

Review of Social Determinants of Health Terms in 2019-2020 State Medicaid Managed Care Contracts

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The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

Additional information about the Geiger Gibson Program can be found online at <https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy>.

Background

In recent years, states increasingly have sought to use Medicaid managed care to promote health care as an entry point into access to services aimed at addressing underlying social determinants of health (SDoH). State Medicaid programs primarily rely on managed care to provide efficient, comprehensive, quality care. Today, approximately seven in ten Medicaid beneficiaries are enrolled in managed care.¹ As research continues to establish the importance of addressing social determinants of health,² the ongoing pandemic highlights significant needs to address and incorporate SDoH into services for low-income and racial/ethnic minority beneficiaries. This blog describes findings from the first phase of the study. George Washington University (GW) researchers conducted a contract review of Medicaid managed care organization (MCO) contracts from 39 states and the District of Columbia (DC). The contract review was based on the 40 MCO model or executed contracts that were publicly available as of October 1, 2019 and the contract review process was completed in June 2020.

Methodology

Researchers applied a review instrument focused on ten major domains: 1) a formal SDoH screening process, 2) discretionary value-added SDoH services, 3) data collection and reporting of SDoH information, 4) social services provider relationships, 5) SDoH expenditure requirements or incentives, 6) provider training in SDoH, 7) MCO staff dedicated to SDoH activities, 8) SDoH quality measures, 9) SDoH care coordination or management, and 10) member education for SDoH (see Appendix A for all domains).

State-by-State Contract Review Findings

Though each state takes a unique approach (see table and associated contract terms in the Appendix B), several patterns emerge. Thirty-five state Medicaid managed care “boilerplate” contracts include some SDOH language (contracts for DC, MO, ND, NV, and UT did not include any SDOH language based upon the domains assessed). Thirty-two states require some sort of collection of SDOH-related data from beneficiaries, most often through screening in primary care settings (30 states), but less often through collection and/or reporting of social determinant-related information (nine states). They primarily want MCOs to use this data directly by including relationships with social services providers in their contracts (33 states), care coordination with an emphasis of SDoH (26 states), and direct beneficiary education for SDoH (nine states). Nineteen states required having MCO staff members who are dedicated to SDoH activities.

¹ Kaiser State Health Facts. (2021). Total Medicaid MCO Enrollment. <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment>

² Magnan, S. (2017). Social Determinants of Health 101 for Health Care (Discussion Paper). National Academy of Medicine. <https://nam.edu/wp-content/uploads/2017/10/Social-Determinants-of-Health-101.pdf>.

Two significant overlapping practices in efforts to address SDOH are screening for social needs and referral to public and nonprofit resources to address these needs. Thirty states require some kind of social needs screening in a primary care setting. This requirement appears with both very high and low levels of specificity, with some states requiring a specific screening process or tool and others leaving it to the MCO to work out the details. For example, California requires that primary care providers use a screening tool supplied by the state and to administer the screening within 120 days of enrollment. This compares to vaguer language from Indiana's contract: "Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care."

In turn, 33 states require MCOs to have relationships with social service providers whose programs can help meet the social needs of beneficiaries. Of the states that specify certain types of social needs and related organizations, they most frequently cite education, food, housing, and employment related resources as targets of MCO coordination. States are more likely to specify government agencies and programs, such as schools, nutrition programs, and housing authorities than private community resources, but frequently indicate that MCOs should coordinate with entities in both the public and private sectors. For example, Hawaii requires contractors to coordinate with Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), a narrow but specific contract provision. In contrast, Colorado requires that MCOs "establish relationships and collaborate with economic, social, educational, justice, recreational, and other relevant organizations to promote the health of the local communities and populations... establish relationships and communications channels with Community organizations that provide resources such as food, housing, energy assistance, childcare, education, and job training in the region." This leaves it to the discretion of the contractor to work out which agencies and organizations to develop relationships with and the extent of these relationships, but lays out a broader set of social determinants for MCOs to address.

In addition to these majority trends, there are several minor themes. Twelve states (AZ, CA, DE, FL, GA, KS, LA, MN, NC, NH, NY, TN) have provider training requirements that could cover social determinants of health. Eight contracts (DE, FL, IA, LA, NH, NM, TX, WV) explicitly permit or require "value-added services," which are services not traditionally covered by Medicaid and not included in capitation rate setting, but which can be included in calculating the medical loss ratio; these provisions do not explicitly contemplate SDOH-focused services, but such services would certainly fit within the umbrella of value-added services. Four states (CO, KS, OR, PA) either direct MCOs to make minimum expenditures on social determinants of health programs (OR), incentivize SDOH performance measures (CO), or focus funding and activities on SDOH (KS, PA).

In summary, a June 2020 review of Medicaid managed care organization (MCO) contracts publicly available as of October 1, 2019 shows:

- Thirty states require the use of a screening process in primary care that incorporates various factors relating to social determinants in order to systematically detect health-related social needs of beneficiaries.
- Nine states (CO, DE, FL, KS, LA, MI, NE, NH, OH) require MCOs to collect and/or report social determinant related information.
- Thirty-three states require MCOs to have relationships with social service providers whose programs can help meet the social needs of beneficiaries.
- Four states (CO, KS, OR, PA) direct MCOs to incentivize, make minimum expenditures, or focus funding or activities on social determinants of health programs.
- One state (CO) includes performance incentives for social determinants.
- Twelve states (AZ, CA, DE, FL, GA, KS, LA, MN, NC, NH, NY, TN) have provider training requirements to identify and respond to social determinants of health.
- Nineteen states require MCOs to have staff dedicated to social determinants.
- Fourteen states (AZ, CO, HI, IL, KS, LA, MD, MI, NH, NJ, OH, OR, PA, WI) require MCOs to submit SDOH-related quality performance measures.
- Twenty-six states require care coordination and/or management related to social determinants.
- Nine states (AZ, CA, CO, GA, IA, LA, MD, MI, TX) require MCOs to provide member education regarding social determinants or social service resources.

Conclusion

At this early stage of SDOH incorporation, many states are targeting their programming, particularly screening and care management/coordination, towards high-risk populations, such as beneficiaries in substance use disorder treatment or those with significant behavioral health needs, children with complex care needs, beneficiaries living with HIV, and individuals with multiple comorbidities. With limited resources, MCOs and providers are unlikely to have the capacity to address a wide range of SDOH needs to the broader at-risk populations. Very few states seek to provide separate funding for SDOH services or account for those expenditures in their payment methodology. However, much like data collection and reporting provisions, the terms of various financial obligations are not specified. The lack of specificity and early setting of SDOH requirements likely reflect limited understanding of health-related social needs and costs as well as the needed local or regional flexibility to address the wide range of community SDOH issues.

Appendix A: SDOH Contract Review Domains

1. Use of Social Determinant Screening Process in Primary care
 - a. Use of a social determinant screening process in primary care means use by primary care providers/in primary care settings of screening tools such as CMS's Accountable Health Communities Health-Related Social Needs Screening Tool to systematically detect the health-related social needs of beneficiaries.
2. Value-Added Services Related to Social Services
 - a. Value-added services means additional services not included in the state Medicaid plan but that could be counted in calculating a plan's medical loss ratio, that is, the percentage of the managed care premium spent on medical care as well as activities that improve quality or address fraud prevention. Although value-added services can be considered in calculating the medical loss ratio, they cannot be counted for purposes of setting the capitation rate. In effect, these are additional services furnished at the discretion of the MCO and/or its provider network. (Note that the Medicaid managed care rule provides no definition of value-added services, although the Preamble to the final rule contains a brief discussion of the concept). This could apply to primary care or behavioral health care in primary care settings.
3. Collection and/or Reporting of Social Determinant-Related Information
 - a. Collection and reporting of social determinant-related information means collection by the MCO and/or reporting of data to the state of the social determinant needs of the beneficiary population.
4. Social Service Provider Relationships
 - a. Social service provider relationships mean interactions—including care coordination, care integration, data sharing, referrals and communication—between primary care providers and local, state or federal agencies or other entities tasked with providing social services to the beneficiary. Social services deal with economic stability, housing, education, relationships, neighborhood, and other environmental influences.
5. Social Determinant Expenditure Requirements or Incentives
 - a. Social determinant expenditure requirements or incentives (individual patients or community-wide) means contractual requirements or incentives for managed care organizations to make certain expenditures, such as a fixed portion of their profit, to address the social determinants related needs of beneficiaries.
6. Provider Training in SDOH
 - a. Provider training in social determinants of health (SDOH) means requiring programs to train medical professionals to identify and respond to patient needs

related to SDoH, including case management and referrals to community-based organizations.

7. MCO Staff Dedicated to SDoH Activities

- a. MCO Staff Dedicated to SDoH Activities means managed care organizations (MCOs) employing staff including but not limited to case managers or social workers to facilitate the provision of social determinants of health activities to their beneficiaries. This may also refer to specific “programs” without reference to specific staff.

8. Social Determinant-Related Quality Performance Measures

- a. Social determinant-related quality performance measures means requiring performance measures capturing the managed care organization’s activities addressing social determinants of health in the beneficiary population, including data collection, service referrals, provider training, and MCO spending on social determinants of health. If contract specifies, please note whether measures are MCO-specific, state, demonstration, or other measure.

9. Care Coordination/Management for SDoH

- a. Care coordination/management for SDoH means the development of care plans and arranging for and managing access to and management of services related to social determinants of health (note that this definition excludes coordination between health care and social service providers, which is identified by the Social Service Provider Relationships domain).

10. Member Education for SDoH

- a. Member education for SDoH means provider provision of information regarding social determinants or social service resources to MCO members.

Appendix B. Social Determinants of Health Activities in Medicaid Managed Care Contracts

This table provides an overview of states' use of comprehensive Medicaid managed care to address social determinants of health. It allows readers to view the extent to which any single state addresses any one of the ten major domains of managed care and primary care purchasing within its state purchasing agreements, as well as the actual language used by the state in addressing any particular contract domain.

State	Use of a Social Determinant Screening Process in Primary Care*		Value-Added Services Related to Social Determinants [†]		Collection and/or Reporting of Social Determinant-Related Information [‡]		Social Service Provider Relationships [§]		Social Determinant Expenditure Requirements or Incentives ^{**}	
	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)
	Y/N		Y/N		Y/N		Y/N		Y/N	
AZ	Y	X ¹	N		N		Y	X ²	N	

Notes: All contract language included in footnotes is directly quoted from state MCO model or executed contracts, depending on what the state made publicly available, as of October 1, 2019, unless otherwise noted.

* Use of a social determinant screening process in primary care means use by primary care providers/in primary care settings of screening tools such as CMS' Accountable Health Communities Health-Related Social Needs Screening Tool to systematically detect the health-related social needs of beneficiaries.

[†] Value-added services means additional services not included in the state Medicaid plan but that could be counted in calculating a plan's medical loss ratio, that is, the percentage of the managed care premium spent on medical care as well as activities that improve quality or address fraud prevention. Although value added services can be considered in calculating the medical loss ratio, they cannot be counted for purposes of setting the capitation rate. In effect, these are additional services furnished at the discretion of the MCO and/or its provider network. (Note that the Medicaid managed care rule provides no definition of value-added services, although the Preamble to the final rule contains a brief discussion of the concept.) This could apply to primary care or behavioral health care in primary care settings.

[‡] Collection and reporting of social determinant-related information means collection by the MCO and/or reporting of data to the state of the social determinant needs of the beneficiary population.

[§] Social service provider relationships means interactions-- including care coordination, care integration, data sharing, referrals and communication-- between primary care providers and local, state or federal agencies or other entities tasked with providing social services to the beneficiary. Social services deal with economic stability, housing, education, relationships, neighborhood, and other environmental influences.

** Social determinant expenditure requirements or incentives (individual patients or community-wide) means contractual requirements or incentives for managed care organizations to make certain expenditures, such as a fixed portion of their profit, to address the social determinants related needs of beneficiaries.

± Given California's decentralized healthcare system, we reviewed contract material relating to Medi-Cal's three separate models: County Organized Health Systems; Geographic Managed Care; and Imperial/Regional/San Benito/Two-Plan. The state has over 10 million covered lives under Medicaid managed care. For the purposes of this analysis, contractual language included was obtained from the County Organized Health System boilerplate contract.

¶ Indiana's managed care contract covers both of the state's comprehensive risk-based managed care plans, Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP). The HHW program covers pregnant women, children and parents and provides acute, primary, specialty, and behavioral health services. Pharmacy and dental benefits are carved out from the benefit package and provided on a FFS basis. The HIP program covers adults earning under 200% FPL and includes private insurance features such as Health Savings Accounts. HIP covers similar benefits as HHW but the state pays for most HIP members on a full-risk, capitated basis.

State	Use of a Social Determinant Screening Process in Primary Care*		Value-Added Services Related to Social Determinants†		Collection and/or Reporting of Social Determinant-Related Information‡		Social Service Provider Relationships§		Social Determinant Expenditure Requirements or Incentives**	
	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)
	Y/N		Y/N		Y/N		Y/N		Y/N	
CA‡	Y	X ³	N		N		Y	X ⁴	N	
CO	Y	X ⁵	N		Y	X ⁶	Y	X ⁷	Y	X ⁸
DC	N		N		N		N		N	
DE	Y	X ⁹	Y	X ¹⁰	Y	X ¹¹	Y	X ¹²	N	
FL	Y	X ¹³	Y	X ¹⁴	Y	X ¹⁵	Y	X ¹⁶	N	
GA	Y	X ¹⁷	N		N		Y	X ¹⁸	N	
HI	Y	X ¹⁹	N		N		Y	X ²⁰	N	
IA	Y	X ²¹	Y	X ²²	N		Y	X ²³	N	
IL	Y	X ²⁴	N		N		Y	X ²⁵	N	
IN [§]	Y	X ²⁶	N		N		Y	X ²⁷	N	
KS	Y	X ²⁸	N		Y	X ²⁹	Y	X ³⁰	Y	X ³¹
KY	Y	X ³²	N		N		Y	X ³³	N	
LA	Y	X ³⁴	Y	X ³⁵	Y	X ³⁶	Y	X ³⁷	N	
MA	Y	X ³⁸	N		N		Y	X ³⁹	N	
MD	Y	X ⁴⁰	N		N		Y	X ⁴¹	N	
MI	N		N		Y	X ⁴²	Y	X ⁴³	N	
MN	Y	X ⁴⁴	N		N		Y	X ⁴⁵	N	
MO	N		N		N		N		N	
MS	Y	X ⁴⁶	N		N		Y	X ⁴⁷	N	

‡ The document retrieved from the Nebraska website includes four amendments to the contract between the state of Nebraska and a Managed Care Organization (Nebraska Total Care, Inc.), as well as Nebraska’s original Request for Proposal (RFP). For purposes of this analysis, we have reviewed the four amendments as well as Nebraska’s RFP to ensure a comprehensive review of Nebraska’s Medicaid managed care system. We have added notations about the clauses to specify whether they are from the amendments or the RFP.

€ Nevada's contract with Amerigroup incorporates the original Request for Proposal (RFP). Thus, the parties are bound by the language in the RFP as well. Subsequent amendments deal primarily with provisions included in the RFP. For provisions in the original RFP that are not amended by subsequent documents, we cite to the original RFP. For amendments that change language in the original RFP that is incorporated into the Amerigroup Contract, we cite as Amendment # whatever it may be.

⌘ Oregon’s 2019 MCO model or executed contract was not publicly available at the time of this analysis.

State	Use of a Social Determinant Screening Process in Primary Care*		Value-Added Services Related to Social Determinants†		Collection and/or Reporting of Social Determinant-Related Information‡		Social Service Provider Relationships§		Social Determinant Expenditure Requirements or Incentives**	
	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)
	Y/N		Y/N		Y/N		Y/N		Y/N	
NC	Y	X ⁴⁸	N		N		Y	X ⁴⁹	N	
ND	N		N		N		N		N	
NE ^c	N		N		Y	X ⁵⁰	N		N	
NH	Y	X ⁵¹	Y	X ⁵²	Y	X ⁵³	Y	X ⁵⁴	N	
NJ	Y	X ⁵⁵	N		N		Y	X ⁵⁶	N	
NM	Y	X ⁵⁷	Y	X ⁵⁸	N		N		N	
NY	Y	X ⁵⁹	N		N		Y	X ⁶⁰	N	
NV ^e	N		N		N		N		N	
OH	Y	X ⁶¹	N		Y	X ⁶²	Y	X ⁶³	N	
OR ^h	N		N		N		Y	X ⁶⁴	Y	X ⁶⁵
PA	Y	X ⁶⁶	N		N		Y	X ⁶⁷	Y	X ⁶⁸
RI	Y	X ⁶⁹	N		N		Y	X ⁷⁰	N	
SC	Y	X ⁷¹	N		N		Y	X ⁷²	N	
TN	Y	X ⁷³	N		N		Y	X ⁷⁴	N	
TX	N		Y	X ⁷⁵	N		Y	X ⁷⁶	N	
UT	N		N		N		N		N	
VA	Y	X ⁷⁷	N		N		Y	X ⁷⁸	N	
WA	Y	X ⁷⁹	N		N		Y	X ⁸⁰	N	
WI	Y	X ⁸¹	N		N		Y	X ⁸²	N	
WV	N		Y	X ⁸³	N		Y	X ⁸⁴	N	
Total	Y = 30 N = 10		Y = 8 N = 32		Y = 9 N = 31		Y = 33 N = 7		Y = 4 N = 36	

State	Provider Training in SDOH ^{††}		MCO Staff Dedicated to SDOH Activities ^{‡‡}		Social Determinant-Related Quality Performance Measures ^{§§}	
	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)
	Y/N		Y/N		Y/N	
AZ	Y	X ⁸⁵	Y	X ⁸⁶	Y	X ⁸⁷
CA [±]	Y	X ⁸⁸	Y	X ⁸⁹	N	
CO	N		N		Y	X ⁹⁰
DC	N		N		N	
DE	Y	X ⁹¹	Y	X ⁹²	N	
FL	Y	X ⁹³	N		N	
GA	Y	X ⁹⁴	Y	X ⁹⁵	N	
HI	N		Y	X ⁹⁶	Y	X ⁹⁷
IA	N		Y	X ⁹⁸	N	
IL	N		N		Y	X ⁹⁹
IN [°]	N		Y	X ¹⁰⁰	N	
KS	Y	X ¹⁰¹	Y	X ¹⁰²	Y	X ¹⁰³
KY	N		N		N	
LA	Y	X ¹⁰⁴	Y	X ¹⁰⁵	Y	X ¹⁰⁶
MA	N		N		N	
MD	N		N		Y	X ¹⁰⁷
MI	N		Y	X ¹⁰⁸	Y	X ¹⁰⁹
MN	Y	X ¹¹⁰	N		N	
MO	N		N		N	

^{††} Provider training in social determinants of health (SDOH) means requiring programs to train medical professionals to identify and respond to patient needs related to SDOH, including case management and referrals to community-based organizations.

^{‡‡} MCO Staff Dedicated to SDOH Activities means managed care organizations (MCOs) employing staff including but not limited to case managers or social workers to facilitate the provision of social determinants of health activities to their beneficiaries.

^{§§} Social determinant-related quality performance measures means requiring performance measures capturing the managed care organization's (MCO's) activities addressing social determinants of health in the beneficiary population, including data collection, service referrals, provider training, and MCO spending on social determinants of health.

State	Provider Training in SDOH ^{††}		MCO Staff Dedicated to SDOH Activities ^{‡‡}		Social Determinant-Related Quality Performance Measures ^{§§}	
	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)
	Y/N		Y/N		Y/N	
MS	N		N		N	
NC	Y	X ¹¹¹	Y	X ¹¹²	N	
ND	N		N		N	
NE ^c	N		N		N	
NH	Y	X ¹¹³	Y	X ¹¹⁴	Y	X ¹¹⁵
NJ	N		N		Y	X ¹¹⁶
NM	N		Y	X ¹¹⁷	N	
NY	Y	X ¹¹⁸	N		N	
NV ^e	N		N		N	
OH	N		N		Y	X ¹¹⁹
OR ^d	N		N		Y	X ¹²⁰
PA	N		Y	X ¹²¹	Y	X ¹²²
RI	N		Y	X ¹²³	N	
SC	N		N		N	
TN	Y	X ¹²⁴	N		N	
TX	N		Y	X ¹²⁵	N	
UT	N		N		N	
VA	N		N		N	
WA	N		Y	X ¹²⁶	N	
WI	N		Y	X ¹²⁷	Y	X ¹²⁸
WV	N		Y	X ¹²⁹	N	
Total		Y = 12 N = 28		Y = 19 N = 21		Y = 14 N = 26

State	Care Coordination/Management for SDOH ^{***}		Member Education for SDOH ⁺⁺⁺	
	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)
	Y/N		Y/N	
AZ	N		Y	X ¹³⁰
CA [±]	Y	X ¹³¹	Y	X ¹³²
CO	Y	X ¹³³	Y	X ¹³⁴
DC	N		N	
DE	Y	X ¹³⁵	N	
FL	N		N	
GA	Y	X ¹³⁶	Y	X ¹³⁷
HI	Y	X ¹³⁸	N	
IA	N		Y	X ¹³⁹
IL	N		N	
IN ^e	Y	X ¹⁴⁰	N	
KS	Y	X ¹⁴¹	N	
KY	Y	X ¹⁴²	N	
LA	Y	X ¹⁴³	Y	X ¹⁴⁴
MA	Y	X ¹⁴⁵	N	
MD	Y	X ¹⁴⁶	Y	X ¹⁴⁷
MI	N		Y	X ¹⁴⁸
MN	Y	X ¹⁴⁹	N	
MO	N		N	
MS	Y	X ¹⁵⁰	N	
NC	Y	X ¹⁵¹	N	
ND	N		N	
NE ^c	N		N	

*** Care coordination/management for SDOH means the development of care plans and arranging for and managing access to and management of services related to social determinants of health (note: this definition excludes coordination between health care and social service providers, which is identified in the Social Service Provider Relationships column)

+++ Member education for SDOH means provider provision of information regarding social determinants or social service resources to MCO members.

State	Care Coordination/Management for SDOH ^{***}		Member Education for SDOH ⁺⁺⁺	
	Incl. in Contract	Relevant Provision(s)	Incl. in Contract	Relevant Provision(s)
	Y/N		Y/N	
NH	Y	X ¹⁵²	N	
NJ	Y	X ¹⁵³	N	
NM	Y	X ¹⁵⁴	N	
NY	N		N	
NV ^ε	N		N	
OH	Y	X ¹⁵⁵	N	
OR ^h	Y	X ¹⁵⁶	N	
PA	Y	X ¹⁵⁷	N	
RI	Y	X ¹⁵⁸	N	
SC	Y	X ¹⁵⁹	N	
TN	Y	X ¹⁶⁰	N	
TX	Y	X ¹⁶¹	Y	X ¹⁶²
UT	N		N	
VA	Y	X ¹⁶³	N	
WA	Y	X ¹⁶⁴	N	
WI	N		N	
WV	N		N	
Total		Y = 26 N = 14		Y = 9 N = 31

¹ Social Determinants of Health: AHCCCS is prioritizing social determinants of health (SDOH) as the next system innovation following integration to continue to enhance the service delivery system to focus on whole-person health. Contractors are expected to expand existing efforts with the provider network to screen for social needs of members, incorporate ICD-10 social determinant diagnosis codes on claims, properly refer members to community-based resources to address the social needs and document the completion of the referral and services provided. (p. 157, October 2019, Amendment 14, Arizona Medicaid Managed Care Contract).

² Social Determinants of Health: AHCCCS is prioritizing social determinants of health (SDOH) as the next system innovation following integration to continue to enhance the service delivery system to focus on whole-person health. Contractors are expected to expand existing efforts with the provider network to screen for social needs of members, incorporate ICD-10 social determinant diagnosis codes on claims, properly refer members to community-based resources to address the social needs and document the completion of the referral and services provided. (p. 157, October 2019, Amendment 14, Arizona Medicaid Managed Care Contract).

³ 3. Initial Health Assessment (IHA). An Initial Health Assessment (IHA) consists of a comprehensive history and physical examination and the Individual Health Education Behavioral Assessment (IHEBA) that enables a Provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract. (Exhibit A, Attachment 10, p. 74).

6. Services for Adults (Age 21 and older). A. IHAs [Initial Health Assessments] for Adults (Age 21 and older). 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment. 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to: ... i) IHEBA [Individual Health Education Behavioral Assessment]. (Exhibit A, Attachment 10, p. 83).

7. Perinatal Services.... B. Risk Assessment. Contractor shall implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per 22 CCR 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, health education, psychosocial, and risk assessment components. (Exhibit A, Attachment 10, p. 85).

A. Health Education.... 8) ... Contractor shall ensure that medical Providers use the IHEBA [Individual Health Education Behavioral Assessment] tool and other relevant clinical evidence as part of the basis for identifying Members' health education needs and conducting educational intervention. Contractor shall provide resource information, educational materials and other program resources to assist Providers to provide effective health education services for Members. 9) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the IHA [Initial Health Assessment]; and that all existing Members complete the IHEBA at their next non-acute care visit, but no later than their next scheduled health screening exam. Contractor shall ensure that: a) the DHCS Form 7098 and bilingual translations, or alternative tools approved by DHCS, are used by Primary Care Providers to satisfy the IHEBA requirement; b) the IHEBA is administered and reviewed by the PCP during an office visit; c) the IHEBA is reviewed at least annually by the PCP with Members who present for a scheduled visit; d) the IHEBA is re-administered by the PCP at the appropriate age-intervals utilized by the Staying Healthy Assessment (0-3 years, 4-8 years, 9-11 years, 12-17 years, and 18 years and older). This should occur at the patient's first scheduled health screening exam upon changing into the next age group. e) the IHEBA includes documentation, at initial and subsequent visits, of health education interventions, risk factors addressed, intervention codes, date and primary care Provider's signature or initials. f) the completed IHEBA tool is included along with the medical history and problem list as a permanent part of the Member's Medical Record. g) assistance is provided to Members in completing the assessment tool, if needed. h) interventions are conducted and arrangements are made for follow-up services to address the needs identified by the IHEBA. Contractor is responsible to assist Primary Care Providers in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate and visually and hearing impaired Members.... B. The Health Information Form (HIF)/Member Evaluation Tool (MET) Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services (Exhibit A, Attachment 10, pp. 88-90, California 2017 Final Rule GMC Non-CCI Boilerplate Contract).

⁴ 1. Comprehensive Case Management Including Coordination of Care Services.... A. Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the Contractor, and shall include: ... 6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies. (Exhibit A, Attachment 11, p. 101).

11. Early Intervention Services. Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program. These include children who have a developmental delay in either cognitive, communication, social, emotional, adaptive, physical, motor development, including vision and hearing, or a

condition known to lead to developmental delay, or those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation. (Exhibit A, Attachment 11, pp. 108-109).

12. Local Education Agency Services (LEA).... The Contractor is responsible for providing a Primary Care Provider and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's PCP cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. Contractor shall provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation. (Exhibit A, Attachment 11, p. 109).

Services coordinated by Contractor. In addition to the requirements for unbundled CBAS [Community Based Adult Services] contained in this provision, and in accordance with Exhibit A, Attachment 11, Provision 5, Out-of-Network Case Management and Coordination of Care, Contractor shall coordinate care for unbundled CBAS, based on the assessed needs of the member eligible for CBAS, that are not covered services, including: a) Personal Care Services; b) Social Services; ... d) Meals. (Exhibit A, Attachment 19, p. 187, California 2017 Final Rule GMC Non-CCI Boilerplate Contract).

⁵ 11. POPULATION HEALTH MANAGEMENT AND CARE COORDINATION. 11.1. The Contractor shall manage the health of all its Members.... 11.1.2. The Contractor shall understand that population health management requires a detailed understanding of the distribution of health conditions and health related behaviors, and is strengthened by the consideration of social determinants of health, such as income, culture, race, age, family status, housing status, and education level. The Contractor shall possess capabilities to leverage and build upon the Department's data systems and perform analytics to successfully implement an information-based approach to delivering and coordinating care and services across the continuum.... 11.1.7. The Contractor shall educate providers on tools available to assist physicians on best practices as tools become available in partnership with the Department. (Exhibit B-3, pp. 68-69, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

⁶ 10.5. Health Neighborhood and Community Report. 10.5.1. The Contractor shall create a report to the Department describing the Contractor's recent activities to engage and build the Health Neighborhood and Community, including the following information: ... 10.5.1.10. Collaboration with Local Public Health Agencies. 10.5.1.11. Activities to engage Members with evidence-based/promising practice programs in the Community to address social determinants of health, particularly those promoted by identified in the Colorado Opportunity Framework Project. 10.5.1.12. Identification of barriers to access of Health Neighborhood and Community resources and proposed initiatives to address the barriers. 10.5.1.13. Progress on reducing roadblocks to Health Neighborhood and Community resources. 10.5.1.14. Activities designing and implementing regional activities that align with and address the Colorado Opportunity Framework. (Exhibit B-3, p. 68).

16.4.8.1.3. Public Reporting. 16.4.8.1.3.1. The Contractor shall improve network performance on core health and utilization measures that will be reported publicly at least one time annually. The Public Reporting measures will be divided in the following way: ... 16.4.8.1.3.1.2. Public Health and System Level Measures: Reporting of program goals where the RAE [Regional Accountable Entity], and Network Providers play a critical but perhaps not determinative role, such as obesity rates, suicide rates, and passive tobacco exposure. (Exhibit B-3, p. 108, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

⁷ 10. HEALTH NEIGHBORHOOD AND COMMUNITY. 10.1. The Contractor shall promote Members' physical and behavioral well-being by creating a Health Neighborhood and Community consisting of a diverse network of health care providers and Community organizations providing services to residents within the Contractor's geographic region. 10.1.1. As Members living within the Contractor's geographic region may be attributed to another RAE [Regional Accountable Entity], the Contractor shall collaborate with other RAEs to assist them in leveraging the Contractor's Health Neighborhood and Community to address Members' social and other health needs.... 10.2. Health Neighborhood. 10.2.1. The Contractor shall recognize the value that all Medicaid providers offer to improving Member health and functioning. The successful engagement and utilization of the full range of Health Neighborhood providers, including specialty care, LTSS providers, Managed Service Organizations and their networks of substance use disorder providers, hospitals, pharmacists, dental, non-emergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary

providers, is critical to helping Members improve their health and life outcomes.... 10.2.2. The Contractor shall establish and strengthen relationships among its Network Providers and the Health Neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts.... 10.2.11. The Contractor shall collaborate with LTSS providers and care coordinators/case managers, No Wrong Door Entities, Area Agencies on Aging, and Aging and Disability Resources for Colorado to develop holistic approaches to assisting LTSS Members achieve their health and wellness goals. (Exhibit B-3. pp. 63-65).

10.3. Community and the Social Determinants of Health. 10.3.1. The Contractor shall demonstrate an understanding of the health disparities and inequities in their region and develop plans with Providers, Members and Community Stakeholders to optimize the physical and behavioral health of its Members. 10.3.2. Recognizing that the conditions in which Members live also impact their health and well being, the Contractor shall establish relationships and collaborate with economic, social, educational, justice, recreational and other relevant organizations to promote the health of local communities and populations. 10.3.3. The Contractor shall know, understand and implement initiatives to build local communities to optimize Member health and well-being, particularly for those Members with complex needs that receive services from a variety of agencies. 10.3.4. The Contractor shall establish relationships and communication channels with Community organizations that provide resources such as food, housing, energy assistance, childcare, education and job training in the region. 10.3.4.1. The Contractor shall collaborate with school districts and schools to coordinate care and develop programs to optimize the growth and well-being of Medicaid children and youth.... 10.3.7. The Contractor shall work with Community organizations to remove roadblocks to Member access to programs and initiatives, particularly evidence-based/promising practice programs in the region. 10.3.8. The Contractor shall share information with Community organizations in the region about identified Community social service gaps and needs. 10.3.9. The Contractor shall engage with hospitals and local public health agencies regarding their community health needs assessments to develop and implement collaborative strategies to reduce health inequities and disparities in the Community. 10.3.10. The Contractor shall collaborate with the Department, other state agencies, and regional and local efforts in order to expand the Community resources available to Members. (Exhibit B-3, p. 66).

10.4. Statewide Health Infrastructure. 10.4.1. The Contractor shall participate in and align its activities with advisory groups, existing programs and statewide initiatives designed to strengthen the health care system, including: ... 10.4.1.4. Colorado Opportunity Framework: a life stage, indicator-based framework designed to develop a health care delivery system that incorporates key social determinants of health. The Department has been working on a cross-agency collaborative that coordinates and aligns the interventions of government, private, non-profit, and community partners with the goal of delivering evidence-based initiatives and community-based promising practices so that all Coloradans will have the opportunity to reach and maintain their full potential. (Exhibit B-3, p. 67).

12.8. General Information and Administrative Support.... 12.8.2. The Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for the following topics: ... 12.8.2.5. Community-based resources, such as child care, food assistance, services supporting elders, housing assistance, utility assistance and other non-medical supports. (Exhibit B-3, p. 74, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

⁸ 16.4.8. Accountable Care Collaborative Pay for Performance. 16.4.8.1. The Contractor shall participate in four (4) components of pay for performance. 16.4.8.1.1. Key Performance Indicators: 16.4.8.1.1.1. The Contractor shall be capable of working to improve performance for up to nine (9) Key Performance Indicators (KPIs) in order to earn performance payments. For the first year, KPI measures will be as stated in Exhibit E. Following the first year of the contract, they will be established at the Department's discretion to align with new statewide initiatives and through consultation with the Department, RAEs [Regional Accountable Entities], and stakeholders. 16.4.8.1.1.1.1. Following the first year of the contract, the Department will include a public health measure as a KPI, reflecting the RAE's role in the Health Neighborhood and Community addressing social determinants of health. (Exhibit B-3, p. 108, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

⁹ 3.6.3.4.5.1 Within 30 calendar days of identifying a member as eligible for Level 2, the member's assigned clinical care coordinator shall perform a member assessment that is comprehensive and evaluates the member's physical and behavioral health, social and psychological needs. (p. 106).

3.7.2.4.17 The plan of care must: 3.7.2.4.17.1 Include an assessment of member's strengths and needs in at least the following areas: ... 3.7.2.4.17.1.4 Social/environmental/cultural factors ... (p. 128).

3.7.2.5.15 During the onsite reviews the case manager shall meet with the member and/or member representative in order to: ... 3.7.2.5.15.2 Assess the member's current functional, medical, behavioral and social strengths and needs... (p. 137).

3.7.2.6.4 A member's electronic case record must include, at a minimum: ... 3.7.2.6.4.3.1 Member's current functional, medical, behavioral and social strengths, needs, goals and plans ... (p. 145, December 2017, Delaware Medicaid Managed Care Model Contract).

¹⁰ 3.4.8.2 Value Added Services 3.4.8.2.1 The Contractor may provide "value added" services in addition to Covered Services. 3.4.8.2.2 The cost of a "value added" service provided by the Contractor will not be reflected in rate setting. 3.4.8.2.3 If the Contractor provides a "value added" service on a routine basis and/or includes the service in the member handbook, the "value added" service shall be prior approved in writing by the State. In accordance with Section 2.1.7 of this Contract, any changes to a "value added" service must also be prior approved in writing by the State. 3.4.8.2.4 The Contractor shall not require a member to accept a "value added" service instead of a Covered Service. (p. 74, December 2017, Delaware Medicaid Managed Care Model Contract). [While this clause does not specify SDOH, we have included it because it is broad enough to cover them.]

¹¹ 3.21.8.2 The Contractor shall submit a monthly MFP Report that at a minimum shall include: (i) member demographic information including housing situation; (ii) tracking of key dates in each member's transition (e.g., referral date, planning meeting date, discharge date); (iii) tracking of any re-institutionalization; and (iv) home visit tracking (e.g., dates of home visits). (p. 323, December 2017, Delaware Medicaid Managed Care Model Contract).

¹² 3.6.3.2.1.2 The Contractor shall coordinate services it furnishes to members: ... 3.6.3.2.1.2.3 With the services the member receives from community and social support providers. (p. 101).

3.8.12.5 Coordination with School-Based Services Provided by the State 3.8.12.5.1 The State contracts with Delaware school districts to provide screening and health-related services that the schools must provide to children with special needs under IDEA. Under Part B of IDEA, school districts must prepare an IEP for each child, which specifies all special education and "related services" needed by the child. Per Federal policy the State can pay for some of the health "related services" if they are covered by Medicaid. Examples of health-related services commonly provided under an individualized education program (IEP) and reimbursed by Delaware Medicaid are physical therapy, speech pathology services, occupational therapy, psychological services and medical screening and assessment services. The least restrictive environment requirement has been interpreted to mean that therapy services should be delivered on school premises. 3.8.12.5.2 The State will continue to pay for these health-related services on an FFS basis. The Contractor is not responsible for paying for these services, but the Contractor must work with school districts and their providers to create and implement procedures for linking and coordinating services for children who attend school and receive health-related services under an IEP. The Contractor must also coordinate with school districts and their providers to prevent the provision of duplicate services. (p. 174, December 2017, Delaware Medicaid Managed Care Model Contract).

¹³ F. Quality Enhancements. The Managed Care Plan shall offer QEs to enrollees as specified below: ... 2. Domestic Violence. The Managed Care Plan shall ensure that participating PCPs screen enrollees for signs of domestic violence and shall offer referral services, as applicable, to domestic violence prevention community agencies. (Attachment II, Exhibit II-A, p. 37, February 2020, Florida Medicaid Managed Care Model Contract).

¹⁴ 6. Healthy Behaviors Program.... c. The Managed Care Plan may, through its healthy behavior programs, deploy a number of interventions as part of the overall therapeutic process. Examples of interventions: (1) Series of counseling sessions; (2) Series of health educational classes; (3) Gym membership; (4) Nicotine replacement therapy patches; (5) Meal planning services (e.g. NutriSystem®); (6) The provision of medication therapy management support services provided by a community health worker; and (7) Diabetes prevention programs with a status of recognized, pending recognition, or preliminary recognition on the CDC registry. (Attachment II, p. 66, February 2020, Florida Medicaid Managed Care Model Contract).

¹⁵ 6. Healthy Behaviors Program.... n. The Managed Care Plan shall report on its healthy behavior programs in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide. This shall include submitting data related to each healthy behavior program, caseloads (new and ongoing) for each healthy behavior program, and the amount and type of rewards/incentives provided for each healthy behavior program. (Attachment II, p. 68, February 2020, Florida Medicaid Managed Care Model Contract).

¹⁶ F. Quality Enhancements. The Managed Care Plan shall offer QEs to enrollees as specified below: ... 2. Domestic Violence. The Managed Care Plan shall ensure that participating PCPs screen enrollees for signs of domestic violence and shall offer referral services, as applicable, to domestic violence prevention community agencies. (Attachment II, Exhibit II-A, p. 37).

6. Nutritional Assessment/Counseling. a. The Managed Care Plan shall ensure that its providers supply nutritional assessment and counseling to all pregnant enrollees, and postpartum enrollees and their children. b. The Managed Care Plan shall determine the need for non-covered services and referral of the enrollee for assessment and refer the enrollee to the appropriate service setting (to include referral to WIC and Healthy Start and other social services) with assistance. (Attachment II, Exhibit II-A, p. 38).

6. Healthy Behaviors Program.... f. The Managed Care Plan shall consider partnering with other agencies such as State and local public health entities, provider organizations, local community groups, or other entities to educate enrollees about the program or to help administer it. (Attachment II, p. 67, February 2020, Florida Medicaid Managed Care Model Contract).

¹⁷ 4.11.10.6 Levels of Case Management for the GF [Georgia Families] Program include: 4.11.10.6.1 Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem, and a plan of care that has been developed which provides for health and social problem follow-up as indicated. (p. 738, Georgia CareSource Medicaid Managed Care Contract).

¹⁸ 4.7.3.4 The Contractor shall have a lead Case Management program for EPSDT eligible children and their households when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter. The lead Case Management program shall include education, a written Case Management plan that includes all necessary referrals, coordination with other specific agencies, environmental lead assessments, and aggressive pursuit of non-compliance with follow-up tests and appointments. The Contractor must ensure reporting of all blood lead levels to the Department of Public Health. (p. 99).

4.11.8.8 Coordination with Other Entities: 4.11.8.8.1 The Contractor shall coordinate and work collaboratively with all divisions within DCH [Department of Community Health], as well as with other State agencies, and with other CMOs [Care Management Organizations] for administration of the Georgia Families program.

4.11.8.8.2 The Contractor shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children’s Intervention School Services provided by the LEAs to ensure Medical Necessity and prevent duplication of services. 4.11.8.8.3 The Contractor shall coordinate the services furnished to its Members with the service the Member receives outside the CMO {Care Management Organization}, including services received through any other managed care entity. (p. 152).

System of Care: A spectrum of effective, highly coordinated community-based services and supports for children and youth with or at risk for Mental Health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families’ and youths’ needs to help them to function better at home, in school, in the community, and throughout life. System of Care core values and philosophy include an expectation that services and supports: are culturally and linguistically competent; ensure availability and access to effective traditional and nontraditional services as well as natural and informal supports that address physical, emotional, social, and educational needs; are planned in true partnership with the child and family and a family peer

professional representative; and include intensive care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs. (pp. 326-327, Georgia CareSource Medicaid Managed Care Contract).

¹⁹ 3.1.1 Regional Health Partnerships.... 4. RHPs are intended to be community-driven and community-focused in their approaches. Therefore, by definition, RHP pilots are likely to be diverse and in alignment with community needs. Health Plans are encouraged to support innovative community-based strategies proposed by RHPs to improve care delivery and enhance SDOH efforts within their communities. 5. The activities, specific service requirements, and tasks for RHPs will be dependent on the nature of the organizations in regions where RHPs exist. Examples of activities of the RHP pilots for which the Health Plan will provide coordination and support are as follows: a) Screening, referral, and community navigation services which impact health care costs and reduce health care utilization; b) Identifying and partnering with clinical delivery sites (e.g., physician practices, behavioral health providers, clinics, hospitals) to conduct and capture systematic health-related social needs screenings of all members and make referrals to community services that may be able to address the identified health-related social needs. (pp. 187-188, August 2019, Hawaii Medicaid Managed Care RFP).

²⁰ The Health Plan shall coordinate the referral of potentially eligible women, infants, and children to the WIC Supplemental Nutrition Program and the provision of health data required by the WIC program, within the timeframe required by WIC, from their providers. The Health Plan shall cover the cost of specialty formula when medically indicated (p. 176, August 2019, Hawaii Medicaid Managed Care RFP).

²¹ 9 Care Coordination.... 9.1.1 Initial Screening. The Contractor shall obtain Agency approval for a plan to conduct initial health risk screenings for: (i) new members, within ninety (90) days of enrollment for the purpose of assessing need for any special health care or care coordination services; (ii) members who have not been enrolled in the prior twelve (12) months; and (iii) members for whom there is a reasonable belief they are pregnant.... 9.1.1.1 Tool. The Contractor shall obtain Agency approval of an initial health risk screening tool. At minimum, information collected shall assess the 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 questions that can tie to social determinants of health. The actual tool used will be designated by the Agency shortly after execution of the Contract. Contractor tools will be compared against the current approach by the Agency and a uniform tool is preferred across Contractors. (Appendix 1, pp. 135-136, January 2016, Iowa Amerigroup Medicaid Managed Care Contract).

²² 3.2.14: Value Added Services: Additional services for coverage are referred to as "Value-added Services." The Agency is particularly interested in the promotion of evidence-based programs and direct services that improve the health and well-being of Medicaid enrollees, Value-Added Services may be actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improved health outcomes among members. Examples of Value-Added Services may include, but are not limited to, items such as: (i) incentives for obtaining preventive services; (ii) medical equipment or devices not already covered under the program to assist in prevention, wellness, or management of health conditions; (iii) supports to enable workforce participation; and (iv) cost effective supplemental services that can provide services in a less restrictive setting. (Appendix 1, pp. 65-66, January 2016, Iowa Amerigroup Medicaid Managed Care Contract).

²³ 2.11 Coordination with Other State Agencies and Program Contractors: The Contractor agrees to reasonably cooperate with and work with the other program contractors, subcontractors, state agencies and third-party representatives and to support community-based efforts as requested by the agency, including but not limited to: ... 2.11.7 Community Based Agencies: The Contractor is expected to support community-based efforts to build better interfaces with agencies, such as: (i) school districts; (ii) area education agencies; (iii) Decategorization Boards; (iv) MHDS regions; (v) local public health agencies; (vi) job training, placement, and vocational service agencies; (vii) judicial districts; and (viii) the Iowa Department of Corrections. The Agency will work with the Contractor to prioritize community-based efforts to support the success of the program. (Appendix 1, p. 27, January 2016, Iowa Amerigroup Medicaid Managed Care Contract).

²⁴ All entries in the medical record must be legible, accurate, complete, and dated, and include the following, where applicable: ... 5.26.3.2 personal health, social history and family history, with updates as needed ... (p. 116).

Contractor shall ensure that a complete health history and physical examination is provided to each Enrollee initially within the first twelve (12) months of his or her Effective Enrollment Date. Thereafter, for Enrollees from the age of twenty-one to sixty-four (21–64), Contractor shall ensure that a complete health history and physical examination is conducted every one to three (1–3) years, as indicated by Enrollee's assessed needs and clinical care guidelines. [For purposes of this section, a "complete health history and physical examination" shall include, at a minimum, the following health services regardless of age and gender of each Enrollee: ... 2.1.2.5 assessment of social and economic determinants of health: housing, transportation availability, and employment...] (p. 314).

5.13.1.1 Health-risk screening. Contractor will develop and maintain a health-risk screening tool which includes Behavioral Health risk, and will provide that tool to the Department. This tool will include behavioral health risk, and Contractor shall administer the tool to all new Enrollees within sixty (60) days after enrollment to collect information about the Enrollee's physical, psychological, and social health. (p. 85, January 2018, Illinois Medicaid Managed Care Model Contract Draft).

²⁵ 5.12.2.2 Contractor shall coordinate services with the services the Enrollee receives from community and social support providers. (p. 84). 2.1.3.12.2 Contractor shall have ... a provider network for social services support ... (p. 321, January 2018, Illinois Medicaid Managed Care Model Contract Draft).

²⁶ Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care. (p. 147, Amendment #7, April 2019, Indiana Anthem Medicaid Managed Care Contract).

²⁷ Goals for Hoosier Healthwise include: ... Coordinate health and social services (p. 9, Amendment #4, March 2018, Indiana Anthem Medicaid Managed Care Contract).

²⁸ 5.8.3.1. SOCIAL DETERMINANTS OF HEALTH AND INDEPENDENCE A. The CONTRACTOR(S) shall develop a process for identifying Social Determinants of Health and Independence needs when interacting with Members and connecting them to necessary resources when appropriate. Such needs could include, but not limited to safe housing, food security, transportation, employment and career training, and education, within the UM [Utilization Management] program and UM activities. (p. 111, December 2018, Kansas Medicaid Managed Care RFP).

²⁹ D. The CONTRACTOR(S) shall make all Service Coordination data, inclusive of Social Determinants of Health and Independence, including that which is generated by Subcontractors, available to the State upon request. (p. 65, December 2018, Kansas Medicaid Managed Care RFP).

³⁰ Additional aims for providing all services in a comprehensive managed care CONTRACT are to: ... 2. Support Members successfully in their communities, as well as connect Members to housing, food, employment, education, and to other Social Determinants of Health and Independence as needed ... (p. 10).

2.0. The State seeks to promote the goals of helping Kansans achieve healthier, more independent lives by providing services and connecting to supports for Social Determinants of Health and Independence in addition to traditional Medicaid benefits. These goals and the 1115 Waiver renewal hypotheses below are key focus areas of the RFP and should be considered in bidder responses in this section. (p. 101, December 2018, Kansas Medicaid Managed Care RFP).

³¹ A. Value Based Models and Purchasing Strategies: 2. Social Determinants of Health and Independence: The State seeks innovative CONTRACTOR(S) models to address Social Determinants of Health and Independence that impact the overall health and well-being of Members and result in decreased medical expenditures. Programs that address Social Determinants of Independence are personal plans that are tailored to an individual's vision for their good life. Such strategies may include direct interventions by the CONTRACTOR(S) or linkages to local resources for Members that result in employment opportunities, housing supports, food and nutritional security, educational opportunities, and advancement in education levels. Such interventions may be accomplished through the use of web-based technologies that link Members to available resources, community health workers or similar Providers that are CONTRACTOR(S) staff or embedded with Participating Providers, or other interventions that address Social Determinants of

Health and Independence. The State is interested in innovative strategies that focus on Members that are in foster care, pregnant, managing chronic diseases, experiencing transient housing status, showing high ER utilization, and individuals served under the PD [Physical Disabilities] and IDD [Intellectual/Developmental Disabilities] Waivers. Proposals do not have to address Social determinant of Health and Independence strategies for each population type identified herein; however, the State is interested in strategies that focus on the needs of those populations. (p. 105, December 2018, Kansas Medicaid Managed Care RFP).

³²28.9 Provider Maintenance of Medical Records ... A Member's medical record shall include the following minimal detail for individual clinical encounters: A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status... (p. 86).

33.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment ...Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. (p. 113, July 2019, Kentucky Medicaid Managed Care Contract).

³³20.4 Performance Improvement Projects (PIPs)... The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies, community based health/social agencies and health care delivery systems to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives. The Contractor shall be committed to ongoing collaboration in the area of service and clinical care improvements by the development of best practices, use of encounter data-driven performance measures and establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection. Evidence of adequate partnerships should include formal documentation of meetings, input from stakeholders and shared responsibility in the design and implementation of PIP activities. (p. 52, July 2019, Kentucky Medicaid Managed Care Contract).

21.2 National Standards for Medical Necessity Review ...E. The Contractor shall have written policies to ensure the coordination of services: ... 4 With the services the Enrollee receives from community and social support providers... (p. 55, July 2019, Kentucky Medicaid Managed Care Contract).

³⁴ 2.7.2.1 The Contractor shall attempt to conduct enrollee health needs assessments (HNA) as part of the enrollee welcome call to identify health and functional needs of enrollees, and to identify enrollees who require short-term care coordination or case management for medical, behavioral or social needs. Where an enrollee is a child, the HNA [Health Needs Assessment] shall be completed by the enrollee's parent or legal guardian... 2.7.2.5 The Contractor's HNA shall: ... 2.7.2.5.5 Screen for needs relevant to priority social determinants of health as described in the Population Health and Social Determinants of Health... (pp. 89-90).

2.7.6 Tiered Case Management Based on Need 2.7.6.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive case management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and shall include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). ... 2.7.6.2 Case Management (Medium) (Tier 2) Enrollees engaged in the medium level of case management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section)... 2.7.6.3 Case Management (Low) (Tier 1) Enrollees engaged in this level of case management are of the lowest level of risk within the case management program and typically require support in care coordination and in addressing SDOH. A plan of care shall be completed in person within ninety (90) calendar days of identification and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). (pp. 91-92).

3.1.15.2 [Health Needs Assessment] questions shall include: 3.1.15.2.5 Questions to identify enrollees' health-related social needs, including housing, food insecurity, physical safety, and transportation. (Appendix B: Model Contract, p. 290, February 2019, Louisiana Medicaid Managed Care RFP).

³⁵ 2.5.5 Value-Added Benefits: 2.5.5.1 As permitted under 42 C.F.R. §438.3(e)(1), the Contractor may offer value-added benefits (VAB) which are not Medicaid covered services or prohibited services. Value-added benefits are provided at the Contractor's expense, are not included in the capitation rate, and shall be identified as value-added benefits in encounter data in accordance with the MCO Manual. 2.5.5.2 At a

minimum, the Contractor shall offer the VAB proposed in its response to the RFP [Request for Proposals] and agreed upon by LDH [Louisiana Department of Health], consistent with this Section. Additional VAB may be offered, at the Contractor's option, and shall be reported in accordance with the MCO Manual. 2.5.5.3 At the Contractor's discretion, it may provide or assist enrollees with transportation to access a VAB. Encounters for transportation related to VAB shall be identified as such. 2.5.5.4 The Contractor may propose to change the VAB proposed in the Contractor's RFP response on an annual basis as pre-approved in writing by LDH. Additions, deletions or modifications to these VAB shall be submitted to LDH for approval at least six (6) months in advance of the effective date for open enrollment. 2.5.5.5 The VAB proposed in the Contractor's RFP response, and as amended annually, shall be listed in Attachment C, Value-Added Benefits. 2.5.5.6 Annually, for the VAB proposed in the Contractor's RFP response, and as amended, the Contractor shall: 2.5.5.6.1 Indicate the PMPM actuarial value of VAB based on enrollment projections for the Contractor's plan, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information; and 2.5.5.6.2 Include a statement of commitment to provide the VAB for the year. 2.5.5.7 The Contractor shall be directed to revise its proposed PMPM based on any feedback from LDH, following an independent review of any statements of actuarial value provided by the Contractor. 2.5.5.8 The proposed monetary value of value-added benefits shall be considered a binding Contract deliverable. If for any reason, including but not limited to lack of enrollee participation, the aggregated annual PMPM proposed is not expended by the Contractor, LDH reserves the right to require the Contractor to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended. 2.5.5.9 Value-added benefits are not subject to appeal and state fair hearing rights. A denial of these benefits shall not be considered an adverse benefit determination for purposes of enrollee grievances and appeals. The Contractor shall send the enrollee a notification letter if a value-added benefit is not approved. (Appendix B: Model Contract, p. 77-78, February 2019, Louisiana Medicaid Managed Care RFP).

³⁶ 2.6.2.1 Data Aggregation: 2.6.2.1.1 The Contractor shall collect and maintain enrollee self-reported demographic, social determinants, and health needs assessment data for aggregate use in, at a minimum, population health management, network adequacy determination, and quality improvement activities... 2.6.2.1.1.2 The Contractor shall use the Health Needs Assessment to survey enrollees for demographic and social determinants data as identified in the Population Health Strategic Plan, with a minimum focus on housing, food insecurity, physical safety, and transportation. (p. 81). 2.6.2.1.2 The Contractor shall incorporate consideration of SDOH into their Population Health Strategic Plan including: ... 2.6.2.1.2.2 The manner in which social determinants data will be collected and analyzed for each enrollee; 2.6.2.1.2.3 The manner in which the social determinants risk determinations are validated; 2.6.2.1.2.4 The timeline and rationale for implementing social determinants data analysis to support population health management; (pp. 81-82). 2.6.2.2 Data Analysis to Support Population Health Management: 2.6.2.2.1 The Contractor shall utilize information obtained from the mechanisms described in this section to identify targeted populations for tailored interventions, including: 2.6.2.2.1.1 Subpopulations experiencing a disparate level of needs, including housing, food insecurity, physical safety, and transportation; 2.6.2.2.1.2 Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as geographic location, age, ethnicity, race, gender identity, sexual orientation, religion, primary language, disability status, and income level... (Appendix B: Model Contract, p. 82, February 2019, Louisiana Medicaid Managed Care RFP).

³⁷2.6.3.2 Services Provided by Community-Based Organizations or the Office of Public Health 2.6.3.2.1 The Contractor shall identify and coordinate with community-based organizations and/or OPH on population health improvement strategies. 2.6.3.2.2 The Contractor shall identify and, to the extent applicable, enter into agreement with community-based organizations and/or OPH [Office of Public Health] to coordinate population health improvement strategies which address socioeconomic, environmental, and/or policy domains; as well as provide services such as care coordination and intensive case management as needed and supported by evidence-based best practices. Agreements shall address the following topics: 2.6.3.2.2.1 Data sharing; 2.6.3.2.2.2 Roles/responsibilities and communication on development of care coordination plans; 2.6.3.2.2.3 Reporting requirements; 2.6.3.2.2.4 Quality assurance and quality improvement coordination; 2.6.3.2.2.5 Plans for coordinating service delivery with primary care providers; and 2.6.3.2.2.6 Payment arrangements. (p. 83).

2.6.3.3 Services Provided by State Health Agencies: The Population Health Strategic Plan shall include referral to the following LDH [Louisiana Department of Health] programs as appropriate. The Contractor shall actively support LDH's public health initiatives and coordinate with existing public health programs, including reporting, education, and care management activities. LDH shall maintain a webpage containing centralized resources for the Contractor to use to access population health surveillance data, community needs assessments and core programs they are required to coordinate with. The Contractor shall establish relationships with the LDH programs and create joint-plans to coordinate activities during Year 1 of the Contract or on a time frame otherwise defined by LDH and annually thereafter. The Contractor shall be responsible for ensuring that cooperation exists between each program and its enrollees as applicable and based upon the interest, desires and needs of the enrollee. Activities shall include enrollee and provider education on programs, coordination of referrals including the program, enrollee, provider and Contractor, based on program criteria, data sharing and agreements as needed to accomplish goals and care

coordination. The Contractor shall comply with all state and regulatory laws where applicable, including screening and follow up. LDH programs and initiatives include, but are not limited to, the following: 2.6.3.3.1 Comprehensive reproductive health services, Women, Infants, and Children (WIC), and tobacco cessation; 2.6.3.3.2 Programs, services, and initiatives administered through the State's Title V, Maternal and Child Health Block Grant Program... 2.6.3.3.3 Louisiana Commission for the Deaf; 2.6.3.3.4 STD/HIV Program (SHP) Community Based Organizations for individuals with HIV/AIDS; 2.6.3.3.5 Programs to optimize outcomes in individuals with viral hepatitis; 2.6.3.3.6 Disease intervention specialists to support partner notification for STD/HIV, viral hepatitis, and syphilis; and 2.6.3.3.7 OCDD waiver services, EarlySteps and services under the Office of Behavioral Health. (Appendix B: Model Contract, pp. 86-87).

2.6.1.2 The Population Health Strategic Plan shall include, at a minimum, the following components: ... 2.6.1.2.5 Plan for incorporating community-based health and wellness strategies through promotion of LDH public health programs and linkages and collaborations with community-based agencies... (Appendix B: Model Contract, p. 81, February 2019, Louisiana Medicaid Managed Care RFP).

³⁸ 2. The Contractor's Care Needs Screening shall: ... h. As further directed by EOHHS, evaluate Enrollees' health-related social needs, including whether the Enrollee would benefit from receiving community services to address health-related social needs. Such services shall include but not be limited to: 1) Housing stabilization and support services; 2) Housing search and placement; 3) Utility assistance; 4) Physical activity and nutrition; and 5) Support for Enrollees who have experience of violence. (p. 79).

D. Behavioral Health Clinical Assessment and Treatment Planning: The Contractor shall: 4. Ensure that Behavioral Health Clinical Assessments conducted by Behavioral Health Providers are in writing, dated and signed, and include, at a minimum, the following: ... f. Family, social history and linguistic and cultural background... (Attachment A, Model MCO Contract, pp. 180-181, September 2017, Massachusetts Medicaid Managed Care RFR Amendment).

³⁹ A. General Care Delivery Requirements: In accordance with all other applicable Contractor requirements, the Contractor shall ensure that all Enrollees receive care that is timely, accessible, and Linguistically and Culturally Competent. The Contractor shall: ... 11. Establish such affiliations with providers (including Community Service Agencies (CSAs) in the Contractor's geographic area, as determined by EOHHS [Executive Office of Health and Human Services]) and organizations as necessary to fulfil the requirements of this Section, including affiliations with Community Partners and other community-based organizations and social services organizations... (p. 76). F. Social Innovation Financing for Chronic Homelessness Program: The Commonwealth is implementing its Social Innovation Financing for Chronic Homelessness Program (SIF Program), a Housing First model, and has procured an entity to facilitate this implementation (SIF Intermediary). The Contractor shall support the SIF Program as described in this Section... 2. SIF Program participants shall be those Enrollees who the SIF Intermediary refers to the Contractor (a "referral"). The Contractor shall accept from the SIF Intermediary referrals that identify Enrollees, including veterans, who are SIF Program participants... The Contractor may also work with the SIF Intermediary and SIF Program providers to develop a process for the Contractor to refer Enrollees to the SIF Intermediary and SIF Program providers who the Contractor believes may qualify to be SIF Program participants. (Attachment A: Model MCO Contract, pp. 170-171, September 2017, Massachusetts Medicaid Managed Care RFR Amendment).

⁴⁰ .09 Special Needs Populations — Homeless Individuals. An MCO's initial health screen shall attempt to identify homeless individuals and link them to the appropriate provider of services. (Appendix N, p. 88, January 2020, Maryland Medicaid Managed Care Model Contract).

⁴¹ 3. To implement procedures to deliver care to and coordinate services for all Enrollees. These procedures must do the following: ... c. Coordinate the services the MCO furnishes to the Enrollee: ... iv. With the services the Enrollee receives from community and social support providers. (p. 10).

C. General Requirements for Special Needs Populations.... (4) The MCO shall demonstrate the use of a primary care system of care delivery which includes a comprehensive plan of care for an enrollee who is a member of a special needs population and which uses a coordinated and continuous case management approach, involving the enrollee and, as appropriate, the enrollee's family, guardian, or caregiver, in all aspects of care, including primary, acute, tertiary, and home care. (5) To meet the commitment outlined in §C(4) of this regulation, an MCO shall: ... (g) Be familiar with community and social support providers for the special populations. (Appendix N, p. 82).

.08 Special Needs Populations — Pregnant and Postpartum Women.... F. An MCO shall refer pregnant and postpartum women, infants, and children younger than 5 years old to the WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) Program, and shall provide to WIC necessary medical information to determine WIC nutritional eligibility. (Appendix N, p. 87).

.09 Special Needs Populations — Homeless Individuals. An MCO's initial health screen shall attempt to identify homeless individuals and link them to the appropriate provider of services. (Appendix N, p. 88).

C. AIDS Case Management Services. (1) An MCO shall ensure that an enrollee with HIV/AIDS receives case management services that: ... (b) Link the enrollee with any additional needed services including: ... (iv) Social services; (v) Financial services; (vi) Counseling services; (vii) Educational services; (viii) Housing services; and (ix) Other required support services. (Appendix N, p. 89).

C. An MCO shall provide referrals for services not covered by Medicaid, but which are furnished at little or no cost to recipients, including appropriate referrals to: (1) The Head Start Program; (2) The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); (3) School Health-Related Special Education Services; (4) Vocational Rehabilitation; and (5) Maternal and Child Health Services located at local health departments. (Appendix N, p. 172).

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: ... (3) Enriched maternity services, including: ... (d) Appropriate referrals to services that may improve the pregnancy outcome, including: (i) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and (ii) Healthy Start services; (e) High-risk nutrition counseling services for nutritionally high-risk pregnant women. (Appendix N, p. 172, January 2020, Maryland Medicaid Managed Care Model Contract).

⁴² A. Data Aggregation, Analysis and Dissemination: 1. General: ... b. Contractor must maintain a multi-year plan to incorporate Social Determinants of Health into their process for analyzing data to support Population Health management as outlined in section X-A (2), including: i. Which determinants will be added; ii. The manner in which social determinant data will be collected and analyzed for each Enrollee; iii. The manner in which the social determinant risk determinations are Validated; iv. The timeline for implementing the new factors into the data analysis to support Population Health management; v. The plan for training Contractor staff and embedded care managers on using the social determinants data incorporated into the data analysis. 2. Data Analysis to Support Population Health Management a. Contractor must utilize information such as claims data, pharmacy data, and laboratory results, supplemented by UM [Utilization Management] data, Health Risk Assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS [Children's Special Health Care Services], to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including: i. Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. (p. 58).

b. Data Analysis Update Requirements ... ii. Contractor must systematically re-stratify the entire Enrollee population, including the stratifications required in section X-A (2) Data Analysis to Support Population Health Management, at intervals designated by MDHHS [Michigan Department of Health and Human Services] to ensure Enrollees with increasing health risks and social needs are identified for Population Health management Services. iii. Upon receiving MDHHS's approval of the plan to incorporate social determinants into their process for analyzing data to support Population Health management, the Contractor must submit semiannual updates to MDHHS regarding plan implementation, noting compliance with respect to the plan timeline, the plan of correction to realign activities to the timeline, and timeline revisions, if necessary. (p. 59, January 2016, Michigan Medicaid Managed Care Model Contract).

⁴³ B. Provide or Arrange for Services: 2. Community Health Workers (CHWs) a. Contractor must provide or arrange for the provision of Community Health Worker (CHW) or Peer-Support Specialist Services to Enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or Peer-Support Specialist Services. Examples of CHW services include but are not limited to: ... viii. Arrange for social services (such as housing and heating assistance) and surrounding support services. (p. 54).

3. Services Provided by Community-Based Organizations: a. Contractor must, to the extent applicable, enter into agreement with community-based organizations to coordinate Population Health improvement strategies in the Contractor's Region which address the socioeconomic, environmental, and policy domains; as well as provide services such as care coordination and intensive care management as needed and supported by evidence-based medicine and national best practices. Agreements must address the following topics: i. Data sharing; ii. Roles/responsibilities and communication on development of care coordination plans; iii. Reporting requirements; iv. Quality assurance and quality improvement coordination; v. Plans for coordinating service delivery with Primary Care Provider; vi. Payment arrangements. b. Contractor must, to the extent applicable, 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. Examples of CHW services include but are not limited to: ... viii. Arrange for social services (such as housing and heating assistance) and surrounding support services (pp. 60-61, January 2016, Michigan Medicaid Managed Care Model Contract).

⁴⁴ 6.1.4.9 Hospital In-reach Community-based Service Coordination (IRSC). The MCO will cover in-reach community based service coordination that is performed through a hospital emergency department for an Enrollee who has frequented a hospital emergency department for services three or more times in the previous four consecutive months.... (2) The in-reach service coordination will include performing an assessment to address an Enrollee's mental health, substance use, social, economic, and housing needs, or any other activities targeted at reducing the incidence of emergency room and other non-medically necessary health care utilization and to provide navigation and coordination for accessing the continuum of services to address the Enrollee's needs. (p. 83).

(23) Adult Mental Health Targeted Case Management (AMH-TCM). The MCO shall make available to Enrollees AMH-TCM services to adults with Serious and Persistent Mental Illness (SPMI).... (b) The MCO may offer substitute models of AMH-TCM services to Enrollees who meet SPMI criteria with the consent of the individual, if the substitute model includes all four activities that comprise the CMS definition for targeted case management services in 42 CFR §440.169. These activities include: i) Comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services.... (pp. 97-98).

(24) Children's Mental Health Targeted Case Management (CMH-TCM). The MCO shall make available to Enrollees CMH-TCM services to Children with Severe Emotional Disturbance (SED).... (a) The MCO may offer substitute models of CMH-TCM services to Enrollees who meet SED criteria with the consent of the Enrollee if the substitute model includes all four activities that comprise the CMS definition for targeted case management services, including: i) A comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services.... (pp. 103-104, January 2020, Minnesota Medicaid Managed Care Model Contract).

⁴⁵ 6.1.4 Care Management Services.... At a minimum, the MCO's Care Management system must incorporate the following elements: 6.1.4.3 A method for coordinating the medical needs of an Enrollee with his or her social service needs. This may involve working with Local Agency social service staff or with the various community resources in the county. Coordination with the Local Agency social service staff will be required when the Enrollee is in need of the following services. (1) Pre-petition screening, preadmission screening or Home and Community-Based services; (2) Child protection; (3) Court ordered treatment; (4) Developmental disabilities; (5) Assessment of medical barriers to employment; or (6) SMRT or social security disability determination. (7) Coordination may also involve working with Local Agency social service staff or county attorney staff for Enrollees who are the victims or perpetrators in criminal cases. If the MCO determines that an assessment is required in order for the Enrollee to receive Covered Services related to these conditions, the MCO is responsible for payment of the assessments, unless the requested assessment has been paid for by an MCO within the previous one hundred and eighty (180) days. (p. 82).

6.1.17 Health Homes (BHH; HCH; CCBHC). 6.1.17.1 Behavioral Health Home (BHH). Behavioral Health Home services consistent with Minnesota Statutes, §256B.0757 are covered. BHH services are a set of services designed to integrate Primary Care, behavioral health, and social/community services for children with emotional disturbance (including severe emotional disturbance) and adults with serious mental illness (including serious and persistent mental illness). (p. 88).

6.1.17.3 Certified Community Behavioral Health Clinics (CCBHC). CCBHC services are covered. CCBHCs provide a set of services designed to integrate primary care, behavioral health, and substance use disorder services (SUDs), social/community services for children with emotional disturbance (including SED) and services for adults with SMI [Serious Mental Illness] (including SPMI [Serious and Persistent Mental Illness]). (p. 90).

6.1.33.3 Prenatal Care Services. The MCO must ensure that its Providers perform the following tasks: (1) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent, which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk pregnant woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met. (p. 106).

6.18.3.6 Mental Health Services. At the time of initial enrollment in managed care, the MCO shall consider the individual Enrollee's prior use of mental health services and develop a transitional plan to assist the Enrollee in changing mental health Providers, should this be necessary, and to develop a plan to assure continuity of care for any Enrollee or family who is receiving ongoing mental health services. The MCO shall also develop a transitional plan for Children who have previously been excluded from PMAP [Prepaid Medical Assistance Program] because they have been involved in the Child protection system, placed in foster care, diagnosed with SED [Severe Emotional Disturbance], or placed in a juvenile corrections facility. A treatment regimen may be initiated for Children who are assessed as having behavioral or other mental health problems while the Child is excluded from PMAP. However, because the duration of the exclusion from PMAP will vary from one Child to the next, some of these Children may be enrolled in the MCO before their treatment program is completed. As part of this transition plan, the MCO should have a process to assure proper communication and coordination between the Local Agency social services agency and the MCO regarding the specific needs of each Child. (p. 131, January 2020, Minnesota Medicaid Managed Care Model Contract).

⁴⁶ 1. Assignment of Risk Levels ...The Care Manager must contact the Member via telephone or face-to-face interview to assess the Member's Care Management needs. This detailed health risk assessment must evaluate the Member's medical condition(s), including physical, behavioral, social and psychological needs... The detailed health risk assessment must be reviewed by a qualified health professional appropriate for the Member's health condition. The detailed health risk assessment shall address the following, at a minimum: ... c. Demographic information (including ethnicity, education, living situation/housing, legal status, employment status... (p. 132).

5. Health Education & Promotion. To effectively address the specific health needs of enrolled Members, the Contractor must employ a comprehensive risk assessment and stratification methodology. The Contractor will conduct a health risk assessment at the time of enrollment and update at regular intervals thereafter based on the Member's initial risk level. The risk assessment must include both qualitative data reported by the Member and available quantitative data to support appropriate stratification. The risk assessment must consider socioeconomic and environmental risk factors that may impact the Member's health outcomes, as well as the Member's health behaviors and readiness to change. (p. 166-67, July 2017, Magnolia Health Plan, Mississippi Medicaid Managed Care Contract).

⁴⁷ The Contractor's Provider agreements must include at least the following provisions: ... 10. A requirement that the Provider must make referrals for social, vocational, education or human services when a need for such service is identified. (p. 118).

4. Transition of Care Process ... Contractor's process for facilitating continuity of care will include: ... c. Making accommodations such that all community supports, including housing and other support services, are in place prior to the Member's transition and that treating providers are fully knowledgeable and prepared to support the Member, including interface and coordination with and among social supports and medical and/or Behavioral Health/Substance Use Disorder services... f. Summary of Member's history and current medical, Behavioral Health, and social needs and concern's [sic]; (pp. 137-38).

3. Community Partnerships: The Contractor will seek out and enter into agreements with community-based entities to address social determinants of health in each region of the state. Such agreements will be designed to support the implementation of coordinated, culturally competent care strategies and will include, but are not limited to, protocols for: a. Data sharing and data protection; b. Implementing health promotion and disease prevention initiatives; c. Coordinating services delivery with the Member's Health Home; d. Tracking Member outcomes and measuring success. (p. 166).

2. Care Management Services... The Contractor must develop and adopt policies and procedures to ensure all Members have access to required services. At a minimum, Members shall have available the following services: ... f. Coordination with other health and social programs such as MSDH's [Mississippi State department of Health] PHRM/ISS [Perinatal High Risk Management/Infant Services System] Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services; Developing, planning and assisting Members with information about community-based, free care initiatives and support groups... (p. 133-34, July 2017, Magnolia Health Plan, Mississippi Medicaid Managed Care Contract).

⁴⁸ c) Comprehensive Assessment to Identify High-Need Members 1. The PHP [Primary Health Provider] shall perform a Comprehensive Assessment for every Member who is: ... ii. Referred to the PHP for care management by a provider, Member (self-referral), family member, or other person or entity, including social services. (pp. 122-123).

e. The PHP shall use North Carolina-developed tools to address the four priority domains for Opportunities for Health including: i. Standardized Screening Questions: As part of care management, the PHP shall undertake best efforts to conduct a Care Needs Screening of every Member as defined in the Contract. The Screening shall include standardized screening questions, to be developed by the Department, to identify Members with unmet health-related resource needs who required a Comprehensive Assessment for care management (Addendum #1, p. 142, October 2018, North Carolina Medicaid Managed Care RFP).

⁴⁹ i. The Care Management Policy shall include the PHP's [Prepaid Health Plan] policies and process for: ... g) Care coordination, including assigning ongoing source of care, coordination across settings of care, and coordination during Member transitions (including transitions from a Standard Plan to a BH I/DD TP, from Medicaid Fee-for-Service into Medicaid Managed Care, among managed care organizations, among payers, and between community and social support providers); h) Linkages with community resources for all Members as needed, including for those identified as having unmet health-related resource needs; i) Providing information and navigation regarding community providers of social services and tracking effectiveness of these interventions... (Addendum #1, p. 137, October 2018, North Carolina Medicaid Managed Care RFP).

3. The PHP [Prepaid Health Plan] shall identify at-risk children for referral to Local Health Departments, by the following methods: ... ii. Social service agency referrals... (p. 134).

⁵⁰ [Nebraska collects the following] NEBRASKA MEDICAID MANAGED CARE CLIENT ELIGIBILITY DATA Document B: [Headers include] Health Plan Client Eligibility File Data Descriptive Notes Notes for Health Plan Client Eligibility Header Data Record – "H"... Field D12 Client Living Arrangement Field Name: NMC-CLIENT-LIVING-ARRANGE PIC 9(02) Purpose: This field contains a numeric code describing the client's living arrangements. REQUIRED: NO. Valid Values: 01 - Apartment or House, Single Family House, House Arrest Community Service, Halfway House, House Arrest Work Release, Adoptive Home, Adult Day Home 03 - Homeless Shelter for Profit or Non Profit, Room Only, (Dorms, Sororities, Fraternities - Meals Not Provided, Hospital - Acute Hospital Care, Room Only – No Meals Provided, Job Corps, Military, Hospital 05 - Public Housing (not responsible for paying heating bills), (Dorms, Sororities, Fraternities - Meals Provided), Battered Women and Children Shelter - Non Profit, Temporary Lodging 06 - Public Housing, Pub Hsing - Multi-Fam Hse Not Responsible for Heating & Cooling Bills, Pub Hsing - Multi-Fam Hse Not Responsible for Heating Bills, Pub Hsing - Multi-Fam Hse Not Responsible for Cooling Bills, Multi-Family Dwelling, Adult Day Center, Adult Day Health Center 07 - Pub Hsing - Single Fam Hse Responsible for Heating Bills & Cooling Bills, Pub Hsing - Single Fam Hse Responsible for Heating Bills, Pub Hsing - Single Fam Hse Responsible for Cooling Bills, Child Care Center 09 - Board and Room, Chemical Dependency Treatment and Rehabilitation Center 10 - Licensed Mental Health Center, Licensed Domiciliary Facility, Assisted Living - Waiver 12 - Veterans Hospital/Veterans Nursing, Nursing Home/Long Term Care, Nursing Home 13 - Institution - Psychiatric Care – IMD, Psych Residential Treatment Facility 14 - Child Caring Agency, Child Caring Agency, Child Placing Agency, Emergency Shelter Center, Family Child Care Home I, Family Child Care Home II 17 - Licensed/Approved Foster Home, Emergency Shelter Foster Home, Foster Home, Foster Home - Agency Based, Foster Home - Child Specific, Foster Home – Relative 18 - Licensed Residential Care Facility, Assisted Living 19 - Licensed Center for Developmentally Disabled 20 - Certified Adult Family Home, Adult Family Home

30 - Group Home For Profit, Group Home - Institution Non-Profit Meals Provided, Boarder - Board And Rooms - Meals Provided, Incarceration, Residential Care, Preschool 32 - Boardinghouse - Commercial - Non-Profit, Boardinghouse - Commercial - For Profit, licensed Drug Treatment Center, Boarding Home 35 - Licensed/Approved Group Home For Children, Disabled Group Home – Non Profit - Meals Provided, Group Home, Group Home for Adults 36 - Institution for Mental Diseases (IMD) 37- Correctional Facility (Amendment One, p. 1804, January 2017, Nebraska Total Care, Nebraska Medicaid Managed Care Contract).

⁵¹ 4.10.5.2 The MCO shall identify Members who may require a Comprehensive Assessment for Care Management through multiple sources to include but not be limited to: 4.10.5.2.1 Health risk assessment screenings... 4.10.5.2.6 Referrals from community based medical, mental health, Substance Use Disorder Providers, or social service entities... (pp. 177-178).

4.10.5.7 The MCO will develop and implement a Comprehensive Assessment tailored to Members that include, at a minimum, the following domains/content: ... 4.10.5.7.15 Social determinants of health needs... (p. 179).

4.10.9.7 The MCO shall ensure coordination between the children and adolescent service delivery system as these Members transition into the adult mental health service delivery system, through activities such as communicating treatment plans and exchange of information. The MCO shall coordinate inpatient and community services, including the following requirements related to hospital admission and discharge: ... 4.10.9.7.3 An evaluation shall be performed prior to discharge to determine what, if any, mental health or Substance Use Disorder services are Medically Necessary. Once deemed Medically Necessary, the outpatient Provider shall be involved in the discharge planning, the evaluation shall include an assessment for any social services needs such as housing and other necessary supports the young adults need to assist in their stability in their community... (p. 189).

4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)]. 4.10.10.3 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. The MCO must establish Care Management competencies, as outlined below: 4.10.10.3.1 Health Risk Assessment Screening, Claims Analysis, and/or Member or Provider Referral: the MCO ensure that a care needs screening, including social determinants of health questions, is conducted. 4.10.10.3.2 Risk Scoring and Stratification by Member Level of Need: The MCO must identify Priority Populations for further review and likely receipt of intensive Care Management services. With respect to social determinants, the MCO, at minimum, must ensure that Priority Populations are inclusive of homeless Members, Members facing multiple barriers to food, housing and transportation. 4.10.10.3.3 High Risk/High-Need Members: The MCO must ensure that a more in-depth assessment is conducted to confirm the need for Care Management services and begin to develop a care plan. As with the screening, the in-depth assessment must include questions regarding social determinants of health. The MCO must provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services must include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community. 4.10.10.4 For Members who not require such intensive services, the MCO must provide guidance/navigational coordination, which includes: 4.10.10.4.1 Ensuring that each Member has an ongoing source of care and health services appropriate for his or her needs; 4.10.10.4.2 Coordinating services provided by community and social support Providers; 4.10.10.4.3 Linking Members to community resources and social supports; and 4.10.10.4.4 Reporting on closed loop referrals or the overall effectiveness of the types of social determinant–related Care Coordination services, in accordance with Exhibit O. (Appendix C, pp. 189-190, August 2018, New Hampshire Medicaid Managed Care RFP).

⁵² 4.1.7 Value-Added Services: 4.1.7.1 The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i). 4.1.7.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO’s discretion, but the cost of these Value-Added Services will not be included in Capitation Payment calculations. The MCO shall submit to DHHS an annual list of the Value-Added Services being provided. (p. 80, August 2018, New Hampshire Medicaid Managed Care RFP). [While this clause does not specifically mention SDOH, we have included it because it is broad enough to include them.]

⁵³ 4.10.10 Coordination and Integration with Social Services and Community Care... 4.10.10.6 The MCO shall report on the number of referrals for social services and community care provided to Members by Member type, consistent with the format and content requirements in accordance with Exhibit O. (p. 190). 5.1.1.7 The MCO will be responsible for preparing, submitting, and presenting to the Governor, Legislature, and DHHS a report that includes the following information, or information otherwise indicated by the State: ... 5.1.1.7.3 A description of how the MCO is addressing social determinants of health, and the outcomes associated with MCO implemented interventions... (Appendix C, pp. 276-277, August 2018, New Hampshire Medicaid Managed Care RFP).

⁵⁴ 4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)]. 4.10.10.3 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. ... 4.10.10.3.3 High Risk/High-Need Members: ... The MCO must provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services must include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community. For Members who do 4.10.10.4 not require such intensive services, the MCO must provide guidance/navigational coordination, which includes: 4.10.10.4.1 Ensuring that each Member has an ongoing source of care and health services appropriate for his or her needs; 4.10.10.4.2 Coordinating services provided by community and social support Providers; 4.10.10.4.3 Linking Members to community resources and social supports; and 4.10.10.4.4 Reporting on closed loop referrals or the overall effectiveness of the types of social determinant-related Care Coordination services, in accordance with Exhibit O. (pp. 189-190).

4.10.10.5 The MCO shall 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 not limited to: 4.10.10.5.1 Juvenile Justice and Adult Community Corrections; 4.10.10.5.2 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.; 4.10.10.5.3 Family Organizations, Youth Organizations, Consumer Organizations, and Faith Based Organizations; 4.10.10.5.4 Public Health Agencies; 4.10.10.5.5 Schools; 4.10.10.5.6 The court system; 4.10.10.5.7 ServiceLink Resource Network; 4.10.10.5.8 Housing; and 4.10.10.5.9 VA Hospital and other programs and agencies serving service Members, veterans and their families. (p. 190).

⁵⁵ B. Identification and Service Delivery. The Contractor shall have in place all of the following to identify and serve enrollees with special needs: ... 2. Methods and guidelines for determining the specific needs of referred individuals who have been identified through a Comprehensive Needs Assessment as having complex needs and developing care plans that address their service requirements with respect to specialist physician care, durable medical equipment, medical supplies, home health services, social services, transportation, etc. (Art. 4, p. 59).

Targeted Case Management (TCM) Service Descriptions: Services that will assist targeted individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment.... Services are designed to assist consumers in their recovery by helping them gain access to needed mental health, medical, social, educational, vocational, housing and other services. (p. 615 [not internally paginated], January 2019, New Jersey Medicaid Managed Care Model Contract).

⁵⁶ 4.3 COORDINATION WITH ESSENTIAL COMMUNITY PROGRAMS: A. The Contractor shall identify and establish working relationships for coordinating care and services with external organizations that interact with its enrollees, including State agencies, schools, social service organizations, consumer organizations, and civic/community groups. B. For enrollees receiving MLTSS, the Contractor shall: 1. Establish working relationships and standard operating procedures for coordinating primary, acute, behavioral and long term services and supports with external organizations that interact with its MLTSS Members. 2. At a minimum, forge ongoing partnerships and communication linkages with independent client advocates; Area Agencies on Aging/Aging and Disability Resource Connections (ADRCs); the Division of Aging Services (DoAS); Office of Community Choice Options (OCCO); County Welfare Agencies (CWAs); the Department of Community Affairs; the Division of Disability Services (DDS); County Offices on Disability; the State Health Insurance Assistance Program (SHIP), the Centers for Independent Living (CIL); Early Intervention Special Child Health Services; and both County and State Offices of Emergency Management. 3. Develop policies and procedures that ensure that MLTSS Members are afforded linkages to protective services through agencies including, but not limited to: Adult Protective Service (APS), the Office of the Public Guardian, the Department of Children and Families (DCF) and the NJ Office of the Ombudsman for the Institutionalized Elderly. Refer to Article 9.10 for information on critical incidents. 4. Develop policies and procedures to

assure integration between the roles and responsibilities of the Division of Disability Services (DDS) and the Contractor's Care Managers and/or utilization management departments for Members choosing participant direction. See Article 9.8 for information on participant direction. (Art. 4, p. 52-52, January 2019, New Jersey Medicaid Managed Care Model Contract).

⁵⁷ 4.4.5.4 In performing CNA [Community Needs Assessment] the CONTRACTOR shall use a tool that has been approved by HSD [Human Services Department], in accordance with protocols specified by HSD, to assess the Member's medical, Behavioral Health, Long- Term Care and social needs... 4.4.5.5 At a minimum, the CNA shall: ... 4.4.5.5.5 Determine a social profile including but not limited to: living arrangements; demographics; transportation; employment; natural supports; financial resources (other insurance, food, utilities); Medicare services; other community resources in place such as senior companion or meals-on-wheels; living environment (related to health and safety); IADLs [Instrumental Activities of Daily Living], Individualized Education Plan (IEP); Individual Service Plan (ISP) for DD or medically fragile Members (if applicable)... (p. 52 p. 73, January 2018, New Mexico Medicaid Managed Care Contract Amendment).

⁵⁸ 4.7 Value Added Services 4.7.1 The CONTRACTOR may offer to its Members Value Added Services that are not Covered Services. The CONTRACTOR may offer Value Added Services in the ABP. 4.7.2 Value Added Services shall be approved in writing by HSD to supplement the Covered Services provided to such Members. 4.7.3 The cost of Value Added Services will not be included when HSD determines the Capitation Rate. All Value Added Services shall be identifiable and measurable through the use of unique payment and/or processing codes, approved by HSD. 4.7.4 Value Added Services are not Medicaid-funded services; therefore, there is neither Appeal nor Fair Hearing rights. The CONTRACTOR shall send the Member a notification letter if the requested Value Added Service required prior approval and was not approved, i.e., denied 4.7.4.1 Denial of a Value Added Service will not be considered an Adverse Benefit Determination for purposes of Appeals or Fair Hearings. (p. 103, January 2018, New Mexico Medicaid Managed Care Contract Amendment). [While this clause does not specifically mention SDOH, we have included it because it is broad enough to include them.]

⁵⁹ ii) Except where the Enrollee refuses these services, the Contractor shall ensure, consistent with the terms of the subcontract executed between the Contractor and the Health Home, that all Health Homes provide comprehensive Care Management to all Health Home Participants, which shall include the following: A) A comprehensive assessment that identifies the Health Home Participant's medical, behavioral health, and social service needs... (pp. 21-31).

43. Medical Social Services a) Medical Social Services are covered by the Contractor only for those Enrollees who have transitioned to the Contractor's Medicaid Managed Care plan from the Long Term Home Health Care Program (LTHHCP) and who received Medical Social Services while in the LTHHCP. Medical Social Services is the assessment of social and environmental factors related to the participant's illness, need for care, response to treatment and adjustments to treatment; assessment of the relationship of the participant's medical and nursing requirements to his/her home situation, financial resources and availability of community resources; actions to obtain available community resources to assist in resolving the participant's problems; and counseling services. Such services shall include, but not be limited to, home visits to the individual, family or both; visits preparatory to the transfer of the individual to the community; and patient and family counseling, including personal, financial, and other forms of counseling services. b) Medical Social Services must be provided by a qualified social worker licensed by the Education Department to practice social work in the State of New York. (p. K-48, March 2019, New York Medicaid Managed Care Model Contract).

⁶⁰ e) The Contractor must provide case management services as appropriate and as medically necessary to Enrollees receiving [Personal Care Services] and must coordinate with appropriate local government programs to address any social and environmental issues necessary to maintain the Enrollee's health and safety in the home. (p. 10-37).

The Contractor agrees to require that providers of home health services to pregnant or postpartum women document the following in the case records: ... iii) Referral and coordination with appropriate health, mental health and social services and other providers... (p. K-27).

d) [Applicable to the HARP [Health and Recovery Plan] and HIV SNP [Special Needs Plan] Programs only]: The Contractor, through a Health Home wherever possible or other State-designated entity, must promote access and ensure referrals to fee-for-service Medicaid benefits and to other social and behavioral health resources necessary to promote recovery outcomes and wellness, including housing subsidies and supports, public benefits, meaningful employment, social networks and legal services, for Enrollees determined to be in need of such services, through the HARP and HIV SNP care coordination processes. (p. 10-1).

b) The Contractor shall base its determination [of eligibility for the Child Teen Health Program] on medical and other relevant information provided by the Enrollee's PCP, other health care providers, school, local social services, and/or local public health officials that have evaluated the Enrollee. (p. 10-3).

a) The Health Home program provides reimbursement for care management to approved Health Home providers for the following services provided to Enrollees with behavioral health and/or chronic medical conditions who are determined eligible for Health Home services: ... referrals to community and social support services... (p. 21-27, 21-28, March 2019, New York Medicaid Managed Care Model Contract).

⁶¹ The MCP shall identify the factors that will be considered when determining a member's risk stratification level. At a minimum, the MCP shall consider the following current and historical factors: acuity of chronic conditions, substance use and/or mental health disorders, maternal risk (e.g., prior preterm birth), inpatient or emergency department utilization, social determinants of health and/or safety risk factors. (p. 121, January 2020, Ohio Medicaid Managed Care Model Contract).

⁶² k. Addressing Health Disparities. The MCP shall participate in, and support, ODM's efforts to eliminate health disparities in Ohio. According to the U.S. Department of Health and Human Services' Office of Minority Health, and for the purposes of this Agreement, a health disparity is "a particular type of health difference closely linked with social or economic disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location). To further advance ODM's efforts to achieve health equity, the MCP shall collect and meaningfully use member-identified race, ethnicity, language, and social determinants of health data to identify and reduce disparities in health care access, services and outcomes. This includes, where possible, stratifying HEDIS and CAHPs, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities. (p. 145, January 2020, Ohio Medicaid Managed Care Model Contract).

⁶³ a. ... In addition, the MCP [Managed Care Provider] may be required to communicate with the member's local County Department of Job and Family Services (CDJFS) agency any requests made by the member for County coordinated services and/or supports (e.g. social services). b. Informing Members about Pregnancy Related Services (PRS): ... ii. The MCP may be required to communicate with the member's local CDJFS agency any requests made by the member for County coordinated services and supports (e.g. social services). (pp. 26-27, January 2020, Ohio Medicaid Managed Care Model Contract).

⁶⁴ b. Contractor shall work with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific Community based organizations, Community-Based mental health services, DHS Medicaid-funded long term care services and mental health crisis management services. (p. 59).

(2) Contractor shall ensure all Care Coordinators work with team Members to coordinate integrated care. This includes coordination of: physical health, Behavioral Health, intellectual and developmental disability, DHS, OYA, social determinants of health and Ancillary Services. (p. 197).

b. State and Local Government Agencies and Community Social and Support Services Organizations: Contractor shall promote communication and coordination with State and local government agencies and culturally diverse Community social and support services organizations, including early child education, special education, Behavioral Health and public health, as critical for the development and operation of an effective delivery system. Contractor shall consult and collaborate with its Providers to maximize Provider awareness of available resources to ensure diverse Members' health, and to assist Providers in referring

Members to the appropriate Providers or organizations. Contractor shall ensure that the assistance provided regarding Referrals to State and local governments and Community social and support services organizations takes into account the Referral and service delivery factors identified in the Community Health Assessment and Community Improvement Plan. (p. 62).

2. Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) a. The Contractor, through its [Community Advisory Council], shall adopt a CHA and a CHP with responsibilities identified in OAR 410-141-3145 and in compliance with ORS 414.627 and ORS 414.626... b. To the extent practicable, Contractor shall include in the CHA and CHP a strategy and plan for: (1) Working with the Early Learning Council, Early Learning Hubs, the Youth Development Council, Local Mental Health Authority, oral health care Providers, the local public health authority, Community-based organizations, hospital systems and the school health Providers in the Service Area/region; and (2) Coordinating the effective and efficient delivery of health care to children and adolescents in the Community. (pp. 215-216, January 2020, Oregon Medicaid Managed Care RFA).

⁶⁵ 3. Social Determinants of Health and Health Equity a. 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). b. Contractor shall submit to OHA, by March 15, 2020, an implementation plan using the template provided by OHA [Oregon Health Authority] that includes the selected priorities for health disparities and SDOH-HE required spending in the subsequent year. The selected priorities shall be aligned with the CHP [Community Health Improvement Plan] and identified from analysis of any existing CHP priorities that meet the OAR [Oregon Administrative Rules] SDOH-HE [Social Determinants of Health & Health Equity] definition and fall into one of four SDOH-HE domains: Economic Stability, Neighborhood and Built Environment, Education, and Social & Community Health. Contractor must include the OHA-designated statewide priority for SDOH-HE spending, namely: housing-related services and supports, including Supported Housing, as defined in this Contract. Contractor shall comply with future statewide priorities as set by OHA. Contractor may select additional priorities aligned with CHP priorities according to Community need. The plan shall identify any infrastructure needs or gaps for addressing the selected priorities and ways to satisfy those needs or gaps... (pp. 218-219, January 2020, Oregon Medicaid Managed Care RFA).

⁶⁶ The PH-MCO will collaborate with the Department to develop, adopt and disseminate a Social Determinants of Health assessment tool. (p. 74).

v. Requirements regarding coordination [between] Behavioral Health Providers [and the physical health MCO] (if applicable): ... Make referrals for social, vocational, education or human services when a need for such service is identified through assessment. (p. CCC-4).

B. The PH-MCO will ensure the PCMH [Patient Centered Medical Home] provider meets the following requirements: Will complete a Social Determinants of Health assessment using a Nationally recognized tool and submit ICD-10 diagnostic codes for all patients... (Exhibit DDD, p. DDD-2, January 2019, Pennsylvania Medicaid Managed Care Contract).

⁶⁷ V. Requirements regarding coordination [between] Behavioral Health Providers [and the physical health MCO] (if applicable): ... Make referrals for social, vocational, education or human services when a need for such service is identified through assessment. (p. CCC-4).

B. The PH-MCO will ensure the PCMH [Patient Centered Medical Home] provider meets the following requirements: ... The CBCM [Community Based Care Management] team will ... connect 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... 12. Will complete a Social Determinants of Health assessment using a Nationally tool and submit ICD-10 diagnostic codes for all patients... (p. DDD-2).

⁶⁸ A. CBCM [Community Based Care Management] activities and funding must primarily be focused on: ... 3. addressing social determinants of health... (Exhibit B(5), p. B(5)-1, January 2019, Pennsylvania Medicaid Managed Care Contract).

⁶⁹ In addition, Contractor agrees to do the following: Perform appropriate clinical and social risk assessment of pregnant women... (p. 79-80).

2.09.08 Health Risk Assessments: For all members, Contractor shall conduct a Health Risk Assessment with the member, caregiver or guardian. The Health Risk Assessment will be used to identify members who require short term care coordination or intensive care management for medical, behavioral or social needs. (p. 130).

A primary focus of the Health Plan's Care Management program will be: 2.16.04: To identify members with significant health and social needs that are at high risk of poor health outcomes who may require care management services, such as children with special health care needs and individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional facilities... (p. 423).

The Health Risk Assessment conducted by the Health Plan and/or its delegated accountable entity, medical home, health home, or community health team must identify adults who have transition of care needs and who may benefit from care management services: The Health Risk Assessment shall have an interdisciplinary, holistic, preventive health and strength-based focus, and screen for medical/physical needs, behavioral health needs, functional, social and financial issues with an aim of maximizing independence and functioning... The Screen shall identify member's risk factors that may indicate potential need for care management. These must include but are not limited to: ... Sense of being overwhelmed by their condition and how to navigate the health care system, inclusive of potential linguistic or social barriers; social determinants of care... (p. 425, July 2018, Rhode Island Medicaid Managed Care Contract).

⁷⁰ Care management is to be performed by Health Plan staff or agents located in the State of Rhode Island. Rhode Island staff will be key for their ability to work closely with local resources. Face-to-face meetings shall be conducted where appropriate; to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs, social supports and services and out-of-plan services. The Program Coordinator (and/or Care Manager) and all their needed support staff shall be located in Rhode Island. (p. 88).

2.06.05.05 Housing Stabilization Program: EOHHS [Executive Office of Health and Human Services] supports a housing stabilization program that provides sheltering those for whom homelessness is unavoidable, and rapidly re-houses the homeless in stable, permanent housing. The Contractor is required to refer members who have been identified as having housing stability needs to the Housing Stabilization Program. The Contractor is required to coordinate with out of plan housing stabilization providers and report on these activities at an interval defined by EOHHS. At the time of execution of this Agreement, the Contractor should submit its plan for ensuring coordination between its efforts and those of its subcontractors with respect to the Housing Stabilization Program. The Contractor will assist members in accessing necessary housing arrangements and will collaborate with all state and federal housing authorities to assist in accomplishing access. These agencies include but are not limited to; Corporation for Supportive Housing, Rhode Island Housing Authority and the RI Office of Housing and Community Development. The Contractor in collaboration with EOHHS, shall develop a strategy to strengthen networks with housing providers and develop access to affordable housing. The Contractor shall actively participate with EOHHS, other managed care contractors and other stakeholders to develop and implement strategies for the identification of resources to assist in transitioning members to affordable housing. (p. 88-89).

EOHHS [Executive Office of Health and Human Services] supports various special service programs targeted to persons who may be covered by Rite Care, ACA Expansion or Rhody Health Partners. The Contractor is not obligated to provide or pay for any non-plan, non-capitated services. However, Contractor shall develop policies and procedures to guide coordination of its in-plan and other service delivery with services delivered outside of the Health Plan. Examples of services with which it must coordinate are described below, but this list is not exhaustive... Contractor shall not be financially liable for speech, hearing, and language therapy services or other Medicaid-covered services specified in Special Education Individual Education Plans (IEPs) and provided to special education students, but it shall have written policies and procedures for promptly transferring medical and developmental data and for coordinating ongoing care with special education services. Included within these policies and procedures shall be provisions for Contractor participation in IEP development and monitoring, if so requested... The State operates a WIC Nutrition program through the Department of Health for pregnant, postpartum and breast-feeding women and children, birth to age five who are at risk for nutritionally related health and developmental conditions. For its part, Contractor shall have written policies and procedures for referring pregnant women and children to the WIC program... Contractor agrees to have written policies and a procedure to provide lead screening, education, and any Medically Necessary lead reduction therapies and agrees to work cooperatively with the Department of Health Lead Program or the Lead Centers to coordinate delivery of these services with those provided through Contractor... The Rhode Island Department of Health, Rhode

Island Department of Children, Youth, and Families ("DCYF"), and EOHHS operate a number of social and public health programs that are available to Rite Care members. Several key programs are described below, along with the Health Plan accompanying coordination responsibilities. Health Plans are expected to coordinate with/refer members to other programs offered by the State, such as Comprehensive Emergency Services Program (DCYF), and the Early Start Program... Rhode Island Executive Office of Health and Human Services currently operates an Adolescent Self-Sufficiency Collaborative ("ASSC") service network consisting of community-based Programs located throughout the State. These programs provide targeted case management to women under the age of twenty (20) who are pregnant and parenting. The ASSC provides: (1) case management services, including home visiting, and intensive case management to minor parents focusing on parenting education and life-skills development; (2) pregnancy prevention programs that involve teen parents, their parents and other family members, including "hard-to-serve" families where English is not the primary language; and (3) access to programs where participants learn and practice pre-employment/work maturity skills, where they explore vocational options and where they participate in community work experience settings matching their skills and interests. Contractor is encouraged to make referrals to the ASSC programs as appropriate... (pp. 89- 91).

This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. Regardless of the level of care, these outcomes [of the Assertive Community Treatment (ACT) program] are achieved by adopting a whole person approach to the consumer's needs and addressing the consumer's primary medical, specialist and behavioral health care needs; and providing the following comprehensive/timely services: ... Referral to community and social support services, if relevant... (p. 388-89).

Integrated Health Home (IHH) is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support. (pp. 389).

The [Opioid Treatment Program] Health Home services are defined below... The OTP Health Home builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including mental health treatment) in keeping with the needs of persons with a primary diagnosis of opioid dependence and multiple chronic illnesses or who is at risk of chronic illnesses... OTP Health Home teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. (pp. 413-14, July 2018, Rhode Island Medicaid Managed Care Contract).

⁷¹ 5.1.4. Use Care Management and Coordination as a continuous process for: 5.1.4.1. The assessment of a Member's physical health, Behavioral Health and social support service and assistance needs (p. 80, July 2018, South Carolina Medicaid Managed Care Contract).

⁷² 5.5.3. Service Delivery Coordination The CONTRACTOR shall: ... 5.5.3.3. Coordinate services the member receives with community and social support Providers... (p. 84, July 2018, South Carolina Medicaid Managed Care Contract).

⁷³ 2.9.6.5.2.2 At a minimum, for members in CHOICES Group 2 and 3, the comprehensive assessment shall assess: ... (6) the physical health, behavioral health, and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health safety and welfare in the community, delay or prevent the need for institutional placement, and to support the member's individually identified goals and outcomes, including employment (as applicable) and integrated community living... (pp. 163-64, July 2019, Tennessee Medicaid Managed Care Contract).

⁷⁴ 2.9.6.1.3 The CONTRACTOR shall use care coordination as the continuous process of: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement. (p. 128).

2.8.4.3.9 The CONTRACTOR shall provide to members in the highest risk level within the Health Risk Management Program the following minimum interventions: Health Risk Management Program: Highest Risk Level Minimum Interventions: ... B. Referrals and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs... (p. 103, July 2019, Tennessee Medicaid Managed Care Contract).

⁷⁵ Value-added Services means additional services for coverage beyond those specified in Attachments B-2, B-2.1, and B-2.2. Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services. (Attachment A, p. 19, September 2019, Texas Medicaid Managed Care RFP).

⁷⁶Health Home Services must include: ... 14. referral to community and social support services, if relevant... (p. 8-158, September 2019, Texas Medicaid Managed Care RFP).

2.8.4.3.9 The CONTRACTOR shall provide to members in the highest risk level within the Health Risk Management Program the following minimum interventions: Health Risk Management Program: Highest Risk Level Minimum Interventions: ... B. Referrals and linkages to link the members with medical, social, educational and/or other providers or programs and services to address identified needs... (p. 103, January 2019, Tennessee Medicaid Managed Care Contract).

8.3.2.4 Referral to Community Organizations: The MCO must provide information about and referral to community organizations that may not be providing STAR+PLUS Covered Services, but are otherwise important to the health and wellbeing of Members. These organizations include, but are not limited to: 1. state/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health, intellectual or developmental disabilities, 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; and 5. consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.). (p. 8-208, September 2019, Texas Medicaid Managed Care RFP).

⁷⁷ 8.6.A Health Risk Assessment Development The Contractor shall work with the Department to develop a standard Health Risk Assessment tool that all managed care plans will use. This assessment will assist case managers in identifying member physical and behavioral health status and risk factors along with their social, economic and housing needs. The HRA will be used to create a plan of service that will encompass member goals for their health outcomes, strengths and community resources. The goal of both the HRA and service plan shall be to develop member centered care strategies and ultimately aid in the improvement of member health outcomes and overall social and economic independence. The Contractor shall annually submit all applicable policies and procedures to the Department for review, including clinical protocols used to determine appropriate interventions and referrals to other services that may be needed (such as housing referrals, etc.). (p. 218, August 2018, Virginia Medicaid Managed Care Contract).

⁷⁸ Coordination Procedures: In accordance with 42 C.F.R. § 438.208(b), the Contractor must implement procedures to coordinate: ... The services the Contractor furnishes to the member with the services the member receives from community and social support providers. (pp. 142-143).

Placement into a PUMS [Patient Utilization Management & Safety] Program Members may be placed into a [Patient Utilization Management Program] program for a period of twelve (12) months when any of the following trigger events occurs: 8.1.M.b.b Medical providers or social service agencies provide direct referrals to the Department or the Contractor. (p. 149, August 2018, Virginia Medicaid Managed Care Contract)

Early Intervention Targeted Case Management/Service Coordination: The Contractor shall provide coverage for EI [Early Intervention] Targeted Case Management (also referred to as EI Service Coordination). EI service coordination is a service that will assist the child and family in gaining access to needed and appropriate medical, social, educational, and other services. EI Service Coordination is designed to ensure that families are receiving the supports and services that will help them achieve their goals on their child's Individual Family Service Plan (IFSP), through monthly monitoring, quarterly family contacts, and on-going supportive communication with the family. The Service Coordinator can serve in a "blended" role; in other words, a single practitioner can provide both Early Intervention Targeted Case Management/Service Coordination and an IFSP service, such as physical therapy, developmental services, etc. to a child and his or her family. The Contractor shall submit an annual report outlining its efforts in the four social determinants of health areas listed above. (p. 380).

SOCIAL DETERMINANTS OF HEALTH: The Contractor must develop programs or establish partnerships to address social factors that affect health outcomes, also called social determinants of health which contribute significantly to the cost of care and the member's experience of health care. The Contractor shall provide care coordination and case management efforts that identify, address member access to education, housing services, job training, food security, transportation needs, resources that support member connection to social supports in their community and other environmental needs identified by the member. In developing these programs the Contractor must work to address the following social determinants of health as identified by the Department: Economic Stability - Poverty, Employment, Food Security, Housing Stability; Education - High School Graduation, Enrollment in Higher Education, Language and Literacy, Early Childhood Education and Development; Social and Community - Context, Social Cohesion, Civic Participation, Perceptions of Discrimination and Equity, Incarceration/Institutionalization; Health and Health Care - Access to Health Care, Access to Primary Care, Health Literacy Neighborhood and Built Environment - Access to Healthy Foods, Quality of Housing, Crime and Violence, Environmental Conditions. (p. 233).

Nutritional Insufficiency Initiative: As nutritional insufficiency of Medicaid enrollees is a significant concern for the Commonwealth the Contractor shall work collaboratively with the Department to develop and implement an innovative pilot program that all plans will participate in to address nutritional insufficiency to support healthy Virginians and particularly healthy Virginia children. (p. 233). Collaboration with DMAS [Department of Medical Assistance Services], DBHDS [Department of Behavioral Health and Developmental Services], and Interested Stakeholders The Contractor shall work collaboratively with DMAS, DBHDS, DHP [Department of Health Professions], VDH [Virginia Department of Health], providers, DMAS contractors, relevant local, State, tribal, social service agencies, and other interested stakeholders to provide the infrastructure to support successful ARTS benefit and to ensure that the Contractor's ARTS benefit is fully operational by the effective date of this Contract. (p. 407, August 2018, Virginia Medicaid Managed Care Contract).

⁷⁹ In addition to the services required in the Transitional Services section of this Contract, the Contractor shall: ... Assess and address relevant financial and social needs of the enrollee... (p. 101).

Initial Health Assessment: To assess identified individuals who need Long Term Care Supports and Services (LTSS) or those with Special Health Care Needs who was not eligible for Health Home Services, the Contractor's care coordinator shall conduct an Initial Health Assessment (IHA) within sixty (60) calendar days of the identification of special needs or [Initial Health Screening] that indicates the need for care coordination. The assessment shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources... The Contractor shall require the Enrollee's primary care provider and care coordinator to ensure arrangements are made for the Enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers or referral to community-based social health services and LTSS. (p. 238, January 2020, Washington State Medicaid Fully Integrated Managed Care Contract).

⁸⁰ The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to: The Department of Social and Health Services: Aging and Long-Term Support Administration (AL TSA) Home and Community Services including contracted Area Agencies on Aging; Skilled nursing facilities and community-based residential programs; Behavioral Health Administration;

Developmental Disabilities Administration; Division of Vocational Rehabilitation; and Juvenile Justice Rehabilitation Administration (JJ&RA).... Supported Employment programs; State and/or federal agencies and local partners that manage access to housing... HCA's contractive Third Party Administrator for supportive housing and supported employment... (pp. 235-236).

Allied System Coordination Plan: For each RSA [Regional Service Area] in which the Contractor participates, the Contractor shall develop a written Allied Systems Coordination Plan that describes how the Contractor will coordinate and collaborate with healthcare and other allied systems that serve Contractor Enrollees. The Contractor shall collaborate with ACH representative and representatives of the entities listed in Subsection 14.10 to develop and update this plan as needed. The plan must describe how the Contractor will address the elements below and how the Contractor will interact with any Allied System that chooses not to participate in the jointly developed coordination plan and include the following elements: Clearly defined roles and responsibilities of the allied systems in helping Enrollees served by more than one system. For children this includes EPSDT coordination for any child serving agency and a process for participation by the agency in the development of a cross-system ISP [Individual Service Plan] when indicated under EPSDT; Identification of needed local resources, including initiatives to address those needs; A process for facilitation of community reintegration from out-of-home placements... for Enrollees of all ages; A process for working with ACH [Accountable Community of Health], the BH-ASO [Behavioral Health Administrative Services Organization] managing crisis services, and first responders, evaluate the need to develop resources to engage and collaborate with first responders... Facilitating linkages with social services and criminal justice/courts and providers under contract with the county or state; A procedure the Contractor representatives attending relevant stakeholder, planning, and advocacy meetings and communicating/coordinating with other entities to ensure the Contractor is aligned with state and local Behavioral Health initiatives. (pp. 233-234).

The Contractor shall submit its customer services policies and procedures to the HCA [Health Care Authority] for review at least ninety (90) calendar days before implementation. Customer services policies and procedures shall address the following: ... Requirements for responding promptly to family members and supporting linkages to other services systems including, but not limited to: State only and federal block grant funded behavioral health services, law enforcement, criminal justice system, social services. (p. 123, January 2020, Washington State Medicaid Fully Integrated Managed Care Contract).

⁸¹ Some Local WIC Agencies are WI Medicaid enrolled as HealthCheck – Other Services providers and may contract with HMOs for blood lead poisoning screenings performed during the WIC appointment as a Medicaid-billable service. (p. 206, January 2020, Wisconsin Medicaid Managed Care Contract).

⁸² 10. Out-of-Network Benefit Coordination (BadgerCare Plus and Medicaid SSI): Per Article III, section C, the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Services or through community and social support providers. The HMO must assign a representative to coordinate services with public health agencies or treatment programs within the HMO's service area that are not included in the HMO's network. These might include but are not limited to county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs, or inpatient programs. The HMO must work with the agency/program to coordinate a member's transition to or from covered mental health and substance abuse care within the HMO's network. Any member transitioning from crisis intervention services must be able to access an appropriate level of ongoing care within 30 days of the crisis. The HMO is not required to pay for ongoing services outside the HMO network, unless the HMO has authorized those services. (p. 98).

11. Memoranda of Understanding (MOU)/Contract Requirement and Relations with other Human Service Agencies: Per Art. III, section C, the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Services or through community and social support providers. The HMO shall develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to members. The HMO must work cooperatively with other community agencies, to treat mental health and/or substance abuse conditions as legitimate health care problems... (p. 98).

HMOs serving members with HIV/AIDS must provide access to ARCW [The AIDS Resource Center of Wisconsin] health home services. Health home services include coordination beyond the health care community. A significant component is focused around the engagement of community partners to ensure successful linkages to community and social supports. (p. 119).

F. Coordination and Continuation of Care The HMO must have a system in place to ensure well-managed patient care, including at a minimum: ... 6. Per Art. III, C, coordinate the services the HMO provides to the member with: ... The services a member receives through community and social support providers. (p. 115, January 2020, Wisconsin Medicaid Managed Care Contract).

⁸³ 3.10 Value-Added Services: The MCO may propose to offer Value-Added Services. If offered, the MCO will not receive additional compensation for the Value-Added Services from the Department. The MCO may report the costs of Value-Added Services as allowable medical or administrative costs for the purposes of Medical Loss Ratio calculation. The cost of Value-Added Services is not included in the MCO capitation rates. The Value-Added Services are not included in the Medicaid benefit package. (p. 109, 2020, West Virginia Medicaid Managed Care Contract). [While this clause does not specifically mention SDOH, we have included it because it is broad enough to do so.]

⁸⁴ The MCO must employ a West Virginia Medicaid Administrator/Contract Liaison... The Medicaid Administrator(s) must be responsible for making recommendations to management on any changes needed to improve either the actual care provided or the manner in which the care is delivered. The Administrator(s) will: ... 3. Coordinate with schools, community agencies, local health departments, state health laboratories and state agencies providing complementary services to Medicaid enrollees... 6. Connect with local community organizations to acquire knowledge and insight regarding the special health care needs of beneficiaries... (p. 117, 2020, West Virginia Medicaid Managed Care Contract).

As part of discharge planning, the MCO shall engage any member exiting a drug rehabilitation program to determine whether employment assistance is needed. If so, the MCO shall coordinate a referral to a local workforce agency and facilitate linkages to other related community supports available. (p. 112).

Community and Social Services: The MCO must have programs for coordination of care that include coordination of services with community and social services generally available through contracting or non-contracting providers in the area served by the MCO. (p. 113, 2020, West Virginia Medicaid Managed Care Contract).

⁸⁵ 23. MEDICAL MANAGEMENT.... The Contractor shall ensure that Contractor care managers are trained on Social Determinants of Health (SDOH) issues and shall have training requirements in place to educate Contractor staff and providers regarding SDOH support addressing the socioeconomic needs of members. (p. 97, October 2019, Amendment 14, Arizona Medicaid Managed Care Contract).

⁸⁶ 23. MEDICAL MANAGEMENT.... The Contractor shall ensure that Contractor care managers are trained on Social Determinants of Health (SDOH) issues and shall have training requirements in place to educate Contractor staff and providers regarding SDOH support addressing the socioeconomic needs of members. (p. 97, October 2019, Amendment 14, Arizona Medicaid Managed Care Contract).

⁸⁷ Quality Management/Performance Improvement Program: ... The Contractor's QM/PI Program shall include, but is not limited to: ... 6. 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 chronic disease management, behavioral health, justice population, opioid and substance use, suicide, and Social Determinants of Health (SDOH) including, but not limited to, homelessness, employment/community engagement, etc.). (p. 84, October 2019, Amendment 14, Arizona Medicaid Managed Care Contract).

⁸⁸ A. Health Education: ... 10) Contractor shall ensure education and training of contracting medical Providers, practitioners, and allied health care personnel to support delivery of effective health education services for Members. Education and training must cover at least the following topics: a) IHEBA [Individual Health Education Behavioral Assessment]; b) Techniques to enhance effectiveness of Provider/patient interaction; c) Plan-specific and community resource and referral information; d) Health education requirement standards, guidelines and monitoring; and, e) GNA findings. Provider training on GNA [Health Education, Cultural and Linguistic Group Needs Assessment] findings shall include information about the identified cultural groups in the Contractor's Service Area, such as the groups' beliefs about illness and health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact patient care, and language and literacy needs. 11) Contractor shall adopt and maintain appropriate health education program standards/guidelines and policies/procedures, and conduct appropriate levels of evaluation, e.g. formative, process, impact and outcome evaluation, to ensure access,

availability and effectiveness in achieving health education program goals and objectives. Contractor shall maintain documentation that demonstrates effective implementation of all DHCS health education requirements under this Contract. (Exhibit A, Attachment 10, p. 90, California 2017 Final Rule GMC Non-CCI Boilerplate Contract). [While this clause does not specifically mention SDOH, we have included it because it is broad enough to do so.]

⁸⁹ A. Health Education.... 2) Contractor shall ensure administrative oversight, direction, management, and supervision of the health education system by a qualified, full-time health education director or manager possessing a master of public health degree (MPH) with an emphasis in health education from a school and program of public health accredited by the Council on Education for Public Health. Contractor shall maintain the organization and staffing to ensure successful implementation and maintenance of an effective health education system. Health education program activities must be coordinated and integrated with the Contractor's overall health care and quality improvement plan. (Exhibit A, Attachment 10, pp. 85-86, California 2017 Final Rule GMC Non-CCI Boilerplate Contract).

⁹⁰ 16.4.8. Accountable Care Collaborative Pay for Performance. 16.4.8.1. The Contractor shall participate in four (4) components of pay for performance. 16.4.8.1.1. Key Performance Indicators: 16.4.8.1.1.1. The Contractor shall be capable of working to improve performance for up to nine (9) Key Performance Indicators (KPIs) in order to earn performance payments. For the first year, KPI measures will be as stated in Exhibit E. Following the first year of the contract, they will be established at the Department's discretion to align with new statewide initiatives and through consultation with the Department, RAEs [Regional Accountable Entities], and stakeholders. 16.4.8.1.1.1.1. Following the first year of the contract, the Department will include a public health measure as a KPI, reflecting the RAE's role in the Health Neighborhood and Community addressing social determinants of health. (Exhibit B-3, p. 108, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

⁹¹ 3.7.1.4.3 The Contractor shall ensure that newly hired case managers are provided orientation and training in a minimum of the following areas: ... 3.7.1.4.3.10 Information on local resources for housing (e.g., Delaware State Rental Assistance Program (SRAP) and Delaware's Section 811 Project Rental Assistance Demonstration (PRA Demo) program), education and employment services/programs (e.g., Pathways) that could help members gain greater self-sufficiency in these areas; ... 3.7.1.4.3.13 General social service information, such as family dynamics, care coordination and conflict resolution ... (pp. 112-113).

⁹² The Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources. This expert must assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options. (p. 116). 3.7.2.3.2 Case managers shall: 3.7.2.3.2.11 Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the area of housing (e.g., SRAP and the PRA Demo), education and employment (e.g., Pathways). (pp. 123-124).

⁹³ 3. Provider Education and Training.... d. The Managed Care Plan shall ensure all participating and direct service providers required to report abuse, neglect, or exploitation of vulnerable adults under s. 415.1034, F.S., obtain training on these subjects. (Attachment II, p. 101).

5. Provider Agreement Requirements.... c. All provider agreements and amendments executed by the Managed Care Plan shall be in writing, signed, and dated by the Managed Care Plan and the provider, and shall meet the following requirements: ... (8) Require all direct service providers to complete abuse, neglect, and exploitation training, including training to identify victims of human trafficking. (Attachment II, p. 95, February 2020, Florida Medicaid Managed Care Model Contract).

⁹⁴ 4.9.3.2 The Contractor shall also provide Provider workshops, data, trainings and technical assistance, webinars and web-based tutorials about the emergence and ongoing operations of Medical Homes and other service delivery innovations, evidence-based and emergency best practices, delivering a person-centered approach to care and the System of Care approach to care delivery. (see definition of System of Care, supra n. 12) (p. 125, Georgia CareSource Medicaid Managed Care Contract) [While this clause doesn't specify SDOH, we have included it because it is broad enough to cover them.]

⁹⁵ 16.1.5 At a minimum, the Contractor shall provide the following Key Staff: ... 16.1.5.20 Staff trained in the System of Care approach to service delivery. (p. 226). [System of Care is defined as: A spectrum of effective, highly-coordinated community-based services and supports for children and youth with or at risk for mental health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families' and youths' needs to help them to function better at home, in school, in the community, and throughout life.]

The Resource Mother provides a broad range of paraprofessional services to P4HB participants in the Interpregnancy Care component of the Planning for Healthy Babies Program and their families. She performs certain aspects of case management including the provision of assistance in dealing with personal and social problems and may provide supportive counseling to P4HB participants and their families and/or serve as a liaison for social services... The Resource Mother will carry out the following responsibilities: ... Assist the P4HB participant with the coordination of social services support for family and life issues; implement and organize the delivery of specific social services within the community and maintain an updated resource file. (pp. 877-878, Georgia CareSource Medicaid Managed Care Contract).

⁹⁶ The Health Plan shall require that care and service coordinators show competency in areas including: f. Understanding and addressing unmet health-related resource and social needs, including expertise in identifying and utilizing available social supports and resources... (p. 154, August 2019, Hawaii Medicaid Managed Care RFP).

⁹⁷ 3. DHS [Department of Human Services] will implement an RHP [Regional Health Partnership] pilot program. The purpose of the pilot program is to leverage RHPs as regional level resources for informing, developing, and supporting the Quality Program as described in Section 5, as well as serving as a resource for providers and members in the regions in which they operate... 5. Examples of activities of the RHP pilots for which the Health Plan will provide coordination and support are as follows: ... b) Identifying and partnering with clinical delivery sites (e.g., physician practices, behavioral health providers, clinics, hospitals) to conduct and capture systematic health-related social needs screenings of all members and make referrals to community services that may be able to address the identified health-related social needs; c) Coordinating and connecting members to community service providers through community service navigation; and d) Aligning partners to optimize community capacity to address health-related social needs. The Health Plan shall support the development of RHPs. The Health Plan will support operational components of the RHP pilots through the following activities and others as defined by DHS: a) Facilitating connections between community partners; b) Educating providers and social services agencies about the RHP pilots and the focus on SDOH; c) Developing community-level solutions that enhance awareness of and referrals from health systems to community based organizations; d) Working with RHPs on aligned VBP strategies for the RHP region; e) Providing data support and access to RHPs as necessary to facilitate SDOH work and other RHP initiatives; f) Facilitating connections between community partners; and g) Coordinating with other Health Plans and DHS to align strategies for incorporating RHPs into the statewide SDOH Transformation Plan and the Health Plan's SDOH work plan. 7. Health Plan activities in support of the development and operationalization of RHP pilots, and engagement of RHPs in SDOH activities, may be included in the Health Plan's SDOH work plan, as discussed in Section 5. (p. 187-89, August 2019, Hawaii Medicaid Managed Care RFP).

⁹⁸ Table 2.9.2: Suggested Staffing. Community-Based Case Managers. Suggested Roles & Responsibilities. Ensure member needs are met, manage resources effectively, and ensure member's health, safety, and welfare are met. Assist the members in gaining access to appropriate resources. Recommend staff have bachelor's degree in social work or related field or commensurate experience. (Appendix 1, p. 24, January 2016, Iowa Amerigroup Medicaid Managed Care Contract).

⁹⁹ At its discretion or as required by the Department, Contractor's QAP must monitor and evaluate other important aspects of care and service, including coordination with community resources. At a minimum, the following areas shall be monitored for all populations: ... 1.1.3.1.4 assistance to Enrollees accessing services outside the Covered Services, such as housing, social service agencies, and senior centers ... (p. 227, January 2018, Illinois Medicaid Managed Care Model Contract Draft).

¹⁰⁰ 2.4.2 Staff Positions: ... Case managers who provide case management, care management, care coordination and utilization management for high-risk or high-cost members receiving physical health and/or behavioral health services. The case managers identify the needs and risks of the Contractor's membership, including social barriers; serve as a coordinator to link members to services; and ensure that members receive the appropriate care in the appropriate setting by the appropriate providers (p. 19, Amendment #7, April 2019, Indiana Medicaid Managed Care Contract)

¹⁰¹ The CONTRACTOR(S) shall develop a comprehensive onboarding and training program to be completed within the first ten (10) days of employment for all Service Coordination and contracted community Service Coordination staff ... (p. 52, December 2018, Kansas Medicaid Managed Care RFP). [While this clause doesn't specify SDOH, it is broad enough to include them.]

¹⁰² C. Key Personnel include: ... 6. A full-time LTSS Director/Manager dedicated to the KanCare LTSS initiatives including care coordination efforts, housing, employment, transportation and community integration activities required for a high performing LTSS system. This position will work closely with the Medical Officers, Quality Director and other clinical partners to provide direction to improve coordination and implement community-based and institutional initiatives, e.g., programs designed to address transitions from long-term institutional settings or Social Determinants of Health and Independence ... 14. A full-time Service Coordination Director/Manager responsible for all Service Coordination activities, within the Service Coordination Program for all KanCare Members. The Service Coordination Director shall be a Kansas licensed clinician with at least five (5) years case and Care Management experience and who is knowledgeable about all KanCare Waiver programs and who will provide oversight for the CONTRACTOR(S)' quality improvement initiatives regarding care coordination, Social Determinants of Health and Independence, and health Outcomes. This position will work closely with the Behavioral Health Supports Director and the Health Services Director to provide integrated, holistic care for all KanCare populations covered under the KanCare CONTRACT... (p. 194, 196).

¹⁰³ A. The CONTRACTOR(S) shall adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors: ... 9. Maximize the quality of life of all Members by addressing Social Determinants of Health and Independence and through delivery of culturally appropriate, integrated, holistic, evidenced based care and services. (p. 120-21, December 2018, Kansas Medicaid Managed Care RFP).

¹⁰⁴ 2.3.6.2 The Contractor shall provide initial and ongoing staff training that includes an overview of contractual, state and federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with enrollees or providers receive initial and ongoing training on health equity and social determinants of health and with regard to the appropriate identification and handling of quality of care concerns. (Appendix B: Model Contract, p. 52).

2.6.2.1.2 The Contractor shall incorporate consideration of SDOH into their Population Health Strategic Plan including: ... 2.6.2.1.2.5 The plan for training Contractor staff involved in care management activities on using the social determinants data incorporated into the data analysis. (Appendix B: Model Contract, pp. 81-82, February 2019, Louisiana Medicaid Managed Care RFP).

¹⁰⁵ 2.6.3.2.3 The Contractor shall, to the extent applicable, support the design and implementation of an evidence-based Community Health Worker (CHW) program which addresses SDOH, promotes prevention and health education, and is tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience. Examples of CHW services include, but are not limited to: 2.6.3.2.3.1 Pilot a CHW demonstration project serving high-risk enrollees in a target region in Louisiana, if selected by LDH; 2.6.3.2.3.2 Conduct in-person holistic assessments to understand enrollee needs, preferences and socioeconomic barriers... (Appendix B: Model Contract, p. 84, February 2019, Louisiana Medicaid Managed Care RFP).

¹⁰⁶ 2.6.4.3.2 The Contractor shall collaborate with its high-volume primary care practices to develop, promote and implement targeted evidence-based practice. 2.6.4.3.3 As part of its Population Health Strategic Plan and annual updates, the Contractor shall measure and report semi-annually to LDH [Louisiana Department of Health] 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 in terms of percentage engaged and timing of engagement. For enrollees working with a Community Health Worker, the Contractor shall fulfill requirements outlined within this section. (Appendix B: Model Contract, pp. 88-89, February 2019, Louisiana Medicaid Managed Care RFP).

¹⁰⁷ .03 Quality Assessment and Improvement.... (e) Effective January 1, 2017, the core performance measures are: ... (x) Lead screening for children 12—23 months old. (Appendix N, p. 77, January 2020, Maryland Medicaid Managed Care Model Contract).

¹⁰⁸ B. Provide or Arrange for Services: 2. Community Health Workers (CHWs) a. Contractor must provide or arrange for the provision of Community Health Worker (CHW) or Peer-Support Specialist Services to Enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or Peer-Support Specialist Services. Examples of CHW services include but are not limited to: ... viii. Arrange for social services (such as housing and heating assistance) and surrounding support services. (p. 54, January 2016, Michigan Medicaid Managed Care Model Contract).

¹⁰⁹ 3. Data Submission and Data Reporting: ... b. As requested by MDHHS [Michigan Department of Health and Human Services], the Contractor must participate in initiatives to develop a core set of Social Determinants of Health, community-based support service provision, utilization, and health outcomes that Providers will submit to for inclusion in performance measure reports, including agreement on how the data must be submitted by Providers in order to minimize the administrative burden... d. Contractor must report on the effectiveness of its Population Health management initiatives including: Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level; Enrollees participating in additional in person support services such as Community Health Worker, patient navigator, MIHP [Maternal and Infant Health Program], or health promotion and prevention programs delivered by a community-based organization; changes in inpatient utilization, emergency department utilization, physician services and outpatient utilization, prescription drug utilization; outpatient CMHSP [Community Mental Health Services Program] services; and selected health outcomes that are pertinent to the population served. (p. 59).

2. Targeted Interventions for Subpopulations Experiencing Health Disparities: a. 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 qualify for those services. b. Contractor must collaborate with its high volume primary care practices to develop, promote and implement targeted evidence-based interventions. To the extent that CHIRs are functioning within the Contractor's service area, the Contractor must collaborate with CHIRs to develop, promote, and implement these targeted evidence-based interventions. c. Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS [Michigan Department of Health and Human Services] within the specified timeframe. d. Contractor must measure and report annually to MDHHS on the effectiveness of its evidence-based interventions to reduce Health Disparities by considering such measures as number of Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level, number Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP [Maternal Infant Health Program], or health promotion and prevention program delivered by a community-based organization, and changes in Enrollee biometrics and self-reported health status. (p. 64). 7. The written [QAPI] plan must describe how the Contractor must: ... b. Analyze data, including Social Determinants of Health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Enrollees... p. Defining roles, responsibilities, and procedures for monitoring and continuously improving the following activities: ... iv. Interventions addressing the Social Determinants of Health. (pp. 65-67).

2018 Pay for Performance on Population Health Management: PURPOSE: The purpose of the 2018 Pay for Performance is to promote Population Health Management and efforts to address Social Determinants of Health for the Michigan Medicaid managed care population. CONTEXT: An individual's health is shaped profoundly by life circumstances that fall outside the traditional purview of the health care system. Housing, nutrition, and other dynamics are often collectively referred to as "Social Determinants of Health". Social determinants are conditions in which people are born, grow, live, work, and age. Social Determinants of Health are cited as factors that collectively have the most significant influence on health outcomes. GOAL: Medicaid health plans will implement a Population Health Management program and other procedures to address Social Determinants of Health for their members. (p. 160, January 2016, Michigan Medicaid Managed Care Model Contract).

¹¹⁰ 6.1.30 Children's Mental Health Services.... (23) The MCO must assure that mental health professionals and clinical trainees have a working knowledge of physical, mental health, educational and social service resources that are available in order to assist the Enrollee with accessing the most appropriate treatment in the least restrictive setting as determined by clinical need. (p. 103, January 2020, Minnesota Medicaid Managed Care Model Contract).

¹¹¹ e) The PHP [Prepaid Health Plan] shall ensure that care manager training include at a minimum: ... 6. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level... (p. 128).

e. The PHP [Prepaid Health Plan] shall be responsible for ensuring training directed toward Member Services staff and contractors include, but are not limited to: ... ix. Understanding the role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to Members' health and health care needs... xi. Linking Members to other state and local programs or assistance, including but not limited to social services, state-funding behavioral health services, law enforcement and the criminal justice system. (Addendum #1, p. 185, October 2018, North Carolina Medicaid Managed Care RFP).

¹¹² ii. Additionally, the following personnel, at a minimum, shall be located in and operate from within the State of North Carolina: ... i) Liaison to the Division of Social Services... (p. 13-14).

c) The PHP [Prepaid Health Plan] shall require that care management staff show competency in areas including: ... 6. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level... e) The PHP shall ensure that care manager training include at a minimum: ... 6. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level... (Addendum #1, p. 128, October 2018, North Carolina Medicaid Managed Care RFP).

¹¹³ 4.11.3.3 the MCO's plan to develop and administer the following behavioral health trainings for all Providers in all settings that are involved in the delivery of Behavioral Health Services to Members: ... 4.11.3.3.7 Community-based resources to address social determinants of health. (p. 201).

4.13.4.1.1 The MCO shall develop and make available Provider support services which include, at a minimum: 4.13.4.1.1.4. Training specific to integration of physical and behavioral health, person-centered Care Management, social determinants of health, and quality... (pp. 237-238, August 2018, New Hampshire Medicaid Managed Care RFP).

4.10.7.3 Care Managers must be trained in the following: ... 4.10.7.3.7 Understanding and addressing unmet resource needs, including expertise in identifying and utilizing available social supports and resources in the Member's community. (p. 183).

¹¹⁴ 3.15.1.2.3 Mental Health Coordinator: Individual shall oversee the delivery of Mental Health Services to ensure that there is a single point of oversight and accountability... Other key functions shall include coordinating... social determinants of health and community-based resources. (pp. 63-64).

3.15.1.2.4 Substance Use Disorder Coordinator: Individual shall be an addiction medicine specialist on staff or under contract who works with the Substance Use Disorder Physician to provide clinical oversight and guidance to the MCO on Substance Use Disorder issues... The individual must have expertise in screening, assessments, treatment, and Recovery strategies; use of MAT [Medication Assisted Treatment]; strategies for working with child welfare agencies, correctional institutions and other health and social service agencies that serve individuals with Substance Use Disorders... Other key functions shall include coordinating... social determinants of health and community-based resources. (p. 64).

4.10.7.2 Care Managers, whether hired by 4.10.7.2 the MCO or subcontracted through a Designated Local Care Management Entity, must have the qualifications and competency in the following areas: ...

4.10.7.2.5 Understanding and addressing unmet resource needs including expertise in identifying, accessing and utilizing available social support and resources in the Member's community. (p 183)

4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR

438.208(b)(2)(iv)] 4.10.10.2 The MCO's Care Management must include help for Members in addressing unmet resource needs through strategies including, at a minimum: 4.10.10.2.3 Having a housing specialist

on staff or on contract who can assist Members who are homeless in securing housing; and 4.10.10.2.4 Providing access to medical-legal partnership for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance Providers... (p. 189, August 2018, New Hampshire Medicaid Managed Care RFP).

¹¹⁵ 4.12.3.5.3 Annually, the MCO shall conduct at least one (1) non clinical PIP, which must be related to one (1) of the following topic areas and approved by DHHS: 4.12.3.5.3.1. Addressing social determinants of health... (p. 228, August 2018, New Hampshire Medicaid Managed Care RFP).

¹¹⁶ The Contractor's quality assurance activities shall include, at a minimum: ... B. Treatment Protocols. The Contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition, level of functioning, and contributing family and social factors. (Art. 4, p. 66, July 2017, New Jersey Medicaid Managed Care Model Contract).

¹¹⁷ 4.4.1.7 Supportive Housing: The CONTRACTOR shall have a full-time Supportive Housing Specialist dedicated to this Agreement to work with Members to assess housing needs and identify appropriate resources in order to help them attain and maintain housing. 4.4.1.7.1 The Support Housing Specialist shall serve as the internal resource to provide training and technical assistance to the CONTRACTOR's care coordinators. 4.4.1.7.2 Supportive Housing specifically targets the following populations: Individuals who are chronically homeless individuals, as defined by the U.S. Department of Housing and Urban Development (HUD) or precariously housed; Individuals with frequent or lengthy institutional care; Individuals with frequent or lengthy adult residential care or treatment stays; Individuals with LTSS and frequent turnover of in-home caregivers or providers; and Individuals at highest levels of risk for expensive care and negative outcomes, defined by a Predictive Risk Intelligence System (PRISM) risk score of 1.5 or higher or similar risk measures. (pp. 49-50).

4.4.18.1 The CONTRACTOR shall employ or contract with dedicated care coordinators or care coordination supervisors with relevant expertise to meet the needs for each population listed below. The dedicated number of care coordinators for each population must be commensurate with the CONTRACTOR's membership in each of these populations: ... 4.4.18.1.6 Members with Housing Insecurity needs... (p. 79, January 2018, New Mexico Medicaid Managed Care Contract Amendment).

¹¹⁸ i) The Contractor shall provide technical assistance to Participating Providers in documenting cases of domestic violence, provide referrals for Enrollees or their Participating Providers to community resources where the Enrollee may obtain protective, legal and/or supportive social services, and ensure that Participating Providers are aware of community resources for suspected victims of domestic violence. (pp. 10-13, 10-14, March 2019, New York Medicaid Managed Care Model Contract).

¹¹⁹ The primary functions of the QI Director position are: xi. Working collaboratively with all MCPs and ODM to improve population health outcomes, including addressing health equity and social determinants of health. (p. 19-20, January 2020 Ohio Medicaid Managed Care Model Contract).

¹²⁰ i. Contractor shall offer correlative arrangements with Participating Providers (including Social Determinants of Health & Health Equity 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... k. Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings. The plan should include: (1) an overview of the methodology and/or strategy used to distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Health Equity (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. (p. 111).

¹²¹ The [Opioid Use Disorder Center of Excellence] must deploy a community based care management (CBCM) team that consists of licensed and unlicensed professionals... They will track and support patients when they obtain medical, behavioral health, or social services outside the practice. They will develop a person-centered individualized care plan for each patient that includes addressing the social determinants

of health. They will facilitate recovery by helping individuals find stable housing, employment, and reestablishing family/community relationships. They will facilitate referrals and respond to social service needs... (p. G-3).

The PH-MCO [Physical Health MCO] must ensure that its dedicated hotline meets the following Member services performance standards: ... Be staffed by individuals trained in: ... the availability of social services within the community... (p. 79, January 2019, Pennsylvania Medicaid Managed Care Contract).

¹²² B. The PH-MCO [Physical Health MCO] must implement a minimum of one rapid cycle (six – twelve weeks) quality improvement pilot programs per year. At least one rapid cycle quality improvement pilot program needs to be implemented by the end of the second quarter. Rapid cycle quality improvement pilot programs should be implemented with community-based organizations and will focus on improving health outcomes and address social determinants of health. If a rapid cycle quality improvement pilot program was proven successful, the PH-MCO must progressively expand the program. (p. B(5)-1, January 2019, Pennsylvania Medicaid Managed Care Contract).

¹²³ Care management is to be performed by Health Plan staff or agents located in the State of Rhode Island. Rhode Island staff will be key for their ability to work closely with local resources. Face-to-face meetings shall be conducted where appropriate; to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs, social supports and services and out-of-plan services. The Program Coordinator (and/or Care Manager) and all their needed support staff shall be located in Rhode Island (p. 88).

The Health Plan will designate a Program Coordinator (and/or Care Manager). The Care Manager will be a licensed professional who shall assure that the Health Risk Assessment, care coordination or Intensive Care Plan development and implementation, as indicated, are completed for each member. The Care Manager must meet the licensure requirements as set forth herein. The responsibilities of the Care Manager shall be inclusive of behavioral health services and social supports and services (p. 429, July 2018, Rhode Island Medicaid Managed Care Contract).

¹²⁴ 2.9.6.12.25 The CONTRACTOR's initial and ongoing training program shall be approved by TENNCARE and shall include training topics as specified by TENNCARE in this Contract or in policy or protocol. At a minimum, the CONTRACTOR's initial training program shall include: ... 2.9.6.12.25.10 Training on essential support services, which at a minimum shall include the following: ... 2.9.6.12.25.10.4 Assessing and coordinating social support needs; and 2.9.6.12.25.10.5 Developing and accessing community supports, and identifying, facilitating, and sustaining informal/natural supports... (p. 206, July 2019, Tennessee Medicaid Managed Care Contract).

¹²⁵ Service coordination teams must be led by at least one Service Coordinator. Team members must have the following expertise or access within the MCO to identified subject matter experts in the following areas: ... Local resources (such as basic needs like housing, food, utility assistance) (p. 8-205, September 2019, Texas Medicaid Managed Care RFP).

¹²⁶ The Care coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices... The Care Coordinator is responsible for: Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs... Care coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment... (p. 241).

The Health Home Care Coordinator shall provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting enrollee's health and health care choices available to Home Health enrollees. (Exhibit H, p. 12).

The Contractor shall ensure the Health Home Care Coordinator: ... Provides interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors that affect an enrollee's health and health care choices... Accompanies the enrollee to critical care and social service appointments when necessary to assist the enrollee in achieving his or her health action goals... (Exhibit H, p. 13-14).

The Health Home Care Coordinator shall ensure that: Available community resources are identified and accessible to the Health Home enrollee. Referrals: Are overseen by the Health Home Care Coordinator; Support the enrollee's health action goals; Include long-term services and supports, mental health, substance use disorder and other community and social supports; and are documented in the enrollee's progress notes and HAP [Health Action Plan]. Assistance is provide to the enrollee to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services, when needed and not provided through other case management systems. Services are coordinated with appropriate departments of local, state, and federal governments and community-based organizations. (Exhibit H, p. 16, January 2020, Washington State Medicaid Fully Integrated Managed Care Contract)

¹²⁷ At a minimum, the care management infrastructure must include the following: a. Care Management Staff and WICT [Wisconsin Interdisciplinary Care Team]... qualified care management staff with the following skills and knowledge needed to coordinate care for members... v. An understanding of the impact of social determinants (e.g., poverty, lack of food or social supports) on health... (p. 56).

10. Out-of-Network Benefit Coordination (BadgerCare Plus and Medicaid SSI): Per Article III, section C, the HMO must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Services or through community and social support providers. The HMO must assign a representative to coordinate services with public health agencies or treatment programs within the HMO's service area that are not included in the HMO's network. These might include but are not limited to county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs, or inpatient programs. The HMO must work with the agency/program to coordinate a member's transition to or from covered mental health and substance abuse care within the HMO's network. Any member transitioning from crisis intervention services must be able to access an appropriate level of ongoing care within 30 days of the crisis. The HMO is not required to pay for ongoing services outside the HMO network, unless the HMO has authorized those services. (p. 98, January 2020, Wisconsin Medicaid Managed Care Contract).

¹²⁸ If an HMO met all the pay-for-performance goals in the prior calendar year, it can choose other study topics from the P4P program and/or Core Reporting, as described in the MY2018 HMO Quality Guide. The HMO may propose alternative performance improvement topics during the preliminary topic selection summary process; approval is at the Department's discretion. The Department's priority areas are: ... B. Non-clinical: ... Social Determinants of Health... (p. 181-82, January 2020, Wisconsin Medicaid Managed Care Contract).

¹²⁹ The MCO must employ a West Virginia Medicaid Administrator/Contract Liaison... The Medicaid Administrator(s) must be responsible for making recommendations to management on any changes needed to improve either the actual care provided or the manner in which the care is delivered. The Administrator(s) will: ... 3. Coordinate with schools, community agencies, local health departments, state health laboratories and state agencies providing complementary services to Medicaid enrollees... 6. Connect with local community organizations to acquire knowledge and insight regarding the special health care needs of beneficiaries... (p. 117, 2020, West Virginia Medicaid Managed Care Contract).

¹³⁰ Engaging Members through Technology Executive Summary: The Contractor shall engage its membership through web based applications, which may include mobile device technologies.... The Contractor shall also identify subpopulations that can benefit from web/mobile based applications used to assist members with self-management of health care needs (e.g. chronic conditions, pregnancy, SDOH resources, or other health related topics the Contractor considers to be most beneficial to members), implementing and evaluating targeted Engaging Members through Technology (EMTT) related activities specific to these areas. (p. 95, October 2019, Amendment 14, Arizona Medicaid Managed Care Contract).

¹³¹ 1. Comprehensive Case Management Including Coordination of Care Services.... B. Complex Case Management Services are provided by the Contractor, in collaboration with the Primary Care Provider, and shall include, at a minimum: ... 2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team. (Exhibit A, Attachment 11, p. 101).

2. Discharge Planning and Care Coordination. Contractor shall ensure the provision of discharge planning when a SPD [Seniors & Persons with Disabilities] beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include: A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received. B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports. (Exhibit A, Attachment 11, p. 102).

11. Early Intervention Services.... Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation. (Exhibit A, Attachment 11, pp. 108-109, California 2017 Final Rule GMC Non-CCI Boilerplate Contract).

¹³² A. Health Education.... 7) Contractors shall maintain a health education system that provides educational interventions addressing the following health categories and topics and ensure that these programs are available and accessible to Members upon referral by Providers and also upon the Member's request. a) Effective use of Managed Health Care Services: Educational interventions designed to assist Members to effectively use the managed health care system, preventive and primary healthcare services, obstetrical care, and health education services; and appropriately use complementary and alternative care. b) Risk-Reduction and Healthy Lifestyles: Educational interventions designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including programs for tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases, HIV/AIDS, and unintended pregnancy; nutrition, weight control, and physical activity; and parenting. c) Self-Care and Management of Health Conditions: Educational interventions designed to assist Members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes, and hypertension. 8) Contractor shall ensure that Members receive health education services as part of preventive and primary health care visits. Contractor shall ensure that health risk behaviors, health practices and health education needs related to health conditions are identified, and that educational interventions, including counseling and referral for health education services, are conducted and documented in the Member's Medical Record.... 13) Contractor shall monitor access and availability of health education programs and services, and implement strategies to remove barriers to Member participation including, but not limited to, distance barriers (program location), availability barriers (frequency and timing of program offerings), and cultural and linguistic barriers, 14) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 11. (Exhibit A, Attachment 10, p. 91, California 2017 Final Rule GMC Non-CCI Boilerplate Contract).

¹³³ 10.3. Community and the Social Determinants of Health. 10.3.1. The Contractor shall demonstrate an understanding of the health disparities and inequities in their region and develop plans with Providers, Members and Community Stakeholders to optimize the physical and behavioral health of its Members. (Exhibit B-3, p. 66).

11.3. Care Coordination.... 11.3.3. The Contractor shall ensure that Care Coordination is part of the Contractor's Population Health Management Plan. Care Coordination shall comprise: 11.3.3.1. A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being. 11.3.3.2. Deliberate provider interventions to coordinate with other aspects of the health system, to interventions over an extended period of time by an individual designated to coordinate a Member's health and social needs.... 11.3.7. The Contractor shall ensure that Care Coordination: ... 11.3.7.9. Addresses potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs in order to achieve optimal health, wellness or end-of-life outcomes, according to Member preferences. 11.3.7.10. Aligns with the Contractor's Population Health Management Plan. (Exhibit B-3, pp. 71-72, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

¹³⁴ 10.3.6. The Contractor shall identify and promote Member engagement with evidence-based and promising initiatives operating in the region that address the social determinants of health, particularly the indicators in the Colorado Opportunity Framework . The Contractor shall align with the framework set up through the Colorado Opportunity Project, a state multi-agency initiative (see <https://www.colorado.gov/pacific/hcpf/colorado-opportunity-project> for more information). (Exhibit B-3, p. 66, July 2019, Region 1, Colorado Medicaid Managed Care Contract).

¹³⁵ 3.7.2.3.4 The case manager’s care planning shall be based on: 3.7.2.3.4.1.4 Social/environmental/cultural factors (p. 124, December 2017, Delaware Medicaid Managed Care Model Contract).

¹³⁶ 4.7.3.4 The Contractor shall have a lead Case Management program for EPSDT eligible children and their households when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter. The lead Case Management program shall include education, a written Case Management plan that includes all necessary referrals, coordination with other specific agencies, environmental lead assessments, and aggressive pursuit of non-compliance with follow-up tests and appointments. The Contractor must ensure reporting of all blood lead levels to the Department of Public Health. (p. 99).

4.11.10.2 Case Management functions include, but are not limited to: ... 4.11.10.2.2 Assessment of a Member’s risk factors such as an over- or underutilization of services, inappropriate use of services, non-adherence to established plan of care or lack thereof, lack of education or understanding of current condition, lack of support system, financial barriers that impede adherence to plan of care, compromised patient safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities ... (p. 155).

System of Care: A spectrum of effective, highly coordinated community-based services and supports for children and youth with or at risk for Mental Health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families’ and youths’ needs to help them to function better at home, in school, in the community, and throughout life. System of Care core values and philosophy include an expectation that services and supports: are culturally and linguistically competent; ensure availability and access to effective traditional and nontraditional services as well as natural and informal supports that address physical, emotional, social, and educational needs; are planned in true partnership with the child and family and a family peer professional representative; and include intensive care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs. (pp. 326-327).

4.11.10.6 Levels of Case Management for the GF [Georgia Families] Program include: 4.11.10.6.1 Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem, and a plan of care that has been developed which provides for health and social problem follow-up as indicated. (p. 738, Georgia CareSource Medicaid Managed Care Contract).

¹³⁷ 4.11.10.6 Levels of Case Management for the GF [Georgia Families] Program include: 4.11.10.6.1 Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem, and a plan of care that has been developed which provides for health and social problem follow-up as indicated. (p. 738, Georgia CareSource Medicaid Managed Care Contract).

¹³⁸ Care Plans shall be developed for each member receiving care coordination. The care plan will be based on the SHCN [Special Health Care Needs] and SHCN+ Assessments and developed with the member and their family. The Care Plan shall be a person-centered written document that describes the medical, behavioral, and social needs of the members, and identifies all the services to be utilized to include but not be limited to the frequency, quantity and provider furnishing the services (p. 142)

A) Pre-tenancy support: The Health Plan shall cover the following pre-tenancy support services: 1. Conducting a functional needs assessment identifying the member’s preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); and providing assistance in budgeting for housing and living expenses. 2. Developing an individualized plan based upon the functional needs assessment as part of the overall

person-centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed. 3. Assisting the member with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. 4. Participating in person-centered plan meetings at redetermination and/or conducting revision plan meetings, as needed. 5. Providing supports and interventions per the person-centered plan (p. 247)

B) Tenancy Sustaining Services: The Health Plan shall cover the following tenancy sustaining services: 1. Service planning support and participation in person-centered plan meetings at redetermination and/or while conducting revision plan meetings, as needed. 2. Coordinating and linking the member to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports. 3. Entitlement assistance including assisting members in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency. 4. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports. 5. Providing supports to assist the member in the development of independent living skills, such as skills coaching, financial counseling, and anger management. 6. Providing supports to assist the member in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. 7. Coordinating with the member to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. 8. Connecting the member to training and resources that will assist the member in being a good tenant and achieving lease compliance, including ongoing support with activities related to household management (p. 248-49, August 2019, Hawaii Medicaid Managed Care RFP).

¹³⁹ 8.7 Health Education and Initiatives. The Contractor shall develop programs and participate in activities to enhance the general health and well-being of members. The Contractor shall develop a strategy to participate in and interface with the Healthiest State Initiative. Examples of health education, disease prevention and outreach programs and activities include, but not limited to, the following: ... 8.7.1 Example Programs: ... 8.7.1.4 Smoking cessation programs with targeted outreach for adolescents and pregnant women; 8.7.1.5 Nutrition counseling; 8.7.1.12 Education for members and caregivers about identification and reporting of suspected abuse and neglect. (Appendix 1, p. 124, January 2016, Iowa Amerigroup Medicaid Managed Care Contract).

¹⁴⁰All care and case management programs should identify psychosocial issues of the members that may contribute to poor health outcomes and provide appropriate support services for addressing such issues. (p. 45, Amendment #5).

The Contractor shall make a spectrum of disease management tools available to the population, including population-based interventions, care management and complex case management, as described below. All care and case management programs should identify psychosocial issues of the members that may contribute to poor health outcomes and provide appropriate support services for addressing such issues. (p. 79, Amendment #7).

Members served in the Contractor's disease management, care management and complex case management services may require additional resources to meet their biopsychosocial needs. To meet these needs, the Contractor shall make every effort to assist members in navigating community resources and linking members with community based services such as Connect2Help211, food pantries, housing and housing supports, legal, employment and disaster services. (p. 80, Amendment #7).

Care plans developed by the Contractor shall include clearly stated health care goals to address the medical, social, educational, and other services needed by the individual and defined milestones to document progress, clearly defined accountability and responsibility and timely, thorough review with appropriate corrections ("course changes") as indicated. The Contractor's case management services and care plan development shall involve the active management of the member and his/her group of health care providers, including physicians, medical equipment, transportation and pharmacy to help link the member with providers or programs capable of helping the member achieve the defined goals of the care plan. (p. 81, Amendment #7, April 2019, Indiana Medicaid Managed Care Contract).

¹⁴¹ Service Coordination shall also assist Members with addressing Social Determinants of Health and Independence. (p. 31).

D. The CONTRACTOR(S) Service Coordination model requires at a minimum that the following groups be enrolled in Service Coordination: ... Other individuals who the CONTRACTOR(S) determines would benefit from Service Coordination. The CONTRACTOR(S) shall use at a minimum information regarding Social Determinants of Health and Independence, such as housing instability, food insecurity, and unemployment/under employment in identifying other individuals who would benefit from Service Coordination. (p. 33).

The Plan of Service records the strategies to meet goals and interventions selected by the Member and team to support them in improving the Member's health and wellbeing and addressing Social Determinants of Health and Independence. (p. 39).

D. The Plan of Service must be compliant with the State's Plan of Service policy, and shall include the following components: ... 2. Member's identified strengths, preferences, and any identified needs including psycho-social needs and needs related to social determinations of health and independence such as housing or financial assistance ... (p. 39).

The [Person Centered Care Plan] records the strategies to meet the goals and interventions selected by the Member and team to support them in improving the Member's health and wellness and in addressing Social Determinants of Health and Independence. (p. 39).

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by providing services and supports for Social Determinants of Health and Independence, in addition to traditional Medicaid and CHIP benefits. Kansas will test the below hypotheses in KanCare 2.0 through this RFP and through the Section 1115 Medicaid Demonstration Waiver: A. Expanding Service Coordination to include assisting Members with accessing affordable housing, food security, employment, and other Social Determinants of Health and Independence will increase independence and stability and improve health Outcomes ... (p. 10-11).

B. The CONTRACTOR(S) shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives: ... 5. Addresses the Social Determinants of Health and Independence, including housing, adequate nutrition, adequate environmental conditions, transportation and other social determinants ... (p. 31, December 2018, Kansas Medicaid Managed Care RFP).

¹⁴² Coordination procedures shall be established for other services needed by eligible Enrollees that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, DCBS, etc. (pp. 114, July 2019, Kentucky Medicaid Managed Care Contract).

¹⁴³ 2.7.6 Tiered Case Management Based on Need 2.7.6.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive case management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and shall include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). ... 2.7.6.2 Case Management (Medium) (Tier 2) Enrollees engaged in the medium level of case management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section)... 2.7.6.3 Case Management (Low) (Tier 1) Enrollees engaged in this level of case management are of the lowest level of risk within the case management program and typically require support in care coordination and in addressing SDOH. A plan of care shall be completed in person within ninety (90) calendar days of identification and include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). (Appendix B: Model Contract, p. 91-92, Louisiana Medicaid Managed Care RFP).

¹⁴⁴ 2.6.4.2 Health Promotion and Disease Prevention Services: 2.6.4.2.1 The Contractor shall ensure its enrollees have access to evidence-based/best practices educational programs, through Contractor programs or referral to local/state public health and community-based programs, that address risk and improve outcomes. (p. 88).

2.14.10.1 No later than the operational start date, the Contractor shall provide a web or mobile based enrollee/patient portal that includes the following information and features: ... 2.14.10.1.2 Social services information and resources, such as housing supports, food programs, etc. ... (Appendix B: Model Contract, pp. 194-195, February 2019, Louisiana Medicaid Managed Care RFP).

¹⁴⁵ The Contractor shall: b. Ensure that Enrollees who are identified as having care needs as described in this Section receive assistance in accessing services to meet those needs. Such assistance shall include activities such as but not limited to: 1) Referring the Enrollee to providers, social service agencies, or other community-based organizations that address the Enrollee's needs, including but not limited to Medically Necessary services; 2) Providing the Enrollee with support to ensure a successful referral, including: ... 3) Providing information and navigation to the Enrollee regarding community providers of social services that address the Enrollee's health-related social needs, as appropriate... (pp. 80-81).

C. With respect to the Contractor's care coordination and Care Management responsibilities, each such agreement between the Contractor and a [Behavioral Health] [Community Partners] shall obligate the BH CP to provide care coordination and Care Management activities and to perform comprehensive assessments, person-centered treatment planning, care transitions, medication reconciliation, health and wellness coaching, and connection to community and social services pursuant to the BH CP's contract with EOHHS. (Attachment A, Model MCO Contract, p. 100, September 2017, Massachusetts Medicaid Managed Care RFR Amendment).

¹⁴⁶ C. General Requirements for Special Needs Populations.... (7) Referral to Local Health Department. (a) An MCO shall make a written referral, or ensure that the enrollee's provider makes a written referral, to the local health department (LHD) for the county in which an enrollee resides, for assistance in bringing into care an enrollee for whom the MCO has been unsuccessful in its documented out-reach efforts pursuant to §C(6) of this regulation, within 10 business days of whichever first occurs: (i) The third consecutive missed appointment; or (ii) The MCO or the enrollee's provider identifies the enrollee's repeated noncompliance with a regimen of care. (b) The MCO may not include information about an enrollee's HIV status on the form used to refer an enrollee to the local health department. (Appendix N, p. 83).

D. An MCO shall provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions or social services, or both, a multidisciplinary team shall be used to review and develop the plan of care for special health care needs children. (Appendix N, p. 84). [While this clause doesn't mention SDOH, it is sufficiently broad enough to include them.]

.03 Access Standards: Outreach.... C. Adults. (1) An MCO shall, before referring the enrollee to the local health department, make documented attempts to ensure that follow-up appointments are scheduled in accordance with the enrollee's treatment plan by attempting a variety of contact methods, which may include: (a) Written correspondence; (b) Telephone contact; and (c) Face-to-face contact. (2) If the enrollee, due to impaired cognitive ability or psychosocial problems such as homelessness or other conditions, can be expected to have difficulty understanding the importance of treatment instructions or difficulty navigating the health care system, the MCO shall, after exhausting its best efforts to contact and bring into care the enrollee in accordance with §C(1) of this regulation, make, or ensure that the enrollee's provider makes, a written referral to the local health department for its assistance within 10 business days of whichever first occurs: (a) The third consecutive missed appointment; or (b) The MCO or the enrollee's provider identifies the enrollee's repeated noncompliance with a regimen of care. (Appendix N, pp. 139-140, January 2020, Maryland Medicaid Managed Care Model Contract).

¹⁴⁷ C. General Requirements for Special Needs Populations.... (6) An MCO shall make documented outreach efforts to contact and educate enrollees who fail to appear for appointments or who have been noncompliant with a regimen of care. These efforts may include, but may not be limited to, notification: (a) By mail; (b) By telephone; (c) By email; (d) By text messaging; and (e) Through face-to-face contact. (7) Referral to Local Health Department. (Appendix N, pp. 82-83).

.08 Special Needs Populations — Pregnant and Postpartum Women.... H. An MCO shall provide risk-related medical and nonmedical preventive treatment services, including nutrition counseling by licensed nutritionists or dietitians and smoking cessation education and treatment for pregnant and postpartum women. (Appendix N, p. 87).

.02 Access Standards: Enrollee Handbook and Provider Directory.... B. An MCO shall, at the time of enrollment, and anytime upon request, furnish each enrollee with a copy of the MCO's enrollee handbook that includes all language in the template provided by the Department and the following current information: ... (10) Information about the availability of EPSDT, prenatal care, family planning, and other wellness services, including education programs. (Appendix N, p. 136).

.21 Benefits — Pregnancy-Related Services. A. An MCO shall provide to its pregnant and postpartum enrollees medically necessary pregnancy-related services, including: ... (3) Enriched maternity services, including: ... (b) Basic nutritional education; ... (e) High-risk nutrition counseling services for nutritionally high-risk pregnant women; ... (g) Smoking cessation education and treatment. (Appendix N, p. 172, January 2020, Maryland Medicaid Managed Care Model Contract).

¹⁴⁸ 2. Health Promotion and Disease Prevention Services ... c. Contractor must implement educational, public relation and social media initiatives to increase Enrollee and Network Provider awareness of public health programs and other community-based resources that are available and designed to reduce the impact of Social Determinants of Health and other common risk factors, such as the community-based public health resources designed to promote Enrollee wellness and available at http://www.michigan.gov/mdch/0,4612,7-132-2940_63445---,00.html. (p. 62, January 2016, Michigan Medicaid Managed Care Model Contract).

3. Contractor must promote within PCMH [Patient Centered Medical Home] practices Enrollee engagement and responsibilities by undertaking person-centered initiatives that: a. Improve access to behavioral health, dental care, CHWs, patient navigators, and health promotion and prevention programs delivered by community-based organizations, or social service programs from the clinical setting. (p. 57, January 2016, Michigan Medicaid Managed Care Model Contract).

¹⁴⁹ 6.1.4.9 Hospital In-reach Community-based Service Coordination (IRSC).... (2) The in-reach service coordination will include performing an assessment to address an Enrollee's mental health, substance use, social, economic, and housing needs, or any other activities targeted at reducing the incidence of emergency room and other non-medically necessary health care utilization and to provide navigation and coordination for accessing the continuum of services to address the Enrollee's needs. For a Child with SED [Severe Emotional Disturbance], this also includes arranging for these community-based services prior to discharge. In-reach community-based service coordination shall seek to connect frequent users with existing covered services including but not limited to, targeted case management, waiver case management, care coordination in a health care home, Behavioral Health Home services, and as relevant, children's therapeutic services and supports, crisis services, and respite care. (p. 83).

6.1.17 Health Homes (BHH; HCH; CCBHC). 6.1.17.1 Behavioral Health Home (BHH). Behavioral Health Home services consistent with Minnesota Statutes, §256B.0757 are covered. BHH services are a set of services designed to integrate Primary Care, behavioral health, and social/community services for children with emotional disturbance (including severe emotional disturbance) and adults with serious mental illness (including serious and persistent mental illness). (p. 88).

6.1.17.3 Certified Community Behavioral Health Clinics (CCBHC). CCBHC services are covered. CCBHCs provide a set of services designed to integrate primary care, behavioral health, and substance use disorder services (SUDs), social/community services for children with emotional disturbance (including SED) and services for adults with SMI (including SPMI). (p. 90).

(23) Adult Mental Health Targeted Case Management (AMH-TCM). The MCO shall make available to Enrollees AMH-TCM services to adults with Serious and Persistent Mental Illness (SPMI).... (b) The MCO may offer substitute models of AMH-TCM services to Enrollees who meet SPMI criteria with the consent of the individual, if the substitute model includes all four activities that comprise the CMS definition for targeted case management services in 42 CFR §440.169. These activities include: i) Comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services.... ii) Development

of a specific care plan that: is based on the information collected through the assessment; specifies the goals and actions to address the medical, social, educational, and other services needed by the Enrollee; includes activities such as ensuring the active participation of the Enrollee, and working with the Enrollee (or the Enrollee's authorized health care decision maker) and others to develop those goals; and identifies a course of action to respond to the assessed needs of the Enrollee. iii) Referral and related activities to help the Enrollee obtain needed services including activities that help link the Enrollee with: medical, behavioral, social, and educational Providers; community services; or programs and services available for providing additional needed services. (p. 98).

(24) Children's Mental Health Targeted Case Management (CMH-TCM). The MCO shall make available to Enrollees CMH-TCM services to Children with Severe Emotional Disturbance (SED).... (a) The MCO may offer substitute models of CMH-TCM services to Enrollees who meet SED criteria with the consent of the Enrollee if the substitute model includes all four activities that comprise the CMS definition for targeted case management services, including: i) A comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services, ii) The development of a specific care plan that: is based on the information collected through the assessment; specifies the goals and actions to address the medical, social, educational, and other services needed by the Enrollee; includes activities such as ensuring the active participation of the eligible Enrollee, and working with the Enrollee (or the Enrollee's authorized health care decision maker) and others to develop those goals; and identifies a course of action to respond to the assessed needs of the eligible Enrollee. iii) Referral and related activities to help the Enrollee obtain needed services including activities that help link an Enrollee with medical, behavioral, social, educational Providers; community services; or other programs and services available for providing needed services... (pp. 103-104).

6.18.3.6 Mental Health Services. At the time of initial enrollment in managed care, the MCO shall consider the individual Enrollee's prior use of mental health services and develop a transitional plan to assist the Enrollee in changing mental health Providers, should this be necessary, and to develop a plan to assure continuity of care for any Enrollee or family who is receiving ongoing mental health services. The MCO shall also develop a transitional plan for Children who have previously been excluded from PMAP [Prepaid Medical Assistance Program] because they have been involved in the Child protection system, placed in foster care, diagnosed with SED, or placed in a juvenile corrections facility. A treatment regimen may be initiated for Children who are assessed as having behavioral or other mental health problems while the Child is excluded from PMAP. However, because the duration of the exclusion from PMAP will vary from one Child to the next, some of these Children may be enrolled in the MCO before their treatment program is completed. As part of this transition plan, the MCO should have a process to assure proper communication and coordination between the Local Agency social services agency and the MCO regarding the specific needs of each Child. (p. 131, January 2020, Minnesota Medicaid Managed Care Model Contract).

¹⁵⁰ 6. Care Management: The Contractor will provide Care Management using a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. The Contractor will develop and implement a Care Management system to ensure and promote: a. Ongoing, culturally relevant support for Members to achieve personal health goals; b. Timely access to and delivery of health care and services required by Members; c. Continuity of Members' care; d. Coordination and integration of Members' care in accordance with 42 C.F.R. § 438.208, including physical and behavioral health/substance use disorder services; and e. Coordination with appropriate resources to reduce socioeconomic disparities, including housing, employment, and nutrition programs. (p. 167, July 2017, Magnolia Health Plan, Mississippi Medicaid Managed Care Contract).

¹⁵¹ 6. Each Care Plan shall contain, at a minimum: ... v. Social, educational, and other services needed by the Member. (p. 124).

3. The PHP [Prepaid Health Plan] 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. The PHP may use existing platforms for this capability until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption. (p. 125).

e. The PHP [Prepaid Health Plan] shall use North Carolina-developed tools to address the four priority domains for Opportunities for Health including: i. Standardized Screening Questions: As part of care management, the PHP shall undertake best efforts to conduct a Care Needs Screening of every Member as defined in the Contract. The Screening shall include standardized screening questions, to be developed by the Department, to identify Members with unmet health-related resource needs who required a Comprehensive Assessment for care management. ii. North Carolina Resource Platform: The NC Resource Platform will be a telephonic, online, and interfaced IT platform providing: (a) a robust statewide resource database of community-based organizations and social service agencies, and b) a referral platform for payers, care managers, clinicians, community health workers, social service agencies, community members, and others to eventually refer and connect Members directly to community resources and track the connections and outcomes through “closed loop referral” capacity. The platform is being developed under the authority of the Foundation for Health Leadership and Innovation. The PHP shall ensure that the care management approach includes help for Members in addressing unmet resource needs. The PHP shall, at a minimum: a) Use the “NC Resource Platform” to identify community-based resources and connect high-need 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. 1. 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. 2. 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. 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. (Addendum #1, p. 142, October 2018, North Carolina Medicaid Managed Care RFP).

¹⁵² 4.10.10.1 The MCO shall implement procedures to coordinate services the MCO furnishes to Members with the services the Member receives from community and social service Providers. [42 CFR 438.208(b)(2)(iv)]. 4.10.10.3 In addressing unmet resource needs for Members, the MCO shall promote access to stable housing, healthy food, reliable transportation, interpersonal safety, and job support. The MCO must establish Care Management competencies, as outlined below: 4.10.10.3.1 Health Risk Assessment Screening, Claims Analysis, and/or Member or Provider Referral: the MCO ensure that a care needs screening, including social determinants of health questions, is conducted. 4.10.10.3.2 Risk Scoring and Stratification by Member Level of Need: The MCO must identify Priority Populations for further review and likely receipt of intensive Care Management services. With respect to social determinants, the MCO, at minimum, must ensure that Priority Populations are inclusive of homeless Members, Members facing multiple barriers to food, housing and transportation. 4.10.10.3.3 High Risk/High-Need Members: The MCO must ensure that a more in-depth assessment is conducted to confirm the need for Care Management services and begin to develop a care plan. As with the screening, the in-depth assessment must include questions regarding social determinants of health. The MCO must provide/arrange for Care Management services that take into account social determinants of health. At minimum, these services must include in-person assistance connecting with social services that can improve health, including a housing specialist familiar with options in the community. For Members who do 4.10.10.4 not require such intensive services, the MCO must provide guidance/navigational coordination, which includes: 4.10.10.4.1 Ensuring that each Member has an ongoing source of care and health services appropriate for his or her needs; 4.10.10.4.2 Coordinating services provided by community and social support Providers; 4.10.10.4.3 Linking Members to community resources and social supports; and 4.10.10.4.4 Reporting on closed loop referrals or the overall effectiveness of the types of social determinant–related Care Coordination services, in accordance with Exhibit O. (pp. 189-90, August 2018, New Hampshire Medicaid Managed Care RFP).

The MCO shall ensure that the Utilization Management Program has criteria and policies that: ... 4.8.1.4.1.4. Are applied based on individual needs and circumstances (including social determinants of health needs)... (p. 159).

4.8.1.6 Prior Authorization: 4.8.1.6.2 Authorizations must be based on a comprehensive and individualized needs assessment that addresses all needs including social determinants of health and a subsequent person centered planning process. (p. 161).

4.4.4.1 The MCO shall embrace and further the concept of “every door for Members is the right door” to eliminate barriers and create a more flexible and responsive approach to person-centered service delivery. The MCO shall provide twenty-four (24) hours a day, seven (7) days a week supports such as... assistance with social determinants of health... (p. 112).

4.14.9.2.1 The MCO's APM Implementation Plan shall address the following priorities, as described in State law (Senate Bill 313 2018): 4.14.9.2.1.7. Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED. (pp. 254-255, , August 2018, New Hampshire Medicaid Managed Care RFP).

¹⁵³ At a minimum, Care Management functions must include, but are not limited to ... 5. Coordination of care actively linking the enrollee to providers, medical services, residential, social, and other support services where needed... (Art. 1, p. 4-5).

Targeted Case Management (TCM) Service Descriptions: Services that will assist targeted individuals eligible under the State plan in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment, development of a specific care plan, referral and related activities, monitoring and follow-up activities. Services are designed to assist consumers in their recovery by helping them gain access to needed mental health, medical, social, educational, vocational, housing and other services. (p. 615 [not internally paginated], January 2019, New Jersey Medicaid Managed Care Model Contract).

¹⁵⁴ 4.4.9.6 The developed [Comprehensive Care Plan] shall at a minimum include: ... 4.4.9.6.9 The Member's psychosocial needs, including any housing or financial assistance needs that could impact the Member's ability to maintain a safe and healthy living environment... life outcomes for the Member; 4.4.9.6.11 Other services that will be provided to the Member, including Covered physical and Behavioral Health Services that will be provided by the CONTRACTOR to help the Member maintain or improve his or her physical or Behavioral Health status or functional abilities and maximize independence, as well as other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, and any non-Covered Services including services provided by other community resources, including plans to link the Member to financial assistance programs including but not limited to housing, utilities and food as needed... (pp. 58-59).

4.4.15.2 For those Members who are candidates for transition to the community, the care coordinator shall facilitate the development and completion of a transition plan, which shall remain in place for a minimum of sixty (60) Calendar Days from the decision to pursue transition or until the transition has occurred and a new CCP [Comprehensive Care Plan] is in place. The transition plan shall address the Member's transition needs including but not limited to: ... 4.4.15.2.4 Housing needs; 4.4.15.2.5 Financial needs... (p. 73, January 2018, New Mexico Medicaid Managed Care Contract Amendment).

The CONTRACTOR shall: 3.5.1.1 Develop a Cultural Competence/Sensitivity Plan that shall be submitted to HSD for approval, describing how the CONTRACTOR shall ensure that Covered Services provided to Members are culturally competent and including provisions for monitoring and evaluating disparities in membership, especially as related to historically and socially disadvantaged Members. (p. 38, January 2018, New Mexico Medicaid Managed Care Contract Amendment).

¹⁵⁵ The MCP's approach to care management shall emulate the features of a high-performing care management system: person and family centeredness; timely, proactive planned communication and action; the promotion self-care and independence; emphasis on cross continuum and system collaboration (e.g., behavioral health); and the comprehensive consideration of physical, behavioral, and social determinants of health. The MCP shall consider the Case Management Society of America's Standards of Practice for Case Management, 2016 when designing and implementing its care management program. (p. January 2020, Ohio Medicaid Managed Care Model Contract).

¹⁵⁶ b. Contractor shall ensure documentation of the following features of the delivery system: ... (4) Members receive assistance in navigating the health care delivery system and in accessing Community and social support services and statewide resources. (p. 61, January 2020, Oregon Medicaid Managed Care RFA).

¹⁵⁷ a. HIV/AIDS Targeted Case Management (TCM) Program The PH-MCO must provide for TCM services for persons with AIDS or symptomatic HIV, including access to needed medical and social services using the existing TCM program standards of practice followed by the Department or comparable standards approved by the Department. (p. 53).

e. If the PH-MCO provides Case Management Services to Members under the age of twenty-one (21) through the SNU, the PH-MCO must require that the SNU assists individuals in gaining access to necessary medical, social, education, and other services in accordance with MA Bulletin #1239-94-01 Medical Assistance Case Management Services for Recipients Under the Age of 21... g. The PH-MCO SNU must assess and assist members with social factors that affect health outcomes. Social determinants of health include, but are not limited to, housing, food insecurity, health literacy, access to transportation, education, and employment. (pp. 108-109).

The [Opioid Use Disorder Center of Excellence] ... community based care management (CBCM) team that consists of licensed and unlicensed professionals... will track and support patients when they obtain medical, behavioral health, or social services outside the practice. They will develop a person-centered individualized care plan for each patient that includes addressing the social determinants of health. They will facilitate recovery by helping individuals find stable housing, employment, and reestablishing family/community relationships. They will facilitate referrals and respond to social service needs... (p. G-3).

Standard V: The PH-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Members identified. Case/Disease and health management programs must: ... H. Include collaboration with the Department to develop, adopt and disseminate a Social Determinants of Health assessment tool. (pp. M(1)-10, January 2019, Pennsylvania Medicaid Managed Care Contract).

Both the PH-MCO [Physical Health MCO] and Network Providers must demonstrate Cultural Competency and must understand that racial, ethnic and cultural differences between Provider and Member cannot be permitted to present barriers to accessing and receiving quality health care; must demonstrate the willingness and ability to make the necessary distinctions between traditional treatment methods and/or nontraditional treatment methods that are consistent with the Member's racial, ethnic or cultural background and which may be equally or more effective and appropriate for the particular Member; and demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to a Member of a particular culture than to another of a differing culture. (p. 115).

¹⁵⁸ Care management is to be performed by Health Plan staff or agents located in the State of Rhode Island. Rhode Island staff will be key for their ability to work closely with local resources. Face-to-face meetings shall be conducted where appropriate; to best coordinate the services and supports needed to meet the needs of members, including behavioral health needs, social supports and services and out-of-plan services. The Program Coordinator (and/or Care Manager) and all their needed support staff shall be located in Rhode Island. (p. 88).

HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV: ... Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. (p. 284).

Integrated Health Home (IHH) is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support. (pp. 389).

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to: ... 2. Safe, clean, affordable housing; 3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance); 4. Social services; 5. Transportation... (p. 397).

The [Opioid Treatment Program] Health Home services are defined below... The OTP Health Home builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including mental health treatment) in keeping with the needs of persons with a primary diagnosis of opioid dependence and multiple chronic illnesses or who is at risk of chronic illnesses... OTP Health Home teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. (pp. 354-355).

Contractor shall have policies and procedures that document how Contractor will conduct transitions of care and hospital discharge activities, to ensure all appropriate medical, social, and behavioral health needs are met when a member transitions back to the community. (p. 385).

2. Chronic condition management and population management: The OTP HH team supports its consumers as they participate in managing the care they receive. Interventions provided under OTP HH may include, but are not limited to: ... Assisting the client in locating and effectively utilizing all necessary community services to address the client's medical, social and psychiatric needs and ensuring that services provided are coordinated with those provided through physical health care professionals... Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy). (pp. 414-15, July 2018, Rhode Island Medicaid Managed Care Contract).

¹⁵⁹ 4.2.27. Targeted Case Management (TCM) Services Services that will assist an individual Eligible under the State Plan in gaining access to needed medical, social, educational and other services to include a systematic referral process to the service with documented follow-up. TCM services are available to alcohol and substance abuse individuals, children in foster care, chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with mental retardation or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Patients who are dually diagnosed with complex social and medical problems may require TCM services from more than one Case Management Provider. The Department is financially responsible for TCM programs. (p. 73-74).

5.1.4. Use Care Management and Coordination as a continuous process for: 5.1.4.1. The assessment of a Member's physical health, Behavioral Health and social support service and assistance needs, 5.1.4.2. The identification of physical health services, Behavioral Health Services and other social support services and assistance necessary to meet identified needs, and 5.1.4.3. The assurance of timely access to and provision, coordination and monitoring of the identified services associated with physical health, Behavioral Health, and social support service and assistance to help the member maintain or improve his or her health status. (p. 80, July 2018, South Carolina Medicaid Managed Care Contract).

¹⁶⁰ 2.9.6.1.3 The CONTRACTOR shall use care coordination as the continuous process of: (1) assessing a member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed in order to ensure the member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement. (p. 128).

Health Link professionals will use care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health, including: ... Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through)... (pp. 573-74, July 2019, Tennessee Medicaid Managed Care Contract).

¹⁶¹ The transition plan [for new STAR+PLUS members] may include information for services outside the scope of covered benefits such as how to access affordable, integrated housing. (p. 8-210, September 2019, Texas Medicaid Managed Care RFP).

¹⁶² The Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for Members in the ECI Program. The Service Plan [for members with special health care needs] should also include information on how to access affordable, integrated housing. (p. 8-109, September 2019, Texas Medicaid Managed Care RFP).

¹⁶³ Coordination Procedures: In accordance with 42 C.F.R. § 438.208(b), the Contractor must implement procedures to coordinate: ... The services the Contractor furnishes to the member with the services the member receives from community and social support providers. (pp. 142-143).

Early Intervention Targeted Case Management/Service Coordination: The Contractor shall provide coverage for EI Targeted Case Management (also referred to as EI Service Coordination). EI service coordination is a service that will assist the child and family in gaining access to needed and appropriate medical, social, educational, and other services. EI Service Coordination is designed to ensure that families are receiving the supports and services that will help them achieve their goals on their child's Individual Family Service Plan (IFSP), through monthly monitoring, quarterly family contacts, and on-going supportive communication with the family. The Service Coordinator can serve in a "blended" role; in other words, a single practitioner can provide both Early Intervention Targeted Case Management/Service Coordination and an IFSP service, such as physical therapy, developmental services, etc. to a child and his or her family. The Contractor shall submit an annual report outlining its efforts in the four social determinants of health areas listed above. (p. 380, August 2018, Virginia Medicaid Managed Care Contract).

¹⁶⁴ The Contractor shall establish protocols for discharge planning during initial and continued stay reviews that addresses: Treatment activity and community supports necessary for recovery including, but not limited to: housing financial support, medical care, transportation, employment and/or education concerns, and social supports. (p. 195, January 2019, Washington State Medicaid Fully Integrated Managed Care Contract).