Opportunities to Address the Non-Medical Drivers of Health in Texas:

A Review of Food, Community Health Worker and Non-Medical Perinatal Interventions, and Alternative Payment Models

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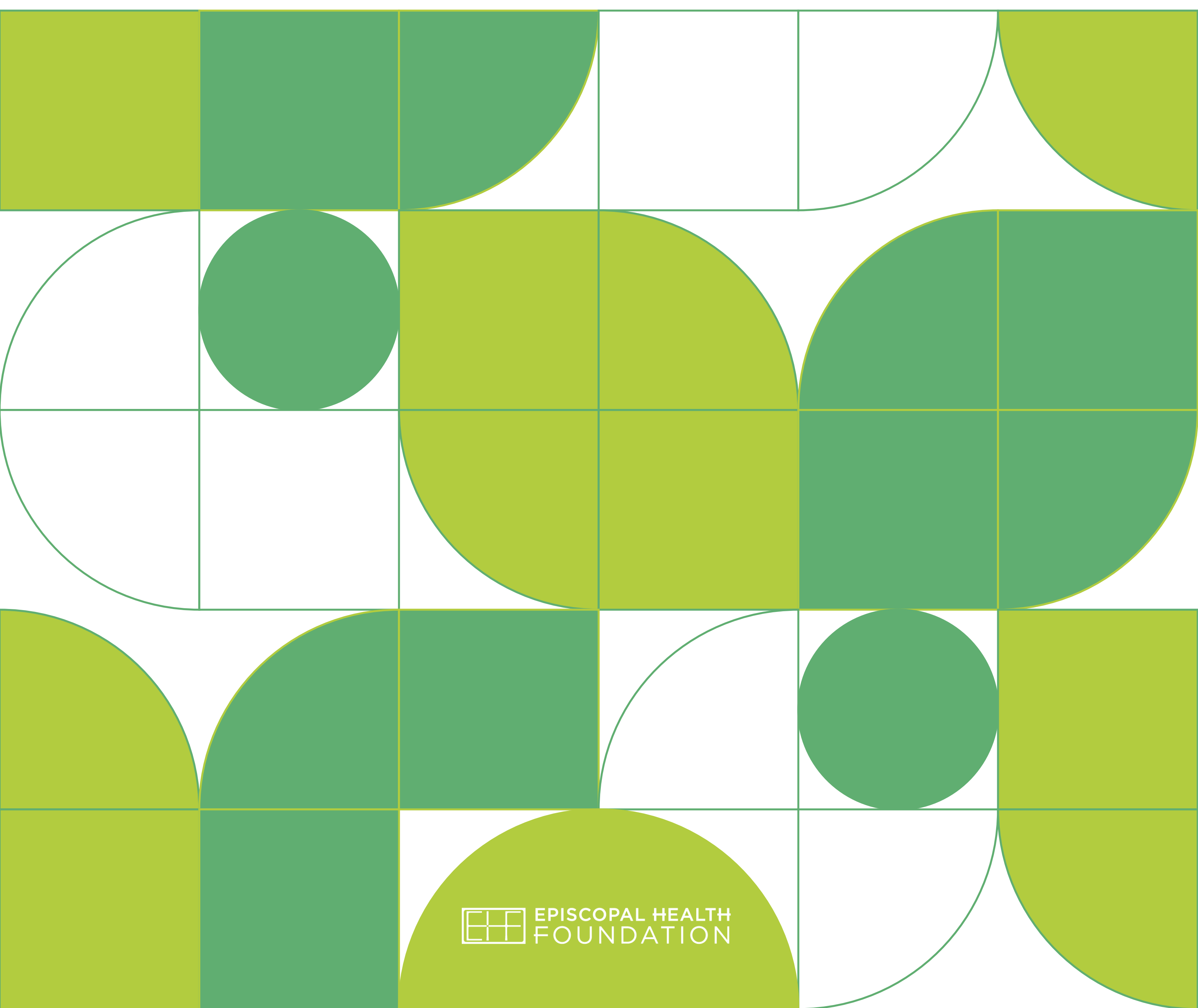

Opportunities to Address the Non-Medical Drivers of Health in Texas:

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About the Authors

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About this Report

With support from the Texas Consortium for the Non-Medical Drivers of Health, hosted by the Baker Institute for Public Policy at Rice University and the Episcopal Health Foundation, the Center for Health Care Strategies developed this report to summarize evidence and implementation options for food interventions and community health worker programs, NMDOH perinatal programs, and alternative payments options to support these efforts. Thie report provides additional background and context for the Texas Value-Based Payment & Quality Improvement Advisory Committee's recommendations for the 89th Legislature.

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Introduction

Non-medical drivers of health (NMDOH) are the environmental factors in which people live, work, play, and age that impact health and well-being.[1] In Texas, non-medical factors such as physical infrastructure (e.g., clean air, safe housing) and economic environment (e.g., income level, educational attainment) have a significant impact on health outcomes for children, adolescents, and pregnant women, as measured by standard Children's Health Insurance Program (CHIP) and Medicaid quality metrics.[2]

Texas continues to make strides in addressing NMDOH. With support from the Episcopal Health Foundation, since 2019 the Texas Health and Human Services Commission (HHSC), Texas Association of Health Plans, Texas Association of Community Health Plans, and the Center for Health Care Strategies have convened the *Managed Care Organization (MCO) NMDOH Learning Collaborative*. The purpose of the learning collaborative is to promote effective strategies for addressing the non-medical needs of Medicaid beneficiaries and support the development and implementation of interventions to address NMDOH. Further, the learning collaborative provides critical input to HHSC with the development of NMDOH program and policy decisions. In 2023, the Texas Consortium for the Non-Medical Drivers of Health was established to bring together researchers, practitioners, and policymakers across the state to advance the incorporation of non-medical services into the health care delivery system in all state-supported health care programs.

In 2023, building on work by the learning collaborative, HHSC released the Non-Medical Drivers of Health Action Plan, a multi-pronged strategy and set of guiding priorities to drive NMDOH activities among MCOs and Medicaid providers, as well as other health care ecosystem stakeholders. The key NMDOH areas outlined in the Action Plan include food insecurity, housing, and transportation. The learning collaborative members also provided key inputs to HB 1575, signed by Governor Abbott in 2023, which requires HHSC to develop standardized screening questions related to non-medical needs and allows community health workers (CHWs) and doulas to become billable provider types under case management for Star Medicaid, HHSC's children and pregnant women's program.

HHSC also convenes the Value-Based Payment and Quality Improvement NMDOH Subcommittee, a part of the legislatively mandated Value-Based Payment and Quality Improvement Advisory Committee, to encourage and support the adoption of cost-effective NMDOH interventions and delivery system approaches.

Additional opportunities to further Texas' NMDOH work include new flexibilities announced by the Centers for Medicare & Medicaid Services (CMS) in the past year for state options to cover NMDOH services.[3,4] CMS' informational bulletin details 15 interventions and four pathways for federal approval, including opportunities related to nutrition services and housing. Relevant authorities include: (1) in lieu of services (ILOS), optional services provided by MCOs with special recognition in capitation rate development; (2) home- and community-based services (HCBS) programs, including Money Follows the Person; (3) Section 1115 demonstrations; and (4) CHIP health services initiatives (HSIs).[5]

About this Report

To support the NMDOH Subcommittee's forthcoming recommendations to the 89th Legislature, the Texas Consortium for the Non-Medical Drivers of Health commissioned the Center for Health Care Strategies to develop this report, which presents state examples of MCO-led interventions related to: (1) **food and nutrition**; (2) **CHW services**; and (3) NMDOH **case management for pregnant women**, including social risk

factor screening. It also outlines recommendations for HHSC to consider for **alternative payment models** (APMs) and coverage options to pay for and provide these NMDOH approaches.

Nutrition Services

According to Feeding Texas, five million Texans are food insecure.[6] The Supplemental Nutrition and Access Program (SNAP), which provides assistance to families in need to purchase food, significantly reduces food insecurity among low-income households.[7] Connecting community members to SNAP — including through application assistance provided by community-based organizations (CBOs), providers, and MCOs — is associated with reduced rates of poverty and health care expenditures, particularly among individuals with diet-sensitive chronic conditions, such as diabetes and heart disease.[8] Among older adults, SNAP enrollment is associated with fewer hospital and long-term care admissions and emergency department visits, resulting in an estimated Medicaid cost-savings of $2,360 per person annually.[9]

For vulnerable and medically fragile populations, directed delivery of food and nutrition services has been shown to improve health outcomes. For example, Healthy Food Rx, a California initiative that aims to increase access to fresh fruits and vegetables and other seasonal foods, has demonstrated improved health outcomes for diabetic members enrolled in the program.[10] Over a 12-month period, patients with diabetes reported improved Hemoglobin A1C levels; decreased food insecurity; improved diet quality; and improved healthy behaviors (i.e., doing more physical activity, following a diabetic meal plan).

Coverage of Nutrition Services

In 2023, CMS released guidance on Medicaid coverage pathways for the following nutrition interventions:

1. ***Case management services for access to food/nutrition***, including, for example:
   - Outreach and education
   - Linkages to state and federal benefit programs, benefit program application assistance, and linkages to application fees
2. ***Nutrition counseling and instruction***, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including:
   - Guidance on selecting healthy food
   - Healthy meal preparation
3. ***Home-delivered meals or pantry stocking***, tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions, and/or for children or pregnant women, including, for example:
   - Medically tailored meals to high-risk expectant individuals at risk of or diagnosed with diabetes
4. ***Nutrition prescriptions***, tailored to health risk, certain nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example:
   - Fruit and vegetable "prescriptions"
   - Protein boxes
   - Food pharmacies
   - Healthy food vouchers
5. ***Grocery provisions***, for high-risk people to avoid unnecessary acute care admission/institutionalization.

State Examples: Coverage of Nutrition Interventions

Approach	State Example
HCBS	***Texas***. Adults with serious mental illness receive home-delivered meals under the HCBS Adult Mental Health program, approved as a 1915(i) state plan HCBS.
ILOS	***New York.*** Home-delivered medically tailored meals are available to individuals 18 years or older, living with severe illness through a referral from a medical professional or health care plan. Eligibility criteria includes diagnoses related to cancer, diabetes, heart failure, and/or HIV/AIDS, or limitations in ability to perform activities of daily living. *July 2023 New York State guidance.*
1115 Demonstration	***New Jersey.*** New Jersey's demonstration includes: 1. Nutrition counseling and education for managed long-term services and supports (MLTSS) members. 2. Medically indicated home-delivered meals to expectant individuals at risk of or diagnosed with diabetes. 3. One-time transition costs including pantry stocking for any MLTSS-eligible beneficiary who is transitioning from an institution. 4. Short-term (no more than 30 days) grocery provision for an MLTSS beneficiary aimed at avoiding an unnecessary emergency department visit, hospital admission, or institutional placement.
1115 Demonstration	***North Carolina.*** Through its Healthy Opportunities Pilot program, North Carolina covers a number of nutrition interventions, including: food support services (e.g., helping individuals with SNAP and WIC applications), fruit and vegetable prescriptions, home-delivered or pick-up healthy meals, and the Diabetes Prevention Program. Eligible individuals include pregnant women and children with one or more risk factors.
Benefit/Medical Policy Change	***Nevada.*** Nevada provides Medical Nutrition Therapy as a covered benefit for recipients diagnosed with diabetes, obesity, heart disease and hypertension. Services are provided by a registered dietician.
1115 Demonstration	***New York*** and ***Massachusetts*** both have approval to provide nutrition counseling and education, home delivered meals (3 meals/day, up to 6 months) and nutrition prescriptions. Both states have approval to provide additional meal/nutrition support for a *household* with a high-risk child or pregnant women.

Managed Care and VBP Investments in Nutrition Interventions

Texas HHSC can encourage, incentivize, or require MCOs or providers in value-based payment (VBP) arrangements to invest in CBOs specializing in food and nutrition.

State Examples: Managed Care and VBP Nutrition Promotion

Approach	State Example
Managed Care -- Community Reinvestment	***Arizona.*** MCOs are contractually required to reinvest six percent of profits into CBOs, including those that provide nutrition interventions. MCOs are required to obtain community input on local and regional needs prior to undertaking improvement activities. The state's Community Reinvestment Template provides an example of investment in "Valley Food Trucks," with a suggested outcome metric of decreased reported food insecurity among members.
Managed Care -- Population Health Management and Quality Improvement Requirements	***Ohio.*** MCOs are contractually required to partner with CBOs and help develop "solutions addressing [social determinants of health]-related needs, such as lack of access to nutritious food (food insecurity, food deserts, and food swamps)." In addition, plans must coordinate with other plans in their region to tackle discrete quality improvement goals and shared community priorities.
Voluntary Contributions to Health-Related Resources	**North Carolina.** Prepaid health plans (PHPs), the state's MCOs, are encouraged to contribute to non-medical services that improve health outcomes and cost-effective delivery of care in the communities they serve. PHPs that voluntarily contribute to health-related resources may count the contributions in the numerator of their medical loss ratio (if plan does not meet 88% medical loss ratio threshold). MCOs receive auto-assignment preference for contributions of 0.1% of capitation revenue or more.
Performance Penalties	**New Mexico.** If MCOs do not meet delivery system improvement performance targets (historically tied to CHW uptake; yet, now tied to non-emergency medical transportation and VBP indicators), the state may direct the MCO to expend any portion of monetary penalties for provider network development or other program enhancements that will directly benefit Medicaid members.
Managed Care – Value-Added Services	***Florida.*** MCOs can provide food assistance as expanded benefits under the Pathways to Prosperity Program, including supports for pregnant enrollees and enrollees raising infants and toddlers (i.e., children under two years old). While expanded benefits typically do not impact Florida's rates, the state's most recent request for proposals noted it is considering a modification to the traditional 2% margin for rates, based on expanded benefit experience. Respondents proposed expanded benefits and anticipated per member, per month (PMPM) cost.
Managed Care – VBP	***Minnesota.*** Integrated Health Partnerships (IHPs) — health care service providers — participate in an alternative payment model that includes a population-based payment, adjusted for both social risks and performance on targeted interventions to reduce health disparities among attributed patients. IHP-selected health equity measures often include food insecurity projects. For example, the state health equity measure template includes the following example: "To address barriers that have a negative impact on health, specifically food insecurity, the IHP will screen the IHP population for food insecurity and connect individuals in need with community resources to help meet those needs."

CHIP HSI for Nutrition Programs

The State Children's Health Insurance Program (CHIP) allows states to use a limited amount of CHIP funds implement health services initiatives (HSIs) focused on improving the health of eligible children.[11] Some of these HSIs address an ongoing need for the community generally, others are more focused on targeted populations or address acute public health issues. Examples of nutrition programs include the Hunger Prevention and Nutrition Assistance program; the Women, Infants and Children (WIC) program; and school health services and breakfast programs.[12]

Texas HHSC can use a CHIP HSI to increase funding for existing nutrition programs for low-income children.

State Examples: CHIP HSI

Approach	State Example
CHIP HSI	***New York*.** The state's CHIP HSI included the Hunger Prevention and Nutrition Assistance Program that provides funding for regional food banks and 38 direct service providers statewide. Through these contracts, approximately 240 million emergency meals are provided each year throughout the state. The program works with an established network of more than 2,500 Emergency Food Programs, including food banks, food pantries and soup kitchens, to leverage private and public partnerships.

Community Health Worker Services

CHWs are frontline workers who provide a range of services addressing the health and non-medical needs of their clients, including culturally appropriate health promotion and education, assistance in accessing medical and non-medical services, translation services, care coordination, and social support.[13] CHWs are trusted members of the communities in which they reside and can facilitate connections and greater trust with Medicaid programs and area health care systems.[14] They are typically members of communities that are underrepresented in health care settings. Increasingly, Medicaid programs recognize the value that CHWs can play in reducing health disparities, improving health outcomes for underserved communities and potentially reducing health care costs.[15] According to the Kaiser Family Foundation, 29 of 48 states recently surveyed reported allowing Medicaid payment for services provided by CHWs, using coverage approaches such as state plan amendments, integrating CHWs into Medicaid Health Homes, Section 1115 demonstration waivers, and CHW services provided by MCOs.[16] MCO arrangements include requiring CHW services in MCO contracts or delivering CHW services as a "value-added" service.

Following are examples of state MCO activity to cover CHW services through a variety of vehicles.

Coverage of CHW Services

Texas HHSC can cover CHW services as a benefit or ILOS.

State Examples: CHW Coverage

Approach	State Example
State Plan Amendment	***Louisiana.*** The state's CHW services state plan amendment includes assessment and screening for health-related social needs (HRSN) and "care planning with the beneficiary and their healthcare team as part of a person-centered approach to improve health by meeting a needs and [HRSN], including time-limited episodes of instability and ongoing secondary and tertiary prevention."
Benefit/Medical Policy Change	***Colorado.*** Medicaid covers "Medicare crossover codes" G0019, G0022, and G0136. These new community health integration and social determinants of health risk assessment codes, formalized in the FY 2024 Medicare physician fee schedule, can be used to support care teams in which a CHW screens for social needs and facilitates access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address social needs.
ILOS	***Oregon.*** The state covers CHW services as a state plan benefit, and also allows coordinated care organizations to provide CHW services *in alternate settings* as an ILOS. For example, ILOS authority allows for evaluation and management of a member in community settings, including by social service agencies that may or may not be able to independently bill for services. Services include: providing preventive medicine counseling and/or risk factor reduction, skills training and development, and comprehensive community support services. Eligible populations include: children and adults with chronic conditions, behavioral health conditions, and/or HRSN (such as homelessness) that exacerbate or prevent effective treatments. Cost and utilization of ILOS can be used to develop rates.

Investments of Flexible Funds in CHWs

Texas HHSC can encourage, incentivize, or require MCOs or providers in VBP arrangements to expand access to CHWs and related non-medical needs interventions.

State Examples: Using Flexible Funds to Support CHW Services

Approach	State Example
Managed Care -- Population Health Management	***Michigan.*** Per 2021 contracts, MCO must, "to the extent applicable, support the design and implementation of CHW interventions delivered by [CBOs] 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." MCOs must maintain and provide or arrange for at least one full-time CHW per 5,000 enrollees. The state now covers CHW services, continues to promote CHW integration through its Social Determinants of Health Framework, and has launched MIHealthyLife contracts with related NMDOH priorities.
Managed Care -- Delegated Care Coordination	***New Mexico.*** MCOs are contractually required to expand the availability and use of CHWs to perform care coordination activities. MCOs can use two models: the Full Delegation Model and Shared Functions Model of Care Coordination. These delegated models are supported by VBP models. In addition, MCOs must delegate care coordination to any primary care clinic that is in a fully capitated arrangement, pending a future Primary Care Council primary care payment model. See the contract.
1115 Demonstration – Managed Care Pilot Program	***New Jersey.*** The state may claim as allowable expenditures up to $5 million for each demonstration year to establish a CHW Pilot program. Specific funded initiatives would be proposed and operationalized by the state's contracted MCOs and approved by the state. Proposals must target Medicaid or CHIP beneficiaries enrolled in the MCO who have been diagnosed with or are at risk for a specific chronic condition, such as asthma, diabetes, depression, or HIV. Payment to MCOs would be made outside of capitation rates.
FQHC Alternative Payment Model	***Oregon.*** The state's Advanced Payment and Advanced Care Model converts fee-for-service Medicaid reimbursement for health centers into a PMPM payment. The model has historically been used to expand access to care teams with CHWs, and recognize alternative encounters or touches like outreach and referral to HRSN services. See 2017 case study.
1115 Demonstration -- VBP & Investments	***Rhode Island.*** As part of certification requirements, the state's Medicaid accountable care organizations ("Accountable Entities") must demonstrate collaboration with community health teams and CHWs as integral partners, as well as collaboration with social service organizations. Ten percent of incentive funds (authorized via an 1115 demonstration) must be allocated to provide specialized services to support behavioral health care, substance use treatment, and/or social determinants.

Approach	State Example
Managed Care – Directed Payment/VBP	***Pennsylvania.*** Maternity care bundled payment model includes care team requirements, including the following: "at least one individual, such as a doula, [CHW], social worker, or peer recovery specialist, to coordinate the care of the pregnant woman to address other needs, including behavioral health, substance use disorder, and Social Determinants of Health." See contract language.
Managed Care – Directed Payment Program	***California.*** Equity and Practice Transformation directed payment program prepares primary care, pediatric, OB/GYN, and behavioral health providers for participation in VBP models. Potential activities include developing processes for social risk factor screening and related interventions, as well as adoption of evidence-based models of care (e.g., Centering Pregnancy, Dyadic Care, and Project Dulce). The program is paired with a managed care incentive program for initial planning efforts.

Non-Medical Drivers of Health Case Management for Pregnant Women

In an effort to improve maternal and child health outcomes, states are increasingly seeking to use Medicaid to cover NMDOH services and supports for pregnant and postpartum women and their children, including through ILOS, HCBS waivers, Medicaid section 1115 demonstrations and CHIP HSIs.[17] Following are state examples of expanded HRSN case management for pregnant women and their families.

Enhance HB 1575 Services

Texas HHSC can formally cover expanded HRSN case management services or other supportive services for pregnant women and their families.

State Examples: NMDOH Case Management Benefits for Pregnant Women and Other Supportive Services

Approach	State Example
Managed Care – Benefit	***Florida.*** Florida's 1115 demonstration has historically included two Healthy Start outreach and case management programs covered under Medicaid managed care, MomCare and Healthy Start Coordinated System of Care. The MomCare component is a mandatory benefit and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care, Healthy Start prenatal risk screening, and WIC services. MomCare assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources. Healthy Start Coordinated System of Care includes outreach and case management services for eligible pregnant women and children identified as at risk through the Healthy Start program. These services are voluntary and are available for all Medicaid pregnant women and children up to age three who are identified to be at risk for a poor birth outcome, poor health, and/or poor developmental outcomes. The services may include nutritional counseling.
CHIP HSI	***Wisconsin.*** Wisconsin has used CHIP HSIs to cover: (1) housing supports for children 18 and younger and women who are pregnant who have low income and do not have housing; and (2) Asthma Care Program for children and pregnant women enrolled in or eligible for Medicaid, including: case management, in-home education, environmental assessment, provision of durable medical equipment, and acute environmental hazard remediation, totaling no more than $5,000.

Advance Community-Based Care Management

Texas HHSC can require or incentivize plans to make investments in community-based NMDOH care management approaches.

State Examples: Community-Based Care Management for Pregnant Women

<table>
<tr><th>Approach</th><th>State Example</th></tr>
<tr><td>Managed Care – Population Health Management Requirements</td><td>Ohio. Members who are pregnant or capable of becoming pregnant who reside in a community served by a qualified community hub (e.g., a Pathways community HUB) may be recommended to receive HUB pathway services. For these members, the MCO at a minimum must provide for the delivery of the following services by a certified CHW or public health nurse, who is employed, or works under contract with, a qualified community hub:
(1) CHW services or services provided by a public health nurse to promote the member's healthy pregnancy; and
(2) Care coordination to help the member connect with employment and educational/training, housing, educational, social, or medically necessary physical and behavioral health services.

Costs associated with HUB contracting requirements are embedded in rates as non-benefit costs under delivery “kick payments.” MCO kick payments, also known as supplemental payments, are one-time payments made to MCOs in addition to the capitated rate. These payments are triggered by a specific event, such as a delivery, and are intended to offset costs that are difficult to predict. See managed care contracts, effective January 2024.</td></tr>
<tr><td>Managed Care – Community-Based Care Management</td><td>Pennsylvania. The HealthChoices Physical Health MCO (PH-MCO) must propose community-based care management (CBCM) activities and funding focused on partnerships with CBOs, hospital/health systems, and providers integrating a holistic approach to patient care and education to, among other goals: (1) assess, refer and mitigate social determinants of health; (2) promote maternal, infant and early childhood assessment, education and referral including expansion and capacity building of existing home visiting programs; and (3) reduce health disparities. The state makes payments for the CBCM program as part of each PMPM base capitation rate. The PH-MCO must spend at least $0.75 PMPM from each base capitation rate after risk adjustment for their approved CBCM program. See contract language.</td></tr>
<tr><td>Managed Care – Withhold/Incentive Payment</td><td>Pennsylvania. The PH-MCO is eligible for a Maternal Home Visiting Performance payout for meeting a set of performance goals.
• Tier 1 – Greater than 6 home visits and 8-10 EPSDT visits: 100% of the relevant incentive pool
• Tier 2 – Between 4-5 home visits and 6-7 EPSDT visits: 20% of the relevant incentive pool
• Tier 3 - Less than 4 home visits: No payout</td></tr>
</table>

Approach	State Example
Managed Care – Withhold/Incentive Arrangement	***Ohio.*** MCOs receive quality withhold payouts contingent on work related to the following quality goals: (1) improving outcomes for members with diabetes; and (2) improving birth/infant outcomes. Expected strategies include work to address HRSN, in collaboration with community entities and providers. MCOs must collaborate with other Medicaid and non-Medicaid health plans for collective impact. See managed care contracts, effective January 2024.
Managed Care – VBP or Directed Payment	***Pennsylvania.*** As part of the Maternity Care Bundled Payment Model, the MCO must develop a target payment that includes "all services provided during pregnancy episode: prenatal care, labor and delivery, care coordination services, and up to sixty days postpartum for the mother and newborn, other than contraceptive care." Quality measures include a health equity score and social risk factor screening measures. Participating providers must have a care team that includes a doula, social worker, peer recovery specialist, or CHW. See contract language.
VBP	***CMS Innovation Center.*** The Transforming Maternal Health model is a state-based model, in which Medicaid agencies serve as model awardees. The model will support relationship building and education to help participating states address barriers that limit access to midwives, doulas, and perinatal CHWs (a focus of HB 1575). The payment model includes technical assistance, infrastructure payments, performance incentive payments, and a VBP roadmap. Technical assistance includes support to link Medicaid data with records and data-matching across social service and benefit programs, like WIC/SNAP and Medicaid, to address cross-program enrollment gaps (a component of Texas' NMDOH Action Plan).

Value-Based Payment and Quality Improvement NMDOH Subcommittee Recommendations

Following are the draft recommendations for Texas HHSC's consideration set forth by the Value-Based Payment and Quality Improvement NMDOH Subcommittee.

Recommendation 1: Leverage Regulatory Tools to Realize NMDOH Action Plan Goals

HHSC should use the various Medicaid authorities and/or regulatory tools to strengthen cross-sector partnerships between MCOs, health care providers, and social service organizations to address beneficiaries' NMDOH. HHSC should focus on the three priorities (food, transportation, and housing) identified in the Medicaid and CHIP Services NMDOH Action Plan. Regulatory tools include, but are not limited to, ILOS, experience rebates, quality improvement cost, and APMs.

Recommendation 2: Identify Strategies to Increase Enrollment in Food Benefits Programs

HHSC should identify strategies to increase enrollment of eligible Medicaid members in federal food benefit programs, such as SNAP and WIC to reduce food insecurity. For example, HHSC could provide Medicaid enrollees' SNAP and WIC enrollment status to MCOs to support targeted outreach and case management.

Recommendation 3: Assess Impact of HB 113 88(R)

HHSC should assess the impact of HB 113 88(R), which allows MCOs in STAR Medicaid to categorize services provided by CHWs as a quality improvement cost, instead of as an administrative expense. HHSC should provide a report to the Legislature by December 31, 2025, on the use of CHWs and quality improvement costs reported by each MCO. The report should describe how CHWs may have impacted each MCO's medical loss ratio, and how these reported costs can be used to develop capitation rates in the future (e.g., as a projected non-benefit cost, or to prepare for potential transition to a state plan benefit).

ENDNOTES

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