# Texas MCO NMDOH Learning Collaborative **In-Person Meeting**

March 27, 2026

Made possible thanks to the support of the Episcopal Health Foundation and the Michael and Susan Dell Foundation

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TEXAS Health and Human Services

Ryan Van Ramshorst, MD
Chief Medical Director, HHSC

Shao-Chee Sim
Executive Vice President for Health Policy, Research & Strategic Partnerships, Episcopal Health Foundation

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Head of Health Initiatives, Michael and Susan Dell Foundation

# Welcome & Introductions

# HHSC Executive Commissioner Remarks

Stephanie Muth
Executive Commissioner,
Health & Human Services
Commission

# Kick-Off Year 7 Learning Collaborative: MCO Survey

Laurie Vanhoose
Founder & CEO, Treaty Oak Strategies

# Background

The Learning Collaborative has conducted 3 previous MCO surveys:

- 2018 Survey – focused on MCO NMDOH investments
- 2020 Survey – focused on COVID 19 impacts
- 2023 Survey – informed Collaborative and Legislative initiatives

4th MCO Survey focused on the following domains:

- NMDOH Screenings
- Data sharing – MCOs, CBOs, and Providers
- MCO and CBO Contracting
- HB 26 – ILOS Implementation
- HB 1575 Implementation

# NMDOH Screening & Needs

- **NMDOH Needs:** Food security remains the most frequently identified need – followed by childcare, transportation, and difficulty paying utilities
- **Screening:**
  - MCOs indicated that they do not use the HB 1575 standardized screening tool for non-pregnant populations
  - MCOs are using similar screening tools/questions for STAR+PLUS population but not standardized
  - At the time of the 2022 survey no MCO reported having an APM that included screening and sharing results but MCOs expressed exploration or pilots in this direction
  - In the most recent survey, MCOs reported that NMDOH screening is now included as a component of some APMs or provider initiative, though it is not typically the primary focus of these arrangements
  - Across all survey years MCOs consistently cited admin burden as a significant barrier to provider-based screening and data sharing

# Data Sharing

- Responses in previous and the current survey continue to highlight the difficulties with sharing data between MCOs, CBOs and providers
- It is hard to understand what data providers have that we need as an MCO and hard to know what to send to a provider
- Not all data is actionable and there are competing priorities so if we take the time to share data it needs to be meaningful
- If MCOs identify meaningful data to share with the provider or CBO it is shared in various ways and there is no standardized approach
- Not all data sets are able to be shared in a usable forma

**"We would have better trust from patients, and could actually provide wraparound services," said an MCO regarding a better bi-directional exchange of data.**

# CBO Contracting

- All MCOs reported some type of a relationship with a CBO however, these relationships vary and do not always involve direct contracts
  - Majority are funded through grants
  - All MCOs reported referring members to CBOs

- **Challenges:**
  - The most frequently cited barrier to contracting is that most CBOs are not recognized as reimbursable provider types and do not always provide covered services
  - CBOs often do not bill in the same manner as traditional health care providers, making it difficult for MCOs to report expenditures as encounters or allowable Medicaid costs

# NMDOH Financing

- **Value-Added Services:** All responding MCOs indicated they offer some form of NMDOH intervention as a VAS
  - Additional transportation, food related needs, housing needs, and assistance in identifying community resources
- **PIPs**: All responding MCOs reported having at least one PIP that includes an NMDOH-related intervention
  - Member outreach, education, and assistance programs addressing NMDOH needs
  - In-home NMDOH assessments to evaluate non-medical factors like housing stability and food security.
- **Quality Improvement:** Four health plans indicated they have some type of program that includes NMDOH-related activities that they categorize under QI

# HB 26 – ILOS Nutrition Support Services

- MCOs consistently identified the need for clear guidance from HHSC while maintaining flexibility to integrate nutrition ILOS into existing or future initiatives
- Many questions regarding provider type that will be allowed to bill
- MCOs need HHSC to clearly identify billable CPT codes and provide clinical guidance
- Concerns expressed regarding the benefit of nutrition instruction and counseling services without the provision of food
- One MCO mentioned the importance for HHSC to align with other ILOS requirements
- Eight MCOs indicated they have some type of targeted food program they are supporting – most designed to address for various conditions and episodes of care including obesity, healthy eating for pregnant women, heart disease, diabetes, and asthma

# HB 1575 Implementation

- All MCOs have open networks for CHWs and doulas but most indicated they have received limited outreach
- Several MCOs indicated they already use doulas but for a greater scope than what is allowed under HB 1575
- Several MCOs indicated they would like to use CHWs with other populations other than just pregnant women and children
- The majority of MCOs indicate they already employ CHWs internally
- The majority of MCOs expressed concerns around duplication of Service Coordination
- MCOs consistently reported that Medicaid enrollment and billing present significant barriers for CHWs and doulas

# HHSC Updates: HB 1575 & HB 26

Joelle Jung, MPH
Manager, Delivery System Quality & Innovation, Medicaid & CHIP Services, HHSC

# Agenda

1. **H.B. 1575:** Update on MCO-reported Data **"Non-Medical Needs Screening Report"**
2. **H.B. 26: Implementation Update on** Nutrition Support Services ILOS
3. **Questions**

# H.B. 1575 **Summary (88th** TX Leg.**)**

- Medicaid managed care organizations (MCOs) and Thriving Texas Families (TTF) screen pregnant women for non-medical health-related needs and coordinate services
- Pregnant women must opt-in

- MCOs and TTF share results with HHSC

- Community Health Workers (CHW) and Doulas as new providers of Medicaid case management for Children and Pregnant Women (CPW) case management services
- Revised provider training for CPW services

- Report sent to the Legislature every two years

# Medicaid Managed Care
# Non-Medical Needs Screening Report: Update

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## Highlights

- MCOs continue to submit the Non-Medical Needs Screening Report monthly to HHSC. To date, MCOs have submitted data for 17 total reporting months (Sept. 2024 – Jan. 2026).
- HHSC continues technical assistance efforts to help MCOs improve accuracy of reported data. Total number of MCO-reported errors has decreased over time.

### Next Steps

- 2026 Legislative Report due Dec. 2026

# Medicaid Managed Care
# Non-Medical Needs Screening Report:
# Snapshot of Oct 2025 Data

TEXAS Health and Human Services

| Non-Medical Needs among Pregnant Women Screened in Oct 2025 | | |
|---|---|---|
| **Non-Medical Need** | **Identified Need** | **Want Help*** |
| Food Insecurity | 30% | 69% |
| Transportation | 10% | 76% |
| Experiencing Homelessness | 2% | 53% |
| Housing Insecurity | 4% | |
| Paying Utilities | 13% | |
| Housing Quality | 7% | |
| Child Care | 20% | 90% |

*The denominator for the "Want Help" question is the subgroup of pregnant women with a positive screening result for the relevant non-medical need.

**Questions about H.B. 1575 non-medical needs screening:** DSQI@hhs.texas.gov

**Questions about H.B. 1575 doula and CHW requirements for CPW case management:**

askcm@hhs.texas.gov

# H.B. 26 **Summary (89th TX Leg.)**

- Requires HHSC to permit Medicaid managed care organizations (MCOs) to offer medically appropriate, cost-effective, evidence-based **nutrition counseling and instruction services** in lieu of services specified in the Medicaid state plan.

- Allows HHSC to establish a pilot that permits MCOs to offer the following in lieu of services (ILOS) to pregnant women with high-risk pregnancies through August 31, 2030:
  - **nutrition counseling and instruction services,**
  - **medically tailored meals**, in combination with nutrition counseling and instruction services,
  - **other evidence-based nutrition support services.**

- Requires HHSC to submit to the Texas Legislature:
  - annual report on all Medicaid ILOS,
  - one-time report on pilot ILOS.



https://capitol.texas.gov/tlodocs/89R/billtext/pdf/HB00026F.pdf#navpanes=0

# H.B. 26 Implementation Update

- **In Progress** – Literature review and research on existing Medicaid nutrition support services in Texas and other states.
- **In Progress** – Development of a draft proposal of the ILOS nutrition support services.
- **Spring 2026** – HHSC will request feedback from the State Medicaid Managed Care Advisory Committee (SMMCAC) and targeted external stakeholders on the draft proposal.

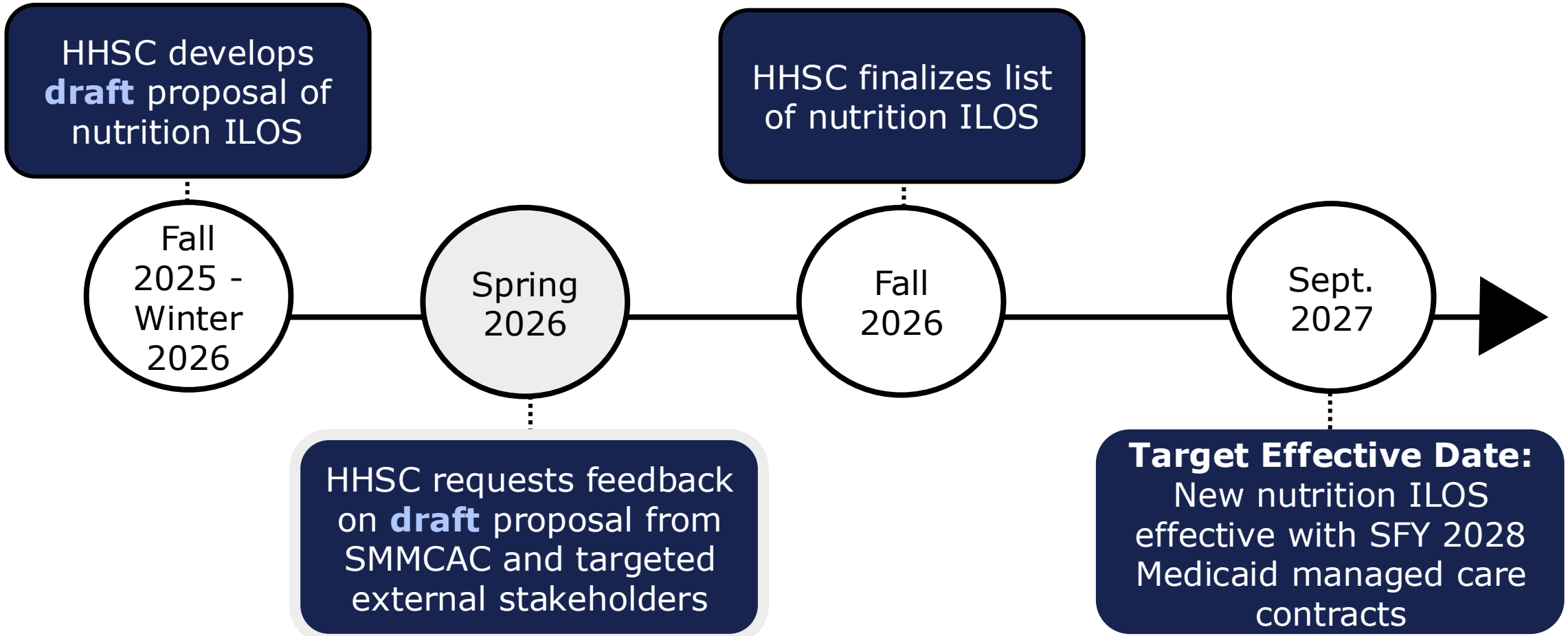
# SMMCAC and External Stakeholder Engagement

- HHSC's goal is to engage the SMMCAC and targeted external stakeholders during this draft development stage before the proposal for the new ILOS is finalized.
- HHSC will request feedback on the following categories of nutrition support services to implement in lieu of a Medicaid state plan service.

**Nutrition Support Services ILOS Categories as Described in H.B. 26**

| | ILOS 1 | ILOS 2 | ILOS 3 |
|---|---|---|---|
| **ILOS Category** | Nutrition Counseling and Instruction (NCI) | Medically Tailored Meals + NCI | Other evidence-based nutrition support services |
| **Target Population** | Medicaid managed care members | Medicaid managed care women with high-risk pregnancy | Medicaid managed care women with high-risk pregnancy |

# H.B. 26 High-Level Implementation Timeline



**Questions about H.B. 26 nutrition ILOS:** DSQI@hhs.texas.gov

# DSHS Updates: CHW Program & Diabetes Prevention

Raiza M. Ruiz, MPA, CPM
Community Health Worker & School Health
Branch Manager, DSHS

Samuel Ortiz Severiano
Diabetes & CVD Branch Manager, DSHS

# CHW Program Updates

# Program Scope

- Manage the rules and policy framework for the CHW program.
- Provides certification for:
  - Promotores or CHWs (required to receive compensation)
  - CHW instructors
  - Training programs
  - Training curricula

**The CHW Program does not create training curricula or train CHWs or CHW instructors.*

*For more information visit [CHW Website]*

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# Texas Certification Trends: December 2022 to February 2026

- **Total certified CHWs:**
  - 120% increase (4,909 to 10,800)
- **Counties with CHWs, from a total of 254:**
  - 28% increase (152 to 194)
- **Training Programs:**
  - 29% increase (51 to 66)

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# Core Competency Enhancements

- DSHS approved updates to the CHW core competencies in August 2024 to:
  - Support expanded and varied CHW roles that are essential to improving the health of Texans; and
  - Incorporate nationally recognized standards.
- These changes became **effective February 1, 2026**
- Training centers must use an initial training curriculum that aligns with the new competencies by August 1, 2026

# What Changed

Nine Core Competencies (Up from eight)

1. Communication Skills
2. Interpersonal **and Relationship-Building Skills**
3. Service Coordination **and Navigation Skills**
4. Capacity-Building Skills
5. Advocacy Skills
6. Teaching **and Education Skills**
7. Organizational Skills
8. Knowledge Base on Specific Health Issues
9. **Evaluation and Research Skills** (New)

Core Competencies | Texas DSHS

# CHW Program Policy

The CHW Program Policy has been updated and includes these new requirements among other changes:

- Enhanced core competencies requirements, including the increase in the initial certification course from 160 to 180 hours.
- Five year expiration date and renewal requirements for DSHS-certified curricula.
- Proof of Texas residency for CHW and CHW instructor applications.
- New Experience Verification Form for CHW and CHW instructor applications based on experience.
- Streamlined Sections 13 and 14 reflecting rule changes required by Senate Bill (SB) 1818, relating to certification for military service members, military spouses, and military veterans.
- New Section 16 relating to applicants and certification holders with a criminal conviction, as required by SB 1080.

*The Policy is also available in Spanish.*

# CHW Program Forms and Templates

All CHW Program application forms and templates have been updated:

- CHW Certification Initial and Renewal Applications
- CHW Instructor Certification Initial and Renewal Applications
- Reciprocity Application for Military Service Member, Military Veteran, and Military Spouse
- Request for Experience Verification Form
- Training Program Certification Initial and Renewal Applications
- All curriculum templates

*The Spanish version of the applications are being posted on the CHW Program website as they become available.*

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# Texas CHW Partnership

- As of November 4, 2025, the Promotor(a) or Community Health Worker Training and Certification Advisory Committee has been discontinued.
- New Texas CHW Partnership starting in 2026 to continue the collaboration
  - DSHS will use a membership form to recruit members to the Partnership
  - The first meeting is tentatively scheduled for July 1, 2026
  - Additional partnership details will be shared on the Community CHW Program webpage.

# HB 1575: DSHS/HHSC Collaboration

- The implementation of HB 1575, 88th Legislative Session, falls under the purview of the Health and Human Services Commission.
- The DSHS CHW Program provides CHW certification data for planning purposes, as requested.
- You may verify certification status or search for a certification in the Online Licensing Services webpage.
  - Search by name, certification number, city or county.

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# Diabetes Curricula

| DSHS-Certified Training Program | Continuing Education Curriculum Title | Total Number of Hours |
|---|---|---|
| **Texas AHEC East Dallas FortWorth (DFW)** | Diabetes + Your Eyes | 1 |
| **Baylor Scott and White Health** | Thought Provoking Facts about Diabetes | 1.75 |
| **Texas A&M Center for Population Health and Aging** | Diabetes Self-Management Education | 2.5 |
| **University of Houston CHW Initiative Honors College** | Atypical Diabetes and Trust in Research | 2 |
| **Familias Triunfadoras** | Focus on Diabetes | 2 |
| **Empowering the Masses** | Diabetes Prevention And Management | 3 |

# The Diabetes Prevention and Control Program at DSHS

# Diabetes Burden

According to March 2023 data from the American Diabetes Association:

- An estimated 12.3% of all adults (about 2.7 million adults) in Texas have been diagnosed with diabetes.
  - This figure is corroborated by the Behavioral Risk Factor and Surveillance System (BRFSS).*
  - About 621,000 Texans may have undiagnosed diabetes, greatly increasing their risk of serious health complications.
  - Each year, an estimated 177,174 Texans are diagnosed with diabetes, and prevalence is expected to increase to 23.8% by 2040.
- An estimated 34% of all Texas adults (about 7.1 million adults) have prediabetes.
  - Blood glucose levels higher than normal but not diagnosed as diabetes.

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*CDC - 2023 BRFSS Survey Data and Documentation*. (2024). Cdc. https://www.cdc.gov/brfss/annual_data/annual_2023.html

# Diabetes Burden

- Prediabetes increases the likelihood of developing Type 2 diabetes and cardiovascular disease (CVD).
- Diabetes increases the likelihood of developing serious complications including but not limited to: CVD, amputation, kidney disease, blindness, and death.
- Medical expenses are about 2.3 times higher for people with diabetes compared to people who do not have diabetes.
- The annual financial burden of diabetes is an estimated $25.6 billion in Texas.
  - $18.9 billion in direct medical costs (e.g., in-patient services, medications, medical supplies, etc.)
  - $6.7 billion in indirect medical costs (e.g., reduced productivity, absence from work, etc.)

*American Diabetes Association. (2018). *The Burden of Diabetes in Texas*. https://diabetes.org/sites/default/files/2023-09/ADV_2023_State_Fact_sheets_all_rev_Texas.pdf

# Diabetes Prevention and Control Program (DPCP) Overview

- The Diabetes Prevention and Control Program oversees federal and state programs that focus on community-based diabetes prevention and self-management programs.
- The goals of the DPCP are to:
  - Prevent type 2 diabetes in persons at high risk for developing the disease.
  - Prevent or delay complications in persons with diabetes.
  - Assist persons who have diabetes in managing the disease and the complications that result if untreated.

# Diabetes Self-Management Education and Support (DSMES)

**DSMES provides personalized services to help individuals manage diabetes while teaching practical strategies to adapt diabetes care into everyday life.**

- DSMES offers ways to:
  - Set and track your health goals
  - Use knowledge, skills, and tools to manage diabetes
  - Fit diabetes care into your everyday routine
  - Create a plan and apply the seven key self-care behaviors
- Benefits of participating:
  - Improvement in blood sugar levels and overall health
  - Prevention or delayed onset of complications from diabetes
  - Reduced healthcare costs
- Eligibility:
  - Must be diagnosed with diabetes
  - Must have a written referral from one of the following healthcare practitioners:
    - Physician (i.e., MD, DO)
    - Physician Assistant (PA)
    - Nurse Practitioner (NP)
    - Advanced Practice Nurses (APN)
- When to refer to DSMES:
  - At diagnosis or annual checkups
  - When diabetes complications develop
  - When life events happen that make diabetes management harder

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# The National Diabetes Prevention Program (National DPP)

**The DPP delivers an accessible, CDC-approved lifestyle change program (LCP) to prevent or delay type 2 diabetes and its complications.**

- Components of the LCP:
  - How to build healthy lifelong habits
  - Provide skills to improve health, encourage physical activity, and cope with stress and challenges
  - Encourage camaraderie and group support
  - Taught by trained lifestyle coaches
- Benefits of participating:
  - Affordable, evidence-based program that promotes behavior changes and a healthy lifestyle
  - Reduced risk of type 2 diabetes
  - Offers strategies to improve overall health and reduce risk of chronic disease
- Eligibility:
  - 18 years and older
  - BMI >25 (>23 for Asian American persons)
  - No previous diagnoses of type 1 or 2 diabetes
  - Must not be pregnant
  - Must meet ONE of these criteria:
    - Diagnosed with prediabetes
    - Previously diagnosed with gestational diabetes
    - At high-risk of prediabetes

# Community Diabetes Education Programs (CDEPs)

- CDEPs work to identify cases of undiagnosed diabetes and prediabetes, provide education on preventing and managing diabetes, and help reduce overall morbidity from diabetes in underserved populations.
- These activities include, but are not limited to:
  - Creating and maintaining bi-directional referral systems to connect individuals with:
    - Diabetes testing resources/services based on health indicators.
    - Evidence-based diabetes education/prevention programs (e.g., DSMES, National DPP).
  - Organizing free or low-cost HbA1c testing events
  - Participating in advisory groups to help build a network of resources.
  - Offering accessible DSMES, National DPP, and other evidence-based LCP classes
    - Flexible medium (i.e., online, in-person, hybrid) and classes located in central areas.
    - Flexible hours (i.e., classes after work hours, weekends, and make-up sessions).
    - Classes available in Spanish.

# Community Diabetes Education Programs (CDEPs)

- DSHS partnered with organizations across the state to carry out CDEP activities who serve areas with a high-disease burden from diabetes.
- The following seven entities implement CDEP services within their service areas and surrounding counties using General Revenue (GR) funds awarded by DSHS:

**Local Health Departments:**

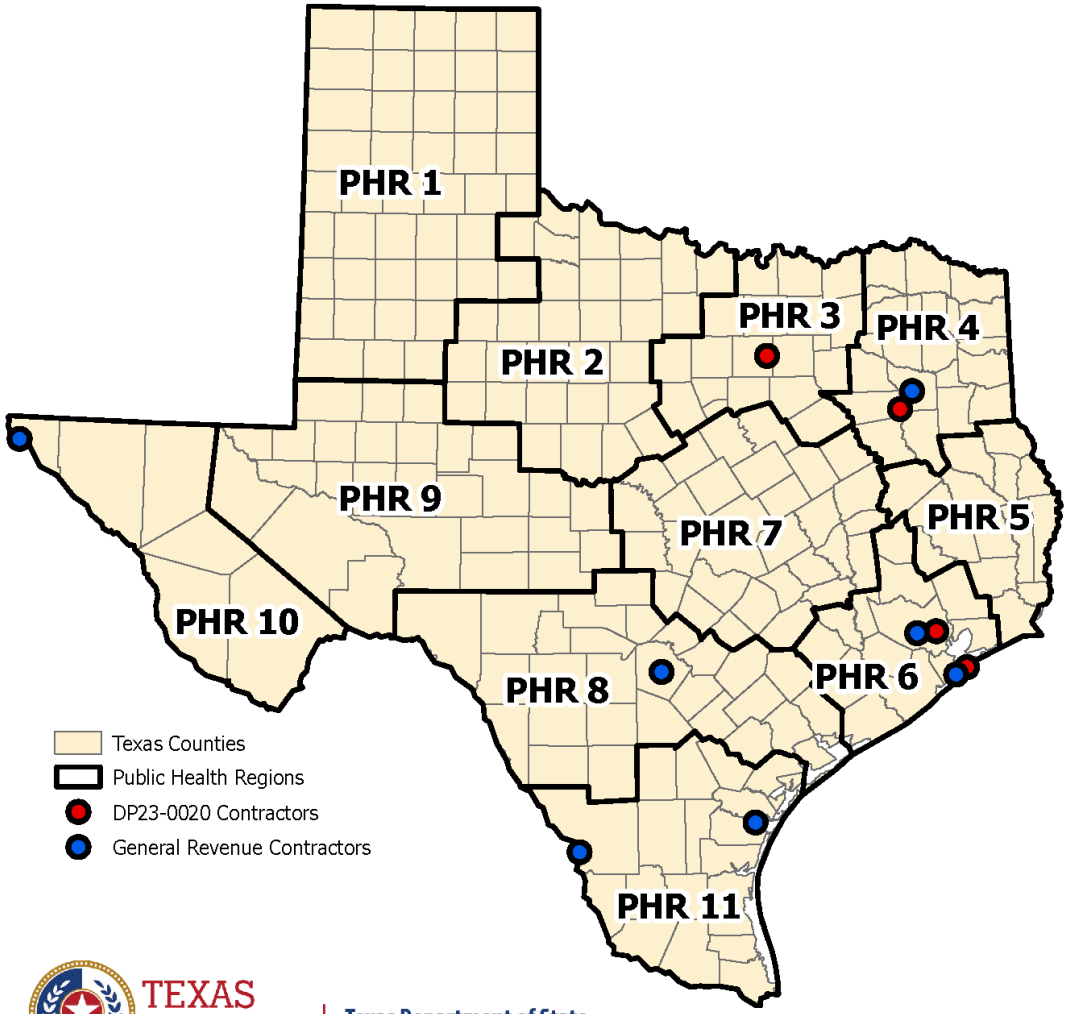
- City of Laredo Health Department
- Houston Health Department
- Northeast Texas Public Health District (NET Health)
- The City of El Paso Health Department
- City of San Antonio Metropolitan Health District (SAMHD)

**Academic Institutions:**

- Texas A&M University Health Science Center
- The University of Texas Medical Branch at Galveston (UTMB)

- Similar activities are also carried out by four contractors funded by a diabetes federal grant. However, they are driven by evidence-based strategies from the CDC.

# Diabetes Prevention and Control Program Contractor Site Locations, 2025




| DP23-0020 Contractors |
|---|
| Dallas-Fort Worth Hospital Council |
| University of Texas Medical Branch |
| UTHealth East Texas |
| UTHealth Houston |

| General Revenue Contractors |
|---|
| Houston Health Department |
| City of Laredo Health Department |
| Northeast Texas Public Health District |
| University of Texas Medical Branch |
| El Paso Health Department |
| City of San Antonio Metropolitan Health District |
| Texas A&M Health Science Center/ Costal Bend Health Education Center |

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Created by Chronic Disease Epidemiology Branch, July 2025

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# Diabetes Resources

**Diabetes Prevention and Control Program (DPCP)**
- Learn more about the Texas Diabetes Prevention and Control Program
- For diabetes education materials in English/Spanish
- Contact Us for more information at Diabetes@dshs.texas.gov

**Diabetes Self-Management and Education and Support (DSMES)**
- For more information on how to become an Accredited or Recognized DSMES Provider
- To find a DSMES class near you with the ADCES
- To find a DSMES class near you with the ADA

*As your doctor for a referral!*

**National Diabetes Prevention Program (National DPP)**
- For more information on how to become a Recognized National DPP provider
- To find a National DPP class near you

**Prediabetes Risk Test**
- To take the 1-minute risk test (available in English and Spanish)

# Thank you!

chw@dshs.texas.gov
diabetes@dshs.texas.gov

# North Texas Maternal Health Incubator

Cameron Combs
Senior Director, Child Poverty Action Lab

# Maternal Health Accelerator

TCU BURNETT SCHOOL of MEDICINE

UT Southwestern Medical Center

## MCO Learning Collaborative

MARCH 2026

CPAL

# **Background** | ARPA-H launches a federal healthcare moonshot called HEROES

Health Affairs

FEBRUARY 27, 2026

## One Step Forward And One Step Back For US Health

*“A massive coalition in North Texas, is still working to launch a large-scale outcomes-based payment model for iron supplementation and broad investments in birthing care to prevent severe maternal bleeding complications”*



Source: "One Step Forward And One Step Back For US Health", Health Affairs Forefront, February 27, 2026 . Link

# **Background** | ARPA-H launches a federal healthcare moonshot called HEROES

Health Affairs

FEBRUARY 27, 2026

## One Step Forward And One Step Back For US Health

*"Three years ago, with bipartisan support, Congress set up a **"health care moonshot" agency called the Advanced Research Projects Agency for Health (ARPA-H**). (It's the health version of the Defense Advanced Research Projects Agency, the guys that brought you radar and the internet.) ARPA-H is intended to take bold bets on breakthrough health solutions. One of its first programs was the HEalth care Rewards to Achieve Improved OutcomES; because all ARPA-H programs must have acronyms, it was called HEROES.*

***HEROES was a fundamentally good idea**. It recognized that the way we've traditionally paid for health care isn't working very well. So instead of adding another layer of complexity to health care finance, with another 600 pages of regulations and waivers and billing codes, it offered a different strategy: **Choose a few giant, meaningful goals, such as a 10 percent citywide reduction in opioid overdoses; set up a clear system for measurement standardized at the federal level; and pay only if partners within those communities actually meet those goals**. Crucially, the outcomes covered the entire population in a geographic area, such as the entire state of Oklahoma or the Atlanta, Georgia, metropolitan area, regardless of insurance status or demographics.*

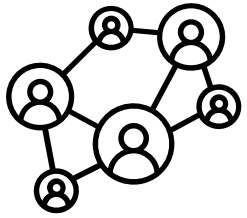
*Then, **keep your hands off** and let them experiment, **trusting partners** to know their context best while **incentivizing them to achieve good results**."*



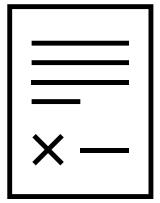
Source: "One Step Forward And One Step Back For US Health", Health Affairs Forefront, February 27, 2026 . Link

# **Trust** | “Accelerators” build generalized trust that benefits the State and MCOs

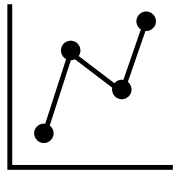
Regional “accelerators” (“action networks”) improve the entire ecosystem’s ability to enter outcome-based contracts across funder types by increasing trust



Incentivize multisectoral **relationships** that improve outcomes



Develop **foundational contracts** and systems



Enhance the region’s **data—currency of trust**

- New types
- Better quality
- More recent

# **Background** | Texas wins HEROES; Feds cancel HEROES; MHA launches anyway

## Timeline

**2022:** Fort Worth Mayor Mattie Parker partners with TCU to reduce maternal and infant mortality rates

**Spring 2024:** ARPA-H launches HEROES; CPAL facilitates partnership between TCU (Fort Worth) and UT Southwestern (Dallas) to create Maternal Health Accelerator

**Winter 2024**: MHA applies to HEROES with five major health systems, over 120 partner organizations, and $23.5M in philanthropic match commitments from 11 Texas foundations

**Spring 2025**: ARPA-H selects MHA as one of six winners, beginning four-month contract negotiation

**June 2025:** Mayor Parker and MHA work with Texas Legislature to appropriate $5M for outcome-based programs reducing SOCs

**August 2025**: ARPA-H and TCU conclude contract negotiations; HEROES cancelled days later, eve of contract execution

**November 2025**: MHA launches anyway thanks to sustained support from funder, healthcare, and community partners




*Mayor Mattie Parker (Fort Worth), Dr. Cathy Spong (Department Chair, UT Southwestern), Chancellor Daniel Pullin (TCU), & Dr. Ann Barnes (CEO, Episcopal Health Foundation) at MHA launch event (November 2025)*

# Details follow

## Mission

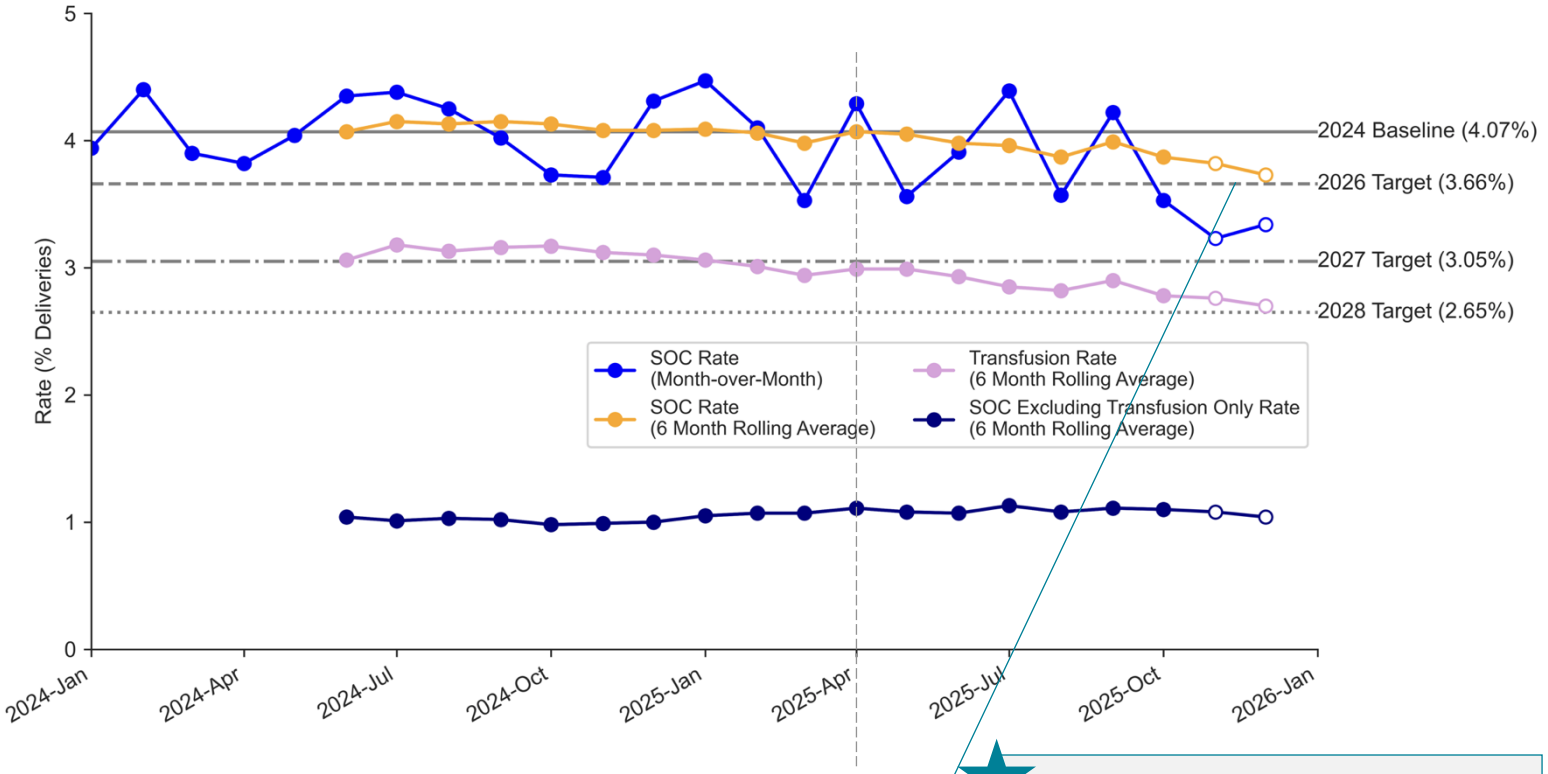
MHA's dual-pronged mandate to disrupt maternal healthcare

MHA retained the original scope of the ARPA-H HEROES program, with **two goals** to expand preventive care:

1. Reduce the *severe obstetric complication (SOC)* rate by 20%+ in a population of 5 million patients—the exact population of Dallas and Tarrant Counties
2. Create self-sustaining financial models for preventive care that last beyond the program period

# **SOC reduction** | Decrease in SOC rate in MHA's first months

## **SOC rate for Dallas and Tarrant Counties,** ~60,000 deliveries/year




MHA begins prenatal iron distribution

SOC rate (yellow line) is tracking towards reduction targets driven by lower transfusion rate (pink line)

Most of MHA's funding is outcome-based: Funders only pay MHA if it reduces the 6-month rolling SOC rate for Dallas and Tarrant Counties by 20% on average over three years

Implication: MHA needs to reduce the rolling six-month SOC rate (yellow line) from a 4.07% pre-intervention baseline to 3.66%, 3.05% and 2.65% by the end of 2026, 2027, and 2028

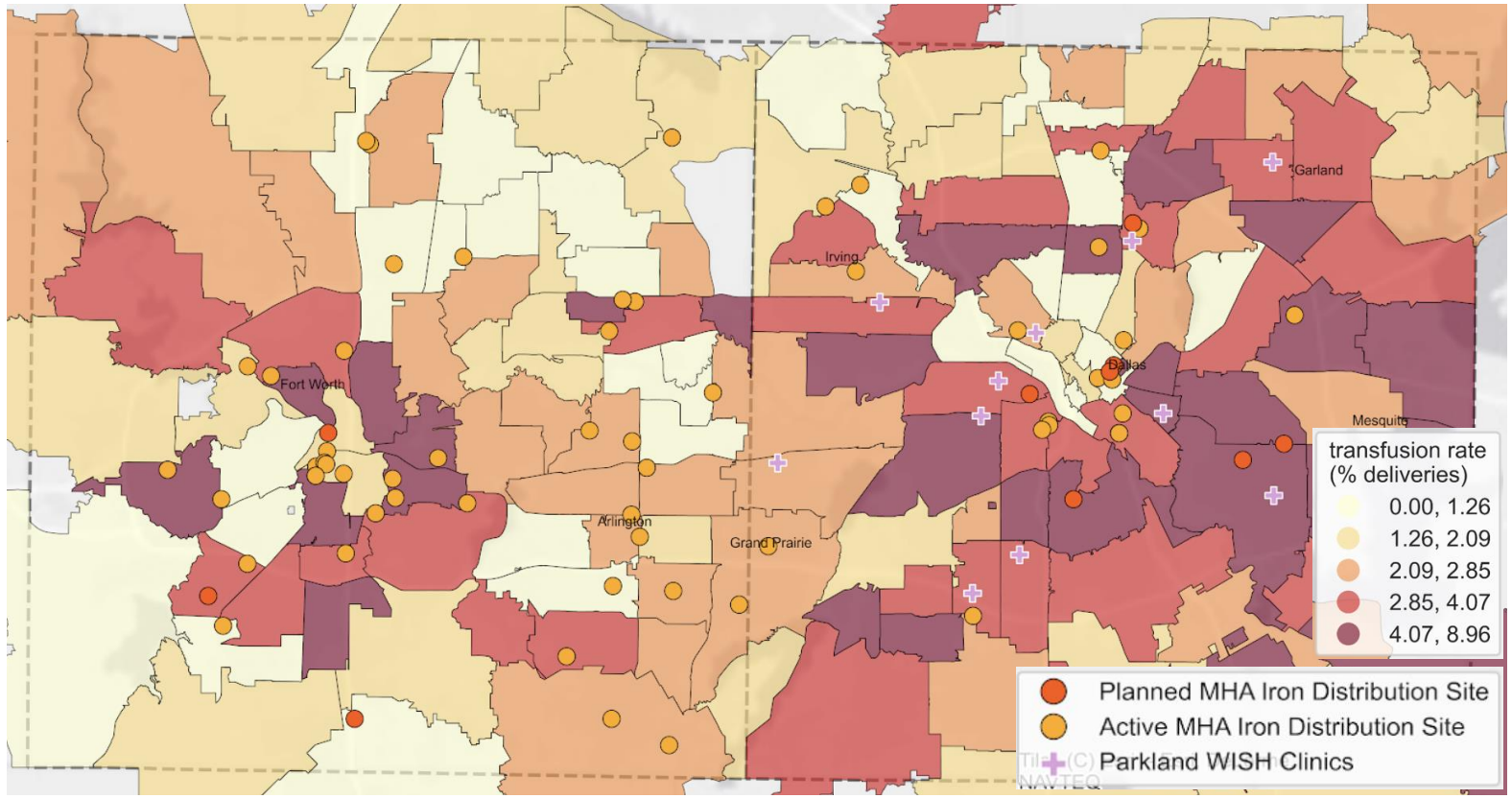
This translates to:

- ~500 averted SOC cases per year
- $50M+ in averted annual costs
- DFW SOC rate is in line with national average by end of Year 3

**Source:** DFW Hospital Council hospital claims data; presented by Parkland Center for Clinical Innovation (PCCI). **Note**: Data is preliminary for December 2025 and January 2026, and data capture remains open for 60-days postpartum, including January 2026.

# SOC reduction | Iron program exemplifies how real-time data drives strategy

## Rolling six-month transfusion rate and prenatal iron distribution sites




SOC data update monthly, iron distribution data updated in real-time

MHA delivers iron through a network of 75 clinics, e.g., FQHCs, independent practices, physician groups

This network accounts for a large share of sites where underserved patients receive prenatal care

But neighborhoods with transfusion rates in the 6-7% (~one-in-fifteen deliveries), like in southeast Dallas County, may not have nearby clinics

Approach: MHA is hiring community health workers and clinic outreach coordinators to expand access to prenatal iron in high-transfusion neighborhoods

**Source:** DFW Hospital Council hospital claims data; presented by Parkland Center for Clinical Innovation (PCCI). Data is for deliveries up to September 2025 with a 60-day postpartum monitoring period (i.e., through November 2025)

# Details follow

## Mission

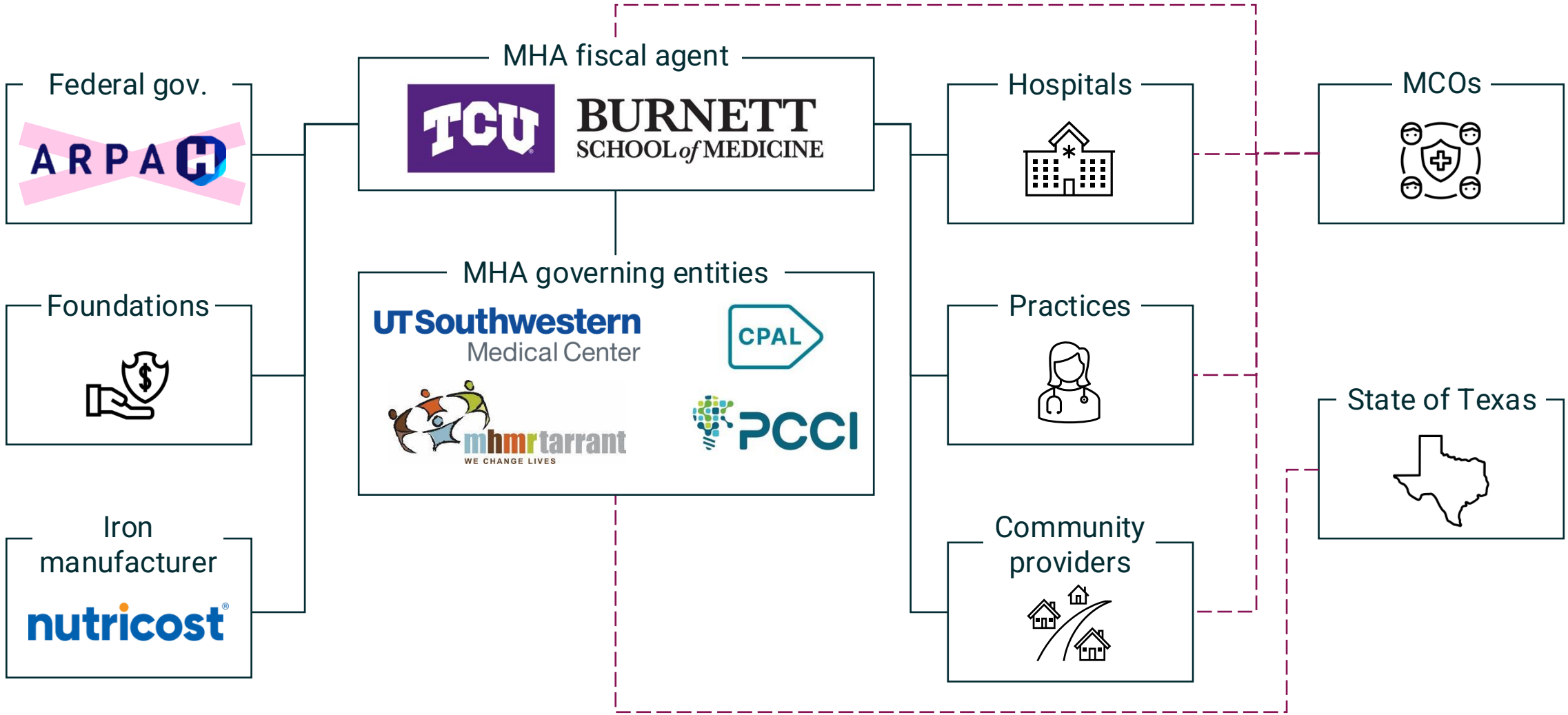
MHA's dual-pronged mandate to disrupt maternal healthcare

MHA retained the original scope of the ARPA-H HEROES program, with **two goals** to expand preventive care:

1. Reduce the *severe obstetric complication (SOC)* rate by 20%+ in a population of 5 million patients—the exact population of Dallas and Tarrant Counties
2. Create self-sustaining financial models for preventive care that last beyond the program period

In progress – details to follow

# **Contract structure** | 100+ contracts and counting support the MHA



# **MCO partnership** | Models under consideration

| | Parties | | **Models in flight and under consideration**, not exhaustive |
|---|---|---|---|
| 1 | MCOs | Community providers | Pay for quality agreements targeting maternal health outcomes<br>Provider enrollment support, e.g., CHW/doulas as CPW providers<br>Shared systems, e.g., Help Me Grow care navigation |
| 2 | MCOs | Practices | Maternal medical home models that incorporate MHA services |
| 3 | MSOs | Community providers | Pay for quality agreements targeting maternal health outcomes |
| 4 | MCOs | Hospitals | MHA provides third-party designation validating hospitals' participation in coalition and outcome improvements<br>MCOs reimburse hospital providers at enhanced rate |

# **State of Texas partnership** | Maternal Health Outcome (MHO) Program

## Funding

$5 million authorized under the 2026-2027 General Appropriations Act

MHO funding structure: Monthly cost reimbursement aligned with pre-determined project scope

## Service

Enhance, expand, or modify existing MHO program:

- Directly target at least on SOC
- Not support direct clinical care
- Strengthen care coordination
- Ensure program sustainability

Performer must be Medicaid provider

## Outcome

Monthly reporting

- Client-level MHO-funded services
- Outcome data



**Source:** Texas Health & Human Services RFA No. HHS0016838

# **State of Texas partnership** | MHA proposal to MHO Program

Maternal Health Accelerated (MHA) applied to MHO via MHMR, which:

- Is a Medicaid provider
- Brought national care navigation model, Help Me Grow, to Texas in partnership with DSHS and expanded it into perinatal space

MHO proposal: Expand care navigation for perinatal patients, pre- and postpartum, through both MHMR and hospital-aligned navigators

Reporting: Client-level service provision, population-level outcome trends

## Opportunity to establish trust

How can the State and performers use this opportunity determine what constitutes an “outcome?”

- Methodology to define SOC
- Acceptable data lag
- Performers’ data sources

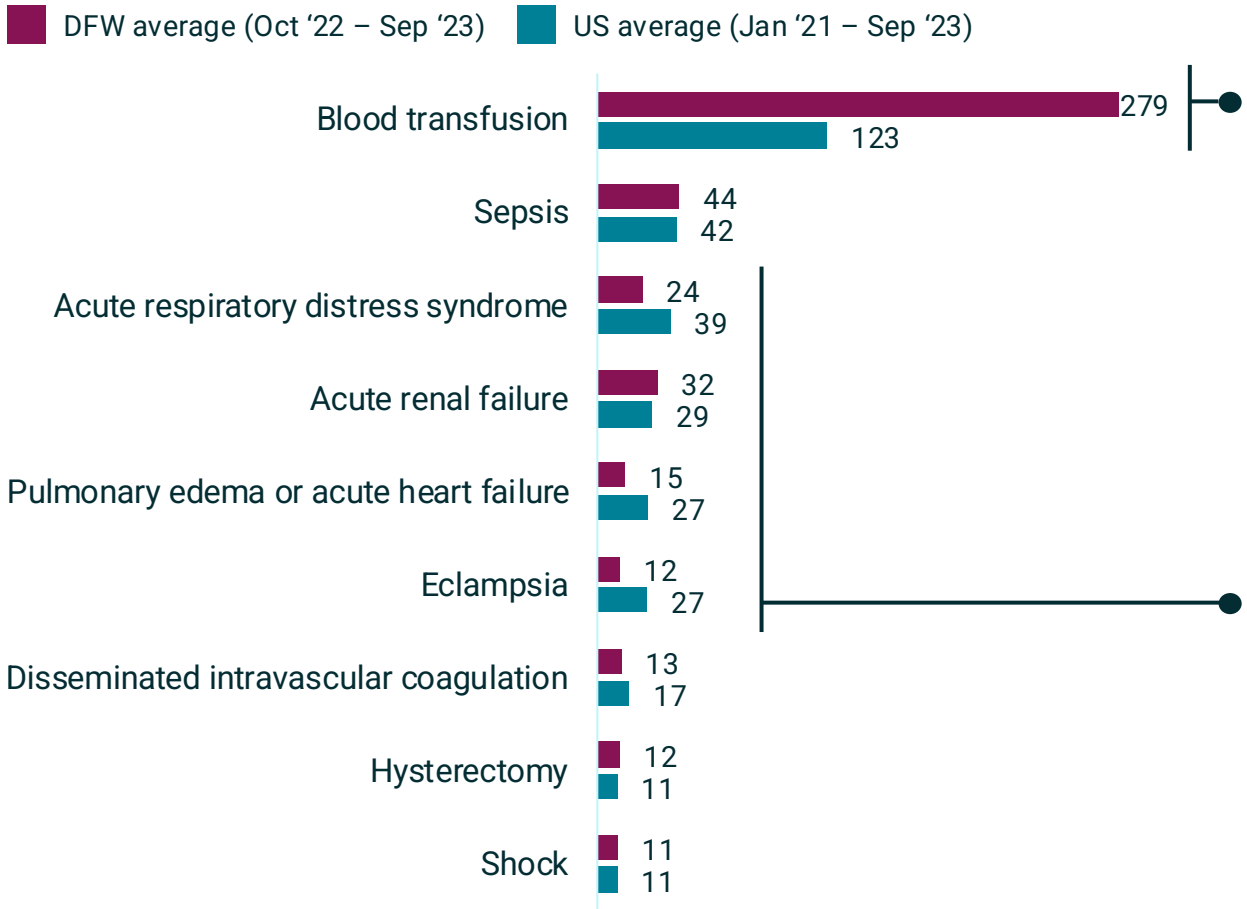


**Source:** MHMR of Tarrant County application to Texas Health & Human Services RFA No. HHS0016838; submitted February 2026

# Appendix

# **SOC reduction** | Transfusions and hypertension are two key drivers

## **Incidence of most common SOCs**, Rate per 10k births




## **Two largest drivers of SOCs**

**1. Anemia**: ~75% of SOCs in DFW are transfusions

Rate of transfusions in DFW (~3% of deliveries) is more than twice the national average estimated by ARPA-H (~1.5% of deliveries)

Underserved patients are especially vulnerable due to higher prevalence of anemia during pregnancy: as many as one-in-fifteen mothers in some DFW communities are transfused (6-7% of deliveries)

**2. Hypertension**: Largest driver of readmissions and SOCs like eclampsia and renal failure

One-in-four postpartum hypertension readmissions in DFW are to a different hospital than where patient delivered, creating major care continuity challenges [4]

CPAL | Maternal Health Accelerator | TCU Burnett School of Medicine | UT Southwestern Medical Center

**Source and notes:** US data (~50% coverage) provided by HealthVerity, Inc data, as presented during HEROES Proposers' Day (Feb 14, 2024), classifications via Outcome Toolkit. DFW data generated by PCCI May 2024 using DFW Hospital Council data (~99% coverage).

# **SOC reduction** | MHA selected four interventions with evidence-based impact

| **Four evidence-based interventions** | **Why it works,** based on evidence on North Texas' own patients |
|---|---|
|  Universally provide prepartum iron supplementation (on-site, no charge) to reduce transfusions due to anemia | 20-30% of pregnant patients (even on "prenatals") develop iron deficiency anemia→ underserved at much higher risk for transfusion[1]<br><br>UT Southwestern/Parkland finding: *Handing* patients a bottle of prenatal iron supplements, *not just recommending they take one*, reduces postpartum transfusion risk by one-third[2] |
|  Standardize simulations for postpartum hemorrhage and hospital coding for peripartum acute kidney injury (AKI) & sepsis | UT Southwestern finding: Simulating postpartum hemorrhage across doctors, nurses and departments in a physiologically safe and standardize way significantly reduces average blood loss[3] |
|  Discharge hypertensive patients with blood pressure cuffs coupled with virtual and home-based provider visits ("integrated practice units") | Hypertension is leading driver of postpartum readmissions; one-in-four in DFW are to a different hospital than where patient delivered[4]<br><br>UT Southwestern/Parkland: Launched award-winning postpartum program recognized by Joint Commission for chronic conditions[5] |
|  Enhance bidirectional referrals between hospital and community partners to address non-medical drivers of health (NMDOH) | ~80% of modifiable health factors are NMDOH[6]<br><br>MHMR: Brought leading care navigation program to Texas (Help Me Grow) and launches expansive nurse visit program[7]<br><br>PCCI: Provides public health practitioners with census-block level NMDOH data on NMDOH[8] |

# **SOC reduction** | MHA has made progress against each intervention

| Four evidence-based interventions | Progress to date |
|---|---|
| Universally provide prepartum iron supplementation (on-site, no charge) to reduce transfusions due to anemia | 75 sites have received >22,000 bottles of iron supplements since April 2025, distributing them to their pregnant patients; dozens more locations in the pipeline |
| Standardize simulations for postpartum hemorrhage and hospital coding for peripartum acute kidney injury (AKI) & sepsis | 6+ hospitals are scheduled to receive simulation support within the first 6 months of 2026<br><br>3 health systems have already approved and rolled out the standardized AKI coding definition |
| Discharge hypertensive patients with blood pressure cuffs coupled with virtual and home-based provider visits ("integrated practice units") | Hypertensive mothers at 10 subcontracted hospitals are getting connected to no-cost blood pressure cuffs, nurse visits, & navigation to NMDOH supports<br><br>Nearly 40 other sites are actively onboarding |
| Enhance bidirectional referrals between hospital and community partners to address non-medical drivers of health (NMDOH) | Expansion of Help Me Grow care navigation program to 10+ North Texas partners, and integration with data tools from PCCI and the Parent Pass app |

*All interventions have proven impact based on published evidence on North Texas' own patient population*

# **Contract framework** | “Traditional” models in healthcare

**Grant**


**Fee-for-service**

# **Contract framework** | “Traditional” models in healthcare

## Grant


## Fee-for-service


- ⊕ Simple
- ⊕ No financial barrier to agent
- ⊕ Funder controls scope
- ⊖ Incentivizes effort not results
- ⊖ Not naturally self-sustaining
- ⊖ Funder bears risk

# **Contract framework** | Funders generally prefer outcome-based models

**Outcome-based**


- ⊕ Resource efficient
- ⊕ Naturally self-sustaining
- ⊕ Risk shifts to implementer

- ⊖ Requires working capital
- ⊖ Parties must agree whether an outcome did, or did not, occur

*Improved through **trust***

# **ARPA-H HEROES** | Genesis of Maternal Health Accelerator (MHA)'s mandate

## Service

Evidence-based interventions targeting largest drivers of severe obstetric complications (SOCs)

## Outcome

20% reduction in SOC rate for patient population of 5 million patients (60,000 deliveries)

*Key: ARPA-H provided outcome data and vetted performers' own reporting ability*

## Funding

$15 million from ARPA-H

*…plus* $30+ million from other "outcome buyers"

# Maternal Health Accelerator

TCU BURNETT SCHOOL of MEDICINE

UT Southwestern Medical Center

CPAL

# Outcome Based Contracting Project Updates

Matthew Melon
**Director, Social Finance**

Danielle Charpentier
**Director, Social Finance**

Zane Hefling
**Senior Advisor, Social Finance**

# EXPLORING OUTCOMES-BASED FUNDING OPPORTUNITIES

## NMDOH Learning Collaborative

*March 27th, 2026*

*Our work is generously supported by:*

Michael & Susan Dell FOUNDATION

TREATY OAK STRATEGIES

SOCIAL FINANCE

# OVERVIEW OF OUR WORK

In September 2025, Social Finance and Treaty Oak Strategies commenced work with the Michael & Susan Dell Foundation to **understand interest from insurers, providers, and community-based organizations in engaging in outcomes-based funding (OBF) to scale services addressing NMDOH that improve long-term health outcomes.**

| | |
|---|---|
| **Scope** | **Multiple in-depth conversations with insurers, HHSC, and other organizations** highlighted interest in improving members' outcomes and scaling services. |
| **Current Status** | **Five insurers** (Community Health Choice, Dell Children's Health Plan, Molina Healthcare, Sendero Health Plans, and UnitedHealthcare) **have indicated interest in participating in the OBF design phase.** |
| **Next Steps** | In the design phase (March 2026 – September 2026), **we will identify the populations, geographies, services, outcomes, and partners for the OBF pilots** aimed at improving outcomes related to maternal health and chronic conditions (current focus on asthma). |

# SHIFT TO THE DESIGN PHASE

Over the next few months, **Social Finance and Treaty Oak Strategies will work closely with insurers to design several OBF pilots**

| **Phase 1: Feasibility**<br>*September 2025 – February 2026* | **Phase 2: Design**<br>*March 2026 – September 2026* |
|---|---|
| **Gauge community interest** | **Design several OBF pilots** |
| ✓ **Understand the opportunities and barriers** that insurers, CBOs, providers, and other organizations face in engaging in OBF opportunities<br>✓ **Complete outreach to promising CBOs and other partners** who can deliver services that address NMDOH at scale<br>✓ **Convene insurers** to gauge interest in participating in OBF pilots | ❑ **Provide technical assistance** to insurers, CBOs, providers, and other partners to design OBF pilots<br>❑ **Collaborate with MSDF to convene other funders** to provide upfront funding<br>❑ **Finalize design for several OBF pilots** |

# PILOT PRIORITIES

Outreach to insurers, providers, and CBOs elevated priority geographies, health areas, and outcome areas for the OBF pilots

| | Current Priorities |
|---|---|
| **Geographies** | **Harris** and **Travis** Managed Care Service Areas |
| **Health Areas** | **Maternal health** and **chronic condition management** |
| **Outcome Areas** | *Maternal health:*<br>▪ Increased access to **prenatal care**<br>▪ Reduced **severe maternal mortality and morbidity**<br>▪ Reduced **perinatal mood and anxiety disorders**<br>*Chronic condition management:*<br>▪ Improved **diabetes management**<br>▪ Reduced **hypertension**<br>▪ Reduced **asthma-related acute care utilization** and **increased asthma medication ratio** |

# STAKEHOLDERS ARE INTERESTED IN OBF

We interviewed 25 organizations to gauge their interest in engaging in OBF to address NMDOH – and heard interest in exploring OBF approaches

# THEMES FROM INSURERS

## What are insurers looking for in a community partner?

- Established credibility and trust
- On-the-ground support
- Early identification and prevention

## How are insurers currently funding preventive services?

- Linked to specific, trackable health outcomes
- Measurable within annual contract cycles
- Value-added services

## What metrics and outcomes do insurers care about?

- Operational and quality measures (HEDIS measures)
- Cost of care

## What are the barriers to investing in preventive services?

- Insufficient funding, tight margins, and inflexible budgets
- Challenges with provider and member engagement

# THEMES FROM PROVIDERS & CBOS

### How are providers and CBOs collaborating to advance their efforts?

- Engaging array of partners
- Advisory bodies
- Elevating the voices of community members

### What do providers and CBOs need to offer more robust preventive services?

- Upfront funding
- Greater stability
- Resources to expand workforce

### What metrics and outcomes are providers and CBOs focused on?

- Standardized measures
- Maternal health outcomes
- NMDOH metrics

### What are the barriers from providers and CBOs' perspectives in funding preventive services?

- Limited staff, funding, and infrastructure
- Insufficient care coordination systems

# PRELIMINARY: OBF PILOT DESIGNS

The five insurers identified several preliminary outcomes of interest

## Harris County Service Area

Severe maternal mortality and morbidity

Perinatal mood and anxiety disorders

Food security

Acute care utilization for diabetes, asthma, and other chronic conditions or during postpartum period

Asthma-related acute care utilization and medication use

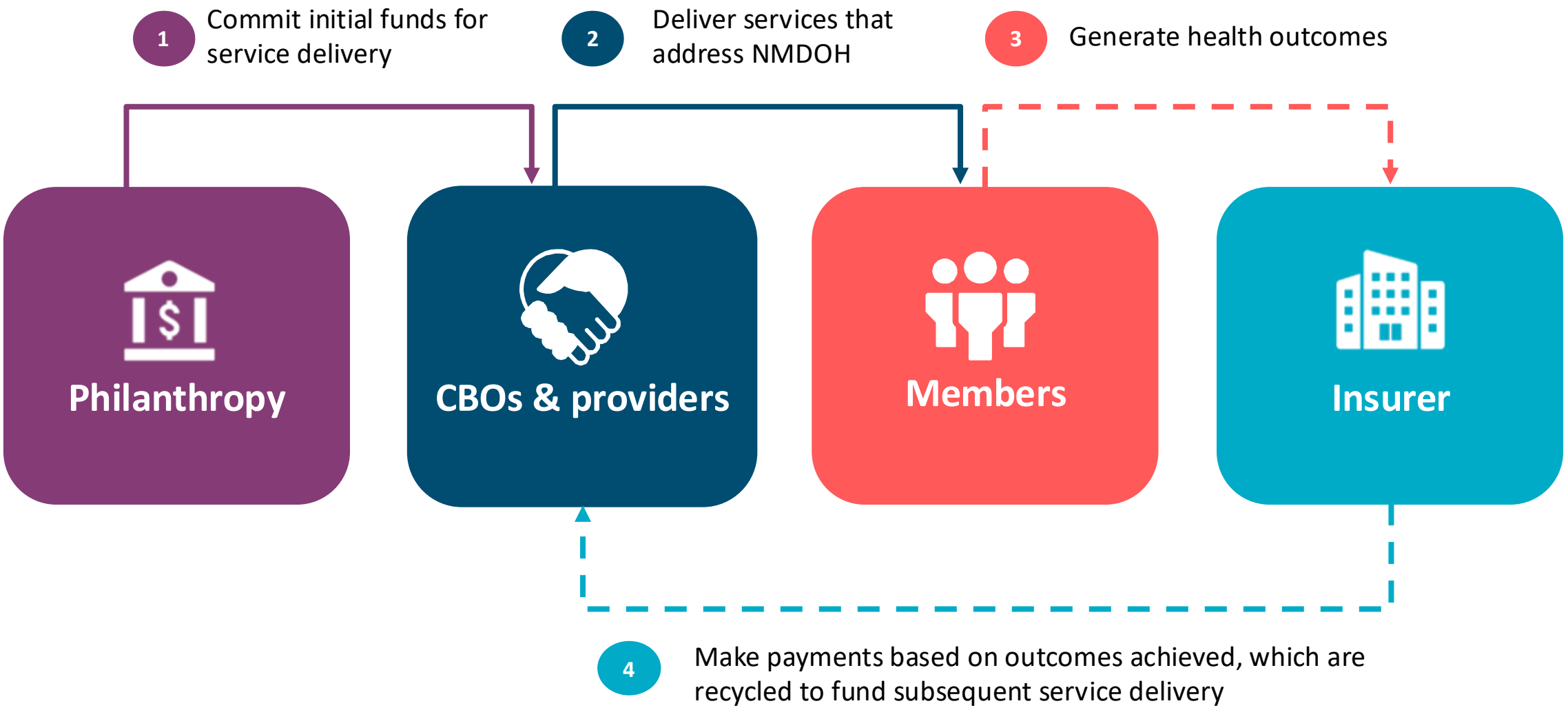
## Travis County Service Area

Access to prenatal care

Food security

Acute care utilization

# OUTCOMES-BASED FUNDING TO ADDRESS NMDOH



# INVITE FOR COLLABORATION

We are interested in collaborating with other partners to explore OBF arrangements

## Key activities will include:

- **Designing the service plan**
- **Identifying process metrics and longer-term outcomes**
- **Determining the final set of partners for implementation**
- **Finalizing and executing outcomes-based contracts**

## Interested in getting involved?

We're actively engaging community-based organizations, providers, and partners to help design and participate in these OBF pilots.

**If you'd like to explore participating, contributing input, or learning more, please reach out to:**

Danielle Charpentier at
**dcharpentier@socialfinance.org**

SOCIAL FINANCE TREATY OAK STRATEGIES

# THANK YOU


# Lunch Break

# National Policy Perspective

Matt Salo
Founder & CEO,
Salo Health Strategies

Shilpa Patel
Director, Population Health,
Center for Health Care
Strategies

# CHCS Approach to Work

**We partner with Medicaid stakeholders — including state and federal agencies, managed care plans, providers, community-based organizations and consumers — to promote innovations in health care delivery where they are needed most.**

Through our work, we:


Identify and advance best practices


Drive policy improvements with evidence and insights


Develop the capacity and expertise of health care leaders


Provide practical training, technical assistance, and tools


Spread success by connecting peers and experts across sectors



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# Agenda

- National Diabetes Prevention Program (NDPP) Scan
  - → Objective and Overview
  - → Interview Findings
- Rural Health Transformation Program (RHTP)
  - → Overview
  - → Texas RHTP
- Food is Medicine State Officer Program



Center for Health Care Strategies

# NDPP

- Proven, evidence-based framework to support behavior change to reduce onset of Type 2 diabetes, reduce long-term risk, and lower health care costs
- Year-long CDC-recognized lifestyle change program that focuses on healthier eating, increased physical activity, and long-term behavior change support
- Adults eligible for NDPP if they have prediabetes or meet criteria for elevated diabetes risk
- To address substantial disease burden and high costs of diabetes care, 31 states have opted to cover NDPP through Medicaid through 1115s, SPAs, and MCO pilots

# NDPP Scan: Project Objective

- To better understand design features, implementation experiences, and lessons learned on making the DPP a Medicaid benefit
- The scan and report would build on existing EHF resources:
  - Preventing Diabetes in Texas
  - Passion, Trust, Person-Centered: A Landscape Scan of Diabetes Prevention Programs in Texas
- Project Approach
  - Literature Review
  - Interviews with key stakeholders
  - Report to EHF

# Interviewed States by Coverage Mechanism

| | |
|---|---|
| **State Plan Amendment** | New York, beginning of 2020<br>Illinois, mid 2021<br>Michigan, mid 2023 |
| **1115 Demonstration Waiver** | North Carolina, beginning of 2022 |
| **Legislative Mandate** | Oklahoma, end of 2025 |

# Interviewee Key Takeaways

- Partnership during the design phase (i.e., public health, managed care, and providers) is paramount, especially for anticipating provider TA needs and determining a reimbursement model/rate structure
- Leveraging state contextual factors and leadership buy-in can support a state's road to NDPP Medicaid coverage
- MCO pilots can be a useful tool to demonstrate impact and support the development of SPAs to achieve coverage
- Billing efficiency, parity with Medicare reimbursement rates, and TA may yield higher provider enrollment and retention rates
- Requiring only organizations to enroll, and not individuals, may support NDPP provider enrollment
- Examining the national landscape for NDPP Medicaid coverage and leveraging state lessons can help build the case for adoption of NDPP coverage as a Medicaid benefit

# MCO Pilots

| | |
|---|---|
| **Michigan** | • Medicaid engaged MCOs and MI Association of Health Plans for a two-year, state supported NDPP pilot<br>• Selected higher risk participants, established BAAs with two NDPP providers, and paid providers using CDC 1815 funding<br>• At least one MCO provided in-kind support to help with implementation (e.g., staffing, outreach, member-facing resources)<br>• Over 80% of individuals who completed the pilot reached 1 of 3 desired outcomes (i.e., weight loss, combo of weight loss and physical activity, A1C reduction) |
| **Illinois** | • Leveraged previous CDC funding and TA to build strategic plan and path to NDPP coverage<br>• One-year MCO mock claims pilot program, funded by Meridian Health Plan of IL, in partnership with IL Public Health Institute<br>• Examined different payment rate structures, engaged MCOs in implementing NDPP, determined process for developing new provider types for reimbursement<br>• Tested claims and data sharing processes between 4 FQHCs and 1 MCO with no actual exchange of money |

# Metrics for MCO Pilots

Program engagement and retention (e.g., retention rate, attendance [per session] rate, participant satisfaction)

Clinical effectiveness (e.g., weight loss, A1C reduction, increase in physical activity)

Financial metrics (e.g., cost per participant, total medical cost reduction [hospitalization, emergency department visits)

Process metrics (e.g., ability to enroll NDPP providers into MCO systems and reimburse)

# Provider Types

- Physicians
- Nonphysician licensed practitioners (e.g., nurse practitioners, registered nurses, registered dieticians)
- Unlicensed practitioners under the supervision of CDC-certified NDPP providers or licensed practitioners (e.g., YMCAs, CBOs, food pantries, CHWs)

# Provider Recruitment and Retention

- Recruitment challenges included:
  - → Negotiating rates with non-traditional NDPP providers that lack experience contracting with Medicaid FFS or managed care.
  - → Administrative burden
  - → Professional liability insurance for non-traditional providers is cost prohibitive
- Retention challenges included:
  - → Lack of a point of contact
  - → Providers not billing Medicaid or contracting with all MCOs
  - → Lack of training on referring to NDPP
- To address challenges in provider recruitment and retention, states often provide supports such as technical assistance, trainings, and opportunities for providers to come together to discuss challenges and ways to overcome them

# Delivery Models

## Available models in all states interviewed

- In-person
- Distance learning (live)
- Online (asynchronous)
- A combination of the above methods

## Delivery in rural areas

- Community sites with captive audience
- Preference for in-person
- Telehealth
- Language access
- Disability access

# Reimbursement Models

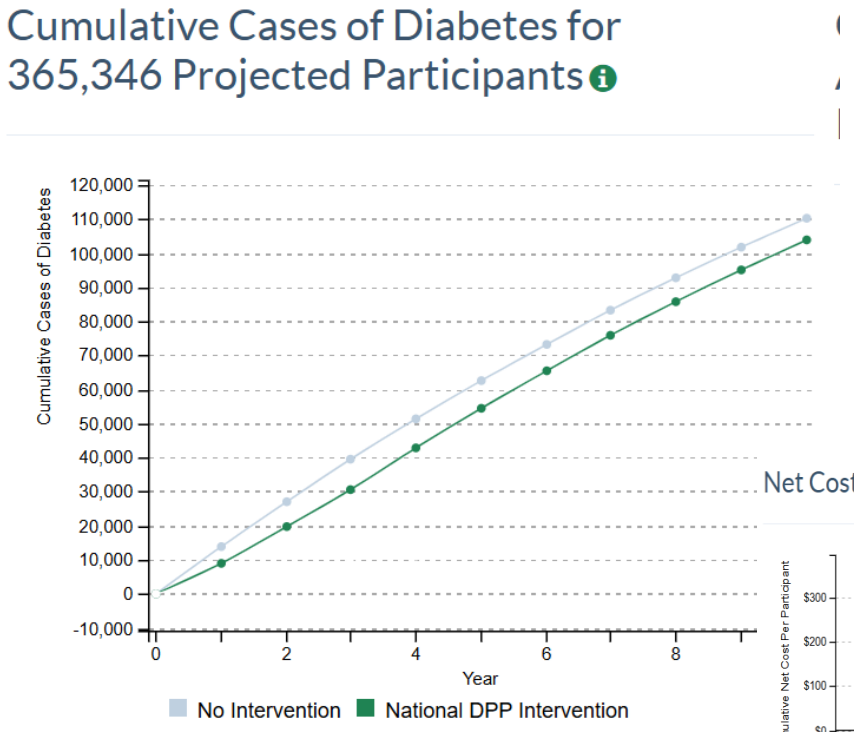
- Session vs. performance vs. completion-based
- Performance-based bonus payments
- Billing efficiency

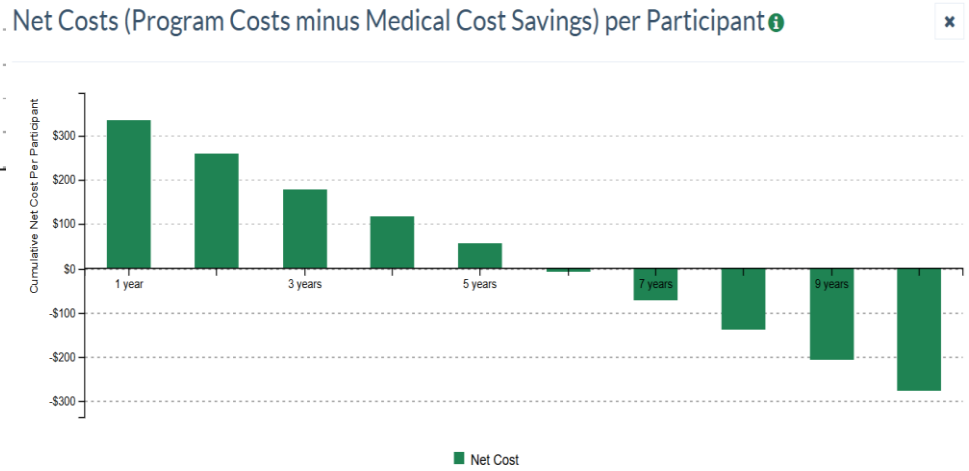
| STATE | MAXIMUM REIMBURSEMENT PER MEMBER |
|---|---|
| **Illinois** | $670 |
| **Michigan** | $755 |
| **New York** | $554 |
| **North Carolina** | $379 |

# Reimbursement Models

| STATE | MAXIMUM REIMBURSEMENT PER MEMBER | REIMBURSEMENT BREAKDOWN |
|---|---|---|
| **IL** | $670 | **Milestone 1**: Attending 1st core session<br>**$180** per-member reimbursement<br>**Milestone 2**: Attending 4 core sessions<br>**$150** per-member reimbursement<br>**Milestone 3**: Attending 9 core sessions<br>**$140** per-member reimbursement<br>**Milestone 4**: Attending 2 core sessions in months 7-9<br>Without 5% weight loss: **$30** per-member reimbursement<br>With 5% weight loss: **$50** per-member reimbursement<br>**Performance**: Achieve 5% weight loss from baseline<br>**$100** per-member reimbursement |

# Cost Effectiveness: Diabetes Prevention Impact Toolkit




*State Results Dashboard for MI, https://nccd.cdc.gov/Toolkit/DiabetesImpact/Dashboard*



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# Cost Effectiveness

- ROI report in Montana, the first state to offer NDPP as a Medicaid benefit in 2012:
  - →Lifestyle program (NDPP) cost $557 per participant.
  - →Treatment costs were approximately $11,268 per person with diabetes annually.
  - →Annual return on investment for preventing one case of type 2 diabetes was close to $10,711 per person.
  - →Overall, the program saves over $1.1 million each year in health care costs.

# Rural Health Transformation Program (RHTP)

- Strategic Goals:
  - → Make rural America healthy again
  - → Sustainable access
  - → Workforce development
  - → Innovative care
  - → Tech innovation
- $50 billion over five budget periods
  - → 50% distributed equally among all approved states
  - → 50% based on a variety of factors in application
- Texas received $281.3 million for the first year of the 5-year RHTP
  - → Continued funding depends on criteria such as availability of funds and satisfactory performance

*https://www.cms.gov/newsroom/press-releases/cms-announces-50-billion-awards-strengthen-rural-health-all-50-states*

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# TX RHTP: Rural Texas Strong

- Make Rural Texans Healthy Again
  - → Direct awards to rural hospital districts
- Rural Texas Patients in the Driver's Seat
  - → RFPs, competitive procurement to CINs, ACOs, or similar cooperatives supporting hospitals, clinics/physicians, and behavioralhealth providers
- Lone Star Advanced AI and Telehealth
  - → RFPs, competitive procurement to CINs, ACOs, or similar cooperatives supporting hospitals, clinics/physicians, and behavioralhealth providers
- The Next Generation of The Small Town Doctor and Team
  - → RFA for rural health providers, with at least one award per rural county
- Unified Care Infrastructure and Rural Cyber Protection
  - → Request for Offer for select vendors
- Infrastructure and Capital Investments for Rural Texas
  - → RFA for rural hospitals, RHCs, behavioral health providers, opioid and substance abuse programs, EMS, pharmacies, and other eligible providers



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# Food is Medicine (FIM) State Officer Program

- Help states advance FIM programming and improve access to healthy food for people with diet-related conditions by strengthening staffing and leadership capacity within state agencies.
- Participating states will receive:
  - → Funding to hire and support a FIM state officer for three years
  - → Training and technical assistance
  - → FIM State Officer Hub
- Facilitated by CHCS, the program is made possible by the **Food is Medicine Impact Fund**, a collaborative philanthropic initiative between The Rockefeller Foundation and Builders Vision hosted by RF Catalytic Capital.



Center for Health Care Strategies

HB 26: ILOS
**Stephanie Stephens**

HB 1575: Screening, CHWs and Doulas
**Shannon Kelley**

Data Sharing: MCOs, CBOs, Providers
**Laurie Vanhoose**

CBO and MCO Contracting
**Michelle Harper**

# Small Group Discussions

# Closing Remarks

Shao-Chee Sim

Laurie Vanhoose