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How **Medicaid in Texas**  
Could Use *In Lieu of Services*  
to Address Non-Medical Drivers of Health:  
Three Potential Interventions and Related  
Evidence

 Center for  
Health Care Strategies

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# In Lieu of Services to Address Non-Medical Drivers of Health: Three Potential Interventions and Related Evidence for Texas

## About the Authors

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**Episcopal Health Foundation** supports solutions that address the underlying causes of poor health in Texas. To learn more, visit [www.episcopalhealth.org](http://www.episcopalhealth.org). The **Center for Health Care Strategies** is a national policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. To learn more, visit [www.chcs.org](http://www.chcs.org).



**About this Report:** With support from Episcopal Health Foundation, the Center for Health Care Strategies (CHCS) provided technical assistance and learning opportunities to the Value-Based Payment & Quality Improvement Advisory Committee from December 2021 to June 2022.<sup>1</sup> This report was created to summarize evidence and implementation options. It provides additional background and context for the Value-Based Payment and Quality Improvement Advisory Committee's Recommendations for the 88<sup>th</sup> Legislature in Texas.

## ■ Introduction

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Non-medical drivers of health (DOH) are the conditions in which people live, work, play, and age that influence their health. According to the World Health Organization, non-medical DOH can account for 30-55% of health outcomes.<sup>2</sup> A recent Texas-specific focus study found that non-medical factors such as physical infrastructure (e.g., clean air, safe housing) and economic environment (e.g., income level, educational attainment) have an influence on health outcomes, as measured by standard CHIP and Medicaid quality metrics.<sup>3</sup> Child and adolescent health outcomes are particularly sensitive to these DOH, and outcomes among pregnant women were also meaningfully associated with some non-medical factors.

Health care payers and providers in Texas and across the country have piloted DOH programs and interventions, with notable effects on health care cost, quality, and experience of care. However, limitations around Medicaid managed care rate setting and payment can limit the growth of these programs.

This report outlines how Texas could better support and sustain these DOH interventions and partnerships using *in lieu of services* authority, with a specific focus on three types of interventions: (1) asthma remediation, (2) Food is Medicine, and (3) services and supports designed to complement existing housing programs. The report includes evidence for each broad category of services, and specific populations that may particularly benefit from these interventions, including children, pregnant women, and people experiencing serious mental illness. It will also explore other options for Medicaid coverage and implementation considerations.

The Texas Value-Based Payment and Quality Improvement Advisory Committee has issued two recommendations relating to (1) approving *in lieu of services* that address non-medical DOH and (2) incenting MCOs to take up and expand access to these services. This report provides additional context and background for those recommendations. For more information, see the *Value-based Payment and Quality Improvement Advisory Committee's Recommendations for the 88<sup>th</sup> Legislature*.<sup>4</sup>

## ■ **In Lieu of Services**

Managed care organizations (MCOs) have the flexibility to provide services that are not formal Medicaid benefits. This flexibility has allowed MCOs to experiment with pilot programs that improve the quality and cost-effectiveness of their members' care. However, MCO payment rates do not typically fully reflect the cost and utilization of these pilot programs, which can discourage MCOs from offering them at a larger scale.

### **Federal Rule Regarding In Lieu of Services**

An MCO, Pre-Paid Inpatient Health Plan (PIHP), or Pre-paid Ambulatory Health Plan (PAHP) may cover, for enrollees, services or settings that are *in lieu of services* or settings covered under the State plan as follows:

- (i) The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan;
- (ii) The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting;
- (iii) The approved *in lieu of services* are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and
- (iv) The utilization and actual cost of *in lieu of services* is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

States can address this gap by categorizing certain services as "*in lieu of services*," a category defined in federal rule. This designation allows states to consider the cost and utilization of these services when setting rates for MCOs.

The use of ILOS is not new in Texas; in fact, the state is currently in the process of negotiating behavioral health ILOS with CMS.<sup>5</sup>

ILOS have typically been used to substitute one medical service for another (e.g., providing a prenatal home visit in place of an office visit for a high-risk pregnancy). Its application to non-medical DOH was theoretical and not widely implemented. Recent developments have shown that CMS is open to a broader definition of ILOS that includes covering evidence-based interventions addressing non-medical DOH like food and housing insecurity.

In 2022, California's Medicaid program gave its health plans the option to provide 14 Community Supports, including services such as medically supportive food and meals, housing-related services and supports, and asthma remediation.<sup>6</sup> CMS approved 12 of these Community Supports as ILOS; the remaining two Community Supports (short-term post-hospitalization housing and medical respite) were approved under the state's 1115 demonstration.<sup>7</sup> Every six months, MCOs can update their county-specific elections to provide additional ILOS.

California's approach stops short of making these interventions a covered benefit; a Medicaid enrollee



will only have access to the service if their plan elects to provide that service as an ILOS. However, California plans to explore making some services a covered benefit in the future, as local capacity to provide these services increases and more data is collected.

## **Forthcoming Federal Guidance**

Dan Tsai, Deputy Administrator and Director of the Center for Medicaid and CHIP Services, has shared that the Centers for Medicare and Medicaid Services (CMS) is excited about this new, broader view of ILOS and is planning to release detailed guidance to states who are interested in pursuing the use of ILOS to support interventions addressing non-medical DOH. Detailed guidance will explore how states can pursue the ILOS authority and what evidence is needed to support their request. This guidance would be based on CMS' approval of California's program. Key criteria for approval include that *in lieu of* services are:<sup>8</sup>

- Cost-effective when evaluated at the aggregate level;
- Evidence-based;
- A defined, clinically-oriented service that is linked to Medicaid's objectives; and
- Designed to serve a defined Medicaid population.

Based on this precedent-setting approval and upcoming guidance, states across the country, including Texas, can consider if and how to use the ILOS authority to support interventions designed to address non-medical DOH for Medicaid enrollees, and whether other options for Medicaid coverage (e.g., a state plan amendment authorizing a covered benefit, or a demonstration pilot program in certain geographic areas) may be more appropriate.

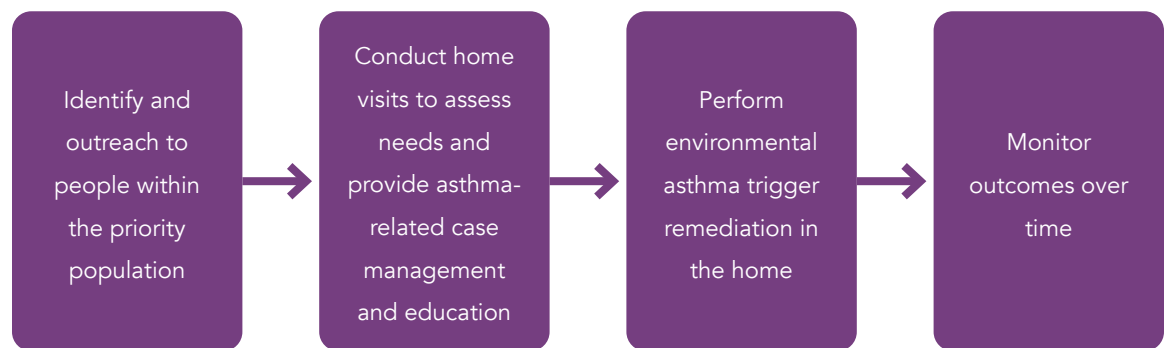
The following sections of this report explore three interventions designed to address non-medical DOH that CMS has previously authorized as ILOS, and were of particular interest to the Texas Value-Based Payment and Quality Improvement Advisory Committee: (1) asthma remediation, (2) medically supportive food and meals (including Food is Medicine interventions), and (3) services and supports designed to complement existing housing programs.

Approval of these interventions as ILOS would allow MCOs to elect to provide the interventions to eligible Medicaid enrollees based on local conditions and plan preferences, and for HHSC to develop rates that reflect the cost and utilization of these services. However, approving these interventions as ILOS, versus a covered benefit, can lead to variable access to these services across the state and within managed care service areas, and missed opportunities to coordinate infrastructure and staffing investments in service providers. For this reason, the report also includes other options for Medicaid coverage, as well as implementation considerations for ILOS.

## ■ Asthma Remediation

### Intervention Description

Asthma remediation programs are designed to identify and ameliorate asthma triggers in the home by providing environmental modifications and asthma supplies and providing asthma case management and education services. These programs typically include the following steps (**Exhibit 1**).



**Exhibit 1:** Asthma Remediation Program Components

Asthma remediation programs can reside in MCOs, provider organizations, community-based organizations (CBOs) or government agencies. These programs typically employ (1) community health workers to provide environmental supplies (e.g., allergy-free bed/pillow covers, HEPA vacuum), case management, and asthma self-management education; and (2) trained housing specialists and contractors to provide home modifications.<sup>9</sup>

### Populations of Interest

Most asthma remediation programs are designed to support the health needs of **children and adolescents with poorly controlled asthma**. Children can become eligible for these programs through several pathways. For example, the San Antonio Kids BREATHE program<sup>10</sup> identifies children who are experiencing acute medical utilization or who are having their quality of life negatively impacted by their asthma. This includes children who have experienced any of the following related to their asthma: (1) two or more visits to the emergency department or urgent care per year; (2) one or more hospitalization(s) per year; (3) two or more steroid bursts per year; (4) 10% or more missed days of school for the school year; or (5) two or more unscheduled school nurse visits per week.<sup>11</sup>

While most asthma remediation research has focused on children, more recent programs have shown that **adults with asthma** can also benefit from asthma remediation programs.<sup>12, 13, 14</sup>

## Case Study: Child with asthma

A 12-year-old with asthma experiences frequent asthma attacks, leading to school absences, costly trips to the emergency room, and high stress for her and her family. When her pediatrician hears about how much asthma is disrupting her life, the doctor refers her to a local asthma remediation program. The asthma remediation program provides health coaching, which helps the 12-year-old and her parents identify triggers for her asthma and develop a better asthma control plan. Employees of the program also identify mold in her home that was exacerbating her asthma and remove and replace the moldy carpeting. Six months after this intervention, the 12-year-old has experienced far fewer asthma attacks, no school absences, no emergency room visits, and her asthma control test score has improved. Her family is more confident in their ability to help her control her asthma, spending on her health care has decreased dramatically, and she is happier and healthier.

### Evidence On Clinical And Cost-Effectiveness

The CDC Task Force on Community Preventive Services has conducted systematic reviews on asthma remediation programs, which indicate that these programs are clinically impactful and result in a financial return-on-investment (ROI)<sup>15</sup>:

#### HEALTH BENEFITS

##### Average decrease of:

- 0.57 acute care visits per year
- 21 symptom days per year
- 12.3 school absences per year

#### FINANCIAL ROI

- \$5.30 - \$14.00 returned for every \$1 invested

Additional rigorous evaluations of individual programs support these findings – showing that asthma remediation programs are cost-effective in the general pediatric and pediatric Medicaid populations:

#### BOSTON CHILDREN'S HOSPITAL PROGRAM<sup>16</sup> (BOSTON, MA)

- Financial ROI of 1.91 over 5 years for a general pediatric population – indicating that every one dollar spent resulted in savings of \$1.91

#### LE BONHEUR CHILDREN'S HOSPITAL PROGRAM<sup>17</sup> (MEMPHIS, TN)

- Medicaid total cost of care savings of \$2,207 per child over 2.3 years

Pediatric asthma remediation programs in Texas have had similarly beneficial impacts. For example, the San Antonio Kids BREATHE program is run through the San Antonio Metropolitan Health Department and has provided asthma remediation services since May 2019. This program found that children who graduated from the intervention saw improvements in asthma control, as measured by average asthma control test scores and metered dose inhaler scores. San Antonio Kids BREATHE has partnered with Community First Health Plans, a local MCO, to provide services in a pilot program, and children engaged in the program had a reduction in emergency department visits.<sup>18</sup>

Research assessing programs focused on adults with asthma in New York State and Washington State have shown that asthma remediation efforts, including education and environmental assessments, are also impactful for the adult population. In New York State, a program working with both children and adults found a financial ROI of 3.58 - indicating that every one dollar spent on the program resulted in savings of \$3.58.<sup>19</sup> Programs in Washington State<sup>20</sup> and New York City<sup>21</sup> assessed the health impact of asthma remediation programs for adults and found health benefits including increases in mean symptom-free days, improvements in quality of life, and improved measures of asthma control.

## Other Options for Medicaid Coverage

In December 2021, CMS approved asthma remediation for children and adults as an ILOS in **California**.<sup>22</sup> The state developed service definitions and eligibility criteria,<sup>23</sup> as well as non-binding price guidance.<sup>24</sup>

States have also approved asthma remediation interventions through:

- **CHIP health services initiatives (HSIs).** **Wisconsin** used its CHIP HSI to cover case management, in-home education, environmental assessment, durable equipment, and environmental hazard remediation in homes of low-income children with moderate to severe asthma.<sup>25</sup> **Maryland** also has a similar initiative that includes asthma home visit services and related supplies like green cleaning kits and pillow covers.<sup>26</sup>
- **Medicaid state plan amendments.** **Missouri** used state plan amendment (SPA) authority for an asthma preventive education and counseling and in-home assessment program for asthma triggers, focusing on youth participants who have evidence of uncontrolled asthma.<sup>27</sup> **California** similarly covers “clinic-based asthma self-management education, home-based asthma self-management education and in-home environmental trigger assessments” as a preventive service.<sup>28</sup>

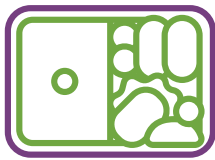


- **1115 demonstrations. Massachusetts** Accountable Care Organizations can provide eligible members home modification services as a “Flexible Service,” approved by CMS via an 1115 demonstration.<sup>29</sup> Services can include: in-home environmental risk assessments, HEPA filters, vacuum cleaners, pest management supplies and services, air conditioner units, and hypoallergenic mattress and pillow covers. **North Carolina’s** Healthy Opportunities Pilot program provides individuals enrolled in Medicaid that meet certain risk criteria: “repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant’s health condition.”<sup>30</sup> The state developed related fee schedules for inspections for housing safety and quality and home remediation services.<sup>31</sup>
- **Value-based Payment Initiatives. New York** requires advanced value-based payment arrangements to include drivers of health interventions, such as asthma remediation. The MCO’s intervention-related expenses and investments can be deemed medical for the purposes of rate setting.<sup>32</sup> The New York State Energy Research and Development Authority and the New York State Department of Health came together to create New York State Healthy Homes Value-Based Payment Pilot.<sup>33</sup> The program is recruiting a pool of qualified community-based organizations that can be integrated into advanced VBP arrangements in Medicaid, and provide environmental trigger reduction measures such as mold remediation or pest management.

## ■ Medically Supportive Food and Meals

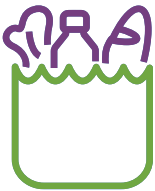
### Intervention Description

Medically supportive food and meals can span a wide spectrum of services, including Food is Medicine programs and home-delivered meals programs. Per the Aspen Institute's *Food is Medicine Research Action Plan*,<sup>34</sup> *Food is Medicine* programs can include: (1) medically tailored meals; (2) medically tailored groceries; and (3) produce prescriptions. **Exhibit 2** describes each of these interventions. All Food is Medicine interventions include (a) provision of food that supports health and (b) a connection to the health care system. Home-delivered meal programs can involve nutritious, but not necessarily medically tailored, meals for older adults, or meals delivered to individuals for a time-limited period, such as after discharge from a hospital.



#### Medically Tailored Meals

- Ready-to-eat meals and snacks
- Complete or near-complete nutrition
- Serve clients who: (1) have severe/chronic illnesses and (2) have limited ability to do "activities of daily living" (e.g., cook, shop)
- Available for short or long duration based on client needs



#### Medically Tailored/Health Supporting Groceries

- Range of grocery items, including produce, that require preparation
- Partial or near-complete nutrition
- Serve clients who: (1) have diet-related health risks/conditions, (2) are food insecure or have other challenges accessing food, and (3) are able to prepare food for themselves but may not be able to shop for themselves
- Typically part of a long-term nutritional management plan



#### Produce Prescriptions

- Vouchers for produce - fresh, frozen, or canned - which may require preparation
- Supplemental nutrition
- Serve clients who: (1) have diet-related health risks/conditions, (2) are food insecure or have other challenges accessing food, and (3) are able to shop for and prepare meals for themselves
- Typically part of a long-term nutritional management plan

**Exhibit 2:** Types of Food is Medicine Programs

## Populations of Interest

Given the broad definition of medically supportive food and meal programs, these programs can be **tailored to serve a wide variety of people** with different needs. As noted in **Exhibit 2**, the more intensive medically tailored meals programs are designed for people with complex conditions and needs, while lighter-touch efforts like the medically tailored/health supporting groceries or produce prescriptions are designed for people with more capacity to shop or prepare food on their own.<sup>35</sup> Home-delivered meals programs can also be customized to address the health needs of **older adults** that may not otherwise be able to receive these services, and address not only nutrition needs, but also in-home safety, socialization, and community connections.<sup>36</sup>

### Case Study: Pregnant woman experiencing food insecurity

A woman with a history of preeclampsia is pregnant with her second child. She struggles to afford nutritious food and has recently been diagnosed with gestational diabetes and hypertension. The woman's obstetrician connects her with additional pregnancy supports, including a Food is Medicine program at a local food bank to address her food insecurity. The food bank helps the woman enroll in SNAP and WIC and provides her with daily healthy meals for her entire pregnancy and postpartum recovery, as well as cooking classes. With the support of the Food is Medicine program, the woman successfully manages her gestational diabetes and hypertension, and eventually gives birth to a healthy daughter at full-term with no complications. Continued support during her postpartum period ensures that the woman can support her own recovery and her daughter's needs early in life.

An example of someone who would benefit from a medically tailored meal program might be a patient at a dialysis center who has **type 2 diabetes and end-stage renal disease**. During their enrollment in the program, a registered dietician would perform a nutrition assessment and develop an appropriate meal plan as part of a larger nutritional treatment plan. Meals would be prepared by the program and delivered to the patient's home, with no or minimal preparation required for meals to be eaten.<sup>37</sup>

In addition to focusing on people with serious, chronic conditions, Food is Medicine programs can also be used for diet-related health conditions. There is growing evidence around the use of Food is Medicine programs to serve pregnant and postpartum women, who may have diet- and pregnancy-related health conditions (e.g., **gestational hypertension or diabetes**) or who may benefit from additional access to nutritious food to improve maternal and infant health outcomes. Factor Health, a partnership between Dell Medical School and Episcopal Health Foundation that focuses on non-medical DOH, is testing Food is Medicine programs to decrease pre-term birth and increase infant birthweight.<sup>38</sup>

The broad spectrum of Food is Medicine programs means they are well-suited to any person who has difficulties accessing nutritious food based on their

health status, geographic location, or income level. The new directed payment program for physicians and professional services in Texas Medicaid, which includes a rate enhancement for food insecurity screening, could be leveraged as one way to identify eligible individuals for these programs.<sup>39</sup>

**Evidence on Clinical and Cost Effectiveness**

The strongest evidence on clinical and cost-effectiveness of Food is Medicine programs is related to medically tailored meals. Research on medically tailored meals consider a variety of primary outcomes, including health care utilization, diet quality, quality of life, and disease-specific outcomes.

A summary of key research on medically tailored meals found the following overall results:<sup>40</sup>

HEALTH BENEFITS	FINANCIAL ROI
<p><b>Average decreases in:</b></p> <ul style="list-style-type: none"><li>• Emergency department visits</li><li>• Inpatient admissions</li><li>• Admissions to skilled nursing facilities</li></ul> <p><b>Average improvements in:</b></p> <ul style="list-style-type: none"><li>• Self-reported healthy eating</li><li>• Self-reported health status</li></ul> <p><b>Some improvements in:</b></p> <ul style="list-style-type: none"><li>• Disease-specific outcomes</li></ul>	<p>Decreased overall health care costs, resulting from decreased acute care utilization</p>

One study explores outcomes for a medically tailored meals program focused on adults dually enrolled in Medicare and Medicaid:<sup>41</sup>

HEALTH BENEFITS	FINANCIAL ROI
<p><b>Average decreases in:</b></p> <ul style="list-style-type: none"><li>• Emergency department visits</li><li>• Emergency transportation usage</li><li>• Inpatient admissions</li></ul>	<p><b>Average decreases in:</b></p> <p>Overall medical spending (estimated monthly net savings of \$220 per person)</p>

Medically tailored/health supporting groceries and produce prescription interventions are used when less specific tailoring is necessary for the person being served. Assessments of program impact are less robust than assessments for medically tailored meals, but a summary of key research studies conducted over the last seven years does show that participants in these programs tend to report improved health status and increased healthy food intake, alongside decreased hospital readmissions.<sup>42</sup>

## Other Options for Medicaid Coverage

CMS has approved the following Food is Medicine and home-delivered meal services as ILOS in **California**:<sup>43</sup> meals delivered to the home immediately following discharge from a hospital or nursing home; medically tailored meals; medically tailored groceries, healthy food vouchers, and food pharmacies; and behavioral, cooking, and/or nutrition education when paired with direct food assistance.

CMS has also approved other similar services through:

- **1915(c) and 1915(i) home and community-based services (HCBS).** Home-delivered meals are a common component of HCBS programs. **Texas** covers home-delivered meals as part of its 1915(i)<sup>44</sup> and many 1915(c) programs.
- **1115 demonstrations. North Carolina** offers healthy food boxes and healthy meals for delivery and pick up.<sup>45</sup> In addition, its Healthy Opportunities pilot program pays for the Diabetes Prevention Program and food and nutrition access case management services (e.g., assistance with SNAP applications).<sup>46</sup> **Massachusetts** also offers “nutrition sustaining supports” through its Flexible Services Program.<sup>47</sup>



## ■ Services and Supports Designed to Complement Existing Housing Programs

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### Intervention Description

According to the Corporation for Supportive Housing, “supportive housing programs combine affordable housing with services that help people who face complex challenges to live with stability, autonomy, and dignity.”<sup>48</sup> Because Medicaid programs are prohibited from paying for room and board, one way Medicaid agencies can help address the needs of their enrollees is through providing supportive services that *complement* existing housing programs run through other state agencies or service organizations—making those housing programs more effective and responsive to individuals’ needs.<sup>49</sup> Medicaid funds can also complement other streams of funding, such as Healthy Community Collaborative funds.<sup>50</sup>

The *Housing Choice Plan*, a stakeholder-led housing roadmap developed for the Texas HHSC published in May 2022, found that key barriers to accessing housing for people with complex health needs include a lack of affordable housing supply and difficulty navigating the complex housing system.<sup>51</sup> While Medicaid’s role in affordable housing supply is limited, its role in housing-related services and supports is more established. These interventions, when combined with other behavioral and physical health services, can help people obtain and maintain housing.<sup>52</sup> Housing-related services and supports that have been approved under *in lieu of services* authority include: (1) housing transition navigation services, (2) one-time community transition costs, and (3) tenancy support services.<sup>53 54</sup> These interventions are described in **Exhibit 3**.

## Housing Transition Navigation Services

- Assist people in obtaining housing in the community as they leave an institutional setting, such as a state hospital. Services may include:
  - Identification of member needs and preferences related to obtaining housing;
  - Development of an individual housing support plan that includes barriers to stable housing and goals to overcome these barriers;
  - Assistance searching for and securing housing including completion of housing applications; and
  - Identifying and securing additional benefits and supports to sustain housing (e.g., securing rent subsidies).

## One-Time Community Transition Costs

- Financial assistance which pays for one-time costs associated with transitioning into the community. Costs may include:
  - Environmental modifications (e.g., disability accessibility);
  - Security deposit payment;
  - Moving expenses; and
  - Essential household furnishings.

## Tenancy Support Services

- Assist people in learning how maintain tenancy once housing has been obtained. Services may include:
  - Education and training on the role, rights, and responsibilities of tenant and landlord;
  - Identifying behaviors that may jeopardize housing (e.g., late rent payment) and addressing them;
  - Assisting in negotiating conflict with landlords or neighbors to prevent eviction; and
  - Advocacy and connection to resources to prevent eviction should the need arise.

**Exhibit 3:** Types of Housing Support Services<sup>55</sup>

## Populations of Interest

Given the broad nature of supportive housing programs, these interventions may be helpful for many different populations served by Medicaid – essentially, anyone who is homeless or unstably housed and would benefit from the wraparound services offered by supportive housing may be eligible for ILOS designed to complement and strengthen the impact of supportive housing programs. For example, pregnant women are a key population covered by Texas Medicaid, and **pregnant women with unstable housing** and at risk for poor health outcomes may have healthier pregnancies and better birth outcomes when connecting to housing-related services and supports. **People experiencing domestic violence**, who are seeking alternative housing to escape an abusive situation, may also benefit from additional aid securing and maintaining housing.

In addition, based on existing programs in Texas and the opportunities identified above, a particularly appropriate priority population for housing supports could be **adults with serious mental illness**, who are covered by Medicaid, transitioning into the community from a state hospital or a nursing facility, and do not have housing. Adults with serious mental illness make up a meaningful percentage of the people experiencing homelessness in Texas, particularly because there is a lack of community-based treatment and support programs for these individuals.<sup>56</sup>

## Case Study: Individual transitioning from state hospital into community living

A young man with schizophrenia has a history of inpatient stays at state hospitals and psychiatric facilities. During each stay, with a degree of stability and support, he learns to manage his mental health condition and begins to see improvements in his overall health and quality of life. After each discharge, however, he struggles with maintaining housing. Housing instability and homelessness exacerbate his conditions, and an acute behavioral health crisis often lands him in a state hospital for another inpatient stay. Each extended stay disrupts or suspends his Medicaid enrollment, and he must navigate a separate state program for his care, supported by limited state-only funds.

During the man's next transition from the state hospital to the community, his Medicaid MCO care coordinator connects him to a supportive housing program, which helps him find and apply for housing and connect with a primary care and behavioral health team to help him manage his conditions. Once he is housed, the MCO partners with supportive housing staff work with him on a regular basis to help identify and resolve any issues, such as support with budgeting to pay rent on time, maintaining positive relationships with his neighbors, and addressing any maintenance needs with the landlord. This program helps the young man live safely in the community on his own and maintain stable mental and physical health – leading to lower health care costs – and he continues to be stably housed more than a year after his discharge from the hospital.

Approving ILOS that complement housing services may be helpful to support and scale existing supportive housing projects already run by Texas HHSC, including the following programs that HHSC has developed to provide supporting housing for adults with serious mental illness:<sup>57</sup>

- Supportive housing rental assistance for adults with behavioral health needs who are currently homeless or are at risk of becoming homeless;
- Money Follows the Person Behavioral Health Pilot, which in its first phase created multi-stakeholder partnerships to transition adults with mental illness from nursing

facilities to the community (this phase ended in 2017, and HHSC is now working on related sustainability and capacity-building efforts);

- MCO Transition Pilot, which embedded a housing navigator within MCOs to transition people with mental illness from nursing facilities to the community; and
- Bridge to STAR+PLUS pilot, which transitions people with serious mental illness from state hospitals to home- and community-based services in Travis and Bexar counties through provision of intensive housing and health supports before and after the transition.

Participants in these programs all experience behavioral health conditions and are going through major housing transitions, which makes them particularly vulnerable to exacerbated health issues and re-institutionalization. They may also have complex histories including lack of a rental history, prior involvement in the criminal justice system, poor credit, or previous evictions that add to challenges obtaining and sustaining housing.<sup>58</sup> Supportive housing programs that include the complementary interventions described above can help people stay stable during these transitions and successfully remain in the community, improving quality of life and decreasing costs to Medicaid and other state programs.

### **Evidence on Clinical and Cost Effectiveness**

Permanent supportive housing programs have been shown to improve health, decrease acute care utilization, and provide savings to Medicaid and other government programs. The report *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homeless* from the National Academies of Sciences, Engineering, and Medicine explores the clinical and cost-effectiveness of supportive housing programs, with the following findings:<sup>59</sup>

## HEALTH BENEFITS

### Average decreases in:

- Days of homelessness (indicating that programs can stabilize and retain participants)
- Inpatient stays
- Emergency room visits
- Residential behavioral health (substance abuse or psychiatric treatment) stays
- Nursing home stays

## FINANCIAL ROI

### Average decreases in:

- Spending on residential treatment
- Spending on legal fees

Findings related to hospital costs support evidence that individuals are more likely to seek outpatient care (showing increased outpatient cost) and less likely to need inpatient and emergency care (showing decreased inpatient and emergency costs). Studies do not clearly indicate if total health care spending tends to increase or decrease, but findings are consistent with increased access to more timely, appropriate care that help individuals manage physical and behavioral health needs.

Research cited in the *CalAIM In Lieu of Services Evidence Library* explores the impact of housing navigation services, case management, and rental subsidies. These programs generally had positive health and cost impacts. For example, a New York State program providing rental subsidies and housing navigation to high-cost Medicaid members who were homeless or living in institutional settings has the following impacts:<sup>60</sup>

## HEALTH BENEFITS

### Average decreases in:

- Inpatient stays (40% reduction)
- Emergency department visits (26% reduction)
- Inpatient psychiatric admissions (27% reduction)

## FINANCIAL ROI

Savings for high-cost (top decile) enrollees totaled \$23,000-\$52,000



Finally, research from Washington State’s Medicaid program, which covers housing support services such as those found in **Exhibit 3**, found that adults enrolled in this program were more likely to access needed care, more likely to successfully transition out of homelessness, and less likely to use the emergency department compared to similar adults who did not receive these services.<sup>61</sup>

### **Other Options for Medicaid Coverage**

California has pre-approved several housing-related services as ILOS.<sup>62</sup> States have also used other vehicles to cover housing-related services and supports. For example,

- **1915(i) and 1915(c) home and community-based services. Minnesota** uses 1915(i) authority for its housing stabilization services program, which includes housing transition and sustaining services.<sup>63</sup> **Texas** includes some limited housing supports in its Home and Community-based Services – Adult Mental Health program, which includes some assistance with maintaining housing through recovery management and community psychiatric supports and treatment.<sup>64</sup> Transition assistance services, including security deposits and home furnishings, are also a part of Texas’s 1915(i) state plan package, as well as other 1915(c) waiver programs.
- **1115 demonstrations. Hawaii,<sup>65</sup> Washington,<sup>66</sup> North Carolina,<sup>67</sup> and Massachusetts<sup>68</sup>** have included coverage for tenancy supports and transition costs in their 1115 demonstrations.

## ■ Implementation Considerations

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The Texas Value-Based Payment and Quality Improvement Advisory Committee has issued two recommendations relating to (1) approving ILOS that address non-medical DOH and (2) incenting MCOs to take up and expand access to these services. This section discusses how HHSC can financially and logistically support MCOs as they work to build the infrastructure, capacity, and partnerships needed to deliver ILOS that address non-medical DOH, as it relates to these two recommendations.

### **Ask for feedback.**

HHSC should seek input from community members, CBOs, health plans, and health systems to ensure that ILOS definitions, eligibility criteria, and related guidance are clear and effective. HHSC can explore a range of options – including advisory committees, requests for information, and listening and roadshow sessions in local communities across Texas. HHSC can particularly look at opportunities to strengthen and not duplicate existing pilots and programs.

### **Strengthen community capacity.**

Implementing ILOS will require close partnerships with CBOs that have traditionally been underfunded and not formally integrated into the health care system. HHSC can consider how to prepare CBOs for these new partnerships with Medicaid MCOs and providers, and explore the role of emerging and existing Community Care Hubs and CBO Networks, such as Pathways Community HUBs and Area Agencies on Aging. Sources of funding for these capacity-building efforts might include: MCO incentive arrangements, value-based payment arrangements with upfront seed money or capacity-building funds, and new federal flexibilities under the American Rescue Plan Act for HCBS Spending Plans.<sup>69</sup> These Medicaid funds would be intended to supplement, and not supplant, other non-Medicaid resources, such as public health funds and grants associated with COVID-19 (e.g., a \$45.2 million grant focused on health disparities in Texas<sup>70</sup>) and supportive housing (e.g., Healthy Community Collaborative funds).<sup>71</sup>

The Value-Based Payment and Quality Improvement Advisory Committee recommends an MCO incentive arrangement to support these capacity-building efforts. Currently, HHSC has existing authority under Texas Government Code § 533.014(c) to create incentive arrangements using excess MCO profits returned to the state. MCOs must pay these excess profits (“experience rebates”) back to the state if the MCO’s net income before taxes is greater than a certain percentage of total revenue for the period. An ILOS-focused incentive arrangement could be consistent with the statutory goals

enumerated in Texas Government Code § 533.014(c). The statute explicitly mentions cost-effectiveness (a key feature of ILOS), and notes that HHSC can “provide incentives to specific managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.”

### **Allow flexibility to tailor ILOS to local community needs, preferences, and assets.**

Texas is a large, diverse state – with many urban and rural areas. HHSC can encourage interventions that are co-designed with individuals who have experienced non-medical risk factors like food or housing insecurity, in each relevant community or region. This engagement will help develop effective, responsive programs that are tailored to local community needs, preferences, and assets. For example, HHSC can encourage culturally appropriate food and meal services that respects individuals’ dignity and agency to choose the foods they would like to eat – delivered by organizations that they trust, in a way that is most convenient to them (e.g., at a community health center, at home, at a food bank). Taking these steps will help maximize use and impact of these services.

### **Integrate primary care teams.**

Primary care teams can help coordinate and manage care, identify non-medical DOH, and refer eligible members for additional services that address identified needs. HHSC can consider ILOS in tandem with other initiatives seeking to advance whole-person, team-based, person-centered primary care. For example, HHSC can consider value-based care initiatives seeking to expand trauma-informed screenings for risk factors relating to DOH and leverage the full spectrum of the health care workforce (e.g., community health workers, peer support providers, pharmacists, community paramedics, doulas, and direct care workers). Further, ILOS that address DOH can help primary care teams address the many factors outside of health care that impact health outcomes, bolstering their ability to succeed under value-based payment models.

### **Support data sharing and coordination.**

To implement ILOS that address non-medical DOH, providers, MCOs, HHSC, and CBOs in Texas will have to form partnerships with clear roles and responsibilities for: (1) identifying needs of Medicaid enrollees through social risk factor screening; (2) collecting and recording data from these screenings, for example through Z codes;<sup>72</sup> (3) referring enrollees to appropriate interventions; (4) tracking and measuring progress; and (5) sharing data about outcomes or other relevant information across the broad

care team. HHSC can consider ways to support the infrastructure needed for community-informed data sharing and coordination across stakeholders, such as developing a closed-loop referral system or community information exchange infrastructure and building on existing strengths of its 2-1-1 system.<sup>73</sup> HHSC and Medicaid MCO can encourage referrals to these new ILOS through multiple pathways, including plans, health systems, primary care teams, CBOs, CBO networks, and local government agencies.

### **Minimize administrative burden.**

The Value-based Payment and Quality Improvement Advisory Committee has discussed administrative burden as a barrier to provider uptake of value-based payment.<sup>74</sup> Based on early experiences in California, administrative burden can also be a barrier for uptake and implementation of ILOS, particularly for CBOs piloting new partnerships with plans, and medical providers referring individuals to new types of services.<sup>75</sup> Without additional support and resources, CBOs may be unable or unwilling to navigate different plans' negotiation and vetting processes, portals, claims submission, and data reporting processes. Primary care teams may shy away from making referrals to ILOS if each plan in their area has different authorization criteria, and different service offerings. Responding to these concerns, HHSC can consider ways to encourage plans in each managed care service area to streamline, standardize, or coordinate technical assistance, capacity-building efforts, authorization criteria, and workflows.

## ■ Summary

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With new demonstration approvals and anticipated ILOS guidance, states across the country will increasingly provide DOH interventions through Medicaid. Evidence from existing programs across the nation and within Texas indicate that interventions addressing non-medical DOH tend to improve health outcomes and result in financial savings as health improves.

Texas Medicaid has the opportunity to build upon work already done by MCOs and CBOs in Texas, and expand access to evidence-based, cost-effective services. The Value-Based Payment and Quality Improvement Advisory Committee has recommended three interventions: (1) asthma remediation programs, (2) Food is Medicine programs, and (3) services and supports designed to complement existing housing programs.

MCOs will need to partner with CBOs, network providers, and other MCOs working in the same regions to develop the infrastructure and capacity to provide these services to Texas Medicaid enrollees. HHSC can explore pathways to financially support these efforts and can also assist with additional implementation considerations including exploring data sharing between stakeholders, aligning requirements across MCOs, and working closely with Medicaid providers and enrollees to ensure interventions are successfully addressing identified needs.



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