Non-Medical Drivers of Health Strategies:

Findings from a 2025 Survey of Managed Care Organizations in Texas

Prepared by Laurie Vanhoose and Shao-Chee Sim
March 2026

Executive Summary

Findings from the 2026 Survey of Texas Medicaid Managed Care Organizations (MCOs) indicate continued progress in how health plans identify and respond to non-medical drivers of health (NMDOH), alongside persistent operational and policy barriers that limit scale and sustainability.

- **Food insecurity remains the most frequently identified NMDOH need**, followed by childcare, transportation, and difficulty paying utilities. The elevated ranking of childcare reflects the impact of HB 1575's standardized screening requirements for pregnant members.
- **Implementation of HB 1575 has significantly expanded NMDOH screening** and formally integrated community health workers (CHWs) and doulas into Medicaid case management. However, MCOs report ongoing challenges related to provider enrollment, billing, limited provider capacity, and concerns about duplication with existing service coordination functions.
- **Administrative burden and data-sharing limitations persist across survey years**, particularly for provider-based screening and referrals to community-based organizations (CBOs). MCOs continue to cite lack of interoperability, inconsistent data standards, and limited CBO infrastructure as major constraints.
- MCOs continue to invest in NMDOH interventions through value-added services (VAS), performance improvement programs (PIPs), and quality improvement (QI) activities, but report uncertainty about how to classify NMDOH investments as allowable Medicaid costs—especially when working with non-traditional providers.
- **Interest in nutrition-related in-lieu of services (ILOS) authorized under HB 26 is high**, but MCOs emphasized that participation will depend on timely, clear guidance from HHSC regarding eligible provider types, billing codes, reporting requirements, and cost-effectiveness expectations.

While recent legislation has created important new opportunities to address NMDOH in Texas Medicaid, survey findings suggest that **policy authorization alone is insufficient**. Clear guidance, operational flexibility, and targeted technical assistance will be necessary to translate these policy changes into sustainable, scalable practice.

As the Texas MCO NMDOH Learning Collaborative enters its seventh year, these findings will inform targeted convenings, implementation support, and policy recommendations aimed at strengthening NMDOH infrastructure and improving outcomes for Medicaid members.

Background and Purpose

In late 2018, the Episcopal Health Foundation (EHF) partnered with the Texas Association of Health Plans (TAHP) and the Texas Association of Community Health Plans (TACHP) to conduct the first ever statewide survey capturing Medicaid health plans' activities to address non-medical drivers of health care (NMDOH). The survey highlighted that while Texas Medicaid managed care organizations (MCOs) were committed to addressing NMDOH, there were challenges in financing, incentivizing and sustaining non-medical interventions. The survey findings were published in a Health Affairs blog article and resulted in the formation of the Texas MCO NMDOH Learning Collaborative.

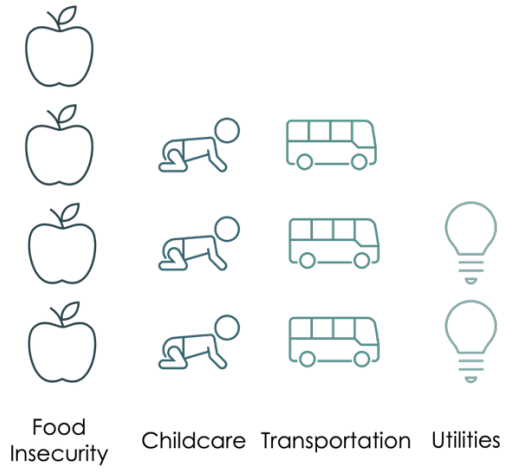
The Learning Collaborative partners have conducted several surveys over the past seven years to continually evaluate the NMDOH landscape in Texas Medicaid and inform Learning Collaborative activities. The 2020 survey, focused on the impacts of the COVID-19 pandemic, highlighted increased NMDOH needs among Medicaid members and the strain placed on community-based organizations (CBOs) to meet those demands with limited funding, as well as increased NMDOH screening efforts by MCOs. The 2023 survey identified potential policy changes to incentivize health plan investment; findings informed legislative initiatives, including the passage of HB 1575 (88th Texas Legislative Session), which established a standardized NMDOH screening tool for pregnant women and the addition of doulas and community health workers (CHWs) as case managers in the Texas Medicaid program.

This year, Treaty Oak Strategies conducted another survey from January 9–21, 2026, to identify strategies for successful implementation and uptake of CHWs and doulas as case managers in the Medicaid program. Fourteen of sixteen Texas Medicaid MCOs responded and follow-up interviews were conducted to gather additional context. Survey findings cover NMDOH needs, screening and data sharing, financing and contracting, implementation of HB 1575, and early considerations related to nutrition ILOS authorized under HB 26.

Medicaid NMDOH Needs

MCOs indicated food security as the highest-identified member need, followed by childcare, transportation, and paying utilities. This is a departure from previous surveys, where MCOs ranked access to permanent/safer housing, trouble paying utilities and other basic living expenses, and transportation as the greatest needs among their members. These differences, especially inclusion of childcare, may be a result of the HB 1575 standardized screening tool as all MCOs now consistently screen for the same needs.[1]

Relative Frequently of Most-Identified NMDOH Needs (2026)



HHSC reporting on HB 1575 implementation aligns closely with survey findings. Notably, HHSC has reported that 93% of pregnant members who identified childcare as a need requested additional assistance from their MCO. Despite transportation being a covered Medicaid benefit, MCOs continue to identify it as a significant unmet need, prompting Learning Collaborative discussions about member awareness and understanding of available benefits.

Engaging Medicaid Members

EHF, Treaty Oak Strategies, the Michael and Susan Dell Foundation, Methodist Health Ministries, and St. David's Foundation partnered with five Medicaid MCOs (Community Health Choice, Baylor Scott & White Health Plan, Molina Healthcare, Superior, and United Healthcare) to establish discussion groups that ensure the voices of pregnant Medicaid beneficiaries are included in conversations about their benefits. The report summarizes key findings about their non-medical needs experiences with and perspectives on employment, housing, transportation, and food supports. The report found a gap in knowledge about medical and non-medical services MCOs offer to Medicaid members.

In response to these findings, another round of workgroups were completed and a second report published summarizing key findings about enrollee's thoughts and perspectives on available information, what information they wish they had, and the best method of communicating both medical and non-medical benefits.

[1] HB 1575 requires MCOs to report the findings of NMDOH screenings to HHSC. Results from the current MCO NMDOH survey closely align with recent HHSC updates on HB 1575 implementation. HHSC data and Learning Collaborative survey responses highlight similar priority needs. Notably, HHSC recently reported that 93% of pregnant members who identified childcare as a need requested additional assistance from their MCO.

Screening for NMDOH Needs

Previous surveys were conducted prior to implementation of HB 1575, which requires MCOs to screen all pregnant women using a standardized NMDOH screening tool developed by HHSC.[2] These surveys indicated an uptake of NMDOH screening, even without a state mandate. In the 2023 survey, all fourteen of the MCO respondents indicated they screened for NMDOH needs, as compared to eleven plans in the 2018 and 2020 surveys.

In the 2026 survey and follow-up interviews, MCOs indicated that they only use the standardized screening tool for pregnant members because the tool is designed for pre- and post-natal needs (for example, inclusion of childcare-specific questions). Responses outlined the various tools MCOs use to screen non-pregnant Medicaid members, which are largely consistent with findings from previous surveys:

- Three plans reported using the screening tool embedded within the Findhelp platform.
- Seven plans reported using internally developed health needs screenings and risk assessments modeled after the HB 1575 screening tool and other nationally recognized tools.
- Three plans reported using the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) tool or select components of the tool.
- One plan reported using screening tools developed by the American Academy of Pediatrics (AAP) and the American Medical Association (AMA), along with additional tools tailored to member age.

Actions Taken Following a Positive Screen

MCOs were asked to describe what happens when a member screens positive for an NMDOH need and requests assistance. All respondents indicated that positive screens are typically referred to Member Advocate or Service Coordination teams, who then connect the member to internal MCO programs (such as disease management or service coordination), educate the member about covered benefits, or refer the member to a CBO or other external resource.

MCOs also reported variation in how actions taken are documented. Most indicated that documentation practices are proportional to the level of need. For example, when a member is referred to Service Coordination, information is documented in their care plan. Many MCOs now use internal closed-loop referral platforms to track identified needs, actions taken, and resolution status.

[2] The STAR+PLUS (Medicaid managed care program for older adults) health plan contract now requires MCOs to conduct NMDOH screenings, but HHSC does not mandate use of a standardized screening tool for the STAR+PLUS program.

Data Sharing

Previous surveys showed remarkable growth in MCO-provider contracts requiring providers to screen for non-medical needs and share NMDOH data. In the most recent survey, MCOs reported that NMDOH screening is now included as a component of some alternative payment models (APMs), though it is not typically the primary focus of these arrangements. This reflects incremental progress following HHSC's implementation of the MCO APM Framework.

Across all survey years, including 2026, MCOs consistently cited administrative burden as a significant barrier to provider-based screening and data sharing. Representative comments from survey respondents across years include:

2018 "We try to balance what is asked of our providers based on all they are expected to accomplish during the course of their services."

2020 "Adding assessments to providers' workflows adds administrative burden."

2026 "We recognize it is a burden on providers to screen, especially if they are not getting paid or do not have resources to assist the patient."

Ongoing Challenges with Data Exchange

Survey and interview responses continue to highlight the difficulties with sharing data between MCOs, CBOs and providers.

MCOs identified that there are too many systems for sharing data with little interoperability between systems. There is no standardized approach for how data is shared from MCOs to providers and CBOs. It might be shared via secure emails, secure file transfer protocols (FTPs), or screening and navigation platforms like Find Help or Unite Us. Some MCOs share data through electronic health record (EHR) platforms, but as ne MCO also noted, not every MCO — and certainly not every CBO or provider — can afford to purchase, maintain, and upgrade EHRs. And some providers will only accept data through fax or paper copies.

MCOs also identified that not all data is actionable or shared in a usable format and that they are unsure data they *can* request from a provider or CBO. MCOs emphasized that bi-directional data exchange would be ideal to avoid duplicative screening and re-traumatization of members.

NMDOH Financing and Contracting

While HHSC has incentivized MCOs to address NMDOH needs through their APM Framework, MCOs continue to report uncertainty regarding how to categorize contracts with CBOs and how to leverage existing financing mechanisms to support non-traditional providers and services within state and federal requirements.

Paying for NMDOH Services

Federal and state rules outline what a Medicaid health plan can claim as an allowable Medicaid cost. When a health plan can classify a service as an allowable Medicaid cost, it significantly increases the incentive to invest in that service or support. However, non-medical services and contracts with CBOs can be challenging to categorize as allowable Medicaid costs. CBOs are often not enrolled as Medicaid providers and may deliver services that are not currently covered benefits under Texas Medicaid.

The Learning Collaborative plans to conduct targeted sessions in 2026 to further explore MCO challenges related to NMDOH financing, including categorization of NMDOH interventions. These sessions will also examine whether additional HHSC guidance or policy changes could help address financing barriers identified by MCOs.

Alternative Payment Models (APMs)

MCOs were asked if they are funding NMDOH-related pilots or programs to better understand how they are investing in NMDOH interventions and working with CBOs. While all respondents reported having programs that address NMDOH needs and indicated working with CBOs in some capacity, only one MCO reported classifying an arrangement with a CBO as an APM.

HHSC incorporated APMs with CBOs and other organizations unable to submit claims in the MCO APM Framework targets in response to recommendations from the 2023 survey. However, MCOs indicated that challenges persist in operationalizing these arrangements.

CBO Contracting

All respondents reported having a relationship with a CBO. However, these relationships vary and do not always involve direct contracts. MCOs described the following types of relationships:

- Grants in which an MCO provides funding to a specific CBO for an entire community rather than a specific Medicaid program or only MCO members.
- Vendor contracts with CBOs to assist on specific programs, such as providing meals under a disease management program.
- Referring members to CBOs when NMDOH needs are identified. (These referrals do not consistently involve direct payment to the CBO.)

The most frequently cited barrier to contracting between MCOs and CBOs is CBOs not being recognized as reimbursable provider types. Additionally, CBOs often bill differently than traditional health care providers and have limited infrastructure, making it difficult and administratively burdensome for MCOs to report expenditures as encounters or allowable Medicaid costs.

Value-Added Services (VAS)[3]

All respondents indicated they offer some form of NMDOH intervention as a VAS, including additional transportation, food related needs, housing needs, and assistance in identifying community resources.

Performance Improvement Programs (PIPs)[4]

All responding MCOs reported having at least one PIP that includes an NMDOH-related intervention. Examples include:

- Member outreach, education, and assistance programs addressing NMDOH needs
- In-home NMDOH assessments to evaluate non-medical factors like housing stability and food security.
- Home visiting programs for pregnant women.

Quality Improvement (QI)[5] Costs

Four MCOs indicated they have some type of program that includes NMDOH-related activities that they categorize under QI. Two MCOs interviewed indicated it was often easier to offer NMDOH interventions as a VAS due to requirements demonstrating the activity can be categorized as QI and potential audits connected to QI expenses.

[3] VAS are extra benefits offered by MCOs beyond Medicaid-covered services. Health plans must use their own funds to support these interventions. As a result, VAS are often limited in scope and duration and are not considered a sustainable long-term approach for addressing NMDOH needs or supporting ongoing contractual relationships with CBOs.

[4] Federal law requires all states with Medicaid managed care to ensure health plans conduct PIPs that are designed to achieve significant improvement through ongoing measurement and intervention, sustained over time, and in clinical and non-clinical areas that have favorable effect on health outcomes and enrollee satisfaction.

[5] The Code of Federal Regulations (42 CFR § 438.8(e)(3)) allows certain MCO expenses for activities that are designed to improve health care quality to be included in the numerator of the medical loss ratio. These activities do not count against administrative cost caps, providing an additional incentive for health plans to invest in NMDOH-related interventions. HHSC has provided QI guidance to MCOs stating that activities addressing NMDOH that meet the federal QI requirements and are not specifically excluded may qualify as a QI cost.

Nutrition In-Lieu of Services (ILOS)[6] Implementation

The 89th Texas Legislature passed HB 26, which authorizes MCOs to provide nutrition education and counseling as an ILOS and establishes a pilot to study the impact of medically tailored meals and other nutrition support services when paired with nutrition education and counseling. To help inform implementation of HB 26, the survey gathered MCOs' initial recommendations and identified incentives and barriers to offering nutrition-related ILOS.

MCO Considerations for Offering Nutrition ILOS

When asked about initial recommendations and what would incentivize or disincentivize participation in the pilot, MCOs consistently identified the need for clear guidance from HHSC while maintaining flexibility to integrate nutrition ILOS into existing or future initiatives.

Six MCOs expressed concerns regarding provider types, such as understanding which provider types would be included under the ILOS, requirements for using local providers, and whether CBOs can enroll and bill as a provider. Five identified the need to clearly identify billable CPT codes and provide clinical guidance. There were also concerns about the benefit of nutrition instruction and counseling services without providing food.

MCOs recommended that the state provide guidance on clinical need and population, what these services can be offered in-lieu of, and how to report ILOS on financial statistical reports,

Existing Food and Nutrition Programs

The survey asked MCOs to identify medically tailored meals or Food RX programs they are offering outside of a VAS. Eight MCOs indicated they have some type of targeted food program supported through disease management, PIPs, or other initiatives. Responses indicated MCOs design these programs for various conditions and episodes of care including obesity, healthy eating for pregnant women, heart disease, diabetes, and asthma.

[6] Federal regulations allow states to include ILOS in MCO contracts. ILOS are alternative services or settings that are substituted for services covered under the Texas Medicaid program. They are voluntary for both the Medicaid member and Medicaid MCO and most be medically appropriate and cost effective

HB 1575 Implementation

The survey sought information about implementation of HB 1575. Information gained from the survey will guide discussions in Year 7 and inform policy recommendations to HHSC and the Texas Legislature.

Contracting with CHWs and Doulas

MCOs were asked if they currently contract with CHWs and doulas as providers. All respondents reported they have open networks for CHWs and doulas, but most indicated limited outreach from individuals or organizations that are enrolled, credentialed, and ready to contract. Several MCOs noted that while interest in doula and CHW services exists, few providers are able to navigate Medicaid enrollment and billing requirements.

Implementation Challenges and Opportunities

MCOs were also asked to identify challenges with implementing HB 1575 and opportunities to improve the program. Several indicated they already use doulas but for a greater scope than what is allowed under HB 1575 — most MCOs would appreciate the ability for doulas to bill for these additional services. Similarly, several MCOs indicated they would like to use CHWs with populations other than just pregnant women and children.

Most MCOs indicated they already employ CHWs internally for various programs (including Service Coordination) and are concerned that if they use CHWs under HB 1575 it will be seen as a duplication of Service Coordination, which is not allowed under state and federal laws. Several indicated they would like better guidance around the duplication issue.

MCOs consistently reported that Medicaid enrollment and billing present significant barriers for CHWs and doulas:

> ***"CHWs and doulas have not traditionally enrolled and billed health insurance, so enrolling and billing Medicaid is a major barrier for them."***

> ***"We have talked to several FQHCs that employ CHWs and they are experiencing billing issues with MCOs. This is not due to the CHWs and doulas as new providers, they claim it has been an issue under CPW for years."***

Existing CHW and Doula Programs Outside of CPW

All respondents indicated they have some type of program outside of CPW that includes a doula or CHW. For example, five MCOs offer doula services through VAS or other maternal health programs. All MCOs indicated they utilize CHWs in some capacity, either as internal Service Coordinators or Member Advocates or through other types of relationships aimed at disease management or addressing NMDOH needs.

Conclusion

Findings from the 2026 MCO NMDOH survey demonstrate continued progress in how Texas Medicaid MCOs identify and respond to NMDOH while also highlighting ongoing challenges that limit scale and sustainability. Food insecurity, childcare, transportation, and utility assistance remain among the most commonly identified needs, with the prominence of childcare reflecting the impact of HB 1575's standardized screening requirements.

Implementation of HB 1575 has advanced NMDOH screening and formally integrated community health workers and doulas into Medicaid case management. However, MCOs continue to report barriers related to provider enrollment, billing, program flexibility, and potential duplication of services. Similarly, while MCOs expressed interest in nutrition-related in-lieu of services authorized under HB 26, they emphasized the need for clear guidance from HHSC to support effective implementation.

Across survey domains, administrative burden, data-sharing challenges, and uncertainty around allowable Medicaid costs continue to constrain deeper investment in NMDOH strategies and partnerships with community-based organizations. As the Learning Collaborative enters its seventh year, these findings will help guide targeted discussions, inform technical assistance, and support policy development aimed at strengthening NMDOH infrastructure and improving outcomes for Texas Medicaid members.