Social Risk Factor Screening in Medicaid Managed Care

Authored by Bailit Health

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

A grantee of the Robert Wood Johnson Foundation

October 2020

Introduction

The past two years have seen a sharp increase in state Medicaid program interest in how social determinants of health (SDOH) influence Medicaid enrollee health status and spending. This brief provides an introduction to the first step most states are taking in response through their Medicaid managed care programs—screening members for social risk factors (SRFs). It explains why Medicaid managed care members should be screened for SRFs, identifies screening design decisions, identifies common SRFs, and reviews options for screening tool selection.

What are Social Risk Factors?

State Medicaid agencies are increasingly recognizing the impact that nonmedical factors have on health, perhaps even a greater impact on health outcomes than medical care.[1] One of these nonmedical factors is the social determinants of health, or "conditions under which people are born, grow, live, work, and age,"[2] which may have beneficial or harmful impacts on the health of a population. When we consider only their potential harmful impact and apply the term at the individual person level, we refer to them as social risk factors. Examples include homelessness and food insecurity.[3]

Why Should Medicaid Managed Care Programs Screen for Social Risk Factors?

Certain groups, including low-income individuals[4] and communities of color, disproportionately experience SRFs, contributing to health disparities[5] and increasing health care costs.[6] Screening for SRFs supports identification of members impacted by SRFs. To mitigate the impact of SRFs, clinical care may be modified to account for the SRF, or members may be targeted for interventions implemented by providers designed to mitigate the impact of SRFs, thereby improving health status, advancing health equity, and slowing the rise in health care costs.[7,8]

Medicaid managed care organizations (MCOs) can also play critical roles in addressing Medicaid enrollee SRFs. The first step for MCOs to address SRFs is to promote screening of their members. MCOs can conduct SRF screening or can direct or incentivize their network providers and other contractors to do so. MCOs can also implement mitigation strategies for members with positive SRF screens. Mitigation strategies can include care coordination, care management, MCO/social service agency partnerships, additional plan services, use of community resource referral platforms, and performance incentives in value-based payment arrangements.

SRF screening data are just beginning to be used within risk adjustment and payment models to account for the costs associated with caring for populations with high social needs. Additionally, SRF screening data may be used within quality measurement activities, particularly to enable a more accurate comparison of an MCO's quality performance relative to other MCOs.[9]

Design Decisions

States may include SRF screening requirements within Medicaid managed care contracts or provide voluntary managed care guidance for conducting SRF screening. Either way, states will want to consider the following prior to engaging their MCOs in SRF screening:

- **Whether screening for SRFs should be required or optional:** In *New York*, MCOs are encouraged but not required to screen members.

- **Who to screen:** Screening requirements can be focused on all members or on specific high-cost, high-needs populations. *Massachusetts* requires screening of all MCO members with some exceptions,[10] whereas *Hawaii* will focus screening on three high-cost, high-needs populations.[11]
- **Who is responsible for screening:** MCOs and/or providers can be held responsible for screening. If MCOs are the accountable entities, they can be allowed to delegate this responsibility to providers and independent entities engaged in care coordination or care management. In *Oregon*, Coordinated Care Organizations will be held responsible for screening. In a 2019 study that examined patient acceptability of SRF screening, a majority of respondents reported SRF screening by providers in primary care and the emergency department, as well as inclusion of results in electronic health records (EHRs), to be acceptable.[12]
- **Where the screen should occur:** Screening could be restricted to a clinical setting,[13] or permitted in any setting or modality. This decision relates to who is responsible for conducting the screening. In *Massachusetts*, *North Carolina*, and *Rhode Island*, social risk factor screens can be conducted in both clinical and nonclinical settings.
- **If the screen should be conducted for individuals or for families:** Screening could be conducted on an individual level or a household level. *Rhode Island* allows screening to be completed for households if the enrollee is a young child.
- **At what frequency should screening occur:** In *Rhode Island*, screens must be completed annually, but ACOs are only measured and assessed for those members with a primary care office visit. In *Massachusetts*, screening is an annual requirement to be applied to all ACO-attributed members and ACOs are held accountable through measurement for all members being screened.
- **Whether the screen should be stand-alone:** Most SRF screens are performed apart from other screens, but in some states they are to be completed as part of a care management assessment or health risk assessment. Within the CalAIMS waiver,[14] *California* will require that MCOs conduct Individual Risk Assessments to assess medical information such as health status, along with SRFs including lack of transportation, social isolation, and housing needs.[15]
- **Whether there will be a standardized screening tool:** A state could standardize the screening tool and/or domains to be screened or allow MCOs and/or providers to select their own tool and/or screening domains. If MCOs/providers are allowed to select their own tool and/or domains, the state could require approval of the tool. Once Managed Care is implemented, *North Carolina* will conduct SRF screening using a standardized tool. *Massachusetts* and *Rhode Island* have specified the domains that must be screened for and require approval of the screening tool.
- **How to document, aggregate, and analyze screening results:** How screening data are documented and aggregated will influence whether and how screening data can be shared between the MCO, providers, and the state. If MCOs conduct SRF screenings, new data-sharing mechanisms will be necessary to ensure that screening results can be shared in a timely and accurate manner with providers, thereby enabling these results to be used for clinical decision-making and EHR documentation. States may require that MCOs aggregate and transmit screening data in order to calculate statewide SRF prevalence, track trends over time, and analyze screening-related performance.

Common Social Risk Factor Domains

Medicaid agencies may decide to focus screening on priority SRFs. SRFs could be designated as a priority because they are prevalent among members, align with a state's values, or because the evidence base is robust on how the SRF or corresponding interventions impact health outcomes.

Common screening tools and frameworks differ on which SRFs are included and how those SRFs are defined. Table 1 includes common SDOH, their corresponding SRFs, and an explanation of each SRF. SDOH and their corresponding

SRFs were identified through a comparison of the SDOH and SRFs included within Healthy People 2020 and common SRF screening tools. Additional resources on each SDOH are included within the endnotes.

Table 1. Common SDOH and their Corresponding SRFs

SDOH: Housing[16,17,18]	
SRF 1. Homelessness	Lack of housing (sheltered or unsheltered)
SRF 2. Housing insecurity	An unstable housing condition, which may be caused by being rent burdened, experiencing overcrowding, frequent moves, or other conditions.[19]
SRF 3. Poor-quality housing	Poor physical condition of the home
SDOH: Employment[20]	
SRF 1. Unemployment	An active job seeker cannot find a job
SRF 2. Underemployment	Involuntary part-time employment, poverty-wage employment, or insecure employment
SDOH: Education[21]	
SRF 1. Low educational attainment	Often defined as less than a high school diploma
SRF 2. Low literacy	An inability to listen, speak, write, read, numerate, and/or gain knowledge
SRF 3. Low health literacy	An inability to obtain, process, and/or utilize information to make health decisions
SDOH: Economic Security[22]	
SRF 1. Financial strain	Inability to pay for utilities, child care, or other essential items
SDOH: Food[23,24]	
SRF 1. Food insecurity	An absence of reliable access to food
SRF 2. Low-quality nutrition	A diet lacking the appropriate nutrients
SDOH: Incarceration[25]	
SRF 3. History of incarceration	Unmet needs after release/transition to community
SDOH: Safety[26]	
SRF 1. Interpersonal violence	Abuse within personal, intimate relationships
SRF 2. Neighborhood safety	The presence of crime or violence within one's neighborhood that makes it unsafe
SDOH: Social Support[27,28,29]	
SRF 1. Social isolation	Lack of social contact or support
SRF 2. Loneliness	The feeling of being alone or isolated
SDOH: Transportation[30]	
SRF 1. Lack of medical transportation	Lack of transportation to medical appointments or to get medication
SRF 2. Lack of nonmedical transportation	Lack of transportation to nonmedical activities, such as for work

Common SRF Screening Tools

States must decide the degree of *standardization* to implement within their screening requirements. A highly standardized approach could include mandating the use of a preexisting screening tool or a subset of screening questions from a preexisting tool. Alternative approaches include creating a state-specific tool that must be used as *North Carolina* did,[31] or to specify domains that must be screened and allow the screening entity to choose or develop its screening tool, like *Massachusetts*.[32]

Screening tools vary in their psychometric and pragmatic properties. Psychometric properties (e.g., reliability and validity) enable screening tools to accurately identify SRFs, whereas pragmatic properties (e.g., cost, language, training to administer, and length) assess the appropriateness of the tool and the ease of administration. Ideally, an SRF screening tool would have both strong psychometric and pragmatic properties. Many of the common screening tools have strong pragmatic properties yet have been subject to minimal psychometric assessment, thereby limiting certainty that these tools accurately and precisely measure social risk factors.[33] Reliability and validity further decrease if individual screening questions are "mixed and matched" between screening tools, or if the wording of questions is altered.[34]

Screening tools further vary in the number of domains included, which domains are included, translation options, the population for which they were designed, and reading level. Screening tools may include core (i.e., mandatory) domains and optional (i.e., supplemental) domains. Optional domains commonly include questions on health, behaviors, or demographic information. Examples include questions on substance use, physical activity, refugee status, and mental health. Characteristics of the three tools highlighted below and additional common tools are profiled in the Social Interventions Research & Evaluations Network's Comprehensive Screening Tool Comparison.[35]

Three common tools include:

Accountable Health Communities Health-Related Social Needs (AHC HRSN): AHC HRSN was developed by the Centers for Medicare & Medicaid Services Center for Medicare and Medicaid Innovation (CMMI) originally for the screening of social needs among individuals eligible for Medicare and Medicaid. The core domains included in AHC HRSN include housing, food, transportation, utilities, and interpersonal violence, along with eight supplemental domains.[36]

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE): PRAPARE was developed by the National Association of Community Health Centers. The core domains included within PRAPARE are housing, education, employment, transportation, food, financial strain, and social support. PRAPARE also includes questions on incarceration and safety as supplemental domains. The questionnaire has been translated into twenty-six languages and comes with a companion implementation toolkit.[37]

Health Leads' Social Needs Screening Tool: Health Leads developed a 10-question screening tool available in English and Spanish. Core domains include food, housing, financial strain, transportation, and safety, with supplemental domains that include education, employment, and social support. Health Leads' Social Needs Screening Tool is available with an implementation toolkit that is updated annually.[38]

Research suggests that patients who are screened for SRFs by providers believe screening is important, particularly when screening is conducted in a compassionate and patient-centered manner. Screening alerts a patient's care team to the presence of any SRFs, thereby helping patients to feel "cared for" by their clinician.[39] Although surveys have shown that patients trust physicians more than insurers,[40] no comparison studies have assessed patient acceptability of SRF screening when conducted by MCO staff rather than health care teams. If MCOs conduct SRF screenings, strengthening data-sharing and communication mechanisms between MCOs and providers may better enable screening results to be used for clinical decision-making.

After screening for SRFs, Medicaid agencies and their Medicaid managed care plans should identify if members would like assistance addressing their SRF(s) and, if a member screens positive for multiple SRFs, which to prioritize. Allowing members to decide if their SRF is addressed supports shared decision-making and confirms that the SRF is, in the eyes of the member, an actual social need.[41]

Conclusion

As discussed above, because there is not yet sufficient research evidence demonstrating that the currently available SRF screening tools accurately and precisely measure SRFs, it is important to be mindful of the limitations of these tools and the implications for the quality of the data collected using them. Evidence on the value of SRF screening and interventions for improving health status, advancing health equity, and slowing the rise in health care costs is gradually emerging. It is therefore important that states build in evaluation opportunities on effectiveness and implementation. This can inform necessary program improvements and help share promising practices with other states.

States should also consider measuring MCO performance for the delivery of SRF screens through employing a screening rate measure.[42] This topic is explored further in the State Health and Value Strategies brief *Developing a Social Risk Factor Screening Measure* authored by Bailit Health.

While this brief has focused on SRF screening, states should be mindful of the steps that must follow screening and likewise engage in thoughtful consideration of how to develop MCO expectations for SRF mitigation.

Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

ABOUT BAILIT HEALTH

This brief was prepared by Rachel Isaacson and Michael Bailit. Bailit Health is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see *www.bailit-health.com*.

ACKNOWLEDGMENTS

The authors thank Laura Gottlieb, Sally Mabon, and Tara Oakman for reviewing and offering insightful feedback on this brief.

Endnotes

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