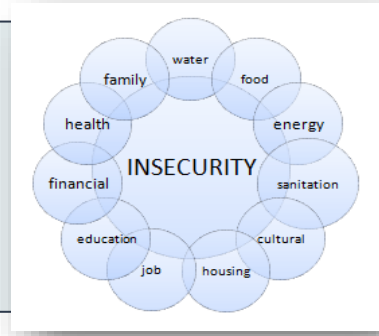
SNP Alliance

The National Voice for Special Needs and Medicare-Medicaid Plans

A National Nonprofit Leadership Organization

Performance Evaluation Quality Leadership Group
Focus on: Health Risk Assessment



Deborah Paone,
DrPH, SNP Alliance

- **Understanding by SNPs on new HRA requirements for SRS**
- **SNPA plans' feedback RE: items used in HRAs and process (May/June 2022)**
- **Considerations and recommendations to MMCO as requested**
- **Opportunity for group call & Follow up in July**

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Level-set on HRA Social Risk Screening Requirements – 3 Social Risks must be on HRA

Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments (§ 422.101) (pp. 67-112)

CMS finalized language at § 422.101(f)(1)(i) **that requires SNPs to include one or more questions on housing stability, food security, and access to transportation from a list of screening instruments specified by CMS** (forthcoming in sub-regulatory guidance) **as part of their initial and annual health risk assessments** (HRAs) **beginning in contract year 2024.**

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SNP Alliance Member Survey & Discussion Findings

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Level-set on HRA Social Risk Screening Requirements – CMS on accepting *State HRA*

Medicaid HRA – "As described in Medicare Part C Plan Technical Specifications for D-SNPs, CMS will accept a Medicaid HRA that is performed within 90 days before or after the effective date of Medicare enrollment as meeting the Part C obligation to perform an HRA, provided that the requirements in § 422.101(f)(1)(i) are met." (p. 91)

State requirements will be considered - "**We will consider State requirements** in establishing the list of screening tools in sub-regulatory guidance. As a result, the sub-regulatory guidance will include the option to use any State-required Medicaid screening instruments that include questions on these domains." (p.91)

SNPs Comments: (1) Regarding the Medicaid HRA – what if the State has a different timeframe than 90 days? (2) Does "consider State requirements" mean that SNPs can safely comply with the requirement by using the State-required items for housing, transportation, and food insecurity without having to add duplicative questions on these items in their HRA (effectively having to ask the beneficiary twice about these social risk factors?) ***SNPs recommend that CMS recognize any State required tool.***

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Level-set on HRA Social Risk Screening Requirements – CMS on Processes

***CBOs or other sub-contractors for HRA completion**:* "SNPs can choose to utilize community-based organizations or other entities as subcontractors to conduct HRAs or portions of an HRA, and we have seen successful examples of this both with SNPs and MMPs. SNPs and MMPs are responsible for ensuring that their subcontractors meet all CMS care coordination requirements." (p. 91)

SNPs Comments:(1) Health plans report that social risk factor screening is often done by other entities, such as county case managers, clinic care coordinators or social workers, community health workers, etc. outside of the HRA but within the 90-day or annual timeframe. **We assume that the SNP can accept this information from these other entities and incorporate it into the member's HRA**. Please confirm.

(2) CBOs often do not have sophisticated electronic data platforms with data exchange/interoperability as are common in medical clinics. Are there specifications about how CBOs are to transfer social risk screening data to the health plan? Will CBOs be audited or reviewed by CMS for their data exchange or does CMS expect the health plan to do this? SNPs are concerned that CBOs such as community shelters, food banks, volunteer ride programs, etc, are not set up for responding to SNPs questions regarding follow-up status for their beneficiary members.

We assume that the SNP can document the referral was made and then monitor if the need was met in the next care plan review with the beneficiary.

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Level-set on HRA Social Risk Screening Requirements - CMS on *Sources*

Use of other sources on enrollee social risk factors - "We clarify that the new requirement at § 422.101(f)(1)(i) does not say that SNPs are to use the HRA as the only source of information on enrollee social risk factors. In addition to HRAs**, we encourage SNPs to use sources of information outside of the HRA process in order to ensure that SNPs have a complete picture of an enrollee's physical, psychosocial, functional, and social needs and their personal goals**. This can include, but is not limited to, interactions between enrollees and providers, care coordinators, other members of the integrated care team, or community-based organizations. This information can assist with the development of and any updates to an enrollee's individualized care plan.

SNPs Comments: (1) Based on this language, SNPs understand that they can use information outside of the HRA to populate the HRA, as long as the information came from the member, and it is within the 90-day or annual (365 day annually) timeframe.

2) SNPs would like to clarify that the responses by the beneficiary to the social risk questions are automatically to be provided to the interdisciplinary care team—is this correct? In other words, additional permission from the member/beneficiary is not required to comply with the requirement by CMS.

SNPs request that CMS consider HIPAA and State privacy requirements that the health plan must follow. If there are extra steps or processes, please indicate what these are and how to document them.

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Level-set on HRA Social Risk Screening Requirements - CMS on *Sources*

Use of other sources on enrollee social risk factors - *continued*- Though SNPs may use a variety of sources of information to better understand their enrollees' needs, **we are finalizing a requirement for SNP HRAs to include questions from a list of CMS-specified screening tools about housing stability, food security, and access to transportation because all SNPs are required at § 422.101(f)(1)(i) to conduct a comprehensive HRA.** Making this requirement part of the HRA ensures all SNPs are universally collecting this information, at minimum, in their assessments, regardless of any other sources of information on enrollee social risk factors they may use." (pp. 94-95)

Comments from SNPs: (1) Based on this language, SNPs understand that these social risk questions must be asked of the beneficiary and responses entered into the HRA. Regarding refusal by the beneficiary--Should the health plan or other entity collecting the HRA and social risk information make a notation if the beneficiary refuses to answer? How should this be done? (2) Beneficiary refusal to participate in the HRA is common. This is, unfortunately, similar to observed decline in response rates to surveys such as CAHPS and HOS. Refusal or "unable to be reached" is documented by the health plan. Plans would like clarification that documenting refusal does not lessen the goal of trying for 100% participation, but that **such documentation will avoid a negative action by CMS if audited around the SRS requirement.** In addition, beneficiaries have the right to refuse. These questions can trigger emotional responses, and the member may feel that they do not want to divulge this information.

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Level-set on HRA Social Risk Screening Requirements – CMS on *Validated items*

Validated screening instruments **-** ”In developing this sub-regulatory guidance, we will consider the extensive work that health plans, the Federal Government, tool developers, and other stakeholders have already done to research and validate screening instruments. **We clarify that we did not propose to create new measures, nor did we intend to require that SNPs adopt new assessment tools wholesale. Rather, we proposed to require SNPs to incorporate CMS-specified standardized questions about housing stability, food security, and access to transportation into their HRAs**; we had intended that existing standardized questions, from existing validated assessment tools. would be specified by CMS for use by SNPs.

Comments from SNPs: (1) Based on this language, SNPs understand that plans can continue to use the processes and tools that they have put in place for their HRAs, as long as items on the 3 social risk factors in the HRA are from validated instruments OR are items required by the State in which the health plan operates. SNPs request that any validated item/tool and any State-directed item be approved by CMS, at least in 2024. [Please note that not all States can trace their questions on housing stability, food security, or access to transportation back to validated screening instruments—despite this lack of clarity about the source of the item, the health plan is required to use the state-directed form/items.]

(2) The other issue is that the State timeframe for the screening/assessment is not always within the 90-day timeframe or annual review timeframe for the health plan to complete the HRA—therefore a challenge for the plan and the beneficiary could be the need to do the social risk screening twice (duplication). If CMS could offer a solution for this, it would be appreciated.

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Level-set on HRA Social Risk Screening Requirements – CMS on *Validated items*

Validated screening instruments – continued

Although we are not finalizing a requirement for SNPs to use CMS-specified standardized questions, we are finalizing a requirement **that SNPs use questions from a list of screening instruments specified by CMS in sub-regulatory guidance**. We anticipate this list will include validated, widely used assessment tools that include questions on housing stability, food security, and access to transportation." (p. 96)

Comments from SNPs:

(1) Several SNPs explained that the social risk screening items on their HRAs come from several validated and other "internally created" instruments. In other words, a housing item may come from one instrument, and the food item from another. **SNPs assume that use of validated items would be considered in compliance with the regulation.** It appears that CMS will not accept internally developed items that some plans have used for years. This is unfortunate, as plans have trending information on beneficiary needs; comparisons year over year are used in a variety of ways (care management, quality monitoring).

(2) Some SNPs have several versions of the HRA, for different beneficiary groups. **They assume this is acceptable**, as long as the SRS items are from validated instruments OR are those required by the State to be used.

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SNP Alliance Health Plans report multiple data sources for identifying social/SDOH risk factors faced by members:

- ***Health risk assessments***
- Internal care management records
- Member services information gathered through phone contact
- Claims data, encounter data, including ICD-10 “z” coded visits
- Member surveys
- Initial member enrollment forms
- Medical record information from providers
- External care management records
- State long-term services and supports data
- State Medicaid data
- American Community Survey data
- Census data
- County data, county health rankings
- Community (regional) health assessments

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PE/Quality Group – conducted a "Mini-survey" with 2 key HRA questions posed:

Q1: Do you include social risk screening as part of your HRA? If so, what risks?

A: Yes, but

- **Plans do screen for SDOH, but not always all 3 of the targeted risk factors. Housing & food most often included**
- Plans mentioned many types of screening forms, including State-required SDOH screening forms and "internally created" forms. Plans said it sometimes hard to assess if the items in the State form have been adopted without changes from validated instruments.

Examples of other risk factors screened in addition to the 3 of interest:

- Unemployment
- Low Income, financial barriers
- Language barriers
- Domestic or other abuse/violence
- Lack of support systems, caregiver
- Substance use/abuse,
- Inability to pay bills
- Difficulty with communicating needs or concerns
- Legal & criminal issues
- Lack of advance care planning

Plans described costs associated with changing the HRA form—vendors must re-program and those costs are passed to the health plan.

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To assist MMCO, SNP Alliance conducted a convenience sample of health plans regarding their HRAs and the source of the Social risk screening questions on these 3 items. This IS NOT a comprehensive/exhaustive list of instruments used:

- AHC Tool
- PRAPARE
- Health Leads
- Health Begins
- WellRX
- Minnesota LTC Consultation Assessment
- AAFP Screening Tool
- Hunger Vital Sign
- Virginia Commonwealth University Health System Screen
- EPIC Social Risk Screen & Framework/Smart Set
- Redwood Community Coalition – with Protocol for Latino & migrant families
- North Carolina Medicaid SRS tool
- Access Health
- BMC
- Some plans also report “internally developed” items on these three social risk factors.

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EXAMPLE - Validated Items/Instruments used by SNPs- HOUSING

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

Accountable Health Communities

Living Situation

4. What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but **I am worried** about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

5. Think about the place you live. Do you have problems with any of the following?

CHOOSE ALL THAT APPLY

- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

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EXAMPLE - Validated Items/Instruments used by SNPs - HOUSING

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Note: Same as earlier version but the underline options are delineated as indicating level of need

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

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EXAMPLE - Validated Items/Instruments used by SNPs- HOUSING

HealthBegins

Housing Insecurity	First visit & annually	8a. In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?	YES NO	+1 for YES
		8b. In the last month, have you had concerns about the condition or quality of your housing?	YES NO	+1 for YES
		8c. In the last 12 months, how many times have you or your family moved from one home to another?	Number of moves in past 12 months _____	+1 for 2 or more moves in past year

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EXAMPLE - Validated Items/Instruments used by SNPs- HOUSING

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

Note: Seems to use items from PRAPARE and AHC, but some wording differences.

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EXAMPLE - Validated Items/Instruments used by SNPs - FOOD

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

Accountable Health Communities

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

6. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

7. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

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EXAMPLE - Validated Items/Instruments used by SNPs - FOOD

WellRX TOOL:

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food? _____ Yes _____ No

HealthBegins

Food Insecurity	First visit & annually	9. Which of the following describes the amount of food your household has to eat: (Check one.)	Enough to eat Sometimes not enough to eat Often not enough to eat	+1 for "Often not enough to eat"

Hunger Vital Sign[1]

Domain: Food Insecurity

Children's HealthWatch. The Hunger Vital SignTM. Children's HealthWatch website. https://childrenshealthwatch.org/public-policy/hunger-vital-sign/. Accessed August 7, 2019

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EXAMPLE - Validated Items/Instruments used by SNPs - FOOD

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE): Used by the Redwood Community Health Coalition

Family and Home

6. **How many family members, including yourself, do you currently live with?** _____
7. I choose not to answer

8. **What is your housing situation today?**

☐ I have housing ☐ I do not have housing (staying with others; in a hotel, shelter, or car; or outside) ☐ I choose not to answer

9. **Are you worried about losing your housing?**

☐ Yes ☐ No ☐ I choose not to answer

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EXAMPLE - Validated Items/Instruments used by SNPs - FOOD

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

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EXAMPLE - Validated Items/Instruments used by SNPs- TRANSPORTATION

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Accountable Health Communities

Transportation

8. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?**

- ☐ Yes
- ☐ No

AAFP

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]

- ☐ Yes
- ☐ No

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Additional Items/Tools Used in HRA for social risk screening by SNP Alliance members s

Virginia Commonwealth University Health System: Social Needs Assessment*

Where is this assessment taking place?

☐ Inpatient ☐ Emergency department ☐ Patient's home ☐ Complex care clinic
☐ Outpatient clinic ☐ Observational stay ☐ Phone

Social Needs Screening Tool

1. In the last month, did you ever eat less than you felt you should because there wasn't enough money for food?
☐ Yes ☐ No ☐ N/A

1a. Would you like to receive assistance with this need?
☐ Yes ☐ No

1b. Is this need urgent?
☐ Yes ☐ No

2. In the last month, has your utility company shut off your service for not paying your bills?
☐ Yes ☐ No ☐ N/A

2a. Would you like to receive assistance with this need?
☐ Yes ☐ No

2b. Is this need urgent?
☐ Yes ☐ No

3. Are you worried that in the next month, you may not have stable housing?
☐ Yes ☐ No ☐ N/A

3a. Would you like to receive assistance with this need?
☐ Yes ☐ No

3b. Is this need urgent?
☐ Yes ☐ No

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EXAMPLE: SDOH Screening & Smart Set built into EPIC

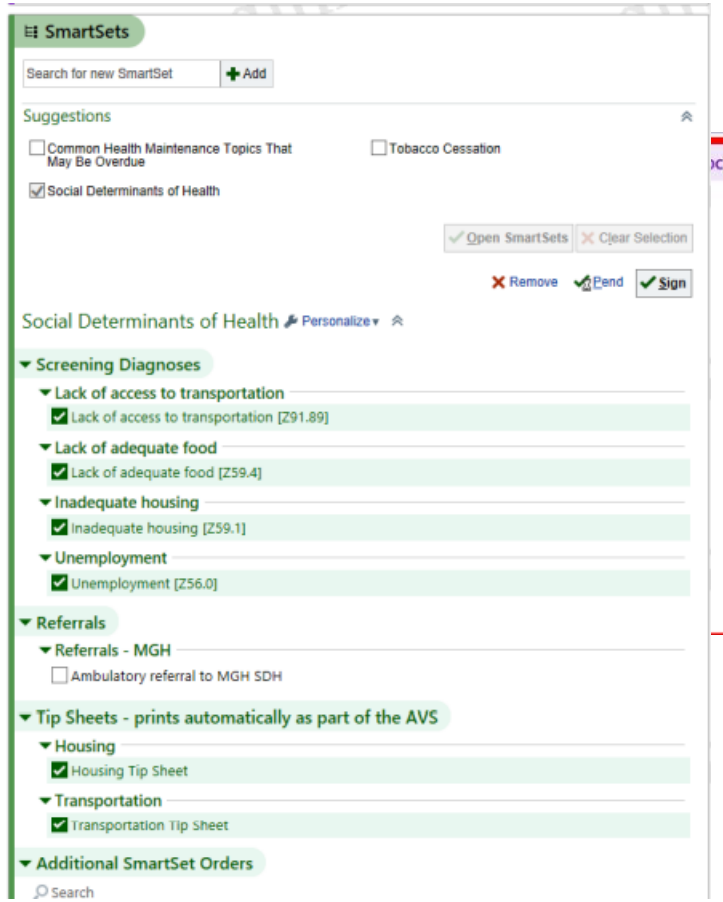
	Has the lack of transportation kept you from medical appointments or from getting medications?	◯ Yes	◯ No		
	Within the past 12 months we worried whether our food would run out before we got money to buy more.	◯ Never True	◯ Sometimes True	◯ Often True	
	Within the past 12 months the food we bought just didn't last and we didn't have money to get more.	◯ Never True	◯ Sometimes True	◯ Often True	
	What is your housing situation today?	◯ I have housing	◯ I do not have housing *(staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)*	◯ I choose not to answer	
	How many times have you moved in the past 12 months?	◯ Zero (I did not move)	◯ One time	◯ Two or more times	◯ I choose not to answer
	Are you worried that in the next 2 months, you may not have your own housing to live in?	◯ Yes	◯ No	◯ I choose not to answer	
	Do you have trouble paying your heating or electricity bill?	◯ Yes	◯ No	◯ I choose not to answer	
	Do you have trouble paying for medicines?	◯ Yes	◯ No	◯ I choose not to answer	
	Are you currently unemployed and looking for work?	◯ Yes	◯ No	◯ I choose not to answer	
	Are you interested in more education for yourself related to completing high school / applying to college / learning the English language / developing job or technical skills / developing parenting skills?	◯ Yes	◯ No	◯ I choose not to answer	
	Do you have trouble with childcare or the care of a family member?	◯ Yes	◯ No	◯ I choose not to answer	

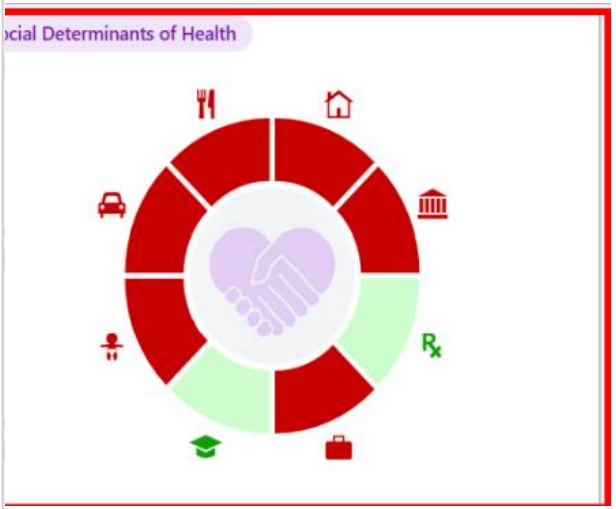
Would you like information about any of the following topics? ☐ None

☐ Transportation	☐ Food	☐ Housing
☐ Paying utility bills	☐ Paying for medications	☐ Job search or training
☐ Education	☐ Childcare	☐ Care for elder or disabled

In the last 12 months, have you received assistance from an organization or program to help you with any of the following: ☐ None

☐ Transportation	☐ Food	☐ Housing
☐ Paying utility bills	☐ Paying for medications	☐ Job search or training
☐ Education	☐ Childcare	☐ Care for elder or disabled





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DEPARTMENT OF HUMAN SERVICES

Minnesota Long Term Care Consultation Services Assessment Form

[DHS-3428-ENG (Minnesota Long Term Care Consultation Services Assessment Form) (state.mn.us)]

Ba.16 My current housing type:

LTC SD 32 ☐

01	Homeless	04	Board & Lodge	11	NF/Certified Boarding Care
02	ICF/DD	05	Foster Care	12	Noncertified Boarding Care
03	Hospital	09	Own Home, Apartment	16	Correctional facility

Ba.18 Who do you currently live with?

LTC SD 27 ☐

01	Living alone	04	Living in congregate setting
02	Living with spouse/parents	05	Homeless
03	Living with family/friend/ significant other		

F.28 I am able to buy enough food for my self each month. ☐ Yes ☐ No

F.28a Do you want information about food assistance? ☐ Yes ☐ No

Assessor Evaluation of Environment

I.6 Assessor, please indicate the specific area(s) in which there are potential safety or accessibility problems for the person. Check "None" if no potential problems.

Yes	Area	Yes	Area
☐	Structural damage	☐	Insufficient hot water/water
☐	Barriers to access (including steps and stairs)	☐	Insufficient heat
☐	Electrical hazards	☐	Shopping not accessible
☐	Signs of careless smoking	☐	Transportation not accessible
☐	Other fire hazards	☐	Telephone not accessible
☐	Dangerous floors? Scatter rugs	☐	Neighborhood environment unsafe
☐	Unsanitary conditions/odors	☐	Other (Specify) _____
☐	Insects or other pests	☐	None
☐	Poor lighting		

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From SIREN – USC: https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

	AAFP- Tool	AccessHealth: Spartanburg	AHC-Tool	Arlington	BMC-Thrive	HealthBegins	Health Leads	MLP IHELLP	Medicare Total Health Assessment Questionnaire	NAM Domains	NC Medicaid	PRAPARE	Structural Vulnerability Assessment Tool	WellRx	Your Current Life Situation
lumber of social needs uestions	15	10	19	11	11	24	10	10	9	12	11	17	37	10	19
lumber of non-social needs uestions	0	28	8	0	0	4	0	0	30	12	0	4	6	1	10
atient or clinic population	Non-specific	Non-specific	Medicare and Medicaid	Non-specific	Non-specifc	Non-specific	Non-specific	Non-specific	Medicare beneficiaries	Non-specific	Medicaid	Community Health Centers	Non-specific	Primary care	Non-specific
eading Level	7th grade	5th grade	8th grade	10th grade	7th grade	11th grade	6th grade	8th grade	College	6th grade	5th grade	8th grade	6th grade	2nd grade	9th grade

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Additional Tools, Resources & Links used by SNPs in their HRAs

SDoH-Report.pdf (unc.edu)

S-HIE Screening Implementation Guidance.pdf (colorado.gov)

DHS-3428-ENG (Minnesota Long Term Care Consultation Services Assessment Form) (state.mn.us)

Social Needs Screening Tool Comparison Table | SIREN (ucsf.edu)

Psychometric and pragmatic properties of social risk screening tools: A systematic review | SIREN (ucsf.edu)

Well Rx (kpwashingtonresearch.org) Well Rx is an 11-item questionnaire assessing needs in 4 domains (economic stability, education, neighborhood & physical environment, and food).

The Health Leads Screening Toolkit — Health Leads (healthleadsusa.org)

Microsoft Word - HealthBegins Social Screening Tool and Guide - v6.docx (aamc.org)

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Selected Sources for Items Used in HRA for social risk screening by SNP Alliance members s

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

https://www.chcs.org/media/Redwood-PRAPARE-Questions_102517.pdf

https://www.chcs.org/media/VCU-Health-Social-Needs-Assessment_102517.pdf

https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

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AHC Model Core Needs
LOINC for full core set*: 96777-8

AHC HRSN Domain	Item #	Reference	Citation and tracking process	Author contact information (if applicable)	LOINC
Living Situation	1	National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/	Any organization can use this screening question, as long as they **reach out to the screening question author to notify them of their plan to use it**, and cite the screening item appropriately.	PRAPARE team: prapare@nachc.org	71802-3
	2	Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327	Any organization can use this screening question, as long as they cite the item appropriately.		96778-6
Food	3-4	Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.	Any organization can use this screening question, as long as they cite the item appropriately.		88122-7, 88123-5
Transportation	5	National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/	Any organization can use this screening question, as long as they **reach out to the screening question author to notify them of their plan to use it**, and cite the screening item appropriately.	PRAPARE team: prapare@nachc.org	93030-5

Q2: What do you do with the results/responses? What, When, Who, How is follow-up done [if a social risk vulnerability is found]?

A: Plans most often mentioned the care coordinator who follows up and refers to community services and a date for follow up is determined – in keeping with the member's preferences and priorities.

A variety of processes were discussed, but most often a Care Manager/Coordinator or other person (e.g., Life Coach) is assigned to the member and this person does the follow up. Some plans discussed this being telephonic, some discussed Face to Face HRA assessment and follow up.

In some SNPs, such as a FIDE-SNP, the Care Coordinator or person assigned to the member conducts the HRA (whenever possible F2F), discusses all needs including SDOH with the beneficiary/member, and starts the service. – Together the care manager and member determine what the person wants/needs help with, then develops care plan, authorizes services, makes referrals to providers of those services, checks in with the member to see if services have begun and if so, does the service meet needs.
Some plans designate the HRA to sub-contractor agency so the individuals who do the HRA are not necessarily employed by the health plan, nor are they the person assigned for follow up.

Plans described costs of these changes – any changes to the HRA requires re-programming of software and of analytic and predictive models. Plans that use an outside vendor will be charged for every change requested. Therefore, if CMS anticipates further changes to the HRA including tool items or processes, it would be very helpful to have that information now. Finally, smaller plans report that re-programming through a vendor can take a long time—they are concerned about having enough lead time to have this done before it has to be used in the field.

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Q2: What do you do with the results/responses? What, When, Who, How is follow-up done [if a social risk vulnerability is found]? - continued

A: continued -

The risk vulnerability factors are noted/information is included in the ICP and flagged for follow up-- but depending on the member's priority and desire to have the health plan or care manager assist with that, the care plan may set a timeframe and plan that is more than 30 days (more than one month) out and/or note when this need is to be revisited.

There are often others involved where CBO staff, county staff, or others are involved in the member's situation, such as SNAP benefit application that has been started, but the determination has not been completed.

These community service providers do not always have the capacity or database operability to circle back to the health plan and let them know on follow up or to be able to respond to the plan's care coordinators' questions about whether/how the services were provided and the result of the referral. There is sometimes a gap in information available (even to the CBO, for example, if the individual cannot be reached for follow up to get feedback).

Plans request that CMS build recognition of the following into the sub-regulatory guidance: member preferences regarding SRS information, the member's preferences and priorities in the ICP that would drive what services/when in response to SRS, the CBOs/service providers challenges in being able to respond within 30 days, challenges in tracing what happened, and the ability of the CBO/service provider to give follow up data to the plan.

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CMS on NCQA SRS Measure Development

CMS: "The proposed NCQA measure does not require use of a specific tool or questions but would allow use of questions from a list of selected validated assessment instruments, similar to the new requirement finalized here at § 422.101(f)(1)(i). We anticipate our list of screening instruments in sub-regulatory guidance **will overlap with the list of screening instruments NCQA includes in the specifications for its proposed measure,** which will provide the opportunity for SNPs to align their compliance with the new requirement at § 422.101(f)(1)(i) with data to be used for the proposed NCQA measure."

Comments from SNPs:

(1) It will be crucial that NCQA measure development for the SRS measure align with the CMS sub-regulatory guidance. It will also be crucial that the SRS measure be informed by what is feasible, useful, valid, and accurate in terms of measuring something that provides information for assessing the plan performance, and where the plan has ability to affect change (improve).

(2) Plans ask: "Please do not set up a measure that does not recognize the reality of member preferences and priorities, member engagement, and community-based capacity issues." We bring this up, because the initial proposed measure floated by NCQA has a 30-day timeframe that may not be feasible for community providers. [see next slide]

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NCQA SRS Measure Development

Social Need Screening and Intervention: The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported:

- *Food screening*: The percentage of members who were screened for unmet food needs.
- *Food intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet food needs.
- *Housing screening*: The percentage of members who were screened for unmet housing needs.
- *Housing intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet housing needs.
- *Transportation screening*: The percentage of members who were screened for unmet transportation needs.
- *Transportation intervention*: The percentage of members who received a corresponding intervention within 1 month of screening positive for unmet transportation needs.

04.-SNS-E.pdf (ncqa.org)

20201009_SDOH-Resource_Guide.pdf (ncqa.org)

SNPs Comments: The screening process measures are reasonable as long as there is some recognition that the member has the right to refuse the HRA and each item/question. These individuals should be removed from the denominator. However, the follow up "intervention" component is not reasonable. There are three issues: (1) member may have been advised to have an intervention but refused, (2) there were no "interventions" available (capacity issue) within the community—and the member is on a wait list or other efforts are being pursued but these take longer than 1 month, and (3) the member was given the information and did receive services but there is no pathway for the health plan to know about that—no information is available, the service agency does not have the bandwidth to provide the information, or they are unwilling to release that information due to their own privacy policies.

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Level-set on HRA Social Risk Screening Requirements – CMS on *Follow up*

Using the SDOH information/health plan follow-up – "We agree that it is important for SNPs to not only assess their enrollees for social risk factors**, but also connect them to needed services based on enrollee goals and preferences, whether such services are plan- covered benefits or referrals to community resources.**

. . . The SNP must take steps to provide the services or connect the enrollee with appropriate services in order to accomplish the goals identified in the individualized care plan. The SNP can take these social risk factors into account in the development and implementation of the individualized care plan, even if the SNP is not accountable for resolving all social risk factors."

Question from SNPs: (1) As discussed earlier, SNPs replying to the SNP Alliance have indicated that beneficiary members are connected with a care manager or other person (from delegated contracted agencies or employed by the SNP) to develop the ICP and discuss the member's priorities and timeframe for action.

When social risk or other care vulnerabilities are discovered, all plans indicate that they make referrals to services including community resources. They also work to maintain contact with the beneficiary member to check on follow up. However, depending on the community organization's capacity/bandwidth and the member's willingness to either make use of the service or to respond to the health plan's request for follow up—the services may not be initiated within 30 days/1 month. Even if the individual begins the service, they may not respond to the health plan's check-in call. Therefore, SNPs are wondering how compliance would be determined. SNPs assume that documenting steps taken will be sufficient.

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CMS Comments on *Tie to Model of Care*

Relation to Individualized Care Plan and Model of Care - "The information gathered in the HRAs must be used to inform the development of the individualized care plan per § 422.101(f)(1)(i) and (ii). Section 422.101(f)(1)(i) requires the SNP to ensure that the results from the initial and annual HRAs are addressed in the individualized care plan. Section 422.101(f)(1)(ii) also provides that the individualized care plan must be developed and implemented in consultation with the beneficiary.

Questions from SNPs:

(1) Some SNPs have a 3-year approval of their MOC past 2024 when this HRA screening rule takes effect. Their MOC was approved including the HRA tool and processes. Confirming that these SNPs DO NOT have to re-submit their Model of Care off-cycle, thus not requiring another NCQA review—can CMS confirm this?

(2) SNPs already use the information from the HRA to inform the ICP. However, a fairly high number of beneficiary members refuse participation in the annual HRA or are unable to be reached after multiple attempts. Therefore, SNPs utilize other sources of information such as described earlier (slide #9) to understand the member's needs and social risk factors. These other sources of information are used to create an individualized care plan in consultation with the member.

Can CMS clarify that these other sources of information can also be used to meet this SRS requirement as long as they are collected within the 90-day timeframe and then at least annually thereafter?

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CMS Comments on *Tie to Model of Care, continued*

Relation to Individualized Care Plan and Model of Care - "As per § 422.101(f)(1), the enrollee's providers should be included as part of the interdisciplinary care team (ICT) and **the information from HRAs should be shared with the ICT** as described in the SNP's MOC." (p. 109)

"§ 422.101(f)(1)(i) does not stipulate that specific plan personnel must conduct the HRA.

CMS does not require physicians to oversee providers or other staff when conducting an HRA and allows SNPs flexibility to determine the level of clinical expertise needed to conduct the HRA. **CMS does not preclude the use of telehealth to conduct HRAs. SNPs must conduct their HRA in a manner that is consistent with the plan's approved MOC**; approval of the MOC is required by § 422.101(f)(3)." (p. 109)

Questions from SNPs:

(1) SNPs understand from this language that a telephonic, virtual visit is acceptable to conduct the HRA and the social risk screening to comply with this requirement, as long as the SNP has indicated this within their Model of Care. Can CMS confirm?

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Level-set on HRA Social Risk Screening Requirements – CMS on *Audits*

CMS Audits – We clarify that the SDOH data collected as part of an HRA would be used to inform a SNP enrollee's individualized care plan based on the enrollee's goals. The language we are finalizing at § 422.101(f)(1)(i) **does not require SNPs to submit HRA data to CMS**. However, as we outlined in the proposed rule at 87 FR 1859, **we continue to consider whether, how, and when we could have SNPs report this data to CMS under other regulations**. If SNPs do submit this data to CMS in the future, we believe having such information could help us better understand the prevalence and trends in certain social risk factors across SNPs and consider ways to support SNPs in improving enrollee outcomes." (pp. 101-102)

"We remind the commenter who expressed concerns about how SNP auditors may interpret this proposed requirement that **CMS welcomes stakeholder feedback on the audit protocols when the collection becomes available for public comment** under the Paperwork Reduction Act of 1995. We also remind commenters of the requirement at § 422.503(b)(4)(vi) for MA organizations to **adopt and implement an effective compliance program to prevent, detect, and correct non-compliance with CMS's program requirements, including the requirement at § 422.101(f)(1)(ii) that SNPs must develop and implement an individualized care plan." (p. 104)**

Comment from SNPs/SNP Alliance: We will provide feedback on audit protocols when they are issued for public comment. Our main request is to align and synchronize the CMS audit review guidance and timing with the NCQA review guidance/expectations and timing, so that plans are not held to different expectations by NCQA and CMS auditors.

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Summary:

- Regarding CMS **sub-regulatory guidance forthcoming in 2022 -** clarification is needed in several areas. SNPs **request that CMS include attention to these areas in the sub-regulatory guidance.**
- In canvassing our plan members, **SNPs indicated they currently screen** for SDOH/social risk factors, **but not always these 3 items**. They focus on the risks most often experienced by their members. Therefore, some plans will need to revise their HRAs and revise instruments/forms, processes by contractors if the plan delegates this function.
- Most plans **use a variety of items from several screening instruments,** including "internally developed" items.
- Some plans have more than one **HRA form** (more than one version) and processes for different beneficiary groups/plan products.
- Changes to the **HRA can be expensive**—reprogramming the HRA software and other components tied to results, e.g., predictive models. This is especially so for plans that use outside vendors.
- **State-issued** Social Risk Screening (SRS) items **are assumed to be acceptable.**
- It will be very important to **sync the CMS HRA requirements with the Model of Care** requirements so that there is not confusion, duplication, or conflicting rules.
- The SNPA **offers suggestions to CMS** for the sub-regulatory guidance, based on analysis of the information obtained.

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Further discussion and development:

- PE/Quality Leadership Monthly Call – next one is July 13th
- Plans *are willing to discuss further with MMCO at the Agency's convenience in July or August to inform and provide insight – SNP Alliance can set up a call.*

For more information:

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