

Addressing Health-Related Social Needs Through Medicaid Managed Care

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I. Introduction

States are increasingly leveraging their Medicaid programs to transform healthcare delivery and improve individual and population health with a focus on addressing health-related social needs (HRSN) (see Box 1 for key terms^{1,2}). States use a variety of approaches to measure and incentivize Medicaid managed care (MMC) entities' efforts to address HRSN.³ Most of these efforts intervene at the individual level by 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 HRSN screening provisions into their contracts. 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 investments in communities.

This toolkit identifies examples of approaches states are taking through their MMC programs to address HRSN.

Since the publication of the original toolkit in October 2022, state HRSN approaches and requirements in MCO contracts are more extensive, and in some cases more integrated into broader MCO requirements and system transformation strategies. The Centers for Medicare & Medicaid Services (CMS) issued guidance in 2021 describing how Medicaid agencies can utilize managed care authorities, in addition to other mechanisms, to address enrollees' HRSN.⁴ On November 16, 2023, CMS issued additional guidance to states on the use of Medicaid and Children's Health Insurance Program (CHIP) authorities to address enrollees' HRSN, along with an accompanying framework of services and supports to address HRSN that CMS considers allowable under specific authorities.^{5,6}

States interested in implementing specific strategies to identify and address HRSN 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 addressing HRSN. 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 HRSN policies into their contract language.

The primary focus of this toolkit is on policy options that fall within Medicaid state plan and general managed care authorities. Most Medicaid initiatives to address members' HRSN are focused on MCOs, which is the most common type of state managed care arrangement. However, some states can and do apply HRSN approaches with contracted managed behavioral

Box 1. Key Terms

HRSN: An individual's unmet, adverse social conditions that contribute to poor health. These needs—including food insecurity, housing instability, unemployment, and/or lack of reliable transportation—can drive health disparities across demographic groups.

Some states may instead use the following terms to refer to HRSN: social needs, health-related resource needs, non-clinical needs, non-medical needs, social risk factors, and non-medical risk factors, among other terms.

Social Determinants of Health (SDOH):

Conditions in which individuals are born, grow, work, live, and age, and the wider set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems. An individual's HRSN are related to their community's underlying SDOH.

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). SDOH influence health and well-being, either by conferring health benefits or contributing to health risks.

health organizations (MBHOs), accountable care organizations (ACOs), and managed long-term services and supports (MLTSS) programs as noted in the profiled states.

The toolkit includes a curated set of examples from 20 profiled states. Table 1 identifies eight types of approaches states are taking to address HRSN in MMC based on the 20 profiled states.⁷

Table 1: State MMC Approaches to Address Members' HRSN
A. Identifying and addressing HRSN, including within MCO care coordination/management
B. Requiring use of ICD-10 Z codes
C. Encouraging use of value-added services to address HRSN
D. Encouraging use of in lieu of services to address HRSN
E. Directing MCOs to engage providers in HRSN activities
F. Encouraging HRSN activities and approaches through incentives
G. Accounting for social risk factors in managed care payment methodologies
H. Addressing HRSN through community engagement, partnerships and/or investments

States may target certain HRSN interventions based on the strength of the evidence and the return on investment, such as housing-related services, nutrition interventions, and care management programs with demonstrated savings. For example, California cited research showing how medically-tailored meals/medically-supportive food can reduce some emergency department visits and hospitalizations and improve outcomes to demonstrate to CMS that such services should be considered medically-appropriate and cost-effective in lieu of services for certain Medicaid managed care populations.⁸

States may also design and implement special HRSN initiatives targeting a specific MMC subpopulation (e.g., children in foster care, individuals transitioning from the hospital to the community, from a nursing facility to the community, or from incarceration to the community) or a specific HRSN domain(s) (e.g., housing, food security, employment). Medicaid programs can pay for housing-related services that promote health and community integration such as assistance in finding and securing housing, and home modifications when individuals transition from an institution to the community. However, Medicaid cannot pay for rent or for room and board, except in certain medical institutions or through demonstration waivers authorized under section 1115 of the Social Security Act.⁹ **Box 2** highlights examples of states that focus aspects of their HRSN initiatives on housing-related services.

This toolkit is focused on states' use of broad HRSN initiatives in MMC. While several state Medicaid agencies may have specific pilot programs for certain populations or HRSN domains, those types of pilots are beyond the scope of this resource.

State examples profiled in [Section II](#) are presented 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 that states incorporated into MMC procurements to both signal that HRSN is a priority area of focus for the state and to better understand respondent preparedness to support HRSN 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 HRSN.
- [Appendix B](#) includes the specific language states are using in their MMC contracts pertaining to the HRSN 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 and procurements referenced in this document.

Box 2. Examples of states with HRSN initiatives targeting MMC members with housing instability

- **Arizona** requires MCOs 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 appropriate services.
- **California** Medi-Cal managed care members experiencing homelessness or transitioning from incarceration are eligible for enhanced care management, which “will meet beneficiaries wherever they are—on the street, in a shelter, in their doctor’s office, or at home.”¹⁰ In addition, members “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.”¹¹
- **New Hampshire’s** MMC RFP requires MCOs to employ a housing coordinator whose responsibilities include helping to identify, secure, and maintain community-based housing for members and developing, articulating, and implementing a broader supportive housing strategy. The RFP also requires MCOs to outreach to members with a history of homelessness and establish partnerships with community based organizations (CBOs) to connect these members to housing services. Further, New Hampshire authorizes “assistance in finding and keeping housing” (not including rent) as an MCO in lieu of service, subject to CMS approval.
- **Pennsylvania’s** Community HealthChoices (the state’s managed long-term services and supports program) contracts require MCOs to provide housing supports to enrollees at risk of homelessness or institutionalization. The MLTSS contract identifies that pre-tenancy and tenancy supports may include housing search assistance, support for applying for housing and benefits, assistance with Supplemental Security Income eligibility processes, advocacy and negotiation with landlords and other tenants, moving assistance, eviction prevention, motivational interviewing, and incorporating HRSN into the person-centered planning process. MLTSS MCOs must also participate in local and statewide housing collaboratives.
- **Virginia’s** Cardinal Care Managed Care RFP requires MCOs to develop formal referral and assistance processes and procedures in its care management policies and processes and case management programs for members experiencing homelessness.

This toolkit does not include all state MMC procurement questions or contract language related to addressing enrollees’ HRSN, but instead represents a curated list of specific examples from 20 profiled states (see [Table 2](#) for a summary of states and approaches).¹² In some cases, the relevant MMC contract language was excluded from this toolkit 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 20-page Exhibit K as part of its managed care contracts describing Medicaid requirements related to SDOH and equity.¹³ In addition, MMC contracts are updated regularly, and the examples captured in this toolkit may change over time. The full MMC contracts referenced in this toolkit (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’ HRSN

State Medicaid agencies utilize different terms and definitions related to HRSN, often characterizing HRSN broadly to include interventions that focus on individuals’ social risk factors and health needs (see Box 1). Table 2 provides more detail on how the 20 Medicaid programs included in this toolkit utilize one or more of the identified approaches to identify and address HRSN for managed care enrollees.¹⁴

Table 2: Overview of State MMC Approaches to Addressing HRSN of MMC Enrollees

Approach	AZ	CA	FL	GA	HI	IA	LA	MA	MI	MN	MS	NH	NV	NC	OH	OR	PA	RI	TX	VA
A. Identifying and addressing HRSN, including within MCO care coordination/management	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
B. Requiring use of ICD-10 Z codes	Y		Y	Y				Y							Y		Y			
C. Encouraging use of value-added services to address HRSN			Y	Y	Y		Y				Y					Y				Y
D. Encouraging use of in lieu of services to address HRSN		Y	Y	Y					Y			Y				Y				
E. Directing MCOs to engage providers in HRSN activities	Y	Y	Y		Y			Y	Y			Y	Y	Y	Y	Y	Y	Y		
F. Encouraging HRSN activities and approaches through incentives			Y			Y		Y	Y					Y	Y	Y	Y	Y		
G. Accounting for social risk factors in managed care payment methodologies	Y		Y					Y		Y										
H. Addressing HRSN through community engagement, partnerships and/or investments	Y	Y	Y	Y					Y		Y		Y		Y	Y	Y			Y

The HRSN procurement and contract examples cited in this section are intended to be illustrative of the state's approaches, not an exhaustive record of all its approaches to address members' HRSN. Similarly, the MMC contract language in [Appendix B](#) does not include contract language from all states or all MMC programs identified.

Many states profiled here have multiple MMC programs (e.g., AZ, CA, MA, MN, PA, 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, the specific approaches cited for Texas include those from the state's MLTSS (STAR+PLUS) procurement and in Rhode Island and Massachusetts, some approaches are within Medicaid ACO contract provisions. [Appendix C](#) provides website links to Medicaid managed care contracts and procurements referenced in this toolkit.

A first step in addressing HRSN is to promote screening of MMC members to identify enrollees' social risk factors and needs. Some state MMC contracts specifically direct MCOs and/or ACOs and provider entities to conduct HRSN screening as part of health needs assessments and within care coordination/management.¹⁵ Certain MMC contracts may go further and require or incentivize managed care entities to implement mitigation strategies to address identified HRSN.¹⁶ MCO mitigation strategies can be incorporated within care coordination/management requirements, require use of community resource referral platforms to connect individual members with CBOs, and may extend to MCO financial incentives to partner with CBOs and invest in communities to improve HRSN.

While some states require Medicaid MCOs to screen for HRSN or at least for certain domains such as housing stability, until recently, there has been no standardized measure to assess MCO performance of screenings. 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 2023.¹⁷ 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 HRSN screening and intervention measures, as discussed under Approach F related to encouraging HRSN activities and approaches through incentives.

State agencies may focus MMC strategies on certain HRSN domains and interventions or on initiatives targeting a specific subpopulation. Medicaid agencies may work with their executive leaders, actuaries, contracted MCOs, providers, members, and CMS to identify and refine HRSN approaches based on priorities, resources, the prevalence of the social risk factors and the potential to improve health and reduce medical expenses.

Below is a summary of each of the HRSN approaches listed in Table 2 (A through H) using state examples.

A. Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

All 20 states profiled in this toolkit direct Medicaid MCOs to screen for social needs, largely within care management assessments and/or address social needs within care management interventions. Some states require managed care entities to screen for HRSN 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 HRSN, 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 HRSN care coordination/management provisions.)

- **Hawaii, Iowa, Louisiana, Massachusetts, Michigan, Mississippi, Nevada, North Carolina, and Virginia** require MCOs to screen for HRSN and use the information to inform interventions (Hawaii, Michigan) and identify individuals for care management support (Hawaii, Louisiana, Massachusetts, Michigan, Mississippi, Nevada, North Carolina, and Virginia). In Hawaii, Iowa, Louisiana, and North Carolina, MCOs must use HRSN questions these states prescribe in their screening tools.
- **Texas's** STAR+PLUS 2022 procurement scope of work requires MCOs to use an evidence-based screening tool for HRSN, coordinate and track referrals to community organizations for community-based resources, and provide social needs resources to network providers, such as education on the screening tool and community-based resources, to address members' needs. In addition, requirements for service coordination and a specialized care management service are also used to identify and address HRSN. Texas's STAR & CHIP 2022 procurement scope of work emphasizes service coordination in the prenatal and postpartum periods, including educating members on community organizations that can address medical or social needs immediately before or after delivery and coordinating supports such as transportation to postpartum visits.
- **Ohio** requires, and **Georgia** will require, Medicaid MCOs to use risk stratification to assess population-level and member-level risk levels. Risk stratification criteria and thresholds must include HRSN, 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 members' HRSN. **Georgia's** MCOs will be required to take into consideration a member's HRSN when identifying and evaluating criteria for tiered care management.
- **California** has extensive MMC care management requirements for Medi-Cal MCO care managers, including to screen for HRSN, refer individuals to community health workers or community-based services to address identified needs, and track referrals to ensure fulfillment. **Virginia** also encourages the use of "care extenders" to complete select non-clinical care management activities, including coordinating social services.
- **Florida, Georgia, Michigan, and Mississippi** require MCOs to track and close the loop on HRSN referrals for Medicaid members. For example, Georgia's new MMC procurement defines "Closed-loop Referral Management" as a "mechanism to ensure Members are connected to the right services based on screening and assessment, engage with those services in order to receive benefit from the social services provided by community-based organizations, and have data regarding need fulfillment or gap relayed back" to the MCO and the state Medicaid agency.¹⁸

- **Arizona** requires MCOs to join the state’s closed-loop referral system (CLRS) and encourage provider network utilization of the CLRS to refer members to CBOs that provide services to address HRSN. In conjunction with utilization of the CLRS, MCOs must maintain a publicly available Community Resource Guide with information on local resources specific to member needs and geographic areas.

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

B. Requiring Use of ICD-10 Z Codes¹⁹

ICD-10 Z codes provide a standardized way to document some HRSNs at the member-level and allow for this data to be aggregated, analyzed, and utilized to improve care. 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. Z code categories include, for example: problems related to education and literacy, problems related to employment and unemployment, problems related to housing and economic circumstances, and other problems related to primary support group, including family circumstances.²⁰ Use of Z codes enables social needs data to be used for clinical, operational, reporting, or other usages. Below are examples of states that require the use of Z codes. (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** Whole Person Care Initiative requires MCOs to promote and educate providers on the use of HRSN ICD-10 codes on claims to support data collection on social risk factors.
- **Florida’s** 2023 MMC procurement indicates that MCOs must 1) require primary care providers to conduct screening of at least 95% of enrollees for HRSN and record the identified ICD-10 codes in the enrollee’s electronic health record, and 2) require such providers to assess each enrollee’s HRSN, document identified needs in the enrollee record utilizing Z codes and provide such codes via claims submissions to the MCO.
- **Georgia’s** new MMC procurement requires MCOs to identify reimbursable education, evaluation and management, and/or treatment-associated billing codes that correlate with Z codes.
- **Massachusetts’** Medicaid ACO model contract requires ACOs to ensure providers include relevant ICD-10 codes, including Z codes, on claims when a HRSN is identified in an encounter.
- **Ohio’s** MMC agreement requires MCOs to reimburse providers for ICD-10 Z codes included on the Medicaid fee schedule to help ensure referral and follow-up related to identified HRSN.
- **Pennsylvania** requires physical health MCOs to ensure contracted Patient Centered Medical Home (PCMH) providers screen patients for HRSN 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 HRSN and document results using ICD-10 Z codes.

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

C. Encouraging Use of Value-Added Services to Address HRSN

Value-added services are additional services or benefits not covered under a Medicaid state plan that MCOs may offer to members. Examples specific to addressing HRSN include respite services and other housing supports, transportation to the grocery store or food bank, and assistance with rental housing deposits and utilities payments. 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 HRSN; examples are below. (See [Table 5](#) in [Appendix B](#) for the language some of these states are incorporating into their MMC contracts related to HRSN value-added services.)

- **Hawaii** requires Medicaid MCOs to develop a separate HRSN work plan describing how they will provide HRSN value-added services. The HRSN work plan is a sub-component of the MCOs' Quality Assurance and Performance Improvement program.
- **Florida's** MMC procurement emphasizes "expanded benefits" related to housing assistance, food assistance, non-emergency transportation, life skills development, and K-12 tutoring to advance its "Pathway to Prosperity" initiative. Pathway to Prosperity uses navigators to guide members, focusing on community collaboration to maximize resources. In their bids, managed care plans were asked to describe the Pathway to Prosperity enhanced benefits they propose to offer.
- **Georgia's** 2023 MMC procurement will require future MCOS to identify gaps in services and resources that prevent fulfillment of goals and needs identified by care plans and use this analysis to guide its approach for value-added services. In addition, the RFP scoring notes that respondents should demonstrate capabilities to use interventions to meaningfully address HRSN, including value-added services.
- **Mississippi** identified in its 2021 MMC procurement a list of "desired" value-added HRSN benefits such as nutrition assistance, utility payment assistance, pest/bed bug control, education and employment supports, and internet access in the home.
- **Virginia's** 2023 MMC procurement encourages MCOs to offer enhanced benefits targeting members' HRSN and includes examples of potential enhanced benefits, including HRSN interventions.

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

D. Encouraging Use of In Lieu of Services to Address HRSN

In lieu of services (ILOS) can be used by Medicaid MCOs to provide medically appropriate, cost-effective substitutes for covered services to address HRSN.²¹ These may be services or settings and could include housing-related services, respite services, or in-home prenatal care, for example. Results from the "Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023" indicated that nearly one-third of the 34 states permitting ILOS reported that allowable ILOS include services to address HRSN, such as food and housing needs.²² 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 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."²³ (See Box 3.) 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 CBOs have capacity to accept referrals, provide social services, and track fulfillment of services.²⁴ 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, services provided by traditional health workers, 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.
- Both **Florida** and **New Hampshire** place emphasis on MCOs' use of ILOS related to housing, while **Michigan** encourages MCOs to use ILOS to address food insecurity. **Florida's** MMC procurement encourages managed care plans to provide ILOS for housing assistance and targeted case management for people experiencing or at risk for homelessness, while **New Hampshire's** MMC procurement

authorizes MCOs to provide “assistance in finding and keeping housing” (not including rent) as an ILOS, subject to CMS approval.

- Consistent with its approach to value-added services, **Georgia** will require future MCOs to identify gaps in services and resources that prevent fulfillment of goals and needs identified by care plans and use this analysis to guide its approach for ILOS. Georgia’s 2023 MMC procurement notes that respondents should demonstrate use of interventions to meaningfully address HRSN, including use of ILOS.

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

E. Directing MCOs to Engage Providers in HRSN Activities

Some states require that MCOs support, engage and/or incentivize providers to participate in HRSN activities for Medicaid members. Others require MCOs to implement certain alternative payment models (APM) that advance HRSN priorities and/or provide technical assistance or support to providers for HRSN activities. Examples of these approaches follow. (See [Table 7](#) in **Appendix B** for specific language some states are using in their contracts to encourage or direct MCO activities with providers.)

- **Arizona** requires MCOs to encourage provider use of HRSN screening and referral tools available through, or compatible with, their CLRS. In addition, under a State Directed Payment arrangement, MCOs must pay eligible providers, including CBOs, an enhanced rate for meeting certain state requirements related to using the CLRS to screen and refer members to improve their HRSN.²⁵
- **Florida’s** MMC procurement requires MCO value-based payment (VBP) programs to include contractual agreements with providers focused on defined populations and emphasizes foundational payments to providers to support advancement towards VBP, including supplemental payments to address HRSN. In addition, Florida encourages MCOs to use the enrollees’ area deprivation index or other social vulnerability index rankings to adjust provider risk when calculating VBP targets.
- **Hawaii** requires MCOs to support providers in understanding and assessing HRSN and to connect with social services providers to address member HRSN as part of broader VBP transformation requirements.
- For enrollees with identified HRSN in **Massachusetts**, MCOs must establish and maintain at least one relationship with a provider or social services organization to assist enrollees in obtaining Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) benefits.
- **Nevada** directs MCOs to focus APM contracting strategies on incentivizing providers to address members’ HRSN, among other strategies. Such strategies must consider provider administrative burden and support providers with data analytics and technical assistance.
- **New Hampshire’s** MMC procurement requires MCOs to implement and provide administrative support for a “Provider-Delivered Care Coordination Program” that includes reimbursement and other incentives to enable participating providers to coordinate members’ health-related and community support services, including but not limited to housing. New Hampshire also requires MCOs to educate and train providers on how to access information about community support services and housing for members

Box 3. 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*

and how to facilitate member closed-loop referrals; incentivize providers for the use of closed-loop referrals for effective care coordination; and assist providers with actively linking members with other state, local, and community programs that address HRSN.

- **North Carolina** requires MMC plans to participate in enhanced case management pilots to address HRSN. Such participation requires plans to contract with and make payments to CBOs that can deliver evidence-based interventions related to North Carolina’s priority HRSN domains (housing, food, transportation, and interpersonal safety). **Michigan’s** MMC procurement also requires MCOs to contract with CBOs to support population health improvement strategies in the MCOs’ regions, including efforts to address HRSN. Michigan will require MCOs to support the design and implementation of community health worker interventions delivered by CBOs to address HRSN. In addition, Michigan MCOs must collaborate with high-volume primary care practices and Community Health Innovation Regions to develop, promote, and implement targeted interventions for subpopulations experiencing HRSN.
- **Ohio** requires MCOs to play a key role in supporting Comprehensive Primary Care (CPC) practices with achieving optimal population health outcomes. MCOs must collaborate with CPC practices to determine their level of support based on the practice’s infrastructure, capabilities, and preferences for MCO assistance, including addressing HRSN.
- **Oregon** requires CCOs to offer incentive arrangements with providers, including HRSN 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 Community HealthChoices (the state’s managed long-term services and supports program) MCOs to include provisions in their provider agreements that stipulate coordination with behavioral health providers and referral “for social, vocational, education, or human services when a need for such service is identified through assessment.”

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

F. Encouraging HRSN Activities and Approaches Through Incentives

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

- MCOs participating in **Iowa’s** MMC program have 10% of their annual performance withhold at risk for establishing accurate HRSN data reporting from the MCO to the state. MCOs will be given three months to implement data sharing, and the state will review HRSN 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 HRSN data reporting.
- Screening for HRSN is factored into Medicaid quality performance calculations in **Massachusetts** and **Rhode Island**.^{26,27} In addition, **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.²⁸
- In **Florida**, if MCOs fail to comply with the state’s “Pathway to Prosperity” requirements (see description under [Approach C](#)), they may be subject to sanctions or liquidated damages as determined by the state.

MCOs are also subject to “performance measure-related liquidated damages and sanctions” for poor performance on HEDIS Social Need Screening and Intervention performance measures.²⁹

- **Michigan, North Carolina** and **Pennsylvania** employ both financial and non-financial incentives for MCOs to advance HRSN priorities. For example, in **North Carolina**, MCOs that voluntarily contribute to health-related resources that address priority domains (housing, food, transportation, and interpersonal safety) are permitted to count the contributions towards the numerator of its MLR. In addition, 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 HRSN 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 HRSNs, and collaboration with community entities, providers, and other stakeholders for collective impact.
- **Oregon** developed a Social Needs Screening and Referral 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.³⁰ In addition, 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-being³¹—as medical expenses in the MLR numerator.³² 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.

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

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

A few states have worked to account for social risk factors in the development of MCO capitation rates and/or ACO payment methodologies in an effort to better align the risk of higher medical costs for individuals with specific HRSNs and the managed care payment amount.³³ Both Massachusetts and Minnesota, have spent significant time and effort developing and refining methodologies to account for social risk factors.³⁴ (See [Table 9 in Appendix B](#) for specific language included in Minnesota’s contracts related to social risk factor payment adjustments.) In other states, such as Arizona and Florida, the utilization of social risk factors in Medicaid managed care payment methodologies may not be as clearly identified in model contracts or procurement documents.

- In **Arizona**, risk adjustment for most managed care populations includes risk markers for four Z code categories as well as risk markers for the top 15% of socially vulnerable zip codes, using the Centers for Disease Control and Prevention Socially Vulnerable Index information at the census tract level aggregated to the zip code level.
- **Florida** includes HRSN in its diagnostic-based risk adjustment methodology for MCO premiums. Specifically, housing insecurity (Z Code “Z59”) is a weighting factor for MCO risk adjustment.
- **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.^{35, 36}
- **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 and procurements referenced in this section.

H. Addressing HRSN through Community Engagement, Partnerships and/or Investments

States are increasingly incorporating requirements into their contracts that direct their MCOs to engage the communities they serve to understand and address community-specific HRSN. Some states go further by stipulating how MCOs can use and distribute any profits or earned incentive dollars back into their communities. The way in which states incorporate these requirements takes different forms and applies varying levels of accountability. Examples are below. (See [Table 10](#) in **Appendix B** for specific language states are using in their contracts related to community engagement to address HRSN.)

- **Arizona, California, Georgia, Michigan, 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.) For example, **Arizona** requires MCOs to “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 Medicaid lines of business to community reinvestment.”³⁷ Arizona’s long-term care procurement adjusts the community reinvestment contribution using a tiered approach dependent on the level of profit earned by the MCO. The required contribution will range from 4% to 10%.
- In addition, **Arizona** requires its MCOs to have a Quality Management/Performance Improvement Program that includes attendance and/or participation in applicable community initiatives, events, and/or activities as well as implementation of specific interventions to address overarching community concerns, including HRSN such as homelessness, employment, and community engagement.
- **Mississippi’s** model contract requires MCOs to devote at least 0.5% of capitation payments to HRSN projects and expects that MCOs will use the funds to partner with CBOs on HRSN initiatives. Similarly, **Florida’s** MMC procurement requires MCOs to establish community partnerships to provide HCBS, including with community organizations that support HRSN.
- **Pennsylvania** requires Physical HealthChoices MCOs to incorporate community-based providers into VBP arrangements to address HRSN. In addition, these MCOs must form Regional Accountable Health Councils (RAHC) to offer technical assistance (TA) to community-based providers. TA is designed to help these providers improve population health and equity and address HRSN of the regions; TA areas include data analytics and measurement, contract management and negotiations, and measuring return on investment. Similarly, Community HealthChoices MCOs must participate in a RAHC to support strategic planning and coordination on community initiatives to improve health outcomes and address regional HRSN.
- **Virginia** requires MCOs, as part of its community assessment and member engagement work, to develop and implement a HRSN Plan that identifies and seeks to address HRSN that exist among its members. The HRSN Plan must align with the state’s Quality Strategy and state initiatives to address HRSN, account for regional variances and opportunities, and be developed in partnership with CBOs. The Plan must include an action plan consisting of specific measurable objectives related to addressing housing stability and food security needs and discuss how it plans to facilitate and document closed loop referrals for members with identified needs.

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

III. Additional State Authorities to Advance HRSN

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 HRSN in ways that are not possible in fee-for-service Medicaid. In addition, states can utilize other federal authorities to address HRSN

among Medicaid enrollees. In its 2021 letter to states regarding HRSN,³⁸ CMS provides sub-regulatory guidance on existing authorities and states' abilities to address HRSN 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 HRSN-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 HRSN components in MMC.³⁹ Given the additional rules and federal terms and conditions related to 1115 waivers, these types of HRSN approaches are not highlighted in this toolkit. 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 HRSN interventions related to food, housing, transportation, and interpersonal violence/toxic stress.⁴⁰ [Appendix C](#) of this resources includes some MMC contract language excerpts that relate to these North Carolina 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 HRSN 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.

Appendix A: Medicaid Managed Care Procurement Questions Related to HRSN

This Appendix focuses on MMC procurement questions related to HRSN for 13 states with MMC procurements no earlier than 2018, including: **Arizona, California, Florida, Louisiana, Michigan, Minnesota, Mississippi, New Hampshire, North Carolina, Oregon, Pennsylvania, Texas, and Virginia**. Not every state MMC procurement is referenced and not every question related to HRSN is included. This Appendix is designed to give examples of the range of different HRSN procurement questions that state Medicaid agencies have used recently. It is not designed to be an exhaustive list. For example, Florida has multiple vignettes that include HRSN components but only one such vignette is included in this Appendix.

See [Appendix C](#) for a link to each state's MMC procurement.

Arizona's Managed Long Term Care RFP

In August 2023, the Arizona Health Care Cost Containment System released an RFP to solicit MCO participation to provide health care services to members of the Arizona Long Term Care System (ALTCS) who are elderly and/or who have a physical disability (EPD). The ALTCS RFP included HRSN bidder questions such as:

B3. The Offeror shall include in its response how the Offeror will address health inequities, health disparities, and/or structural and health-related social needs and promote equitable member care.

B4. The ALTCS E/PD member population is complex, and their care often involves a combination of services and providers to effectively meet their needs. Provide a detailed description of how the Offeror will develop and implement best practices for ALTCS Case Managers, and leverage ALTCS Case Management staff to meet the needs of individuals with complex conditions, to:...

- Assist members prior to, and throughout transitions,
- Coordinate social and community support services...,
- Identify, track, and manage outcomes for members with complex needs,,,

B9. ...Given the Offerors' role in serving people with complex clinical, behavioral health, and social needs, it is critical to address social risk factors. For each of the following populations, describe how the Offeror will provide timely access to services and supports as well as monitor outcomes. The Offeror shall also identify its strategy(ies) for addressing potential barriers to care, as well as best practices to be implemented.

- a. Members residing in rural communities,
- b. Members residing in Tribal communities,
- c. Members in need of community resources, and
- d. Members in need of Peer and/or Family Support services.

California's (Medi-Cal) MMC RFP

In February 2022, the California Department of Health Care Services released a MMC RFP to solicit MCO participation in regions where Medi-Cal offers members a choice of a commercial plan and a local initiative plan. The Medi-Cal commercial plan RFP included HRSN bidder questions such as:

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 managed care 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 Medi-Cal evaluation questions related to HRSN 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)...

Florida's MMC Intent to Negotiate (ITN)

In April 2023, the Florida Agency of Health Care Administration's (AHCA) released a competitive procurement to solicit MCO participation to provide acute and LTSS services to Medicaid members, including but not limited to those who are elderly and/or who have a physical disability. Florida has a number of different types of ITN submission requirements. Some response components are quantitative and automatically scored, others are narrative submissions and are either scored by evaluators or not initially scored but used by the state in best and final negotiations with highest ranking bidders. The Florida ITN also includes details on how the state will evaluate each scored ITN submission by question.

AHCA's statewide MMC ITN includes HRSN bidder questions such as:

Submission Requirement Component (SRC)# 1 – Birth Outcomes Narrative

For the three contracts identified..., the respondent shall provide descriptive information about the services used to improve birth outcomes, including the following:

- A description of partnerships the respondent has established with community-based organizations (CBOs) to improve birth outcomes,... what services will be provided by the CBO that lead to improved birth outcomes...
- A description of services the respondent has provided to enrollees to address health-related social needs that improve birth outcomes, including enrollee utilization data for each service.

SRC# 21 – Vignette – Coordination of Benefits

- Gabriel is a sixty-three-year-old man who has been homeless for the past two years. He survives by staying with relatives and friends but lacks any permanent sustainable housing. His car needs a new timing belt and does not run. Gabriel is currently unemployed and not looking for work, although he worked as a plumber in the past. Currently, he receives supplemental security income. His pertinent medical history includes congestive heart failure (CHF) and type 2 diabetes, which are both managed poorly. His pertinent mental health history includes depression with suicidal ideation and alcohol misuse. In the past 6 months he was treated in an emergency department two times for CHF, which resulted in 2 hospital admissions. After one hospital discharge, Gabriel was re-admitted within 21 days because of problems with medication availability and apathy stemming from his depression. A relative called a local homeless shelter for him, but Gabriel never followed up because he wasn't sure he would qualify and the last time he waited for a ride-sharing driver, he wasn't picked up. Gabriel has been a Medicaid recipient since 2019 and a member of the long-term care plan since December 2021.
 - The respondent shall describe its approach to coordinating care for an enrollee with Gabriel's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:
 - Health Risk Assessment
 - Care Coordination/Case Management
 - Disease Management
 - Service Planning
 - Discharge/Transition Planning
 - Utilization Management
 - Grievance and Appeals
 - Connections to Pathways to Purpose
 - Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

SRC# 6 – Expanded Benefits – Pathways to Prosperity

- The respondent shall identify and describe the Pathway to Prosperity expanded benefits it proposes to offer its enrollees and submit the per member per month cost of each following expanded benefit:
 - Pathway to Prosperity: Housing assistance
 - Pathway to Prosperity: Food assistance
 - Pathway to Prosperity: Non-medical transportation
 - Pathway to Prosperity: Tutoring, vocational training, and job readiness
- For each of the expanded benefits related to Pathways to Prosperity the respondent proposes to offer its enrollees, the respondent shall describe an implementation and evaluation plan.

SRC# 26 – Community Partnerships

- The respondent shall describe the extent to which it has established community partnerships with providers that create opportunities for reinvestment in community-based services....
- The respondent shall provide a list of CBOs with which the respondent has executed a formal contract for health-related services and supports in the upcoming contract period.... the respondent shall list the CBO name, ... the CBO principal address, the respondent's contract execution date, a description of the enrollee population(s) being served, a description of the health-related services and supports for said enrollees, whether the CBO contract was designed to directly improve birth outcomes of enrollees, whether the CBO contract was designed to directly improve mental health of child or adolescent enrollees, whether the CBO contract was designed to directly increase home and community based services for senior enrollees, regions where the CBO will provide services and supports, counties where the CBO will provide services and supports, whether there will be a closed-loop software system of referrals and service verification between the respondent and CBO, annualized financial investment into the CBO, annualized in-kind investment into the CBO, and whether the CBO has a representative on the respondent's committees or advisory boards.

Georgia's MMC RFP

The Georgia Department of Community Health released a MMC RFP in September 2023 seeking Care Management Organizations (CMOs) for its GA Families and GA Families 360° programs. Georgia's RFP questions related to HRSN included:

Mandatory Scored Item #19. Provide an overview of the Supplier's Care Management programs, including...:

- a. Plan for providing timely and effective screening and assessment and re-assessment;
- b. Plan for using screening and assessment tools will be used for each population at the relevant times;
- c. Strategies to use data and analytics to effectively stratify members into risk tiers;
- d. Care planning approach by risk strata;
- e. Approach to contacting and engaging members at appropriate intervals and with sufficiently early intervention;
- f. Plan to integrate admission, discharge, and transfer events into care management processes;
- g. How care managers will identify SDOH-related needs and how Supplier will track referral and follow-up, across a spectrum of special needs, at-risk populations, and particularly with respect to homeless members;
- h. Description of how Supplier will monitor and track its care management program performance, including both activities and outcomes;
- i. Plan for staffing its care management program with qualified individuals and implementing appropriate caseload sizes by risk strata;
- j. Tracking electronic records of assessments and plan of care, including making records available in timely fashion as appropriate to support care planning and any care transitions.

Louisiana's MMC RFP

The Louisiana Department of Health's Bureau of Health Services Financing (Medicaid) released a MMC RFP in June 2021. Louisiana's bidder questions related to HRSN included:

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.

Michigan's MMC RFP

In October 2023, the Michigan Department of Health and Human Services released an RFP to solicit MCO participation in its MMC Comprehensive Health Care Program. The procurement builds off the 2022 MIHealthyLife initiative to strengthen Medicaid services through new Medicaid health plan contracts. The RFP included HRSN bidder questions such as:

7. Describe the Bidder's proposed approach for population health, including an emphasis on prevention and whole person care, care management and disease management programs. Include the Bidder's specific objectives, monitoring strategy, a timeline and approach for continuous improvement, and anticipated outcomes and plan for evaluation.
 - The Bidder must account for priority populations for care management activities, including at a minimum, persons with disabilities, high-risk pregnancies, chronic condition-specific populations, Enrollees in CSHCS, children in foster care, and former foster care youth in Foster Care Transitional Medicaid, as well as individuals within those groups who screen positive for Health Related Social Needs including but not limited to: housing, food/nutrition and transportation. Bidders should outline other populations beyond this minimum set for which they prioritize care management as well as for other population health activities.

The response should describe the Bidder's proposed data-driven approach for identifying members for care and disease management programs. It should also include how the Bidder will use community-based care team members, including Community Health Workers, to connect enrollees to services that serve the whole person.

When citing relevant experience, the Bidder must clearly state what coverage program(s), state(s) and year(s) the experience comes from and how it will translate to a Michigan Medicaid context (e.g., total enrollees in coverage program, covered populations, covered services).

12. Describe three recent examples of using data analysis to inform and/or design strategies and interventions to improve the health status of targeted populations, including consideration of:

- Quality;
- Promotion of equitable outcomes; and
- Social Determinants of Health and enrollee Health Related Social Needs (including monitoring referrals to community-based social services and other resources to address social needs, tracking referral outcomes [e.g., confirmation that service was delivered as well as the type of service delivered to the Medicaid enrollee], and ensuring this information is shared with an Enrollee's care team to meet health related needs).

For each example, identify the types of data sources leveraged, explain how an issue was identified, what interventions were developed, how the impacts of the interventions were assessed and what outcomes were achieved.

Describe the Bidder's planned approach for using data to design interventions to support population health management in Michigan, including specific objectives and a timeline for implementation.

When citing relevant experience, the Bidder must clearly state what coverage program(s), state(s) and year(s) the experience comes from and how it will translate to a Michigan Medicaid context (e.g., total enrollees in coverage program, covered populations, covered services).

16. Describe the Bidder's approach for addressing Enrollee Health Related Social Needs and promoting health equity, including how the Bidder will deploy the following:

- Using a data-informed approach to proactively identify Enrollees who may have HRSN and would benefit from Social Services;
- Connecting Enrollees to Social Services to address HRSN through a medically appropriate, cost-effective, equitable, and nondiscriminatory process that leverages community-based care teams (such as Community Health Workers);
- Managing a network of Providers to offer Social Services to eligible Enrollees;
- Sharing data and tracking referrals to Social Services to address HRSN (including outcomes); and
- Monitoring and providing oversight to ensure Social Services are provided in a medically appropriate and cost-effective way.

The narrative should address how the Bidder will leverage HRSN screening, In Lieu of Services (ILOS), and Community Reinvestment in their approach.

When citing relevant experience, the Bidder must clearly state what coverage program(s), state(s) and year(s) the experience comes from and how it will translate to a Michigan Medicaid context (e.g., total enrollees in coverage program, covered populations, covered services).

The Bidder's response must also reflect how the Bidder's approach differs in counties with Large Metro, Metro, Micro, Rural and CEAC geographic designations. Bidders must only address geographic designations that are present in the regions in which they are bidding (see Table 1, page 2).

17. Describe the Bidder's proposed approach to working with and supporting Community Based Organizations (CBOs) through sustainable financing arrangements to provide Social Services, such as through partnerships related to community reinvestment. The approach should describe how the Bidder will ensure community capacity to deliver Social Services to address HRSNs, anticipated investments, funding, objectives, potential partners, expected impact, and how that aligns with MDHHS goals to address SDOH and provide whole person care by supporting Enrollees' physical, mental and social health, and advancing health equity. Bidder must describe its approach to expanding their current set of agreements with Michigan-based CBOs, as applicable.

The Bidder is expected to complete Schedule M regarding the Bidder's current agreements with CBOs.

The Bidder must also submit one letter of support from a CBO that the Bidder has an active agreement with to provide social services:

- For Bidders currently contracted with Michigan Medicaid, the letter must come from a Michigan CBO.
- For Bidders not currently contracted with Michigan Medicaid, the letter must come from a CBO in the Medicaid market used to populate Schedule M.
- For Bidders not currently contracted with Michigan Medicaid and without recent Medicaid experience, the letter must come from a CBO in the market used to populate Schedule M.

The letter must include:

- Information on any affiliation the organization has with the Bidder;
- Location of the CBO;
- The length of time the Bidder has had an agreement with the CBO to provide services;
- The types of Social Services the organization is contracted with the Bidder to provide; and
- Any demonstrated impact on HRSNs.

The letter of support must be no longer than two pages and does not count toward the page limit in this section. Bidders are limited to submitting one letter of support; additional letters or letters that do not adhere to the instructions above will not be reviewed. Use the following file naming convention for the letter of support: [Bidder Name]_Schedule G_Question 17_CBO Letter.

Minnesota's MMC RFPs

In January 2021 and again in January 2022, Minnesota's Department of Human Services released competitive RFPs to solicit MCOs to provide prepaid healthcare services to eligible individuals through the Families and Children Medical Assistance and MinnesotaCare contracts. The 2021 RFP focused on the seven metropolitan counties and the 2022 RFP focused on providing services to MMC members in the 80 counties outside the Minneapolis/St. Paul metropolitan area.

Minnesota's bidder questions in the 2021 MMC RFP related to HRSN included questions 1 through 4 below. The 2022 MMC RFP in the non-metro areas included questions 1 and 5 below:

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 has your organization approached disparities in well child visits? What have you learned from these efforts and how will you apply these learnings to future efforts? How are you connecting families to broader social supports?
3. How does your organization use value-based purchasing or other incentive arrangements to address social drivers of health to improve quality of care and health outcomes?
4. Describe how you define, evaluate, and ensure the adequacy of your provider networks, beyond what is required under Minnesota Statutes, section 62D.124 and the MHCP contracts. Describe how you ensure the availability of providers of services often unique to the Medicaid program and who are positioned to address social risk factors.
5. 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 (RFQ)

In November 2021, Mississippi's Division of Medicaid's (DOM) released a Medicaid and CHIP managed care procurement to solicit Coordinated Care Organization (CCO) participation in the state's Medicaid managed care program, known as MississippiCAN. The RFQ included HRSN bidder questions such as:

4.2.2.3 Care Management

B. Stratification and Assignment

5. 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.

C. Care Management Services

1. 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.

4.2.3.3. Social Determinants of Health (SDOH)

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.

4.2.3.9 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

New Hampshire's MMC RFP

In September 2023, New Hampshire's Department of Health and Human Services, Division of Medicaid Services released a managed care procurement to solicit MCO participation in the state's Medicaid managed care program, known as New Hampshire Medicaid Care Management (MCM). The RFP included HRSN bidder questions such as:

9.2 *Member Assessment, Screening, and Referral*

The Health Risk Assessment (HRA) screening tool is important to help identify areas of opportunity to improve patient health and equitable access to care for all Members. Under the new Model of Care, PCPs are expected to facilitate HRA screenings with Members. In New Hampshire, utilization of HRA screenings to determine care needs and health-related social needs averages less than twenty percent (20%). Assessment and identification of patient engagement readiness, barriers and opportunities is necessary to effectively establish a Member Care Plan. Please describe:

- How the Respondent will transition HRA screenings to PCPs.
- How the Respondent will archive and utilize HRA information facilitated by Member PCPs to support MCO-Delivered Care Management.
- What practices the Respondent will put in place for the transfer of information to and from the Provider for purposes of supporting concurrent Provider-Delivered Care Coordination and MCO-Delivered Care Management.
- How the Respondent will incentivize the Provider and Member to increase HRA completion rates, and follow through with referrals identified care gaps.

10. *Care Coordination and Care Management*

Care Management and Care Coordination services are fundamental to the added value the Department seeks through its MCO partnerships. In this section, the Department seeks responses that clearly

describe the Respondent's strategies for Provider-Delivered Care Coordination and MCO-Delivered Care Management programs targeted to improve Member care and health outcomes. Under the MCM program's Primary Care and Prevention Focused Model of Care, the MCO is responsible for ensuring effective management, coordination, and Continuity of Care for all Members, including oversight of Provider-Delivered Care Coordination responsibilities for the PCPs' attributed Members. The MCO is responsible for MCO-Delivered Care Management Services for Required Priority Populations as described in the MCM Model Contract (Section 4.11.2.2).

- Q43 Describe Respondent's plan for operationalizing MCO-Delivered Care Management, including:
- 1) The process and timing for conducting a Comprehensive Assessment for the Required Priority Populations;
 - 2) Description of processes, services, and activities the Respondent will undertake to support Care Management for Required Priority Populations including, at a minimum, the coordination of physical, behavioral health and social services, medication management review, referral follow-up, peer support, training on self-management, assistance with meeting unmet resource needs, and the convening of Care Teams, including the frequency of such meetings as well as integration with Provider-Delivered Care Coordination;...

10.5 Priority Population Specialty Services and Programs

- Q49 Understanding New Hampshire's priorities described throughout the RFP, please describe:
- 1) Value-Added Services, In Lieu of Services, or other initiatives the Respondent proposes for introduction to effectively address health-related social needs;
 - 2) The Respondent's experience with addressing health-related social needs identified in Comprehensive Health Assessments and how "warm handoffs," closed-loop referrals, or other approaches to help Members secure needed services are integrated into Provider-Delivered Care Coordination strategies;
 - 3) Specific examples of how the Respondent has supported these functions in other Medicaid markets, including results and measurable outcomes achieved from the Respondent's applied interventions; and
 - 4) The community-based relationships and processes the Respondent will utilize for Member referrals and follow-up to community-based social services in order to ensure Members are successful in securing unmet resource needs.

North Carolina's MMC RFP

North Carolina's Department of Health and Human Services, Division of Health Benefits released a Prepaid Health Plan (PHP) Services RFP in August 2018. North Carolina's bidder questions related to HRSN include:

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 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 (RFA)

In 2019, the Oregon Health Care Authority released a competitive RFA to solicit Coordinated Care Organizations (CCO) participation to provide healthcare services to Medicaid members. The following questions come from Attachment 10 of the RFA on Social Determinants of Health and Equity:

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 RFA

In 2019, Pennsylvania's Department of Human Services released a competitive RFA to solicit MCO participation in the Physical HealthChoices program across five regions and all counties of the Commonwealth. Pennsylvania's 2019 Physical HealthChoices RFA bidder questions related to HRSN include:

- 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 Physical HealthChoices Program.
- 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.
- 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 RFP

In March 2022, Texas released a STAR+PLUS RFP. STAR+PLUS is a MMC program for adults who have disabilities or are age 65 or older. Adults in STAR+PLUS get healthcare and long-term services and support through an MCO. Texas' STAR+PLUS bidder question related to HRSN follows:

- 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.

Virginia Cardinal Care Managed Care RFP

In August 2023, the Virginia Department of Medical Assistance released a competitive procurement to solicit MCO participation to provide acute and LTSS services to the vast majority of Medicaid members, including but not limited to those who are in foster care, those who are elderly and/or who have a physical disability. Virginia's Cardinal Care Managed Care RFP includes the following bidder questions related to HRSN:

- Behavioral Health (Mental Health/SUD):

Vignette: Describe how the Offeror would support the following Member. James is a 33 year old member with diabetes, hypertension, SUD/ODU, and depression. He has not seen a dentist since he was a child and is self-conscious about his appearance. James is often without work and does not have stable housing for his family. James wants to find stable employment and be a better role model for his two young kids, but that is difficult as he cycles in and out of recovery and the family often moves due to housing insecurity. James only recently enrolled in Medicaid, as he is not confident in the health care system or its providers.

- Children and Youth Primary Care/ Well Child Visits and EPSDT

Vignette: Describe how the Offeror would support the following Member: Noah is a six year old for whom English is a second language. He struggles with classroom learning. Noah is behind on immunizations and well-child visits due to language/cultural barriers. Noah's mother is struggling with early pregnancy symptoms. Transportation is an issue for the family. In addition, Noah's mother prefers staying in their neighborhood, and usually just goes to places within walking distance.

- In Lieu of Services (ILOS) and Enhanced Benefits:

9. Describe in lieu of services (ILOS) the Offeror proposes to offer, your rationale for offering such services including improved outcomes for members receiving the services, experience offering ILOS to similar populations, and commitment to work with the Department to develop and obtain CMS approval for services connected with Members' behavioral health, maternal health, or HRSNs.

- Health-Related Social Needs and Community Reinvestment

10. Describe the Offeror's experience with and effectiveness identifying and addressing HRSN for Medicaid populations similar to those included under this Contract and how you plan to apply that experience to the CCMC program....The Offeror's response should include, at a minimum:

- a. Specific strategies or initiatives the Offeror proposes to implement to address the priority social needs of the CCMC population, with focus on housing supports and food security.
- b. Collaborating with stakeholders to address Members' HRSN, including with community care hubs, health care providers, local public agencies, and community-based organizations for the Virginia CCMC Program. Describe the type and scope of proposed partnership(s), including specific services and/or functions to be carried out through or in tandem with the partnership (e.g., care transitions).
- c. Providing non-medical resource supports to Members, such as Community Health Workers, to address HRSN
- d. Addressing HRSN at the individual Member-level and at the Population-level, including how the Offeror uses HRSN data to identify and address predominant HRSN and what the Offeror does to support its Members once an HRSN is identified.

- Care Management:

13. Describe the Offeror's experience with using care management "extenders" (e.g., Virginia Board of Certification-certified Community Health Workers or DBHDS-certified Peer Support Specialists) to support select non-clinical care management activities.

Appendix B: Medicaid Managed Care Contract⁴¹ Language – State Examples

Table 3: Approach A

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management	
State	MMC Contract/Procurement Language
Arizona	<p>Whole Person Care Initiative</p> <p>The Contractor shall join the AHCCCS-Approved Closed-Loop Referral System (CLRS) and actively encourage provider network utilization of the CLRS to refer members to Community Based Organizations (CBOs) that provide services addressing HRSN. The Contractor's Care Management staff shall utilize the CLRS to screen and refer each member on their caseload annually at a minimum. Additionally, the Contractor shall partner with the Health Information Exchange/Health Information Organization (HIE/HIO) to outreach to CBOs to participate in the CLRS.</p> <p>Additional Required Staff:</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 Permanent Supportive Housing and resources within the Contractor's service area. The Housing Specialist may be designated as the expert in other areas as well as housing, but they shall be clearly identified and function as the Housing Specialist. While the Contractor shall have at least one designated Housing Specialist, the Contractor shall have sufficient housing staffing reporting to the Housing Specialist to ensure there is coverage in each Geographic Service Area the MCO operates out of, to ensure there is coverage based on 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"> 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 Housing 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, 2. Provide education and training to providers and support staff on supportive housing and evidence-based practices related to housing services, 3. Supporting provider case managers and network support staff with identifying members with housing needs, making appropriate housing referrals to AHCCCS Housing Programs mainstream housing programs and other housing resources for individuals with housing needs, 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,

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Arizona (continued)	<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 Quarterly Housing 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, AHCCCS, and mainstream subsidized housing programs, receive 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>Care Management Programs 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>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. 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>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
California (continued)	<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>Contractor’s Responsibilities for Administration of ECM</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> <p>F. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources.</p> <p>Review of Utilization Data: Contractor must monitor utilization data to appropriately identify Members eligible for ECM and Community Supports.</p>
Florida	<p>Pathways to Prosperity Initiative Screening and Referrals</p> <p>The Managed Care Plan’s procedures shall address the following minimum functions:</p> <ol style="list-style-type: none"> (1) How results of the Pathways to Prosperity screening are utilized by the MCP to initiate access to care coordination/case management services. (2) How findings of the Pathways to Prosperity screening ensure access to the array of expanded benefits that address barriers to overcoming barriers to employment,

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Florida (continued)	<p>economic self-sufficiency, independence, and achieve inclusion and integration into society.</p> <p>(3) How findings of the Pathways to Prosperity screening ensures referrals to the community partner network for housing assistance, food sustainability, vocational training, and educational support services through Hope Florida: A Pathway to Prosperity and other community resources.</p> <p>(4) Appropriate support to case managers, enrollees, and caregivers, as needed, for referral and scheduling assistance to access community support services.</p> <p>(5) Coordination between the Managed Care Plan’s case managers and Hope Navigators to ensure effective use of resources.</p> <p>(6) The interoperability of the Managed Care Plan’s case management documentation system that will integrate information from providers, including their interface with the integrated data and tracking system for targeting services and supports to address health-related social needs.</p> <p>(7) Documentation in the enrollee record of referrals to community programs and follow up on the enrollee’s receipt of services from community programs (closed loop referral system).</p>
Georgia	<p>Care Management</p> <p>17.3.3 The Contractor must engage in Risk Stratification and assign Members as Low-Risk Members, Moderate-Risk Members, or High-Risk Members. Risk Stratification must be, at minimum, Claims based, per clinical Conditions and/or Utilization data that indicate elevated Member risk. Factors regarding Social Determinants of Health can be overlaid to refine Risk Stratification. This Risk Stratification is subject to change at DCH’s discretion.</p> <p>17.3.6 Care Management activities and outcomes, for each Risk Status level must include, at a minimum:</p> <p>17.3.6.1 Keeping Members well, supporting self-care, and community integration;...</p> <p>17.3.6.5 Identifying and addressing any SDOH needs;...</p> <p>17.3.6.7 Addressing the full range of social, behavioral, environmental, and Health Care needs of the individual.</p> <p>17.6.1 The Contractor must support Care Managers to directly provide and / or partner with Community-Based Organizations (CBOs) to address SDOH-related needs by ensuring the active referral to and follow-up on identified needs related to SDOH.</p> <p>17.6.1.1 The Contractor must identify reimbursable education, evaluation & management, and / or treatment-associated billing codes that correlate with SDOH codes (z codes), where appropriate and subject to DCH written approval;</p> <p>17.6.1.2 The Contractor must follow-up after referral to confirm if the Member engaged and that the Member received the service; and</p> <p>17.6.1.3 The Contract must report on performance of Closed Loop Referral Management</p> <p>17.7.3 The Contractor must provide a quarterly Population Health Report ...including, but not limited to the following:</p>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Georgia (continued)	<p>17.7.3.1 DCH will require the Contractor to report on its efforts and activities to improve care of Members, detailing efforts and activities for Low-Risk, Moderate-Risk and High-Risk Members.</p> <p>17.7.3.2 DCH will require reporting of goal attainment for Medical and non-medical needs (e.g., SDOH) for Members under monthly Care Review process...</p> <p>17.7.3.3 The Contractor must report and improve metrics associated with Utilization of services to address SDOH needs.</p> <p>17.9.2 Case Management functions include, but are not limited to:</p> <p>17.9.2.3 Assessment of a Member's risk factors such as over-Utilization and / or under-Utilization of services, inappropriate use of services, non-adherence to established Care Plan and / or Treatment Plan or lack thereof, lack of education or understanding of current Condition(s), lack of support system, financial barriers that impede adherence to Care Plan, compromised patient safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities;</p> <p>17.9.2.4 Development of a personalized, patient-centered process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value. This process is consistent with Evidence-Based guidelines and includes established goals that are specific and measurable, with emphasis on Member education in order to facilitate shared decision making and self-management. Priorities of Case Management include identifying needs, ensuring access to services / resources; addressing Social Determinants of Health, and facilitating safe Transitions of Care.</p>
Iowa	<p>Health Risk Screening Tool: 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>Health Needs Assessment Instrument (HNA): 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. HNA questions shall include:</p>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Louisiana (continued)	<ul style="list-style-type: none"> • 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; • Questions to identify Enrollees’ needs for culturally and linguistically appropriate services including, but not limited to, hearing and vision impairment and language preference; • Questions to identify the Enrollee’s health concerns and goals; • Questions to identify potential gaps in care; and • Questions to identify Enrollees’ health-related social needs, including housing, food insecurity, physical safety, and transportation.
Massachusetts	<p>Coordinating Care for Enrollees</p> <p>The Contractor shall ensure that care for all Enrollees is coordinated.</p> <p>A. Baseline Care Coordination</p> <ol style="list-style-type: none"> 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"> 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; b. In accordance with Section 2.5.B, ensuring Enrollees are screened for physical health, Behavioral Health, LTSS, and Health-Related Social Needs; c. Coordinating with service providers, community services organizations, and state agencies to improve integration of Enrollee’s care; 4. For Enrollees with identified Health-Related Social Needs (HRSN), the Contractor shall: <ol style="list-style-type: none"> a. Provide the Enrollee with information about available HRSN-related supports, how to contact such supports, and the accessibility of such supports; b. Ensure such Enrollees are referred to HRSN-related supports provided by the Contractor and a Social Service Organization as applicable; <ol style="list-style-type: none"> 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. 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. c. Ensure that its strategy for coordinating HRSN supports is integrated with the Contractor’s overall health equity strategy; 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;

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Massachusetts (continued)	<p>e. Utilize its Community Resource Database, as described in Section 2.15.E.7, to identify supports; and</p> <p>f. Consider referral to the Flexible Services Program, as set forth in Section 2.22, SNAP, WIC, or related programs to address Enrollee’s needs;</p> <p>Care Delivery</p> <p>Health Related Social Needs Screening</p> <p>a. The Contractor shall conduct a Health-Related Social Needs (HRSN) screening for all Enrollees upon enrollment and annually thereafter.</p> <p>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.</p> <p>c. Health Related Social Needs screenings shall:</p> <ol style="list-style-type: none"> 1) Be made available to Enrollees in multiple formats including through the internet, print, and telephone; 2) Include disclosures to the Enrollee about how information will be used; 3) Describe potential services or assistance available to the Enrollee for identified needs; 4) Screen all Enrollees for needs in the following domains <ol style="list-style-type: none"> a) Housing insecurity; b) Food insecurity, such as lack of access to healthy, culturally appropriate foods; c) Economic stress, including lack of access to utilities, including heating and internet; d) Lack of access to transportation; and e) Experience of violence 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"> a) For Enrollees up to the age of 21, needs in school or early childhood education-related services and supports; b) For Enrollees between the age of 21 and 45, needs for employment supports; c) For Enrollees 45 years and older, social isolation. <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"> 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"> a) Housing supports b) Nutrition supports c) Utility assistance, including heating and access to the internet; d) Transportation services; e) Support for Enrollees who have experienced violence; f) Education supports and services for pediatric Enrollees, including early childhood education-related supports;

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Massachusetts (continued)	<p>g) Employment assistance; and h) Support for social isolation;</p> <p>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;</p> <p>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.</p> <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 Section 2.22, as appropriate and as further specified by EOHHS.</p> <p>Care Plans (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>
Michigan	<p>Care Management Services</p> <p>c. Contractor must offer a robust care management program that meets NCQA and/or URAC accreditation standards to Enrollees who qualify for care management services, and other subpopulations as designated by MDHHS, including but not limited to disabled populations, high-risk pregnancies, and populations with chronic conditions, Enrollees in CSHCS, Children in Foster Care and former foster care youth in Foster Care Transitional Medicaid. When determining additional Enrollees to offer robust care management services, Contractor should consider Health Related Social Needs, including but not limited to: housing, food/nutrition and non-medical transportation.</p> <p>f. Contractor must help Enrollees obtain Social Services to address Health Related Social Needs, including access to safe and affordable housing, food, fuel assistance and non-medical transportation. To the extent possible, these services (i-vi below) must be offered by or coordinated with the Enrollee’s care team. Contractor must:</p> <ul style="list-style-type: none"> i. Conduct Enrollee assessments to identify and address Health Related Social Needs when an Enrollee screens positive. ii. Refer Enrollees to community-based Social Services and other resources to address Health Related Social Needs even if they are not Covered Services under this contract. iii. Ensure Enrollees receive all necessary services, including ILOS, to close any gaps in care and address the Enrollee’s Health Related Social Needs. iv. Coordinate health and Social Services between settings of care, delivery systems, and programs, with ILOS providers and other community-based

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Michigan (continued)	<p>resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;</p> <ul style="list-style-type: none"> v. Track and report on outcomes of Social Service referrals in coordination with community health workers, service providers, and other community-based social services including but not limited to ILOS providers and other community-based providers. vi. Assist members in applying for public benefit programs, including but not limited to WIC, SNAP, TANF, and utility and weatherization programs, and using MI Bridges. <p>Targeted Interventions for Subpopulations Experiencing Health Related Social Needs and Health Disparities "Contractor must offer evidence-based interventions that have a demonstrated ability to address Social Determinants of Health and reduce Health Disparities to all individuals who screen positive for Health Related Social Needs. To the extent possible, these services must be offered by or coordinated with the Enrollee's care team." ...</p>
Mississippi	<p>Care Management: 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>Comprehensive Health Assessment 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>Health Needs Assessment 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 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>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Nevada (continued)	<p>Care Management Program Description</p> <p>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:</p> <p>...</p> <p>Care Coordination Process</p> <p style="padding-left: 40px;">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;</p> <p>...</p> <p style="padding-left: 40px;">Process for referrals to community resources and ensuring Members actually access needed resources;</p> <p>...</p> <p>Case Management Process</p> <p>...</p> <p style="padding-left: 40px;">Processes and tools to identify and address social determinants of health;</p> <p>Member Stratification</p> <p>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>Care Coordination Reporting</p> <p>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> <p>Case Management Priority Conditions</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 style="padding-left: 40px;">Homeless/Transient Status</p>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
North Carolina	<p>Care Coordination for All Members</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>Identification of High-Need Members Needing Care Management</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>Provision of Care Management for High-Need Members</p> <p>(b) Care Management Services</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. 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>
Ohio	<p>Care Coordination Requirements</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</p>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Ohio (continued)	<p>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> <ol style="list-style-type: none"> 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.
Texas	<p>STAR+PLUS Assessments</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>Service Planning for Members</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> <ol style="list-style-type: none"> 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. 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.

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Texas (continued)	<p>Transportation needs; and j. Social needs including housing insecurity, substandard housing, social isolation/loneliness, food insecurity, and financial insecurity.</p> <p>7. A list of Covered Services required, and their frequency, including any existing referrals and PAs;</p> <p>8. A description of who will provide the Covered Services; and</p> <p>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.</p> <p>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;</p> <p>11. How Service Coordination will be provided: either in person or by telephone contact;</p> <p>12. How a Member or Provider can reach a Service Coordinator.</p> <p>Referral to Community Organizations</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> <p>STAR & CHIP Service Coordination in the Prenatal and Postpartum Periods</p> <p>Service Coordination in the Prenatal Period</p> <p>...Based on the Member’s needs and conditions, the MCO may make subsequent contact efforts during the third trimester or after the 28th week of pregnancy to assess the Member’s condition and access to care, to make necessary adjustments to the Member’s SP, and to educate the Member about community organizations, including those that provide home visiting, that can meet medical or social needs immediately before or after delivery.</p> <p>Service Coordination in the Postpartum Period</p> <p>...During each postpartum contact, the MCO must:</p>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Texas (continued)	<p>1. Assess the Member’s current medical or social needs and concerns.</p> <p>2. Update the SP with information about needed Covered Services, Non-capitated Services, and non-covered services as Medically Necessary to plan for access to services and Continuity of Care when the Member’s STAR or CHIP enrollment ends. This may include providing referrals to providers in other programs such as Healthy Texas Women the HHSC Family Planning Program.</p> <p>3. Ensure the Member is attending postpartum visits and coordinate supports such as transportation.</p>
Virginia	<p>Risk Stratification ... The Contractor’s risk stratification/scoring methodology should use, as available, the following data sources: ... 11. Referrals from social services;</p> <p>Priority Populations for Care Management Members may be identified as one of three Priority Population groups for assignment to Care Management (or Care Coordination, as appropriate): Mandatory High Priority, Mandatory Priority Populations and MCO Determined Priority.</p> <ul style="list-style-type: none"> • Mandatory High Priority Populations: The Contractor must assign each Member identified as Mandatory High Priority to High Intensity Care Management. For Members who are assigned to the Mandatory High Priority population on a time-limited basis, the Contractor may re-stratify and move those individuals to lower intensity levels of Care Management based on the Member’s need/risk and/or at the Contractor’s discretion. • Mandatory Priority Populations: The Contractor must assign each Member identified as a Mandatory Priority Population to either Low, Moderate, or High Intensity Care Management, depending on the Member’s needs and risk level. The Contractor is not permitted to assign the Member to Care Coordination. • MCO-Determined Priority Populations: The Contractor has discretion to assign MCO-Determined Priority Populations to Care Coordination or Care Management. If the Contractor determines a Member in this population requires Care Management, the Contractor has discretion to assign the Care Management intensity level it deems appropriate based on the Member’s needs and risks. The Contractor may use the data sources outlined above in Section 8.4.1, Risk Stratification, to identify Members for assignment to either Care Management or Care Coordination. <p>...</p> <p>MCO-Determined Priority populations include Members who meet any of the following criteria: ... 5. Members with High Social Needs a. Members experiencing homelessness; b. Justice-involved populations, which includes individuals who have a history of incarceration, detention, probation or parole supervision; and c. Members who have other high social needs that pose a significant risk to their health, safety and welfare, as determined by the Contractor.</p> <p>Health Risk Assessments (HRA) Tool</p>

Table 3: Approach A: Contract Language Identifying and Addressing HRSN, Including Within MCO Care Coordination/Management

State	MMC Contract/Procurement Language
Virginia (continued)	<p>At a minimum, the Contractor’s HRA must effectively identify: 1. The Member’s functional, medical, behavioral, cognitive, LTSS, wellness and preventive, and social needs (such as housing, informal supports, and employment) in addition to any other unmet needs; ...</p> <p>Care Plan (ICP) Required Elements</p> <p>The Contractor must include the following elements in each Member’s ICP. Other elements may also be necessary depending upon the Member’s circumstances. Required elements include but are not limited to:</p> <p>...</p> <p>4. Strategies and actions to address all needs of the Member, including functional, medical, behavioral, cognitive, social, LTSS, safety, wellness and preventive needs.</p> <p>5. Strategies to address social needs may include providing linkages to community-based resources and information on service providers and referrals (social needs are related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and informational supports, and personal goals (e.g., attend school, have a job);</p> <p>6. Actions to address Member needs must include who is attending to the needs such as treating providers, community entities, referrals to other resources, etc.;</p> <p>...</p> <p>Care Management Extenders</p> <p>“The Contractor is encouraged to utilize staff Care Management “extenders” who are not required to meet the minimum qualifications of a Care Manager but are qualified to complete select non-clinical, Care Management activities such as appointment scheduling, coordinating social services, and completing specific non-clinical paperwork/documentation, problem solving in response to complaints and concerns as well as leveraging any specialized expertise and experience in building trusted, authentic relationships with Members. Care Management Extenders must work under the supervision of the Care Manager. Care Management extenders may include Virginia Board of Certification-certified Community Health Workers, DBHDS-certified Peer Support Specialists, housing specialists, and non-specialized administrative staff employed by or under contract with the Contractor.</p> <p>Extenders may not render clinical assessments or deliver clinical care to Members, and the Contractor must ensure the extenders receive adequate oversight and supervision from qualified Care Managers.</p> <p>In order to account for staffing efficiencies generated by employing extenders, the Contractor will have the opportunity to reduce Care Manager staffing levels based on the number of employed extenders. For each FTE-equivalent extender employed by (or subcontracted with) the Contractor, the maximum number of Members for the Care Manager staffing ratios described in Section 8.4.4, Care Manager Staffing Ratios, will be increased by 20% for a corresponding FTE Care Manager. For example, if a Contractor employs two FTE extenders, two corresponding FTE Care Managers will be permitted serve 20% more Members. The Contractor will be permitted to apply extender staffing ratio “credits” on a blended basis.”</p>

Table 4: Approach B

Table 4: Approach B: Contract Language Requiring Use of ICD-10 Z Codes	
State	MMC Contract/Procurement Language
Arizona	"The Contractor shall monitor, promote, and educate providers on the use and importance of SDOH International Classification of Diseases, Tenth Revision (ICD-10) codes, commonly known as "Z" codes. These codes shall be included on claims to support data collection on the HRSN experienced by AHCCCS members."
Florida	<p>The MCP shall:</p> <p>"Require primary care providers to conduct screening of at least 95% of enrollees for health-related social needs using an Agency approved screening tool and record the identified ICD-10 codes in the enrollee's electronic health record. For providers participating as PCPs, require such providers to assess each enrollee's health-related social needs, document identified needs in the enrollee record utilizing the ICD-10-CM Z-codes identified in Table 8, Z-Codes for Health Related Social Needs, below, and provide such codes via claims submissions to the MCP. The following Z-codes are used to identify socioeconomic and psychosocial circumstances:</p> <p>TABLE 8 Z-CODES FOR HRSN: (ICD-10-CM Code - Code Description)</p> <ul style="list-style-type: none"> • Z55 Problems related to education and literacy • Z56 Problems related to employment and unemployment • Z57 Occupational exposure to risk-factors • Z58 Problems related to physical environment • Z59 Problems related to housing and economic circumstances • Z60 Problems related to social environment • Z61 Problems related to negative life events in childhood • Z62 Other problems related to upbringing • Z63 Other problems related to primary support group, including family circumstances • Z64 Problems related to certain psychosocial circumstances • Z65 Problems related to other psychosocial circumstances
Georgia	"The Contractor must identify reimbursable education, evaluation & management, and / or treatment-associated billing codes that correlate with SDOH codes (z codes), where appropriate and subject to DCH written approval;"
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>PCMH Screening for SDOH</p> <p>The Physical HealthChoices 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</p>

Table 4: Approach B: Contract Language Requiring Use of ICD-10 Z Codes	
State	MMC Contract/Procurement Language
Pennsylvania (continued)	<p>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>Maternity Care Bundled Payment “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

Table 5: Approach C: Contract Language Encouraging Use of Value-Added Services to Address HRSN	
State	MMC Contract/Procurement Language
Florida	<p>“The MCP may offer the following expanded benefits: ...</p> <p>c. Services and benefits to advance Pathway to Prosperity in the following domains: housing assistance, food assistance, non-emergency transportation, life skills development, and K-12 tutoring.</p> <p>3. Changes to Expanded Benefits Offered</p> <p>a. The Managed Care Plan’s expanded benefits may be changed on a Contract year basis in a manner and format approved by the Agency, if determined by the Agency to be beneficial to the enrollees.</p> <p>b. The Managed Care Plan may increase its expanded benefits upon approval by the Agency.</p> <p>c. The Managed Care Plan may exchange an expanded benefit for another, if determined to be actuarially equivalent by the Agency, upon approval by the Agency.”</p>
Georgia	<p>“The Contractor must identify gaps in services and resources that prevent fulfillment of goals and needs identified by Care Plans and use this analysis (“Care Plan Insights Report”) to guide its approach for Value-Added Services, In-Lieu-of Services, and community re-investment as well as other Quality improvement activities.”</p>
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>
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>Social Determinants of Health</p> <ul style="list-style-type: none"> • 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 • Utility payment assistance • Pest Control/Bed Bug home treatment • 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”
Virginia	<p>“Examples of potential enhanced benefits for the Managed Care program population may include, but are not limited to, social determinants of health interventions, chiropractic care, environmental modifications and assistive technology for non-CCC Plus HCBS waiver</p>

Table 5: Approach C: Contract Language Encouraging Use of Value-Added Services to Address HRSN	
State	MMC Contract/Procurement Language
	members, supports for pregnant women, vision, hearing, and personal care services for individuals who do not meet waiver or EPSDT criteria.”

Table 6: Approach D

Table 6: Approach D: Contract Language Encouraging Use of ILOS to Address HRSN	
State	MMC Contract/Procurement Language
California	<p>Community Supports</p> <p>DHCS Pre-Approved Community Supports</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>Community Supports Providers</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>Community Supports Provider Capacity</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>Community Supports Model of Care (MOC)</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>Referring Members to Community Supports Providers for Community Supports</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> <p>Data System Requirements and Data Sharing to Support Community Supports</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>

Table 6: Approach D: Contract Language Encouraging Use of ILOS to Address HRSN	
State	MMC Contract/Procurement Language
Florida	<p>“The MCP may provide the following in lieu of services subject to Agency review and approval:</p> <p>...</p> <p>(8) Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.</p> <p>...</p> <p>(17) Housing Assistance and Targeted Case Management for people with homelessness or at risk for homelessness and diagnosis of SMI and/or SUD in lieu of emergency department visit or inpatient hospitalization for SMI and/or SUD.</p> <p>(18) Functional family therapy in home or community for children or adolescents with a history of justice involvement or at high risk for justice involvement in lieu of outpatient clinic visits, emergency department visits, or inpatient hospitalization.”</p>
Michigan	<p>“Contractor is strongly encouraged to provide MDHHS pre-approved ILOS to address food insecurity as a cost-effective alternative to other covered services under the state plan and when the use of such alternative services is medically appropriate (42 CFR 438.3(e)).”</p>
New Hampshire	<p>“The Department has authorized critical time intervention (CTI) services, diabetes self-management, and assistance in finding and keeping housing (not including rent), as In Lieu of Services (subject to CMS approval, as appropriate). This list may be expanded upon or otherwise modified by the Department through amendments of this Agreement, and CMS approval, as appropriate.”</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"> i. Prevention programs ii. Services provided by Traditional Health Workers iii. Community transition services iv. Enhanced case management v. Post-hospitalization recuperative care vi. Lactation consultations vii. In-home health hazard remediation programs”

Table 7: Approach E

Table 7: Approach E: Contract Language Directing MCOs to Engage Providers in HRSN Activities	
State	MMC Contract/Procurement Language
Arizona	<p>Whole Person Care Initiative</p> <p>Contractors shall actively encourage provider usage of SDOH screening and referral tools available through or compatible with the CLRS to screen and refer members for HRSN. At a minimum, the provider’s tool must screen for the following HRSN, regardless of the screening tools selected:: 1. homelessness/housing instability, 2. food insecurity, 3. transportation assistance, 4. employment instability, 5 utility assistance, 6. interpersonal safety, 7. justice/legal involvement, and 8. social isolation/social support.</p> <p>In conjunction with utilization of the CLRS, the Contractor and its providers shall maintain a publicly available Community Resource Guide with information on local resources that address and provide support for HRSN. The resources provided in the Community Resource Guide shall be focused on the needs and geographic area of the Contractor’s member population. The Contractor shall encourage its providers to make the Community Resource Guide easily accessible to members.</p>
Florida	<p>Provider Support for VBP Transformation</p> <p>The Managed Care Plan’s VBP Program shall include contractual agreements with providers focused on defined populations.</p> <p>...</p> <p>The Managed Care Plan shall use the following definitions of patient populations covered in VBP agreements between plans and providers.</p> <p>...</p> <p>7. Foundational Payments for Infrastructure & Operations: Payments to providers to support advancement toward value-based payment agreements. Examples may include, but are not limited to, Care Coordination Fees (PMPM or Lump Sum), Health Information Technology Investment, or Investment in Payment Reform or Supplemental Payments to Address Health-Related Social Needs.</p> <p>General VBP Agreement Requirements</p> <p>(1) The Managed Care Plan must include the following minimum value-based insurance design parameters in all VBP agreements between the MCP and its providers:</p> <p>...</p> <p>(b) A detailed methodology used to calculate the VBP target budget. The MCP is encouraged to use a percent of risk adjusted revenue for the target budget but should also consider the providers’ own historical costs to assess adequacy of the target budget. When calculating target budgets, the Managed Care Plan is also encouraged to use the enrollees’ area deprivation index or other social vulnerability index rankings to adjust provider risk.</p>
Hawaii	<p>Provider Support for VBP Transformation</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>
Massachusetts	<p>Provider Partnership to Address HRSN</p> <p>For Enrollees with identified Health-Related Social Needs (HRSN). the Contractor shall: ...Establish and maintain at least one relationship with a Provider or Social Services</p>

Table 7: Approach E: Contract Language Directing MCOs to Engage Providers in HRSN Activities	
State	MMC Contract/Procurement Language
	Organization to assist Enrollees in obtaining WIC and SNAP in each of the Service Areas that comprise the Contractor's Regions;"
Michigan	<p>Provider Partnerships to Address HRSN</p> <p>Services Provided by Community-Based Organizations</p> <ol style="list-style-type: none"> Contractor must enter into one or more agreement(s) with CBOs in each Region the Contractor serves to support Population Health improvement strategies supported by evidence-based medicine and national best practices in the Contractor's Region, including efforts addressing Social Determinants of Health. Such agreements should include at least one of, but are not limited to, the following activities: referring Enrollees to community-based Social Services to meet health and Health Related Social Needs, providing services to meet Health Related Social Needs, coordinating Social Services between settings and other providers, tracking and reporting on outcomes of referral to address Health Related Social Needs, and assisting members in applying for public benefit programs (SNAP, TANF, WIC, utility and weatherization programs) including through use of MI Bridges, as needed. ... Contractor must, support the design and implementation of Community Health Worker (CHW) interventions delivered by Community-based Organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. ... <p>Targeted Interventions for Subpopulations Experiencing Health Related Social Needs and Health Disparities</p> <p>Contractor must offer evidence-based interventions that have a demonstrated ability to address Social Determinants of Health and reduce Health Disparities to all individuals who screen positive for Health Related Social Needs. To the extent possible, these services must be offered by or coordinated with the Enrollee's care team.</p> <p>...</p> <p>Contractor must collaborate with its high-volume primary care practices to develop, promote, and implement targeted evidence-based interventions. To the extent that Community Health Innovation Regions are functioning within the Contractor's Service Area, the Contractor must collaborate with CHIRs to develop, promote, and implement these targeted evidence-based interventions.</p>
Nevada	<p>Value-Based Initiatives</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</p>

Table 7: Approach E: Contract Language Directing MCOs to Engage Providers in HRSN Activities	
State	MMC Contract/Procurement Language
	successful transition to APM-based reimbursement and progression along the LAN framework.”
New Hampshire	<p>Provider-Delivered Care Coordination</p> <p>4.11.7. Provider-Delivered Care Coordination and Integration with Social Services and Community Care</p> <p>4.11.7.1 The MCO shall implement and provide administrative support of a Provider-Delivered Care Coordination Program that includes reimbursement and other incentives to enable Participating Providers to coordinate health-related and community support services for Members.</p> <p>4.11.7.2 The MCO shall provide program administrative support that includes, at a minimum: Secure transmission of data and other information to Providers about their attributed Members’ service utilization and care coordination needs; Provider assistance with securing:</p> <p>4.11.7.2.1. Health-related services and community support services, including but not limited to housing, that can improve health and family well-being, including assistance filling out and submitting applications; and</p> <p>4.11.7.2.2. Access to medical-legal partnership for legal issues adversely affecting health, subject to the availability and capacity of a medical-legal assistance Provider.</p> <p>4.11.7.2.3 Provider education and training, including:</p> <p>4.11.7.2.3.1. How to access information about community support services, and housing for Members; and 4.11.7.2.3.2. How to facilitate Member closed-loop referrals utilizing the Department’s event notification system and closed-loop referral solution, if available, or another closed-loop referral solution.</p> <p>4.11.7.2.4 Incentivizing the Provider’s use of closed-loop referrals for effective care coordination in accordance with Exhibit O: Quality and Oversight Reporting Requirements.</p> <p>4.11.7.3 The MCO shall assist Providers to actively link Members with other State, local, and community programs that may provide or assist Members with health and social services including, but not limited to: [42 CFR 438.208(b)(2)(iv)] Juvenile Justice and Adult Community Corrections; Locally administered social services programs including, but not limited to, Women, Infants, and Children, Head Start Programs, Community Action Programs, local income and nutrition assistance programs, housing, etc.; Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations; Public Health Agencies; Schools; The court system; ServiceLink Resource Network; 2-1-1 NH; Housing; and VA Hospital and other programs and agencies serving service Members, veterans and their families.</p>

Table 7: Approach E: Contract Language Directing MCOs to Engage Providers in HRSN Activities	
State	MMC Contract/Procurement Language
North Carolina	<p>Enhanced Case Management Pilots to Address Unmet Health-Related Needs</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> <p>v. The PHP shall contract with any LPE operating within the PHP’s Region(s).</p> <p>...</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>Value-Based Initiatives</p> <p>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>Performance Measure Incentive Payments for Participating Providers</p> <p>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</p>

Table 7: Approach E: Contract Language Directing MCOs to Engage Providers in HRSN Activities	
State	MMC Contract/Procurement Language
Oregon (continued)	<p>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 4th Quarter reporting period.</p> <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>Provider Agreements</p> <p>“The CHC-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Participant access to all Medically Necessary Covered Services.</p> <p>The CHC-MCO’s Provider Agreements must include the following provisions:</p> <p>.....</p> <p>v. Requirements regarding coordination with BH Providers (if applicable):</p> <p>...</p> <ul style="list-style-type: none"> ▪ Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.”

Table 8: Approach F

Table 8: Approach F: Contract Language Encouraging HRSN Activities and Approaches Through Incentives	
State	MMC Contract/Procurement Language
Florida	<p>Sanctions, Corrective Action Plans or Liquidated Damages: Related to MCP requirements for A Pathway for Prosperity and A Pathway for Progress: “If the MCP fails to comply with the requirements of this Section, the MCP may be subject to sanctions pursuant to Section XII., Sanctions and Corrective Action Plans, or liquidated damages pursuant to Section XIII., Liquidated Damages, as determined by the Agency.”</p> <p>Related to poor MCO performance on contractually-required performance measures: “Beginning with the Performance Measures Report that is due to the Agency no later than July 1, 2026, covering the measurement period of calendar year 2025, all performance measure-related liquidated damages and sanctions will be in effect.”</p>
Iowa	<p>Performance Withhold: <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>
Michigan	<p>Performance-Based Financial Incentive: “In support of MDHHS’ commitment to meeting the Health Related Social Needs of Enrollees, MDHHS will offer a performance-based incentive payment for Contractors that meet benchmarks defined by MDHHS on the provision of ILOS.”</p> <p>Non-financial Incentive: Contractor Credits Services provided by Community-Based Organizations ... c. Contractor must maintain and provide or arrange for the provision of a CHW to Enrollee ratio of at least one full-time plan-employed or subcontracted CHW per 5,000 Enrollees.</p>

Table 8: Approach F: Contract Language Encouraging HRSN Activities and Approaches Through Incentives

State	MMC Contract/Procurement Language
Michigan (continued)	<p>d. MDHHS will give Contractor 1.25 FTE credit toward meeting the contractually required ratio for every 1 FTE Contractor purchases by contracting with a clinic or community-based organization for CHW services for their members. Contractor agrees to comply with CHW-related requirements pursuant to forthcoming MDHHS guidance.</p> <p>e. Contractor must report the total CHW FTEs hired by Contractor, contracted for through a clinic, or contracted for with a Community-based Organization to MDHHS annually as determined by MDHHS for MDHHS to calculate compliance with the contractually required ratio. MDHHS will utilize the 1.25 FTE credit toward meeting the ratio as applicable.</p> <p>...</p>
North Carolina	<p>MLR calculation: Opportunities for Health</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>PHP Contributions to Health-Related Resources</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>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>Non-financial Incentive: PHP Contributions to Health-Related Resources</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>

Table 8: Approach F: Contract Language Encouraging HRSN Activities and Approaches Through Incentives	
State	MMC Contract/Procurement Language
Ohio	<p>Performance Withhold: Quality Withhold Payout Determination</p> <p>b. Performance Evaluation</p> <p>i. ODM’s performance evaluation of the MCO will include the following:</p> <p>...</p> <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>
Pennsylvania	<p>MLR calculation: “Detail of what is included and how the MLR numerator and denominator are computed can be found in 42 CFR §438.8(e) and (f) respectively. If an expenditure related to Social Determinants of Health is an “activity that improves health care quality” as specified in 42 CFR § 438.8(e)(3), the CHC-MCO may include the costs in the numerator of the MLR. The CHC-MCO is expected to comply with any additional requirements, guidance or instructions released by CMS that relate to the computation of the MLR as required in 42 CFR §438.8.”</p>

Table 9: Approach G

Table 9: Approach G: Contract Language Accounting for Social Risk in Managed Care Payment Methodologies	
State	MMC Contract/Procurement Language
Minnesota	<p>From the 2023 Families and Children MCO Model Contract:</p> <p>4.16 INTEGRATED HEALTH PARTNERSHIPS DEMONSTRATION.</p> <p>4.16.1 The MCO and the STATE will participate in a quarterly population-based payment and shared savings and losses payment methodology through the Integrated Health Partnerships (IHP) Demonstration with the STATE’s contracted IHP Entities in the MCO’s provider network, in accordance with Minnesota Statutes, §256B.0755.</p> <p>From the 2024 Integrated Health Partnerships Model Contract</p> <p>15.3 Quarterly Payment Adjustment – Social Risk</p> <p>15.3.1 Definitions</p> <p>15.3.1.1 “Deep Poverty” means that an individual or family’s income falls below 50% of the Federal Poverty Line.</p> <p>15.3.1.2 “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>15.3.1.3 “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>15.3.1.4 “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>15.3.1.5 “Substance Use Disorder (SUD)” means an individual with a diagnosis of substance abuse, substance dependence, or a substance-induced disorder.</p> <p>15.3.1.6 “Child Protection Involvement (CPI)” means that the individual has been involved with child protection anytime during the analytic period.</p> <p>15.3.1.7 “Adult” means an individual eighteen (18) years of age and older.</p> <p>15.3.1.8 “Child” means an individual under eighteen (18) years of age.</p> <p>15.3.2 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>15.3.3 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</p>

Table 9: Approach G: Contract Language Accounting for Social Risk in Managed Care Payment Methodologies	
State	MMC Contract/Procurement Language
Minnesota (continued)	<p>which may include Deep Poverty, Homelessness, Serious and Persistent Mental Illness, Serious Mental Illness, Substance Use Disorder, and Child Protection Involvement.</p> <p>15.3.4 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>15.3.4.1 The STATE will notify the IHP at least forty five (45) days in advance of changes to the social risk adjustment methodology.</p> <p>15.3.5 The payment modifiers are based on the following relative risk and social risk factor criteria:</p> <p>15.3.5.1 The PBP will be adjusted to reflect the relative number of attributed Adult members identified with SMI and SUD.</p> <p>15.3.5.2 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>15.3.5.3 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>15.3.5.4 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>15.3.6 The dollar amount assigned to each member in Section 15.2.5 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 15.2.4. Individual member monthly PBP amounts will be used to derive an average PMPM amount for an IHP's PBP.</p>

Table 10: Approach H

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment	
State	MMC Contract/Procurement Language
Arizona	<p>Community Investment: “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 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...⁴² Refer to ACOM Policy 303.”</p> <p>Community Engagement: “The Contractor’s QM/PI Program shall include, but is not limited to: ... Attendance and/or participation in applicable community initiatives, events, and/or activities as well as implementation of specific interventions to address overarching community concerns (including applicable activities related to chronic disease management, EPSDT, dental, behavioral health, justice population, opioid and substance use, suicide, veterans, and SDOH including, but not limited to, homelessness, employment, and community engagement, etc.).”</p>
California	<p>Community Investment: 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>
Florida	<p>Community Partnerships:</p> <p>“In 2021, the Department of Children and Families launched the initiative Hope Florida: A Pathway to Prosperity that uses Hope Navigators to guide Floridians on an individualized path to prosperity, economic self-sufficiency, and hope by focusing on community collaboration between the private sector, faith-based community, nonprofits, and government entities to break down traditional community silos, to maximize resources and uncover opportunities. It is the Agency’s intention that the MCP collaborates with the Pathways to Prosperity program to enable eligible enrollees to gain the necessary education, job, and life skills to achieve independence and “graduate” out of Medicaid.</p> <p>...</p> <p>The MCP shall establish community partnerships to provide Home and Community-Based services and supports in the following CPIO priority areas:</p> <ol style="list-style-type: none"> (1) Area Agencies on Aging (AAA) or Aging and Disability Resource Center (ADRC) Partnerships (2) Elder Abuse Prevention Partnerships (3) Healthy Aging Partnerships (4) Advanced Care Planning and End of Life Preparedness Partnerships (5) Partnerships that improve care transitions from institutional care to home and community-based settings

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment	
State	MMC Contract/Procurement Language
Florida (continued)	<p>6) State of Florida Centers for Independent Living</p> <p>(7) Dementia Care & Cure Initiative Partnerships through the Florida Department of Elder Affairs and the AAAs</p> <p>(8) Partnerships that provide home modifications to increase safety, independence, and social connections</p> <p>(9) Caregiver Support Partnerships</p> <p>(10) Partnerships that Increase Social Engagement and Reduce Isolation</p> <p>(11) Community organizations that support Health Related Social Needs (e.g., Intimate Partner Violence Partnerships; Community Reentry for Justice-Involved People Partnerships; Supportive Housing Partnerships including, but not limited to, Continuums of Care and Permanent Supportive Housing Organizations, Vocational Training, and Job Placement Partnerships including, but not limited to, Workforce Development Organizations and Job Centers; and Literacy Partnerships)."</p>
Georgia	<p>Community Investment: "The Contractor must identify gaps in services and resources that prevent fulfillment of goals and needs identified by Care Plans and use this analysis ("Care Plan Insights Report") to guide its approach forcommunity re-investment as well as other Quality improvement activities.</p> <p>18.13 Community Reinvestment</p> <p>18.13.1 The Contractor must create a community reinvestment plan and submit it to DCH for approval. The plan must identify population health strategies aligned with the DCH Quality Strategic Plan and include, but not be limited to, investments to address nonmedical risk factors (e.g., addressing social determinants of health such as housing, food) for Members in a data-driven manner. The community reinvestment plan should include details on the source of funds to be used for community reinvestment.</p> <p>18.13.2 As part of its plan, the Contractor may include strategies for engaging Subcontractors or other CMOs, state agencies, or community-based organizations to increase the impact of activities associated with reinvestment spending.</p> <p>18.13.3 Except in the case of a required reinvestment as a result of deficiencies in meeting VBP Performance Targets, the community reinvestment contributions will be voluntary on part of the Contractor.</p> <p>18.13.4 The community reinvestment amounts are not reportable as medical or administrative expenses and will not be considered for the purposes of development of the Capitation Rates."</p>
Michigan	<p>Community Investment:</p> <p>A. Contractor must contribute a minimum of five (5) percent of its annual pre-tax profits to community reinvestment demonstrating its commitment to the local communities in which it operates. Contractor's community reinvestment or any community investment above the annual minimum must be funded through profits and not divert from medical</p>

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment

State	MMC Contract/Procurement Language
Michigan (continued)	<p>or administrative expenses. MDHHS reserves the right to increase the community reinvestment contribution percentage in future years of the Contract.</p> <p>B. Contractor’s community reinvestment must be used to address Health Related Social Needs, including but not limited to increasing regional community capacity to provide Social Services, including but not limited to approved ILOS, and to addressing Social Determinants of Health. Contractor agrees to comply with reporting requirements on allowable community reinvestment activities pursuant to forthcoming MDHHS guidance. Contractor is encouraged to work with other Contractors in or near their Service Area to maximize the collective impact of community reinvestment activities.</p> <p>C. Contractor must not use community reinvestment funding to pay for services, including ILOS, covered under the Contract.</p> <p>D. Contractor’s community reinvestment must not include entities, such as a Community-based Organization, in which the Contractor has a full or partial ownership stake or any financial interest.</p> <p>E. Contractor must submit an annual Community Reinvestment Plan detailing its anticipated community reinvestment activities for MDHHS review and approval, in accordance with timeliness requirements specified in Appendix 3 and additional requirements specified by MDHHS. The Plan must describe the expected beneficiaries of Contractor’s community reinvestment, how they will benefit, to what extent these investments will support the systems and capacity of local organizations engaged in the delivery of ILOS, and any additional information requested by MDHHS. MDHHS will provide Contractor with a template for this Community Reinvestment Plan.</p> <p>F. Contractor must submit an annual Community Reinvestment Report detailing Contractor’s actual community reinvestment expenditures, including to what extent these investments supported the local organizations engaged in the delivery of ILOS, in accordance with timeliness requirements specified in Appendix 3 and additional requirements specified by MDHHS. The Report must describe Contractor’s community reinvestment expenditures in comparison to the Plan previously submitted. MDHHS will make available a template report for this Community Reinvestment Report.</p>
Mississippi	<p>Community Partnerships: 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 SDOH projects to the Division for review and approval. The Division reserves the right to raise this amount during the life of the Contract.</p>
Nevada	<p>Community Investment:</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>

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment	
State	MMC Contract/Procurement Language
Nevada (continued)	<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>
Ohio	<p>Community Reinvestment: “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"> 1. The MCO must not use community reinvestment funding to pay for Medicaid covered services. 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. 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. 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. 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.”
Oregon	<p>Community Reinvestment: 8. Social Determinants of Health and Equity Spending Programs: SDOH-E Partners and SHARE Initiative</p> <p>a. 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: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx.</p>

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment

State	MMC Contract/Procurement Language
Oregon (continued)	<p>b. Supporting Health for All through Reinvestment Initiative. 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>(1) 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> <ul style="list-style-type: none"> 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; ii. At least one priority that aligns with the OHA-designated Statewide priority for SDOH-E spending in housing-related services and supports, including Supported Housing, as defined in this Contract. Contractor shall comply with future statewide priorities identified by OHA; and iii. Alignment with Contractor’s Transformation and Quality Strategy. <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>(c) Contractor shall designate a role for the CAC in relation to the SHARE Initiative, as described in OAR 410-141-3735.</p>
Pennsylvania	<p>Community Partnerships in Value-Based Initiatives: “...MCOs must incorporate CBOs into VBP arrangements with Network Providers to address SDOH as follows:</p> <p>...18% of the total medical portion of the capitation and maternity care revenue (or 75% of that expended in strategies 9.a.ii. through 9.a.v.), must incorporate at least one CBO that addresses at least one SDOH domain. 6.25% of the total medical portion of the capitation and maternity care revenue (or 25% of that revenue expended in strategies 9.a.ii. through 9.a.v.), must incorporate one or more CBOs that together address 2 or more SDOH domains. For example, if an MCO’s total medical spend is \$20 million, and \$10 million is expended in strategies 9.a.ii. through 9.a.v., \$5 million of the \$10 million could incorporate a CBO that addresses food insecurity, and \$2.5 million of the \$10 million could incorporate CBOs that address both food and housing insecurity. The Department may waive this requirement upon receipt from the PH-MCO of alternate proposals to address SDOH needs through VBP.</p>

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment

State	MMC Contract/Procurement Language
Pennsylvania (continued)	<p>The MCO must incorporate CBOs into VBP arrangements by either:</p> <ul style="list-style-type: none"> Contracting with a CBO directly. The contract structures between the MCOs and CBOs may include, but are not limited to, payment for services rendered, capitation payments, or value-based payments as long as there is no downside risk to the CBO; or Contracting with a Network Provider that subcontracts with a CBO. <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...Capacity for increased referrals from providers or the MCO...Ability to capture and report SDOH data.</p> <p>...</p> <p>The PH-MCO must participate, with all other MA and CHIP MCOs and Behavioral Health Primary Contractors that operate within the region defined by each Physical Health HealthChoices Zone, a Regional Accountable Health Council (RAHC), subject to the following:</p> <p>A. The purpose of the RAHC shall be to serve as a forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes across each region in the state. This planning shall be focused on areas of high burden of disease and on demographic groups impacted by health disparities within the HealthChoices Zone, in order to identify the root causes of those disparities and to establish strategies and interventions to address those root causes of these disparities. The RAHC will use state and community-based health assessments, regional Social Determinants of Health (SDOH) needs assessments, as well as any other specific health indicators, as the basis to advance population health planning.</p> <p>...</p> <p>F. The MCO must form, with all other MA and CHIP MCOs and Behavioral Health Primary Contractors that operate within the region defined by each Physical Health HealthChoices Zone, a Regional Accountable Health Council (RAHC), subject to the following: A. The purpose of the RAHC shall be to serve as a forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes across each region in the state. This planning shall be focused on areas of high burden of disease and on demographic groups impacted by health disparities within the HealthChoices Zone, in order to identify the root causes of those disparities and to establish strategies and interventions to address those root causes of these disparities. The RAHC will use state and community-based health assessments, regional Social Determinants of Health (SDOH) needs assessments, as well as any other specific health indicators, as the basis to advance population health planning.</p> <p>...</p>

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment

State	MMC Contract/Procurement Language
	<p>H. The RAHC shall be responsible for providing CBOs technical assistance that is available on consultation. The MA MCOs shall also support a regional or statewide learning network that is informed by frequently asked questions or topics. The goals of the technical assistance will be to help support administrative functions of CBOs that are important in their ability to improve population health, improve equity, and address the SDOH needs of the region. The technical assistance must include the ability to assist with data analytics and measurement, contract management and negotiations, sharing best practices and outcomes, measuring return on investment, and incorporation of CBOs into VBP agreements.</p>
Virginia	<p>Community Engagement and Partnerships: “As part of its community assessment and Member engagement work, the Contractor must develop and implement an HRSN Plan designed to identify and seek to address non-medical drivers of health that exist among the Contractor’s Members. The HRSN Plan shall be developed in alignment with the Contractor’s model of care, the Medicaid Managed Care Quality Strategy, and related state initiatives to address HRSN and account for regional variances in needs and opportunities across the Commonwealth, and partnerships with community based organizations.</p> <p>The Contractor’s HRSN Plan must describe the Contractor’s process to develop, and over time refine, its community assessment, member engagement and related HRSN approach. The HRSN Plan must include an action plan for Contract Year One and beyond consisting of specific measurable objectives related to addressing housing stability and food security needs of Members based on individual and community needs, including engaging Members, partnering with community-based organizations and utilizing Community Health Workers and other care management extenders. The Contractor’s HRSN Strategic Plan must include how the Contractor plans to facilitate and document closed-loop referrals for members with identified needs. As an example, the Contractor’s HRSN Plan should specifically identify how it will work to engage pregnant and postpartum women, identify HRSNs, and connect Members with Contractor, as well as local and state resources to improve maternal health and birth outcomes and reduce geographic and racial disparities in access to care and outcomes. The HRSN Plan must also describe the Contractor’s process to enable effective member communication and engagement, for example how the Contractor will use different modes of communication, including digital modes where appropriate, to ensure members are aware of the resources available to them and resolve barriers to accessing them.</p> <p>The Contractor must submit its HRSN Plan to the Department as part of Readiness Review. The Contractor must provide updates to Department on implementation of its HRSN Plan in an annual report of its progress on meeting HRSN Plan objectives, findings and proposed approaches and modifications for future Contract Years.</p> <p>The Contractor’s annual report must detail how it is identifying, addressing (i.e., via programs and partnerships), and tracking HRSN such as housing instability, food insecurity, and for specifically addressing HRSN of pregnant and postpartum women and infants. The Contractor should refer to the Cardinal Care Technical Manual for additional information on requirements related to the Contractor’s HRSN Plan and corresponding annual reports.</p> <p>The Department has the discretion to expand the HRSN reporting criteria throughout future Contract years, to include specific data for key areas noted above or additional areas as</p>

Table 10: Approach H: Contract Language Addressing HSRN Through Community Engagement, Partnership and/or Investment	
State	MMC Contract/Procurement Language
	necessary. At a future date, the Department may also consider identifying a statewide community referral platform to help identify resources, generate referrals and close the loop on Members being referred to community organizations for HRSNs and make related amendments to this Contract.

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

Below are links to state Medicaid managed care contracts/procurements reviewed in this toolkit.

1. Arizona: [Link](#) to 2023 MMC Contract; [Link](#) to 2023 ALTCS EPD RFP (long-term care for individuals who are elderly and/or have a physical disability)
2. California: [Link](#) to 2022 Medi-Cal Managed Care Plans RFP
3. Florida: [Link](#) to Florida's Statewide MMC ITN 010-22/23 which includes MCO Model Contract language. (Go to "Search Advertisements," select the "Agency for Health Care Administration" and hit "search.")
4. Georgia: [Link](#) to 2023 MMC RFP and Model Contract
5. Hawaii: [Link](#) to 2020 MMC RFP; [Link](#) to MMC Model Contract
6. Iowa: [Link](#) to 2022 Health Link RFP
7. Louisiana: [Link](#) to 2021 MMC RFP and Model Contract
8. Massachusetts: [Link](#) to 2022 ACO Request for Responses
9. Minnesota: [Link](#) to 2023 MMC Contracts , [Link](#) to 2023 Families and Children MCO RFP, and [Link](#) to 2024 IHP RFP Model Contract
10. Mississippi: [Link](#) to 2021 Medicaid Coordinated Care RFQ and Model Contract
11. New Hampshire: [Link](#) to 2023 MMC RFP
12. Nevada: [Link](#) to 2022 MMC Contracts
13. North Carolina: [Link](#) to PHP Contract
14. Ohio: [Link](#) to 2023 Managed Care Agreement
15. Oregon: [Link](#) to 2022 CCO Contract
16. Pennsylvania: [Link](#) to Physical HealthChoices MCO Contract; [Link](#) to 2019 Physical HealthChoices RFA; [Link](#) to Community HealthChoices MCO Contract
17. Rhode Island: [Link](#) to MMC Contracts
18. Texas: [Link](#) to 2022 STAR+PLUS RFP; [Link](#) to 2022 STAR & CHIP RFP
19. Virginia: [Link](#) to 2023 Managed Care RFP and Model Contract

ENDNOTES

¹ Centers for Medicare & Medicaid Services. “Health Related Social Needs.” Accessed October 13, 2023. [Health Related Social Needs | Medicaid](#)

² 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.

³ 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 toolkit includes examples of MCE approaches which states may be able to apply in their MCO, ACO, MBHO, MLTSS, or other contracts.

⁴ 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

⁵ U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. *Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children’s Health Insurance Program*. CMCS Informational Bulletin. Washington: U.S. Department of Health & Human Services. November 16, 2023. <https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf>. Accessed November 16, 2023.

⁶ U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. *Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children’s Health Insurance Program (CHIP)*. HRSN Coverage Table. Washington: U.S. Department of Health & Human Services. November 2023. <https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf>. Accessed November 16, 2023.

⁷ The October 2023 update to the HRSN toolkit adds Approach H to capture state MMC approaches that address HRSN through community engagement, partnerships and/or investments. Some state examples previously captured under Approach F are now included under Approach H. In addition, the definition for Approach B was changed to capture state MMC approaches that explicitly require the use of ICD-10 Z codes.

⁸ 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-medicaid>. Accessed August 31, 2022.

⁹ Medicaid and CHIP Payment and Access Commission. (2021, June). *Medicaid’s Role in Housing*. <https://www.macpac.gov/wp-content/uploads/2021/06/Medicoids-Role-in-Housing-1.pdf>. Accessed November 10, 2023.

¹⁰ California Department of Health Care Services, *Medi-Cal Transformation: Enhanced Care Management*. <https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdf>. Accessed December 14, 2023.

¹¹ 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.

¹² The October 2023 update of the toolkit reflects changes to profiled states’ approaches resulting from MMC procurements released within the last year, including Florida, Georgia, Michigan, and New Hampshire. The toolkit also includes updates to existing state profiles where HRSN requirements in Medicaid managed care contracts changed.

¹³ Due to its length, this exhibit is not included in its entirety in this toolkit, however, key aspects of Exhibit K related to HRSN and health equity are summarized in this toolkit and the companion [Health Equity Compendium](#). See Appendix C for a link to Oregon’s CCO contract which includes Exhibit K.

¹⁴ This toolkit identifies state MMC examples for highlighted SDOH approaches; however, it does not include an exhaustive review of all MMC SDOH approaches for profiled states.

¹⁵ The Social Interventions Research & Evaluation Network (SIREN) has summarized and compared several widely used HRSN screening tools such as the Accountable Health Communities Health-Related Social Needs Screening Tool and PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences). SIREN’s summary includes information about the number of questions in each tool, available languages, social health domains covered, and domain-specific measures used.

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.

¹⁶ SIREN's publications offer states, plans, and providers resources to better understand the current state of HRSN screening, patient perspectives, and how to act on screening results using the National Academy of Sciences, Engineering and Medicine 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. 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.

¹⁷ 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.

¹⁸ See Appendix C for a link to Georgia's 2023 MMC procurement and model contract which includes this definition.

¹⁹ *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>.

²⁰ CMS Office of Minority Health, Health Equity Programs and Healthcare Resources. "Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes." Accessed October 20, 2023. <https://edit.cms.gov/files/document/zcodes-infographic.pdf>.

²¹ U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. *Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care*. SMD #23-001. Washington: U.S. Department of Health & Human Services. January 4, 2023. <https://www.medicare.gov/sites/default/files/2023-01/smd23001.pdf>. Accessed November 10, 2023.

²² Hinton, E, Guth, M, Raphael, J, Haldar, S, Rudowitz, R, Gifford, K, Lashbrook, A, Nardone, M & Wimmer, M. (2022). *How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023*. KFF. <https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-introduction/>. Accessed October 13, 2023.

²³ 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.

²⁴ 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.

²⁵ Arizona Health Care Cost Containment System. *Differential Adjusted Payment (DAP) Activity, CYE 2023 Final Public Notice*. Revision Posted August 1, 2022. <https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/DAPFinalNoticeCYE2023.pdf>. Accessed November 10, 2023.

²⁶ 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. Accessed August 23, 2022.

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- ²⁷ 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/bso/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410&external=true&parentUrl=close>. Accessed August 23, 2022.
- ²⁸ 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.
- ²⁹ See Appendix C for a link to Florida's 2023 MMC ITN which includes the model contract containing this contract language.
- ³⁰ 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.
- ³¹ 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."
- ³² 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.
- ³³ Medicaid and CHIP Payment and Access Commission. (2022, May). *Financing Strategies to Address the Social Determinants of Health in Medicaid*. https://www.macpac.gov/wp-content/uploads/2022/05/SDOH-Issue-Brief_May-2022.pdf. Accessed November 10, 2023.
- ³⁴ 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. [Risk Adjustment Based on Social Factors: State Approaches to Filling Data Gaps \(shvs.org\)](#). Accessed October 23, 2023.
- ³⁵ 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. [Risk Adjustment Based on Social Factors: State Approaches to Filling Data Gaps \(shvs.org\)](#). Accessed August 23, 2022.
- ³⁶ Commonwealth of Massachusetts. *MassHealth Risk Adjustment Methodology*. MassHealth. Retrieved August 31, 2022, from <https://www.mass.gov/lists/masshealth-risk-adjustment-methodology>.
- ³⁷ See Appendix C for a link to Arizona's MMC contract which includes this contract language.
- ³⁸ 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.
- ³⁹ KFF. (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.
- ⁴⁰ 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.
- ⁴¹ 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.
- ⁴² 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>