Building a Medicaid Strategy to Address Health-Related Social Needs: Environmental Scan

The Center for Health Care Strategies (CHCS), with support from the Episcopal Health Foundation (EHF), conducted an environmental scan to analyze best practices and state activities on health-related social needs (HRSN)-specific interventions; HRSN quality measures and screening tools; value-based payment arrangements involving HRSN; and Medicaid managed care contracting requirements and incentives related to HRSN. This scan highlights the available evidence on specific approaches, particularly in the Medicaid managed care context, as well as relevant resources and tools related to addressing HRSN. A companion tool, ***Building a Medicaid Strategy to Address Health-Related Social Needs***, synthesizes the findings from these analyses and offers considerations for states that are developing a comprehensive strategy to address HRSN.

HRSN-Specific Interventions: Transportation, Food Insecurity, and Housing Instability

Transportation

Medicaid's non-emergency medical transportation (NEMT) benefit provides transportation to and from medical appointments for Medicaid beneficiaries who are unable to access services to ensure necessary transportation and to use the most appropriate form of transportation for the beneficiary. States have discretion over which models they use to deliver non-emergency medical transportation (NEMT) and may use more than one approach to accommodate varying beneficiary needs, delivery systems, and geographic areas. States typically choose one or more of the following models: (1) paying for NEMT on a fee-for-service basis; (2) contracting with managed care plans to provide NEMT and other services; and (3) arranging for transportation brokers to manage the benefit, which is the most common model. Brokerage services can be private, public, or nonprofit. In 2015, 34 states used some form of the brokerage model. Of the four states (AZ, FL, NM, OR) that provided NEMT through contracts with managed care plans, only Arizona does so exclusively.

NEMT services often adequately meet beneficiaries' needs for transportation to regularly scheduled or recurring appointments. However, NEMT services fall short in addressing time-sensitive needs. In addition, given the size and complexity of NEMT programs, states typically face a number of obstacles in administering the benefit. These challenges include customer service concerns, a limited capacity to respond to unplanned transportation needs, lack of strong quality assurance monitoring and reporting mechanisms to prevent fraud and abuse, and outdated approaches to providing and tracking services.

Because the most frequent complaint regarding NEMT services is related to customer service, considerations for states include:

- Strengthening the training requirements for NEMT drivers. Particularly if states or brokers intend to partner with transportation network companies (TNCs), it will be important to provide drivers with adequate information and support to understand how to effectively work with individuals who have complex health and social needs.
- Creating systems that allow beneficiaries to report issues with NEMT directly to the state Medicaid agency, rather than directly contacting the NEMT providers and brokers. A direct line of communication to the state agency for beneficiaries to report grievances would increase the transparency of the NEMT system and should result in greater accountability.

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Program	Description	Evidence/Results
Transportation Network Companies (TNC)	TNCs allow drivers to use their own vehicles to provide ride services to customers, e.g., Uber and Lyft. Six states have signed contracts with Veyo, a TNC-like transportation broker that offers features such as independent drivers; an app and a web-based portal for requesting rides; and predictive analytics to provide transportation services to Medicaid beneficiaries.	TNCs' response times are fast. A 2014 study found that in San Francisco during typical working hours, 93% of TNC customers waited less than 10 minutes for their ride to arrive, as compared to 35% of taxi customers.
Arizona Medicaid	The Arizona Health Care Cost Containment System, effective May 1, 2019, allows TNCs to register as non-emergency medical transportation providers. Under the new provider category, rideshare companies (including Lyft) are eligible to serve Medicaid members who do not require personal assistance during medically necessary transportation. As such, the training required of these providers is reduced as compared to traditional non-emergency transportation providers. The health care plan and/or their transportation broker will assess the member's need and determine whether a TNC is a viable option for that particular transportation need.	
San Francisco Health Plan, California	San Francisco Health Plan has partnered with FlyWheel, an app-based TNC that employs taxicabs, rather than the private citizen driver model used by Uber and Lyft, to provide enrollees with transportation needs with services to and from medical and other appointments.	Early evidence points to high levels of enrollee and staff satisfaction and high rates of appointment attendance when Flywheel is used.
Patients of an internal medicine practice in West Philadelphia	Patients were offered prescheduled, free Lyft rides to primary care appointments. Show rates for 2.5-month period at intervention practice were compared to show rates of similar, control practice in West Philadelphia which did not offer transportation.	Uptake of ridesharing was low among intervention group (19.8%) and no significant difference was found between intervention and control show rates. At the rideshare practice, statistically significant improvement in show rate from 54% to 68%. At control practice, decline in show rate from 60% to 51%.
Nationally representative sample of transportation-disadvantaged people often including low-income, older adults with chronic conditions	Sample identified using National Health Interview Survey and medical expenditure panel survey datasets. Study estimates cost-effectiveness of providing NEMT for patients with 12 types of chronic conditions or preventive medical needs.	Providing NEMT was estimated to save $927 per patient with diabetes, $333 per patient with asthma, and $2,743 per patient with heart disease.
Rural Medicare and Medicaid beneficiaries	Missouri Health Foundation pilot program, "HealthTran," hired a mobility coordinator, trained staff in clinics and hospitals to screen patients for transportation needs, and developed cost-effective solutions for people in need of transportation. Intervention costs and results measured at 17 months into the program.	For every $1 invested in transportation, the hospital earned $7.68 in reimbursement. In total, program resulted in over $730,000 in payments to the hospital and its clinics.
Medicaid beneficiaries	Study estimated the ROI of providing NEMT to dialysis and wound care appointments for diabetes. Researchers processed 2014–2015 medical, pharmacy, and long-term-care claims for members enrolled during the 24-month period for each treatment.	Providing NEMT for people with chronic conditions has a calculated positive ROI of over $40 million per month per 30,000 Medicaid beneficiaries nationally, an amount totaling to $480 million annually. Medicaid cost avoided because of NEMT per survey respondent per month is $3,423 for dialysis patients and $792 for would care diabetes patients. ROI of NEMT per 10,000 dialysis patients per month is $34,229,448. ROI of NEMT per 10,000 diabetic wound care patients per month is $7,920,635.

Food Insecurity

Twelve states require MCOs to screen for food insecurity and have mechanisms in place to refer patients to food and nutrition services. Some states require plans to establish partnerships with community-based organizations to connect patients in need to food and nutrition services, as well as provide application assistance to programs like SNAP and WIC. Florida, for example, requires MCOs to offer the *Healthy Start* services, which is a home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. Through "Mom Care" and "Healthy Start Coordinated System of Care" programs, MCOs provide connections to community resources, including resources related to nutrition, nutritional counseling, and application assistance to WIC.

A recent analysis of peer-reviewed studies of food insecurity-related interventions found that home-delivered meals offered the strongest evidence base for improving food security, eating habits, and on some measures of health and health care utilization. Food voucher programs — programs that provided vouchers or financial incentives for the purchase of fresh fruit and vegetables at local farmers' markets — reduced food insecurity, though results were mixed for health outcomes. Evaluations of food referral programs demonstrated improved food security and on some health outcomes, with active referral programs (assistance given to patients to make connections to community/government agencies that provide food and nutrition services) being more impactful that passive referral programs (patients given information about food and nutrition services).

Considerations:

- Home delivered meals have been shown to result in reduced hospitalizations, emergency department (ED) visits, and overall health care costs.
- Medically tailored meals resulted in a larger ROI than delivered, nontailored meals ($220 per participant compared to $10 per participant).
- Providing Medicaid beneficiaries with linkages to food assistance programs like SNAP, WIC and food pharmacies have been shown to significantly reduce health care utilization for those with chronic conditions, low incomes, or food insecurity.

Program	Description	Evidence
Diabetes self-management support from food banks	Randomized trial across 27 food pantries examining the effectiveness of a 6-month intervention including food, diabetes education, health care referral, and glucose monitoring.	Results showed that food security, food stability, and fruit and vegetable intake significantly improved among intervention participants. There were no differences in self- management (depressive symptoms, diabetes distress, self-care, hypoglycemia, self-efficacy) or HbA1c levels.
Medically-tailored meals (MTM)	MTM programs involve the home delivery of meals prepared under the supervision of registered dietitians. The meals are created to meet the specific needs of patients with complex conditions.	Evaluation study found that seniors receiving Meals on Wheels experienced decreased rates of depression and loneliness, and higher quality of life. They also had improved measures for activities of daily living, significant reductions in hospital readmission rates, and were less likely to be admitted to a nursing home. A JAMA study found a 16% reduction in health care costs among patients who received medically tailored meals, mainly attributed to reduction in admissions to hospitals and nursing homes. When providing complete nutrition for six months, early studies are showing a 63% drop in hospitalizations and a 50% increase in adherence to medication among Type 2 Diabetes and/or HIV/AIDS patients in one 2017 Study, and a 28% to 32% decline in overall health care costs in a 2013 study.

Program	Description	Evidence
Screening and referrals, North Carolina	North Carolina's Medicaid program operates a pilot program through their Healthy Opportunities Initiative whereby certain beneficiaries are screened for food insecurity and receive home-delivered meals or food support services, such as assistance with SNAP or WIC applications.	Referral programs result in notable increases in enrollment in SNAP and WIC and have a positive impact on beneficiaries experiencing food insecurity. There is limited evidence, however, that food referrals affect health behaviors or health outcomes.
Medically-tailored meal plans	A study looked at the difference in usage of selected health services and medical spending for dual eligible members of the Commonwealth Care Alliance health organization.	Members were split into two groups – one received medically-tailored meal plans for five days' worth of meals and the other receiving five days' worth of non-tailored meals – delivered through Meals on Wheels. Both groups also had a comparison groups who did not receive meals. The group receiving the tailored meals had a 70% reduction in ED visions, 52% reduction in inpatient admissions, and $570 difference in spending compared to the control group. Net saving of $220 per participant in tailored meal program.
Medically-tailored meals to members of Medicaid Managed Care Plan (MMCO)	Members of MMCO in Philadelphia and South New Jersey with chronic disease were able to receive three free MTMs from a nonprofit. They also received nutritional counseling and meal planning training. This program lasted six months.	Compared to a control group, the intervention group receiving meals had lower average monthly health care costs, as well as fewer average inpatient stays, visits, and costs.
Connecting members to SNAP	A study looked at the connection between health care spending and participation in the SNAP program. Meals were not delivered as a part of the study.	SNAP participation was associated with roughly $400 lower health care costs annually per person.

Housing Instability

People experiencing homelessness have high rates of chronic health problems compared to the general population, including high blood pressure, heart disease, diabetes, lung diseases like asthma and chronic bronchitis, and HIV disease. As a result, they have high health care utilization rates and health care costs.

There is strong evidence that providing supportive housing — both with and without case management — can reduce ED visits, admissions, and inpatient stays and result in large decreases in health care costs.

While Medicaid funding cannot be used for "room and board," states and health plans are finding new ways to address homelessness, including through: (1) individual housing and transition services; (2) individual housing and tenancy sustaining services; and (3) state-level housing-related collaborative activities. These supportive housing funds can be used to help individuals apply for housing and tenancy support, develop individualized support plans, and participate in the planning activities (and partner with) housing agencies at the state and local level. States are doing this work in a number of ways, including the Healthy Opportunities Pilots in North Carolina and New York's Medicaid Redesign Team efforts.

Considerations:

- By law, Medicaid cannot cover rent, but states can choose to cover housing-related services, such as transition services, housing and tenancy sustaining services, and housing-related collaborative activities.
- Many patients experiencing homelessness are high-cost and high-need, so providing supportive housing services, including medical respite, can generate significant ROI.

Program	Description	Evidence
Hennepin Healthcare	An accountable care organization formed by a local health and human service department, a public teaching hospital, a county health plan, and a Federally Qualified Health Center work together to identify, house, and provide services for the most high-cost, high-need patients in Hennepin County, Minnesota. Minnesota has a General Residential Housing fund that comes out of the state's General Fund, and it can be used directly on rent — allowing recipients to acquire market-rate housing. Hennepin Healthcare is able to use the savings it has as an organization to provide housing navigation services and help establish relationships with landlords.	As of 2014, members placed in housing services: ■ Were admitted to hospital 16% less often; ■ Visited ED 35% less often; ■ Visited psychiatric ED 18% less often; and ■ Received outpatient care 21% more often.
Finger Lakes Performing Provider System	A partnership between DePaul Community Services, a community-based organization that provides supportive housing in upstate New York, and two health centers to provide medical respite services.	Study results show that partnership effort has: Helped over 60% of medical patients and 80% of psychiatric patients transition to permanent housing; and Resulted in significant cost savings to Medicaid, reduced hospitalizations, and improved quality of life and health outcomes for individuals.
Health Plan of San Mateo	Health Plan of San Mateo invested in working with two nonprofits to provide supportive housing and transitional case management for patients needing long-term care. The pilot focused on patients who needed long-term care but could return to the community, individuals who needed acute care or rehab who were subsequently recommended for long-term care, and those residing in the community who would eventually need long-term care.	Per the CMWF ROI Calculator, the program achieved the following: ■ Average overall cost of care per member per month dropped 43% ($10,055 to $5,721) following the intervention. Over $6,000 PMPM was saved on long-term care and skilled nursing facility costs alone; ■ A total of $2.4 million in savings was accrued 6 months post-intervention. When accounting for $1 million in start-up costs, total net savings was $1.4 million; and ■ Estimated ROI was $1.57 in savings for every $1 invested.
Health Opportunities Pilot (North Carolina)	As a part of North Carolina's 1115 waiver demonstration, the state launched the Healthy Opportunities Pilots here the state will allow managed care plans — here called pre-paid health plans (PHPs) — to address HRSN, including housing instability. PHPs will work with lead pilot entities and community-based organizations to use pilot funds for eligible Medicaid beneficiaries to provide supportive housing services, including home modifications (i.e., housing remediation to prevent asthma related hospitalizations).	Program valuation is ongoing.

HRSN Quality Measures and Screening Tools

As Medicaid programs and health plans integrate HRSN interventions into their population health efforts, and as providers are incentivized to address HRSN through alternative payment models and pay-for-performance programs, measuring the effectiveness of HRSN interventions has become increasingly important. While several HRSN screening tools exist, there is wide variation in the HRSN categories included in each tool. With the exception of the Hunger Vital Sign measure, there is also relatively little consensus for the specific indicators used to measure HRSN categories.

States are beginning to require Medicaid providers to screen for HRSN (Massachusetts, Minnesota, North Carolina, Oregon, Vermont) either through an approved screening tool or allowing providers to select from a range of approved tools (i.e. Rhode Island), as well as integrating health equity measures into their Medicaid MCO requests for proposals.

HRSN Quality Measures

Measure/State	Description
Hunger Vital Sign™	The Hunger Vital Sign™ is the only validated HRSN measure that allows clinicians to identify households at risk for food insecurity. The validity of the tool has been tested among low-income families, adolescents, and adults, where it was found to have high sensitivity and specificity. The two-question tool includes the following prompts: (1) Within the past 12 months we worried whether our food would run out before we got money to buy more; and (2) Within the past 12 months the food we bought just didn't last and we didn't have money to get more.
Massachusetts	In 2018, the Massachusetts Medicaid program, MassHealth, introduced accountable care organizations (ACOs) for many of its members. An ACO is a group of doctors, hospitals, and other health care providers that work together with the goals of delivering better care to members, improving the population's health, and controlling costs. ACOs are accountable both for the health of its members and for the cost of the care its members receive. Payments to ACOs are risk-adjusted, and consider both medical and nonmedical factors, including social determinants. Quality measures fall across several domains, including: Prevention and wellness; chronic disease management; behavioral health/SUD; LTSS; avoidable utilization; member care experience and integration of care. HRSN are assessed through the "Health-Related Social Services" category. The Social Service Screening Measure is calculated as the percentage of ACO Attributed members (up to age 65) who were screened for social service needs.
Rhode Island Accountable Entities	Accountable Entities (AE) are Rhode Island Medicaid's version of an ACO in which a provider organization is accountable for quality health care, outcomes, and the total cost of care of its population. A central element of the AE model is the integration of strategies to address HRSN, including assessing social needs, screening and referring to community resources, and using community partnerships and engagement to address identified needs. AEs are required to screen enrollees for HRSN needs. The associated measure is calculated as the percentage of AE enrollees who were screened for HRSN using an Executive Office of Health and Human Services approved screening tool and is currently a pay-for-reporting measure.
Minnesota	Minnesota's Integrated Health Partnerships (IHPs) are required to propose an intervention to address social determinants of health and health disparities, and will be held accountable for agreed upon health equity measures related to the proposed intervention. For IHPs received population-based payment, that payment will be partially determined by their performance on health equity measures.

HRSN Screening Tools

Measure/State	Description
North Carolina	North Carolina has developed a standardized screening tool for use by Prepaid Health Plans (PHPs). Under North Carolina's Care Management Strategy, enrollees are to have access to direct linkages to programs and services that address unmet HRSN. PHPs will be required to screen enrollees for HRSN needs as part of overall care management requirements. HRSN screening questions map to four priority domains: food insecurity; transportation; housing instability and interpersonal violence.
Accountable Health Communities	The Health-Related Social Needs Tool for use by Accountable Health Community organizations is a 10-item survey that includes questions on housing instability, food insecurity, transportation, utilities, and interpersonal safety.
PRAPARE	The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) was developed to help health centers and other providers collect the data needed to better understand patients' social needs. The assessment tool was developed based on a review of existing HRSN that consists of a set of national core measures to help standardize data collection.

Value-Based Payment Arrangements for Addressing HRSNs

This CHCS report identifies several examples of states using payment incentives through MCO contracts to address HRSN, including requiring health plans to address HRSN through VBP initiatives. With regard to plan/provider arrangements, states generally may not direct MCO expenditures within contracts. However, the state may direct the MCO to implement a certain VBP model, meet VBP benchmarks, or participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. Tying MCO incentives to performance on quality measures or requiring MCOs to implement VBP arrangements may incent providers and MCOs to address HRSN in an effort to provide more quality and efficient care, while not directly requiring MCOs to develop an HRSN strategy.

States are beginning to require plans to address HRSN through VBP initiatives and include HRSN-related measures in MCO incentive and withhold arrangements, but these activities are not common. The table below includes examples of states that: (1) require plans to address HRSN through VBP Initiatives; (2) use MCO incentive arrangements, withhold arrangements, and penalties; and (3) other VBP-related MCO HRSN examples.

Addressing HRSN through VBP Initiatives

State	Description
New Mexico	Establishes a Care Coordination Delegation program where care coordination is delegated, or partially delegated, to a specific provider as part of a VBP arrangement. Under one option, the MCO can share care coordination functions related to coordinating referrals and linking members to community services.
Rhode Island	Requires the MCO to work toward incorporating VBP initiatives that integrate medical care with HRSN and related social services.

MCO Incentive Arrangements, Withhold Arrangements, and Penalties

State	Description
Michigan	Ties bonuses under the state's Pay-for-Performance program to the submission of plans and reports relating to a proposed population health intervention focused on HRSN, noting the state's specific interest in housing. Performance bonuses are tied to a withhold arrangement, under which 1% of capitation payments are withheld. Also includes related HRSN-related focus bonus programs on low birth weight and ED use.
New Mexico	Incorporates a community health worker (CHW) delivery system improvement performance target: 3% of the MCO's total enrollment to be served by CHWs, Community Health Representatives, and Certified Peer Support Workers. This metric is assigned 20 points out of 100. If targets are not met, the state can impose performance penalties of 1.5% of the capitation rate.
North Carolina	A plan that voluntarily contributes at least 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 plan contributes.

Other VBP-Related HRSN Examples

State	Description
North Carolina	North Carolina's Section 1115 demonstration authorizes the creation of "Lead Pilot Entities" (LPEs) in each pilot region. The LPEs will develop, contract with, and manage a network of community-based organizations (CBOs), social service providers, and health care providers to deliver case management and services relating to housing, food, transportation, and interpersonal violence. The state's Medicaid health plans must: (1) participate in the pilot program; (2) authorize, and determine eligibility for, services; and (3) work in collaboration with the LPE to track the provision of pilot services. The state is required to create a "pathway" to VBP for this HRSN-focused pilot program, "increasingly linking payments for pilot program services to health and socioeconomic outcomes based on the pilot services" and "gathering the required data and experience needed for more complex risk-based models." By pilot year five, the LPEs responsible for pilot program services will be eligible to receive shared savings from a Medicaid health plan.
New York	New York includes a specific HRSN initiative in its VBP Roadmap to "financially reward, rather than penalize, providers and plans who deliver high-value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health." In furtherance of this goal, New York requires providers in advanced VBP agreements to implement at least one HRSN intervention, with the VBP arrangement also including at least one CBO. The state offers providers a comprehensive menu of possible HRSN interventions, such as a Housing First program to address homelessness or mold abatement to alleviate respiratory issues. MCOs must provide a funding advance for providers investing in the required intervention, as well as bonuses to providers in less advanced VBP arrangements that invest in an HRSN intervention voluntarily.

MCO Contracting Requirements and Incentives to Address HRSN

A recent analysis of state Medicaid managed care contracts showed that states often require MCOs to screen for social needs and link members to community resources, but do not often establish specific expectations around the direct provision of services that address those needs. However, states may choose to be less prescriptive when interacting with MCOs and instead set up financial incentives that give plans the flexibility to address HRSN.

MCO Contracting Requirements

Contracting Incentives	Description
Require a portion of profits/reserves to be spent on HRSN	States have the flexibility to require that a portion of the profits/reserves be spent on HRSN. This can either be in general or specific areas of interest. ■ North Carolina requires a medical loss ratio (MLR) of 88%. "If the MLR is less than the minimum MLR threshold, the plan can either remit a rebate back to the state or 'contribute to health-related resources targeted toward high- impact initiatives. A plan that voluntarily contributes at least 0.1% of its annual capitation revenue in a region to health-related resources may be awarded a preference in auto- assignment. ■ Arizona, for community reinvestment, requires "the Contractor shall demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing 6% of its annual profits to community reinvestment."
Alter Quality Assessment and Performance Improvement (QAPI) requirements	States can require Performance Improvement Projects on HRSN, which require that HRSN be factored into QAPI and Population Health Management processes: ■ Oregon, requires the MCO to commit to addressing population health issues within a specific geographic area and utilizing Certified Traditional Health Workers and Traditional Health Workers.
Require MCOs to invest into or use common infrastructure that enables HRSN work	States can require plans to invest into common infrastructure project that enables HRSN work and also eases burden on state to finance project: ■ Pennsylvania's contract states that the "HealthChoices MCO has the responsibility to coordinate the care of children who require therapeutic interventions and medication to treat mental health conditions especially those children in foster care. In order to improve the quality of care for children that require psychotropic medication, the MCO will contract with a telephonic Psychiatric Consultation Team (PCT) that will provide real time telephonic consultative services to prescribers of psychotropic medications for children." ■ New Mexico's managed care organizations are required to support Project ECHO as a way to improve access and lower costs. ■ North Carolina's pre-paid health plans are expected to use NCCare360, which is a statewide resource referral platform.
Require partnerships with community partners and conduct community outreach/Community Health Assessments	States can require partnerships to ensure that MCOs work with CBOs, accountable health communities, and social service agencies to align investment strategies: ■ Delaware requires the MCO to identify members who may benefit from wellness programs, covered by the MCO or available through community organizations, and to provide appointment assistance and linkages with these services. ■ Iowa requires the MCO to coordinate with state agencies and CBOs to support community-based efforts. Examples of partnerships include the Department of Education, Juvenile Justice Services, and other community-based agencies. ■ Kansas requires the MCO to have a Community Service Coordinator available to members who will act as the single point of contact for the member and will ensure linkage and referral to community resources and non-Medicaid supports. ■ New Hampshire requires the MCO to develop relationships that actively link members with other state, local, and community programs that may provide or assist with related health and social services to members, including but not limited to justice systems, schools, family organizations, youth organizations, consumer organizations, faith-based organizations, and the court system. ■ Washington State requires the MCO to coordinate with and enroll members in social service programs available through other state agencies such as the Department of Health, Department of Corrections, and Department of Vocational Rehabilitation.

MCO Contracting Incentives

Contracting Incentives	Description
Altering MCO payment	Options include: ■ Directly incentivizing health plans to invest in efforts to meet nonmedical needs via withhold and incentive arrangements. Michigan, for example, ties bonuses under the state's Pay-for-Performance program to MCO submission of plans and reports relating to a proposed population health intervention focused on HRSN, noting the state's specific interest in housing. Performance bonuses are tied to a withhold arrangement, under which 1% of capitation payments are withheld. Also includes HRSN-related focus bonus programs on low birth weight and ED use. ■ Adjust health plan capitation rate based on social risk factors. For example, in 2016, Massachusetts' MassHealth included social risk factors into their calculation of plan capitation rates. The state found that the new model improved the accuracy of payments and setting targets for financial goals.
Cover *in lieu of* services	States can make it easier for health plans to cover non-traditional services that are a direct substitute for other covered services, by identifying a defined set of *in lieu of* services as covered services. ■ Kansas, in its list of approved *in lieu of* services, includes services such as: (1) medical nutrition therapy; (2) assisted living rental; and (3) direct costs for transitions outside of institutional settings. ■ California, In its next phase of its managed care program, has proposed to formally incorporate *in lieu of* services that are provided as a substitute, or *to avoid*, other Medi-Cal covered services such as ER utilization, a hospital or skilled nursing facility admission, or a discharge delay. An initial proposed list includes: (1) housing transition and sustaining services; (2) recuperative care; (3) short-term non-medical respite; (4) home and community-based wrap around services for beneficiaries to transition or reside safely in their home or community; and (5) sobering centers.
Encourage use of value- added services	States can make it easier for health plans to pay for non-traditional services; e.g., provide guidance around "value-added services", including HRSN services. ■ Massachusetts, in its guidance to Senior Care Options plans, includes a list of housing-related services that can be voluntarily provided to members as a value-added service (outside of the official Community Support Program). These services include (1) assisting a member with housing search activities, (2) home modifications, and (3) paying for costs related to a member's transition into housing from institutionalization or homelessness (e.g., first month's rent or security deposit).
Incent community-based care coordination	States can strengthen care coordination across clinical and nonclinical contexts; e.g., including performance metrics that track referrals to social services, inclusion of social workers or CHWs in care teams, and data-sharing requirements. ■ New Mexico, in its contracts, notes that care coordination expenses relating to community health workers will be deemed "medical services." The contract incorporates a CHW delivery system improvement performance target: 3% of the MCO's total enrollment to be served by CHWs, Community Health Representatives, and Certified Peer Support Workers. This metric is assigned 20 points out of 100. If targets are not met, the state can impose performance penalties of 1.5% of the capitation rate.