Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

November 7, 2023

The Honorable Guy Guzzone
Chair, Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes
Chair, House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2023 Joint Chairmen's Report (p. 125) - Report on a Closed-Loop Referral Platform for Medicaid and Maryland Children's Health Program Participants' Health-Related Social Needs

Dear Chairs Guzzone and Barnes:

Pursuant to the requirements of the 2023 Joint Chairmen's Report (p. 125), the Maryland Department of Health (MDH) submits this report on current referral services within existing platforms and resources and the feasibility of developing a closed-loop referral platform with capabilities to connect Medicaid and Maryland Children's Health Program participants with community based organizations that will help address health-related social needs.

Background

Maryland Medicaid has several initiatives aimed at addressing the significant, complex health needs of its members by improving their health-related social needs (HRSN). HRSN are an individual's unmet, adverse social conditions that contribute to poor health. These needs–including food insecurity, housing instability, unemployment, and lack of reliable transportation–can drive health disparities across demographic groups. Improving HRSN can have a significant influence on health care utilization and cost, health disparities, and health outcomes.[1]

An individual's HRSN are a result of their community's underlying social drivers of health (SDOH), the conditions in which they are born, grow, work, live, and age, as well as the wider set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.[2]

A closed-loop referral system (CLRS) is an IT solution integrated across organizations that allows health plans and providers to identify the HRSN of an individual, refer them to appropriate and available community-based organizations (CBOs), and receive confirmation

[1] Center for Medicaid and Medicare Services, "Addressing Health-Related Social Needs in Section 1115 Demonstrations." December 6, 2022
https://www.medicaid.gov/medicaid/downloads/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf
[2] Ibid.

when that individual has been helped, all in one platform. For Medicaid participants, a managed care organization (MCO) may serve in the role of a health plan.

The integrated nature of a CLRS allows for efficient and effective connections for participants with HRSN to have their needs met. However, they require significant infrastructure and technology investment for each entity involved. This is especially true for CBOs, who often need additional HIPAA-compliant technology, increased cybersecurity and legal agreements to become part of a CLRS. Additionally, CLRS do not function unless the partner CBOs are able to accept and serve increased referrals on demand. Many CBOs are small and grant-funded, and have limited capacity to scale their services without better financing mechanisms. Several existing CLRS vendors offer technical assistance to CBOs in their network for this reason.

Medicaid CLRS Across the Country

State Medicaid agencies have started to implement CLRS across the country, which, as noted above, has required significant resources to engage CBOs. Arizona and Rhode Island's state Medicaid agencies both implemented statewide CLRS for their participants in 2021. In Arizona, the Medicaid agency partnered with their Health Information Exchange (HIE) and state 211 system. The State used additional tax income from its recently-legalized marijuana industry to select a CLRS vendor and give grants to CBOs to invest in the technology and infrastructure required for a CLRS. Rhode Island implemented the CLRS within its Accountable Entity framework, their version of an Accountable Care Organization. Part of the vendor's contract, over $1 million a year, is providing significant outreach and technical assistance to CBOs who wanted to join the network.

The state of North Carolina implemented the first statewide coordinated care network for all of its residents, NCCARE360, regardless of source of health coverage in 2020. Residents can submit self-referrals through the state's 211 system, or they can be referred by their Local Health Department. North Carolina has worked with federal and private partners to offer grants to support CBOs joining the NCCARE360 system.

However, there are some states that are cautious about implementing a CLRS. Michigan's Department of Health and Human Services recently released a report that concluded there were 'few precedents for success so far' and 'signs of underperformance' for CLRS across the country.[3] Concerns included the cost of development, difficulty in engaging and partnering with CBOs, inherent errors in data matching across systems, and the importance of anonymity for some social services, like domestic violence shelters.

Nationally, there is focus on measuring rates of HSRN screenings. The National Committee for Quality Assurance (NCQA) added a new Healthcare Effectiveness Data and Information Set (HEDIS) measure in 2023 called Social Need Screening and Intervention, which targets unmet food, housing and transportation needs. Starting in 2024, CMS will mandate that hospitals submit two screening HSRN measures as a part of reporting to the Inpatient Quality Reporting

[3] Michigan Department of Health and Human Services, "Michigan Community Information Exchange (CIE) Task Force Final Report." August 2023. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Policy-and-Planning/Social-Determinants-of-Health-Strategy/CIE/CIE-TF-Final-Report-FINAL-08092023.pdf

(IQR) program. While CMS does not mandate a specific screening tool to be used, it recommends the Accountable Health Communities (AHC) Screening Tool, and requires that any screening tool used must ask about housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety. There are a number of HRSN screening tools available and in use by MCOs and providers, such as federally-qualified health centers.

Current HRSN and CLRS Work in Maryland

MDH has had continued conversations with MCOs participating in the Maryland Medicaid program about HRSN. Each of the nine MCOs have strategies to identify and address their members' HRSN. All MCOs have referral processes for members to resources for any unmet needs. Many MCOs actively collaborate with CBOs, and offer navigation assistance through case management for these resources. MCOs also have specific procedures to address HRSN for special needs populations, such as pregnant people, individuals with a disability and/or HIV, and children with special needs.

Several MCOs have already contracted with different CLRS vendors to connect their participants to resources, at least one as a part of a contract with their national organization. MDH's discussions with the MCOs revealed that, with regard to standardization across the Medicaid program, the MCOs agree that requiring screening for a set of HRSN domains (*e.g.*, food, transportation, housing) should be pursued at a minimum. They believe that there are benefits to adopting a state-wide standardized CLRS platform. At a minimum, there is consensus that the state should require any CLRS vendor that a MCO chooses to integrate with CRISP, the state-designated health information exchange (HIE), to foster uniformity and increase efficiencies for the participating CBOs, as well as for referring providers. In 2024, MDH and the MCOs are committed to working on a coordinated HRSN screening and referral strategy.

CRISP has also built and piloted an electronic referral tool that enables hospitals and other healthcare entities to refer to community-based organizations, and receive information back. CRISP does have the capability of receiving data from outside systems, such as other governmental agencies and HRSN referral platforms. By way of example, CRISP has worked with MDH and Maryland 211 to create a directory of resources that can be used in the platform to make referrals. CRISP can gather and report on referral information from established social care provider systems (*e.g.*, CBOs, governmental agencies), HRSN referral platforms (*e.g.*, Unite Us, Find Help) as well as within CRISP's CLRS.

The Maryland Primary Care Program (MDPCP) provides funding and support for the delivery of advanced primary care for Medicare participants. Since January 2022, MDPCP has been implementing CMS' Health Equity Advancement Resource and Transformation (HEART) payments, which can be used to reimburse for HSRN referrals and services. As part of this work, MDPCP has worked with CRISP to build out its resource directory. Specifically, Maryland 211 delivers data in its resource directory to CRISP via an Application Program Interface (API), meaning the connection is maintained on an ongoing basis. As a result, additional practices are screening and referring their patients to CBOs.

Feasibility of Developing a Statewide Closed-Loop Referral Platform

The key considerations for MDH in potentially building a statewide CLRS are numerous, including data flow, the architecture of the system, who maintains the platform, the governance of the data, and the funding streams that would be used to support the costs. While CRISP does have a pilot CLRS, in the context of many other existing CLRS, CRISP prioritizes interoperability over allocating resources to onboard the vast network of CBOs at the scale needed to incorporate them on an intensive, statewide level. CRISP does provide the platform and interoperability to work with any CLRS to show where referrals are being sent and the status of those referrals.

Many MCOs have already invested resources into their own CLRS. It would take time, effort and investment for these MCOs to switch to a new system.

In consideration of these factors, MDH recommends the following approaches:

- *Identify a uniform screening tool:* Work with the MCOs to select a common HRSN screening tool and require the MCOs to submit their screening data to CRISP; and
- *Share referral data:* For MCOs that utilize a CLRS outside of CRISP, require the MCOs to share HRSN referral data with CRISP.

These options, which may be pursued separately or in tandem, recognize CRISP's prioritization of interoperability, as well as the MCOs' autonomy to innovate in developing and implementing HRSN referral pathways. The use of a common screening tool would aid in the predictability and standardization of the screening results across the MCOs. This would result in the data from the nine MCOs aggregated in CRISP, which could then be used to easily analyze and report on it. The addition of referral data would allow CRISP users, such as provider practices, to view HRSN information in a single system and provide support to their patients as needed. MDH will hold further discussions with the MCOs to develop and implement a phased approach.

If you have any comments or questions about this subject, please contact Megan Peters, Acting Director of Governmental Affairs, at megan.peters@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

cc: Marie Grant, Assistant Secretary for Health Policy
Ryan Moran, Deputy Secretary, Health Care Financing and Medicaid
Megan Peters, Acting Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies), MSAR # 14327