1, 2021, 50% or more of VBP strategies must include a contract with at least one CBO to address at least one SDOH.</li> <li>3. By September 1, 2021, 75% or more of VBP strategies must include a contract with at least one CBO to address at least one SDOH, and 25% of strategies must include at least one CBO that addresses at least one other SDOH.</li> </ol> <p>The MCO must require the CBO to address at least one of the following SDOH domains, which are included in the statewide resource and referral tool: i. Childcare access and affordability ii. Clothing iii. Employment iv. Financial Strain v. Food insecurity vi. Housing instability/ homelessness vii. Transportation viii. Utilities.”</p> <p>Additionally, in determining which CBOs to incorporate into VBP agreements, the MCO should also consider the following characteristics of CBOs: ....quality of social services provided and experience addressing SDOH...Ability to capture and report SDOH data.</p>



**Table 8: Approach F: Contract Language Pertaining to Encouraging SDOH Activities With Financial and Non-Financial Incentives**

State	MMC Contract/Procurement Language
Arizona	<p><b>Community Investment:</b> The Contractor shall demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing six percent of its annual profits [on its AHCCCS lines of business] to community reinvestment. The Contractor shall submit a plan, detailing its anticipated community reinvestment activities... The Contractor shall submit a Community Reinvestment Report of actual expenditures...<sup>31</sup></p>
California	<p><b>Community Investment:</b> Contractor shall demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of its annual net income under this Contract to community reinvestment... The percentage of Contractor’s annual net income required to be contributed shall be: 1) 5 percent of the portion of Contractor’s annual net income that is less than or equal to 7.5 percent of Contract Revenues for the year, and 2) 7.5 percent of the portion of Contractor’s annual net income that is greater than 7.5 percent. In addition, if Contractor does not meet quality outcome metrics, it shall set an additional 7.5 percent of its annual net income under this Contract to community reinvestment...</p>
Iowa	<p><b>Performance Withhold:</b> <i>Exhibit A: Capitation Rate Information, MLR, Pay for Performance, Liquidated Damages, and Excluded Pharmaceuticals</i></p> <p>During each measurement year, the Agency will withhold a portion of the approved Capitation Payments from Contractor. The amount withheld in this current rate period is two percent (2%) of the Capitation Payments made. Contractor may be eligible to receive some or all the withheld funds based on the Contractor’s performance in areas outlined [in procurement document].</p> <p><i>Performance Standard 6 Social Determinants of Health</i>  <i>Amount of Performance Withhold at Risk 10%</i>  <i>SDOH Data - Implementation of Accurate Data Stream Reporting</i>            Standard Required to Receive Incentive Payment “The Contractor will be given three (3) months to implement and connect with the Agency by requesting an IT project to automate monthly data submission of this data stream to the Agency. Once implemented, the Agency will review the first six (6) months of data submitted on a monthly basis. The Contractor must correctly implement all directions given by the Agency for each of those six (6) months to receive one hundred percent (100%) of the total withhold.</p>
Mississippi	<p><b>Directed Payment:</b> As part of the Contractor’s Quality Management strategy, the Division requires that the Contractor devote at least 0.5% of Capitation Payments received to Social Determinants of Health (SDOH) projects. It is expected that this expenditure is made through partnerships and initiatives developed with community-based organizations. The Contractor will submit</p>

State	MMC Contract/Procurement Language
	SDOH projects to the Division for review and approval. The Division reserves the right to raise this amount during the life of the Contract.
Nevada	<p><b>Community Investment: Community Reinvestment Requirements</b></p> <p>7.11.7.1. The Contractor must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The Contractor’s community reinvestment must be used to support population health strategies, which will include, but may not be limited to, financial support for Project ECHO and Nevada’s Perinatal Quality Collaborative. The Contractor is encouraged to work with other Contractors to maximize the collective impact of community reinvestment activities.</p> <p>7.11.7.2. The Contractor must not use community reinvestment funding to pay for Medicaid or CHIP services covered under the Contract.</p> <p>7.11.7.3. The Contractor must contribute three percent (3%) of its annual pre-tax profits to community reinvestment. The State may require the Contractor to increase the percentage of community reinvestment contributions in future years of the Contract.</p> <p>7.11.7.4. The Contractor must submit a plan on an annual basis, by March 1 of each Contract Year, detailing its anticipated community reinvestment activities for State review and approval.</p> <p>7.11.7.5. The Contractor must submit an annual report of actual community reinvestment expenditures within three (3) months after the end of the Contract Year.</p>
North Carolina	<p><b>MLR calculation: Opportunities for Health</b></p> <p>c. The Department has identified four priority domains for Opportunities for Health and health related resource needs: housing, food, transportation and interpersonal safety.</p> <p>d. The PHP shall address these domains to the maximum extent practical and appropriate in the context of Medicaid Managed Care, including with respect to:</p> <p>...</p> <p>v. Contributions to Health-Related Resources: The PHP is encouraged to make contributions to health-related resources that help to address Members’ and communities’ unmet health-related needs.</p> <p><b>PHP Contributions to Health-Related Resources</b></p> <p>i. The PHP is encouraged to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves.</p>

State	MMC Contract/Procurement Language
North Carolina (continued)	<p>ii. The PHP that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Medical Loss Ratio (MLR)...</p> <p><b><u>Non-financial Incentive: PHP Contributions to Health-Related Resources</u></b></p> <p>i. The PHP is encouraged to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves.</p> <p>...</p> <p>iii. A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a Region to health-related resources may be awarded a preference in auto assignment to promote enrollment in each Region in which the PHP contributes, contingent on the Department determining that the contribution meets the Department’s Quality Strategy standards. The auto-assignment increase will take effect the next Contract Year, or at a date determined by the Department, after the contribution is made.”</p>
Ohio	<p><b><u>Community Reinvestment: Population Health and Quality</u></b></p> <p>i. The MCO must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The MCO's community reinvestment must be used to support population health strategies within the region or regions the MCO serves.</p> <ol style="list-style-type: none"> <li>1. The MCO must not use community reinvestment funding to pay for Medicaid covered services.</li> <li>2. The MCO must contribute 3% of its annual after-tax profits to community reinvestment. The MCO must increase the percentage of the MCO's contributions by 1% point each subsequent year, for a maximum of 5% of the MCO's annual after[1]tax profits.</li> <li>3. ODM encourages the MCO to work collaboratively with other ODM-contracted MCOs in the region to maximize the collective impact of community reinvestment funding.</li> <li>4. The MCO must submit its Community Reinvestment Plan and Evaluation to ODM as specified in Appendix P, Chart of Deliverables. The MCO's Community Reinvestment Plan must detail the MCO's anticipated community reinvestment activities and describe how those activities support the MCO's population health strategies.</li> <li>5. After the first submission, the MCO must include an evaluation of the Community Reinvestment Plan to ODM as part of its annual Community Reinvestment Plan submission to ODM. The evaluation must describe and quantify the impact of community reinvestment funding on population health improvement.</li> </ol> <p><b><u>Performance Withhold: Quality Withhold Payout Determination</u></b></p> <p>b. Performance Evaluation</p> <ol style="list-style-type: none"> <li>i. ODM’s performance evaluation of the MCO will include the following:</li> </ol> <p>...</p>

State	MMC Contract/Procurement Language
Ohio (continued)	<p>1. The MCO’s Population Health Management and Quality Improvement activities, which include:</p> <p>c. Adherence to the Model for Improvement, including:</p> <p>...</p> <p>ii. Conducting active primary and secondary research to develop changes to the MCO’s normal processes (e.g., care coordination, vendor agreements, data tracking and analysis, coverage of services, addressing health-related social needs) to better serve members experiencing disparities;</p> <p>2. Collaboration</p> <p>a. Evidence of the MCO’s collaboration with community entities, providers, and other stakeholders; and</p> <p>b. Evidence of the MCO’s collaboration with other Medicaid and non-Medicaid health plans for collective impact.</p>
Oregon	<p><b>Community Reinvestment: 8. Social Determinants of Health and Equity Spending Programs: SDOH-E Partners and SHARE Initiative</b></p> <p><b>a.</b> Consistent with OAR 410-141-3735, Contractor shall enter into a contract, Memorandum of Understanding, or other form of agreement including a grant agreement, with each SDOH-E Partner that defines the services to be provided and Contractor’s data collection methods as provided in this Contract. OHA’s Guidance Document with the minimum requirements for Contractor’s written agreements with SDOH-E Partners is located on OHA’s SHARE Initiative webpage at: <a href="https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx">https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx</a>.</p> <p><b>b. Supporting Health for All through Reinvestment Initiative.</b> Contractor shall spend a portion of its previous calendar year’s net income or reserves that exceed the financial requirements prescribed by OHA, in accordance with OAR 410-141-3735, CCO financial solvency regulations in OAR 410-141-5000 <i>et seq</i>, ORS 414.572, and this Contract, on services designed to address health disparities and the SDOH-E.</p> <p><b>(1)</b> For all Contract Years, expenditures made under the SHARE Initiative must meet all requirements as specified in the applicable OARs and in this Contract, including without limitation:</p> <p>(a) SHARE Initiative spending priorities selected by Contractor based on:</p> <p>i. Contractor’s most recent Community Health Improvement Plan that is shared with the Collaborative CHA/CHP Partners, as defined in 410-141-3730, including local public health authorities and local Hospitals. If Contractor has not yet developed a shared CHP, Contractor shall look to CHPs developed by other stakeholders in Contractor’s Service Area, including local public health authorities, Hospitals, and other CCOs;</p> <p>ii. At least one priority that aligns with the OHA-designated Statewide priority for SDOH-E spending in housing-related services and</p>

State	MMC Contract/Procurement Language
Oregon (continued)	<p>supports, including Supported Housing, as defined in this Contract. Contractor shall comply with future statewide priorities identified by OHA; and</p> <p>iii. Alignment with Contractor’s Transformation and Quality Strategy.</p> <p><b>(b)</b> A portion of SHARE Initiative expenditures must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, related to SDOH-E as agreed to by Contractor. Contractor shall enter into a contract, or MOU as applicable, with each SDOH-E Partner that defines the services to be provided and data collection methods as provided in program Guidance Documents posted on the CCO Contract Forms Website.</p> <p><b>(c)</b> Contractor shall designate a role for the CAC in relation to the SHARE Initiative, as described in OAR 410-141-3735.</p>

**Table 9: Approach G: Contract Language Pertaining to Payment Adjustments for Social Risk Factors**

State	MMC Contract/Procurement Language
Minnesota	<p><b>Quarterly Payment Adjustment – Social Risk</b></p> <p>14.3.1 Definitions</p> <p>14.3.1.1 “Deep Poverty” means that an individual or family’s income falls below 50% of the Federal Poverty Line.</p> <p>14.3.1.2 “Homelessness” means that an individual is homeless based on self-reported homelessness, an address-based method of identifying a living situation that is not meant for housing, or has a homeless shelter as an address.</p> <p>14.3.1.3 “Serious and Persistent Mental Illness (SPMI)” means an individual has any of the following diagnoses: schizophrenia, borderline personality disorder, bipolar disorder, and/or major depressive disorder, and is receiving services billed to the following codes: 90804 – 90857, 740 – 760, 90882, H0018, H0019, H0031, H0034, H0035, H0040, H2011, H2012, H2017, S9484.</p> <p>14.3.1.4 “Serious Mental Illness (SMI)” means an individual has any of the following diagnoses: schizophrenia, borderline personality disorder, bipolar disorder, and/or major depressive disorder.</p> <p>14.3.1.5 “Substance Use Disorder (SUD)” means an individual with a diagnosis of substance abuse, substance dependence, or a substance-induced disorder.</p> <p>14.3.1.6 “Child Protection Involvement (CPI)” means that the individual has been involved with child protection anytime during the analytic period.</p> <p>14.3.1.7 “Adult” means an individual eighteen (18) years of age and older.</p> <p>14.3.1.8 “Child” means an individual under eighteen (18) years of age.</p> <p>14.3.2 The STATE will determine the social risk factors present in the attributed population of all IHPs through a combination of enrollment and claims data.</p> <p>14.3.3 The STATE will apply a payment modifier that will adjust the aggregate PMPM for the relative proportion of individuals experiencing social risk factors within an IHP’s population which may include Deep Poverty, Homelessness, Serious and Persistent Mental Illness, Serious Mental Illness, Substance Use Disorder, and Child Protection Involvement.</p>

State	MMC Contract/Procurement Language
Minnesota (continued)	<p>14.3.4 The STATE reserves the right to modify, adjust, add, or delete social risk factors from the payment modifier in order to more accurately represent the presence of social risk factors in an IHP’s population, the cost of providing or coordinating care for individuals with social risk factors, or based on other research.</p> <p style="padding-left: 40px;">14.3.4.1 The STATE will notify the IHP at least forty five (45) days in advance of changes to the social risk adjustment methodology.</p> <p>14.3.5 The payment modifiers are based on the following relative risk and social risk factor criteria:</p> <p style="padding-left: 40px;">14.3.5.1 The PBP will be adjusted to reflect the relative number of attributed Adult members identified with SMI and SUD.</p> <p style="padding-left: 40px;">14.3.5.2 An adjustment will also be included for the relative number of Adult members with SMI or SUD, but are not identified as having both social risk factors. The adjustment will also be applied to reflect the relative portion of Adult members who are homeless or were previously incarcerated.</p> <p style="padding-left: 40px;">14.3.5.3 The PBP will be adjusted to reflect the relative number of attributed Children who are identified as having Child Protection Involvement or parents with an SPMI social risk factor.</p> <p style="padding-left: 40px;">14.3.5.4 The PBP will also be adjusted to reflect the relative number of Infants who were identified as having parents with SUD or SMI social risk factors.</p> <p>14.3.6 The dollar amount assigned to each member in Section 14.2.5 will be adjusted to reflect the estimated relative increase in risk as indicated by their social risk factor, using the risk and PBP methodology described in Section 14.2.4. Individual member monthly PBP amounts will be used to derive an average PMPM amount for an IHP’s PBP.</p>

## Appendix C: Links to Select State Medicaid Managed Care Contracts/Procurements

Below are links to state Medicaid managed care contracts reviewed in this resource.

1. Arizona: [Link](#) to 2021 ACC Contract
2. California: [Link](#) to 2022 Medi-Cal Managed Care Plans RFP
3. Hawaii: [Link](#) to 2020 (QI) Managed Care RFP; [Link](#) to QI Managed Care Model Contract
4. Iowa: [Link](#) to 2022 Health Link RFP
5. Louisiana: [Link](#) to 2021 Medicaid MCO RFP and Model Contract
6. Massachusetts: [Link](#) to 2022 ACO Request for Responses (RFR)
7. Minnesota: [Link](#) to 2022 MMC Contracts
8. Mississippi: [Link](#) to 2021 Medicaid Coordinated Care Request for Qualifications (RFQ) and Model Contract
9. Nevada: [Link](#) to 2022 Managed Care Contracts
10. North Carolina: [Link](#) to PHP Contract
11. Ohio: [Link](#) to Managed Care Agreements; [Link](#) to new Managed Care Agreement
12. Oregon: [Link](#) to 2022 CCO Contract
13. Pennsylvania: [Link](#) to 2022 HealthChoices Physical Health MCO Contract
14. Rhode Island: [Link](#) to MMC Contracts
15. Texas: [Link](#) to 2022 STAR+PLUS RFP
16. Virginia: [Link](#) to Medallion 4.0 Contract; [Link](#) to CCC Plus Contract



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<sup>1</sup> Dwan Everette T, Sathasivam D, Siegel K. *Health Equity Language Guide for State Officials, Part 1: Discussing Racism*. State Health & Value Strategies. August 9, 2021. Page 5. <https://www.shvs.org/wp-content/uploads/2021/08/Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf>. Accessed August 23, 2022.

<sup>2</sup> Alderwick, H & Gottlieb, LM (2019). Meanings and misunderstandings: A social determinants of health lexicon for health care systems. *The Milbank Quarterly*, 97(2), 407–419. <https://doi.org/10.1111/1468-0009.12390>. Accessed August 31, 2022.

<sup>3</sup> Social Interventions Research and Evaluation Network (SIREN) at the University of California, San Francisco. "Defining the 'Glide Path': State Medicaid Agencies' Efforts to Promote Action on Social Determinants." State Health & Value Strategies. July 2022. <https://www.shvs.org/resource/defining-the-glide-path-state-medicaid-agencies-efforts-to-promote-action-on-social-determinants/>. Accessed August 31, 2022.

<sup>4</sup> Medicaid Managed Care Entities (MCEs) include managed care organizations (MCOs), managed behavioral health organizations (MBHOs), managed long term services and supports (MLTSS) organizations, managed dental plan (MDPs) and accountable care organizations (ACOs). This resource includes examples of MCE approaches which states may be able to apply in their MCO, ACO, MBHO, MLTSS, or other contracts.

<sup>5</sup> Gifford K, Lashbrook A, & Nardone M. (2021). *States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022*. Kaiser Family Foundation. <https://files.kff.org/attachment/Report-States-Respond-to-COVID-19-Challenges.pdf>. Accessed August 23, 2023.

<sup>6</sup> U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. *Opportunities in Medicaid and CHIP to Address Social Determinants of Health*. SHO #21-001. Washington: U.S. Department of Health & Human Services. January 7, 2021. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>. Accessed August 23, 2022.

<sup>7</sup> Tsega M, Lewis C, McCarthy D, Shah T, & Coutts K. (2019). *Review of Evidence on the Health Care Impacts of Interventions to Address the Social Determinants of Health*. Commonwealth Fund. <https://www.commonwealthfund.org/publications/2019/jun/roi-calculator-evidence-guide>. Accessed August 31, 2022.

<sup>8</sup> Manatt, Phelps & Phillips, LLP. (2022). *Meeting Health-Related Social Needs Through Medicaid: A New Opportunity for States*. <https://www.manatt.com/insights/webinars/meeting-health-related-social-needs-through-medica>. Accessed August 31, 2022.

<sup>9</sup> Brown E, Fichtenberg C, Frazee T, Bernheim S, & Gottlieb LM. "Conceptualizing Performance Measurement for Social Care Interventions: An Issue Brief for State Medicaid Agencies" State Health & Value Strategies. November 2021. <https://www.shvs.org/resource/conceptualizing-performance-measurement-for-social-care-interventions-an-issue-brief-for-state-medicaid-agencies/>. Accessed August 31, 2022.

<sup>10</sup> National Committee for Quality Assurance, HEDIS MY 2023: See What's New, What's Changed and What's Retired, August 1, 2022. <https://www.ncqa.org/blog/hedis-my-2023-see-whats-new-whats-changed-and-whats-retired/>. Accessed August 23, 2022.

<sup>11</sup> This resource identifies state MMC examples for highlighted SDOH approaches; however, it does not include an exhaustive review of all MMC SDOH approaches for profiled states.

<sup>12</sup> California Department of Health Care Services, *CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program Initiatives*. <https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices>. Accessed August 23, 2022.

<sup>13</sup> *Factors influencing health status and contact with health services Z00-Z99*. ICD10Data.com. Retrieved August 31, 2022, from <https://www.icd10data.com/ICD10CM/Codes/Z00-Z99>.

<sup>14</sup> Two of Medi-Cal's new health-related services were authorized under the state's Section 1115 waiver, not part of its managed care authorities. For more information about California's approach to "in lieu of" services and related waiver services, please see Mann C, Tsai D, Cooper J. Meeting Health-Related Social Needs Through Medicaid: A New Opportunity for States. Webinar presentation; April 6, 2022. <https://www.manatt.com/insights/webinars/meeting-health-related-social-needs-through-medica>. Accessed August 23, 2022.

<sup>15</sup> For additional information regarding the CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS) models of care, please see the following resources:

- California Health and Human Services Agency, Department of Health Care Services. CalAIM ECM and ILOS, Model of Care Template: Instructions and Timelines. 2022. <https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Model-of-Care-Cover-Note-2022.pdf>. Accessed August 23, 2022.
  - California Health and Human Services Agency, Department of Health Care Services. CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program Initiatives. <https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices>. Accessed August 23, 2022.
- <sup>16</sup> Bailit Health. “Developing a Social Risk Factor Screening Measure.” State Health & Value Strategies. October 2020. [https://www.shvs.org/wp-content/uploads/2020/10/Developing-a-SRF-Screening-Measure\\_Issue-Brief.pdf](https://www.shvs.org/wp-content/uploads/2020/10/Developing-a-SRF-Screening-Measure_Issue-Brief.pdf). Accessed August 23, 2022.
- <sup>17</sup> Massachusetts’ new ACO model contract describes its “ACO Quality Score” methodology, which includes performance on a “Health Related Social Needs Screening” quality measure, in Appendix Q of the 2022 RFR, which can be accessed on the state’s bid solicitation website. <https://www.commbuys.com/bsa/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410&external=true&parentUrl=close>. Accessed August 23, 2022.
- <sup>18</sup> Additional information regarding Oregon’s path to considering and implementing a Social Needs Screening & Referral Measure can be found on the Oregon Health Authority’s Social Determinants of Health Measurement Workgroup webpage. <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx>. Accessed August 23, 2022.
- <sup>19</sup> Health-related services are defined by Oregon Administrative Rules ([OAR 410-141-3500](#) and [410-141-3845](#)), the [1115 waiver special terms and conditions](#), and federal regulations.
- <sup>20</sup> Oregon Health Authority. Health-Related Services Brief. November 2021. Page 3. <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf>. Accessed August 23, 2022.
- <sup>21</sup> Oregon Health Authority, Office of Health Analytics, OHP Rate Development. <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx>. Accessed August 23, 2022.
- <sup>22</sup> State of Rhode Island, Executive Office of Health and Human Services, Accountable Entities, Resource Documents. Program Year 5 Requirements Documents. Attachment K – Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities. <https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>. Accessed August 23, 2022.
- <sup>23</sup> Breslin E, Lambertino A. “Medicaid and Social Determinants of Health: Adjusting Payment and Measuring Health Outcomes.” Health Management Associates. July 2017. [SHVS SocialDeterminants HMA July2017.pdf](#). Accessed August 23, 2022.
- <sup>24</sup> State Health Access Data Assistance Center at the University of Minnesota. “Risk Adjustment Based on Social Factors: State Approaches to Filling Data Gaps.” State Health & Value Strategies. August 2020. [FINAL SHVS-Risk-Adjustment-Brief.pdf \(shadac.org\)](#). Accessed August 23, 2022.
- <sup>25</sup> Commonwealth of Massachusetts. *MassHealth Risk Adjustment Methodology*. MassHealth. Retrieved August 31, 2022, from <https://www.mass.gov/lists/masshealth-risk-adjustment-methodology>.
- <sup>26</sup> U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. *Opportunities in Medicaid and CHIP to Address Social Determinants of Health*. SHO #21-001. Washington: U.S. Department of Health & Human Services. January 7, 2021. <https://www.medicare.gov/federal-policy-guidance/downloads/sho21001.pdf>. Accessed August 23, 2022.
- <sup>27</sup> Kaiser Family Foundation. (2022, August 19). *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>. Accessed August 31, 2022.
- <sup>28</sup> Rapfogel, N. & Rosenthal, J. (2022). *How North Carolina Is Using Medicaid To Address Social Determinants of Health*. Center for American Progress. <https://www.americanprogress.org/article/how-north-carolina-is-using-medicaid-to-address-social-determinants-of-health/#:~:text=North%20Carolina's%20Section%201115%20waiver,the%20administrative%20costs%20of%20implementati on>. Accessed August 31, 2022.
- <sup>29</sup> Florida Agency for Healthcare Administration. *Housing Assistance Waiver*. Retrieved August 31, 2022, from [https://ahca.myflorida.com/medicaid/statewide\\_mc/Housing\\_Assist.shtml](https://ahca.myflorida.com/medicaid/statewide_mc/Housing_Assist.shtml).
- <sup>30</sup> Contract is a comprehensive term for current, executed Medicaid Managed Care contracts, model contracts included in procurement documents but not yet executed, and other state procurement documents.

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<sup>31</sup> AHCCCS MCO Community Reinvestment expenditures are detailed in an annual report deliverable which includes an indicator for whether the expenditure represents SDOH activities. Examples of SDOH-related community reinvestment include but are not limited to support for transitional and sober living housing, community and school gardens, food/financial literacy training, libraries, community centers, community fitness project, development of park playground, and transition planning from jail to community. Retrieved October 3, 2022 from “AHCCCS Targeted Investment Sustainability Plan” from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-target-stability-plan-20190812.pdf>