

Identify and Address Social Needs in Primary Care:

Advancing Primary Care Innovation in Medicaid Managed Care

CHCS Center for Health Care Strategies, Inc.

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Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of *Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit*, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit www.chcs.org/primary-care-innovation.

Social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play.¹ For individual patients, social needs, such as food or housing insecurity, can have a substantial effect on health.

This module focuses on how state Medicaid agencies can use managed care contracting levers to focus on both population-level SDOH and individual-level social needs. At the population level, states can advance targeted, coordinated investments in local communities, and encourage managed care organizations (MCOs) to design interventions to reduce health disparities by using and analyzing social needs data. At the individual patient level, states can consider defining how primary care teams (PCTs) and MCOs: (1) screen for health-related social needs; (2) address identified needs through referral and partnerships with CBOs, as well as direct investments; and (3) advance whole-person approaches to care coordination and management. Across this spectrum of activities, states may define appropriate coordination, collaboration, and integration goals for both PCTs and MCOs.²

Design Considerations

Both PCTs and MCOs have an important role to play in identifying and addressing social needs and broader SDOH.³ States may develop a comprehensive strategy that addresses SDOH throughout a managed care contract. For example, the state may integrate a focus on social needs into contract sections relating to: training programs for network providers; care coordination and management; quality assurance and performance improvement; VBP; additional services such as value-added and in lieu of services; and MCO payment incentives. The state may also consider ways to develop a common infrastructure and tools that can enable both PCTs and MCOs to better identify and address social needs. Following are considerations to inform state efforts in developing an SDOH strategy:



IDENTIFY AND ADDRESS SOCIAL NEEDS: Design Considerations Summary

Explore flexible versus prescriptive approaches.

- ✓ Will the state encourage, incent, or require PCTs or MCOs to screen for social needs? If so: (a) what social needs should be screened for; (b) what type of screening tool should be used; (c) who should be screened; and (d) how should social needs information be documented and reported?
- ✓ How should PCTs or MCOs connect beneficiaries to, or invest in, community resources? Will the state mandate a particular tool (e.g., community resource referral platform) or method (e.g., warm hand-off)? Will the state require a certain level of MCO investment, or particular focus area (e.g., housing, food insecurity)?

Define the roles/responsibilities of the state, primary care teams, and MCOs.

- ✓ Who should screen for social needs?
- ✓ Who will define priorities for SDOH-related work? How can they solicit input from local communities to determine priority interventions and investments?
- ✓ How can the state ensure that its planned approach will enhance, and not detract from, the capacity of the community to address SDOH?

Determine how to measure, monitor, and reward progress.

- ✓ How will the state measure progress and hold MCOs accountable for implementing a SDOH strategy?
- ✓ Will the state require or incent MCOs to partner with CBOs, or invest in certain interventions?

Leverage payment reform to drive innovation.

- ✓ Will the state require MCOs to integrate social needs partnerships and related metrics into VBP requirements?

Determine the need for additional investments.

- ✓ What infrastructure and investments are needed to support this work? How will payment models and state investment and leadership support this infrastructure and investment?

✓ **Do PCTs and MCOs in the state already screen for social needs?**

First, the state may want to assess the degree to which: (1) PCTs participate in a particular model that includes social needs screening, such as Accountable Health Communities, Pathways Community HUB, or CPC+; and (2) MCOs integrate questions on social needs into their health risk assessments and other screeners.^{7,8,9} If PCTs and MCOs are already doing this work, states may prefer to be less prescriptive, outlining only general guidelines and avoiding potential conflicts with established systems and processes.

✓ **Who should screen for social needs?**

Both MCOs and PCTs can integrate social needs screening into their standard processes, and each approach has benefits. Individual MCOs are responsible for wider swaths of the Medicaid population and have the resources to systematize the collection of social needs data through health risk assessments and other screeners. However, many MCOs rely on telephonic care coordination processes that may not be as amendable to asking sensitive questions on social needs. By contrast, PCTs can likely develop a deeper, face-to-face connection with the patient, which can yield more complete and honest responses to social needs screening questions. The PCT, however, may not always have the resources to aggregate and analyze data. Building on these respective strengths, states can explore ways to encourage MCOs to partner with PCTs on, and pay PCTs for, care coordination functions that involve screening for social needs — avoiding unnecessary duplication where possible. In both MCOs and PCTs, community health workers can assist with these functions.



Managed Care Procurement

Following is sample state managed care request for proposal language related to social determinants of health:

Minnesota.⁴ “Describe how the Responder will commit resources towards improving population health. Describe how Responder will proactively coordinate with counties and others to address social determinants of health for customers. Describe how providers will be encouraged / incentivized to reach preventative goals for cost saving outcomes.”

Oregon.⁵ “Does Applicant currently have performance milestones and/or metrics in place related to social determinants of health and health equity? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.”

Virginia.⁶

- “How are social determinants assessed by your organization?”
- “What social determinants data elements are currently captured for your member population, and from what sources?”
- “What future data, data source(s), or technology enhancements are planned to capture more social determinants information?”
- “How does the Offeror partner with health care and social service providers to address social determinants? Describe any alternative payment arrangements that include social determinants reporting or intervention as a factor of payment.”
- “Describe your organizations ideas for best practices that should be included in [a] pilot program related to addressing nutritional insufficiency, including outreach and coordination with schools, community resources (including food resources), primary care physicians and/or other social services.”



✓ **Who should be screened?**

States may determine that only certain populations require a full social needs screening — for example, those who require more intensive care coordination because of complex needs or who have screened positively to a preliminary, shorter screen. However, given the prevalence of health-related social needs among Medicaid beneficiaries, gaps in screening practices may contribute to missed opportunities to determine appropriate diagnoses and approaches to care.

✓ **What data does the state need, and what data does the state have?**

The state may choose to allow an MCO to collect social needs information in the way it sees fit. At other times, the state may be interested in collecting standardized data from the plans to inform policy planning or a formal pilot evaluation. In either scenario, the state may assess what social needs information can be aggregated from other sources that can assist the state with its goals, and otherwise supplement MCO and PCT screening practices.

✓ **What needs should be screened for, and what type of screening tool should be used?**

Using current MCO/PCT screening practices and the state’s data needs as starting points, states may consider whether it will require a standardized screening tool or provide general guidelines on an appropriate tool (e.g., a preference for validated questions or for priority social needs, such as housing and food insecurity).¹³

✓ **How will identified social needs be documented?**

States may want to ensure that both MCOs and PCTs can access and supplement social needs screening information. States may defer to MCOs to define appropriate standards for social needs documentation, or encourage a particular approach, such as the use of Z Codes in the ICD-10 set.

Managed Care Contract Excerpts

Following is sample state managed care contract language related to social determinants of health:

Louisiana.¹⁰ [The contractor shall]:

- “Offer evidence-based practices that have a demonstrated ability to address SDOH and reduce health disparities [...]”
- “Collaborate with its high-volume primary care practices to develop, promote and implement targeted evidence-based practice.”
- “Measure and report semi-annually to LDH on the effectiveness of its evidence-based interventions to reduce health disparities. Minimum reporting requirements include data on self-reported race, ethnicity, language, housing, food, transportation, employment and safety needs, care management model utilized, risk stratification criteria highlighting priority populations, and targets for engagement and outcomes stratified by priority subgroup [...]”

Oregon.¹¹ [Contractor must, through its Community Advisory Council:]

- “Include SDOH and Health Equity partners and organizations, counties, traditional health workers, and tribes in development of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHP).”
- [Develop] “shared CHA and CHP priorities and strategies with local public health authorities, nonprofit hospitals, [...] other coordinated care organizations [...], and [...] federally recognized tribe[s...]”

Pennsylvania.¹² The [MCO] will ensure the PCMH provider:

- “Will deploy a community-based care management team [...]that] connect[s] individuals as needed to community resources and social support services through ‘warm hand off’ referrals for assistance with problems such as food insecurity and housing instability.”
- “Will [...] submit ICD-10 diagnostic codes for all patients”

✓ ***How should PCTs and MCOs connect beneficiaries to community resources? Who should be responsible for creating the necessary infrastructure to support this work?***

Under federal rules, MCOs must coordinate the services they deliver with those available through community and social support providers.¹⁴ States may build upon this general obligation to require the MCO to refer enrollees to community resources, or to advance particular types of referral in partnership with PCTs (e.g., “warm handoffs”). The state may also require the MCO to: (1) maintain an up-to-date list of community resources; (2) use specific referral pathways, such as 211; (3) implement closed-loop referral processes, whereby the MCO or PCP tracks whether a beneficiary actually received a service; or (4) facilitate formal partnerships among CBOs, MCOs, and providers. The state may also introduce a common resource for MCOs and PCTs that can facilitate this process, as **North Carolina** has done with its NCCARE360 community resource referral platform.¹⁵

✓ ***Who will define priorities for SDOH-related work?***

States may direct MCOs to: (1) collaborate with PCTs on evidence-based interventions relating to SDOH; (2) target those efforts to a particular state priority area, such as food or housing insecurity; or (3) identify interventions that are relevant to a particular community, as identified through data analysis or stakeholder engagement. Additionally, the state may present its specific SDOH requirements in the context of a particular health disparity, such as maternal mortality or low birth weight.

✓ ***Will the state require or incent MCOs to partner with CBOs, or invest in certain interventions?***

To support care coordination and craft an effective SDOH strategy, MCOs can learn from, partner with, and sometimes fund CBOs that address the social needs of members. The state may direct MCOs to enter into formal partnerships with CBOs, and integrate PCTs into these partnerships and intervention programs, to the extent possible. The state may also encourage, incent, or require MCO investment in local communities, as in **Arizona, North Carolina, and Oregon**.^{16,17,18} The state may also define a priority area for investment, such as housing.

✓ ***How will MCOs or PCTs solicit input from local communities to determine priority interventions and investments?***

States may define expectations around consumer and community perspectives, or require a specific structure or process to capture this input, such as **Oregon’s** community advisory councils and coordinated community health assessments.

✓ ***How can the state ensure that its planned approach will enhance, and not detract from, the capacity of the community to address SDOH?***

States may consider how to advance MCO-CBO partnerships, and avoid unintended consequences arising from MCO contract requirements. For example, states may encourage MCOs to contract with and fund existing community health worker programs with strong connections to local communities, as opposed to merely strengthening and staffing in-house MCO activities. The state may also encourage MCOs to design programs that help CBOs build capacity to address an uptick in referrals from MCOs, such as through upfront working capital or performance-based incentives (See [VBP requirements](#) in **New York** and **Oregon**).

✓ **How will the state measure progress and hold MCOs accountable for implementing an SDOH strategy?**

States may implement specific SDOH requirements in the context of: (1) a larger health equity initiative; (2) a targeted performance improvement project; (3) a VBP initiative; (4) a withhold or incentive arrangement; (5) an MCO care management requirements; or (6) a § 1115 demonstration project or pilot. Each of these approaches will have its own data and monitoring needs, as well as its own relationship to MCO or provider payment. The state may choose to focus on more clinical indicators, such as emergency department utilization or readmission rates. Alternatively, the state may choose to track social needs screening rates, or more subjective measures such as “healthy days” or self-rated health status.¹⁹

State Approaches

States may take various approaches to identifying and addressing social needs in Medicaid programs. The approach may be flexible, defining state expectations and allowing space for MCO customization, or prescriptive, advancing state standardization and MCO implementation of a standardized model or tool. Following are specific state examples for identifying and addressing social needs for Medicaid populations.

Flexible	Prescriptive
Approaches to Identifying Social Needs	
<p>Pennsylvania requires MCOs to ensure that its patient-centered medical homes complete an SDOH assessment using a “nationally recognized tool.” MCO case/disease and health management programs must “include collaboration with the Department to develop, adopt and disseminate a Social Determinants of Health assessment tool.”²⁰</p>	<p>Kansas,²¹ Louisiana,²² and North Carolina²³ require MCOs to use state-developed social needs screening questions.</p>
Approaches to Addressing Social Needs	
<p>Michigan²⁴ and Louisiana²⁵ require its MCOs to collaborate with its high-volume primary care practices to “develop, promote, and implement targeted evidence-based interventions” that can address SDOH and health disparities.</p>	<p>North Carolina requires MCOs to use a community resource referral platform called NCCARE 360.²⁶ The system will enable health care and human service providers to send and receive secure electronic referrals, share client information, and track outcomes.</p>
<p>Pennsylvania requires MCOs to design a community-based care management program and team, which can include provider partners. MCOs must implement at least one rapid cycle quality improvement pilot program, implemented with CBOs and focused on improving health outcomes and addressing social determinants of health.²⁷</p>	<p>Virginia requires MCOs to coordinate with the state on a pilot program addressing nutritional insufficiency, with a particular focus on children.²⁸</p>

Measurement and Payment

Measurement and payment approaches relating to SDOH are relatively nascent, but states are beginning to integrate SDOH measures and incentives into their Medicaid programs, such as through ACO quality measures, VBP initiatives, and MCO incentive and withhold arrangements. Following are examples of state measurement and payment strategies related to social needs.

State	Description
Accountable Care Organization Measures	
Massachusetts	Health-Related Social Needs Screening ²⁹ - Percentage of members who were screened for health-related social needs in the measurement year.
Minnesota	Health Equity Measure ³⁰ - During contract discussions, Minnesota’s Integrated Health Partnership (IHP) attributed population will be examined to determine its predominant health disparities using DHS data as well as information provided by the IHP. The IHP will be required to propose an intervention and health equity measures tied to this intervention that are intended to reduce health disparities among the IHP’s population.
Rhode Island	Social Determinants of Health Screening ³¹ - The percentage of attributed patients who were screened for SDOH using a state-approved screening tool, where the Accountable Entity has documented the screening and results.
Rhode Island	Self-Reported Health Status - Adults ³² - The percentage of attributed patients who completed a Self-Reported Health Status screening, where the AE has documented the screening and the results.
Value-Based Payment Requirements	
New York ³³	New York requires certain advanced VBP arrangements to include at least one SDOH intervention and one partnership with a CBO. MCOs must provide a funding advance that assists the provider or CBO implement the intervention.
North Carolina ³⁴	North Carolina will require plans to “submit a written plan [...] that indicates how it will incorporate addressing Opportunities for Health [activities relating to health-related social needs] into its VBP strategy to align financial incentives and accountability around total cost of care and overall health outcomes.”
Oregon ³⁵	Oregon requires CCOs to design payment arrangements that reward participating providers for their role in achieving MCO incentive metrics under the state’s Quality Pool and Challenge pool. CCOs must: <ul style="list-style-type: none"> ■ “offer correlative arrangements with Participating Providers (including Social Determinants of Health & Health Equity (SDOH-HE) partners, public health partners, and other health-related services providers as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives.” ■ “create a distribution plan for Quality Pool and Challenge Pool earnings. The plan should include [among other factors] [...] an overview of the methodology and/or strategy used to distribute quality pool earnings to participating providers, including SDOH-HE and public health partners, that provides information related to the contractor’s process of evaluating the contributions of participating providers and connecting those evaluations to distribution of funds.”

State	Description
MCO Withhold and Incentive Arrangements	
Michigan ³⁶	<p>Michigan has three MCO pay for performance (P4P) programs relating to SDOH; in each program, the MCO submits a baseline analysis, intervention proposal, and intervention report:</p> <p>Pay for Performance on Population Health and Health Equity. The state’s managed care contract defines a “population health management intervention” relating generally to social determinants of health and notes a particular state interest in housing.</p> <p>Low Birth Weight (LBW) Project. “For FY 2018, the goal is to involve the Medicaid Health Plans, existing home visiting programs, and community health worker programs to design and implement a meaningful P4P project. In order to improve infant health outcomes, the initiative will address documented health disparities and health inequities with particular focus on reducing the LBW-CH rate. The activities in FY18 will include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health. They will also incorporate parties who focus on maternity care to identify and implement models of choice through collaborative processes.</p> <p>The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: [a] Preconception, [b] Timeliness of prenatal care, [c] Post-partum care”</p> <p>Emergency Department Utilization. “Emergency Department (ED) utilization provides a snapshot about quality and access issues faced by Michigan Medicaid beneficiaries and their surrounding community. Health Plans will explore and develop innovative initiatives to improve the effectiveness and performance of ED utilization. Interventions should focus on the reduction and/or elimination of ED visits related to A) behavioral health, or B) substance use disorder treatment, or C) dental problems. They should also emphasize the clinical and non-clinical aspects of a member’s socio-logical system. Goals may include improvement in health outcomes; enhanced coordination of services and partnering with non-traditional healthcare providers; and increased cost-effectiveness with a major effort to lower inappropriate ED Utilization in the Michigan Medicaid Managed Care population. “</p>
Oregon ³⁷	<p>SDOH and Health Equity Bonus Fund. Oregon’s most recent RFP notes that the state “intends to establish a two-year incentive arrangement — the SDOH-HE Capacity-Building Bonus Fund (“SDOH-HE Bonus Fund”) — to offer monetary bonus payments above and beyond the capitation rate to contractors that meet SDOH-HE-related performance milestones and metrics.” These milestones and metrics have yet to be defined.³⁸ CCOs must submit a plan for how Contractor intends to direct its SDOH-HE spending for SDOH-HE that includes an evaluation plan and budget proposal. The CCO must also enter into formal written arrangements with SDOH-HE partners.</p>

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About this Resource

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs. To learn more, visit www.chcs.org.

ENDNOTES

¹ Centers for Disease Control and Prevention. "Social Determinants of Health: Know What Affects Health." Available at: <https://www.cdc.gov/socialdeterminants/>

² "Levels of HRSN and SDH Integration Framework: A Practical Framework to Help Healthcare and Social Service Partners Address Health-Related Social Needs and Social Determinants of Health." HealthBegins, April 2019. Available at: https://www.healthbegins.org/uploads/2/2/0/4/22040328/levels_of_hrsn_and_sdh_integration_framework.pdf

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⁴ Request for Proposals for a Qualified Grantee to: Provide Health Care Services to Families and Children through Medical Assistance (Families and Children) and MinnesotaCare in 80 Greater Minnesota Counties, p. 60. Purchasing and Service Delivery Division, Minnesota Department of Human Services, February 25, 2019. Available at: https://mn.gov/dhs/assets/2019-fc-2020-rfp-amended-to-provide-prepaid-hc-to-greater-mns-eligible-fc-and-minnesotacare-individuals_tcm1053-385010.docx

⁵ RFA OHA-4690-19-0 – CCO 2.0. Attachment 10 — Social Determinants of Health and Health Equity. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/09-CCO-RFA-4690-0-Attachment-10-SDOH-HE-Questionnaire-Final.pdf>

⁶ Page 98. RFP 2017-03 – Medallion 4.0. Commonwealth of Virginia Department of Medical Assistance Services. Available at: <https://www.bidnet.com/bneattachments/?/459484772.pdf>.

⁷ Centers for Medicare & Medicaid Services. "Accountable Health Communities Model." Available at: <https://innovation.cms.gov/initiatives/ahcm/>

⁸ Pathways Community HUB Institute. "Pathways Community HUB Model Overview." Available at: <https://pchi-hub.com/hubmodeloverview>

⁹ Centers for Medicare and Medicaid Services. "Comprehensive Primary Care Plus." Available at: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

¹⁰ Section 2.6.4.3, pp. 88-89. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf

¹¹ OR: Exhibit N, Page 197. RFA OHA-4690-19-0 – CCO 2.0. Appendix B – Sample Contract. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf>

¹² PA; Exhibits DDD-2. HealthChoices Agreement Exhibits – Effective January 1, 2019. Pennsylvania Department of Human Services. Available at: http://dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf.

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¹⁴ 42 C.F.R. 438.208(b)(2)(iv).

¹⁵ Y. Cartier, C. Fichtenberg, L. Gottlieb. “Community Resource Referral Platforms: A Guide for Health Care Organizations.” Available at: <https://sirenetwork.ucsf.edu/tools-resources/resources/community-resource-referral-platforms-guide-health-care-organizations>

¹⁶ Page 185. Contract No. YH19-0001. Amendment #1. Arizona Health Care Cost Containment System. October 1, 2018. Available at: https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/ACC/ACC_Contract_Amend_1.pdf (“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.”).

¹⁷ Page 143, 198-9. Attachment V. Scope of Services. RFP 30-190029-DHB. North Carolina Department of Health and Human Services. Available at: <https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf> (encouraging plans to voluntarily contribute to health-related resources “that help to address Members’ and communities’ unmet health-related needs,” and allowing plans to: count contributions in the numerator of the MLR; donate to health-related resources in lieu of a rebate; and earn a preference in auto-assignment for contributions).

¹⁸ Page 199. Exhibit N. Appendix B – Sample Contract. RFA OHA-4690-19-0 tlh. Oregon Health Authority. Effective January 1, 2020. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf> (“Contractor shall spend a portion of annual net income or reserves on services designed to address health disparities and the social determinants of health, according to requirements in Oregon Administrative Rule and ORS 414.625(1)(b)(C).”)

¹⁹ Humana News. “Humana’s 2019 Bold Goal Progress Report Details A Focus On Social Determinants of Health and Improved Healthy Days in its Medicare Advantage Population.” Available at: <https://humananews.com/2019/04/humanas-2019-bold-goal-progress-report-details-a-focus-on-social-determinants-of-health-and-improved-healthy-days-in-its-medicare-advantage-population/>

²⁰ Exhibits DDD-2, M(1)-10. HealthChoices Agreement Exhibits – Effective January 1, 2019. Pennsylvania Department of Human Services. Available at: http://dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf

²¹ See Attachment E and Attachment F. KanCare 2.0 Request for Proposal and Attachments. Kansas Department of Administration. Available at: <https://admin.ks.gov/offices/procurement-and-contracts/kancare-award> (sample health screen and health risk assessment includes questions on social needs).

²² See Section 2.7.2.5.1, p. 89. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf (referring to a “common survey-based instrument,” to be developed by the state)

²³ See Page 142. Section V: Scope of Services. Request for Proposals 30-190029-DHB. North Carolina Department of Health and Human Services, 2018. <https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf> (referring to “standardized screening questions, to be developed by the Department, to identify Members with unmet health-related resource needs who require a Comprehensive Assessment for care management.”)

²⁴ Page 69. State of Michigan Comprehensive Health Care Program Contract. Michigan Department of Health and Human Services, effective July 2, 2018. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf

²⁵ Section 2.6.4.3.2, page 88. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf

²⁶ North Carolina Department of Health and Human Services. NCCARE 360. Available at: <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360>

²⁷ Exhibit B(5). HealthChoices Agreement Exhibits – Effective January 1, 2019. Pennsylvania Department of Human Services. Available at: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf

²⁸ Section 8.9A, page 233. Medallion 4.0 Managed Care Services Agreement. Commonwealth of Virginia Department of Medical Assistance Services, July 2018. Available at: [http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20\(07.26.2018\).pdf](http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf)

²⁹ Appendix D. DSRIP Protocol. MassHealth (Project Number I I-W-00030/1). Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-appvcd-dsrp-prtcl-20190408.pdf>

³⁰ Page 18. “Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration.” Minnesota Department of Human Services Health Care Administration, June 11, 2018. Available at: https://mn.gov/dhs/assets/2019-ihp-rfp_tcm1053-294430.pdf

³¹ Accountable Entity Social Determinants of Health Measure. Rhode Island Executive Office of Health and Human Services, February 15, 2018. Available at: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/SDOH%20Guidance%20Document%202018-02-15.pdf>

³² Accountable Entity Self-Reported Health Measure. Rhode Island Executive Office of Health and Human Services, February 15, 2018. Available at: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/Self%20Reported%20Health%20Measure%202018-02-15.pdf>

³³ Pages 44-47. "A Path toward Value Based Payment: Annual Update (June 2018: Year 4) New York State Roadmap for Medicaid Payment Reform," New York State Department of Health. Available at: <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/medicaid-redesign-team/ny-medicare-rdsgn-vbp-roadmap-apprvl-20190501.pdf>; *see also* New York State Department of Health. "Social Determinants of Health and Community Based Organizations." Available at: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/

³⁴ Section 8(d)(iii), p. 141. Section V: Scope of Services. Request for Proposals 30-190029-DHB. North Carolina Department of Health and Human Services, 2018. Available at: <https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf>

³⁵ Page 103. RFA OHA-4690-19-0 – CCO 2.0. Appendix B – Sample Contract. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA-4690-0-Appendix-B-Sample-Contract-Final.pdf>

³⁶ https://www.michigan.gov/documents/contract_7696_7.pdf

³⁷ *Ibid.*, p. 201.

³⁸ RFA OHA-4690-19-0 – CCO 2.0. Attachment 10 — Social Determinants of Health and Health Equity. Oregon Health Authority, 2019. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/09-CCO-RFA-4690-0-Attachment-10-SDOH-HE-Questionnaire-Final.pdf>