

# Building Community-Oriented Medicaid Managed Care: Charting a Path Toward Reform

The Geiger Gibson/RCHN Community Health Foundation Research Collaborative and the Episcopal Health Foundation

Policy Issue Brief

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## **About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative**

The [Geiger Gibson Program in Community Health Policy](#), established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The [RCHN Community Health Foundation](#) is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a longstanding commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

## **About the Episcopal Health Foundation**

Episcopal Health Foundation (EHF) believes all Texans deserve to be healthy. EHF is committed to transforming the health of our communities by going beyond just the doctor's office. By providing millions of dollars in grants, working with congregations and community partners, and providing important research, we're supporting solutions that address the underlying causes of poor health. EHF was established in 2013 and is based in Houston. With more than \$1.2 billion in estimated assets, the Foundation operates as a supporting organization of the Episcopal Diocese of Texas and works across 57 Texas counties.

# Foreword

Health means more than just healthcare. While access to clinical care is a contributing factor, our behaviors and the physical, social, and economic environments in which we live, work, and play are the major drivers of health.<sup>1</sup> Although the importance of access to and quality of health care is well recognized, prevention is key. The health of a community requires addressing a much broader set of factors and policies that shape health-related behaviors beyond altering physiological processes related to diseases.

The tenet that health is more than just healthcare formed the basis of the Episcopal Health Foundation's seminal initiative known as the Texas Community-Centered Health Home Initiative that supported community-based clinics to address the social determinants of health as the contributing factor of good health outcomes and community prevention. Launched in 2016, the initiative was a four-year, \$10 million effort to build the capacity of clinics to work beyond their clinic walls and to take action to create healthier communities. Externally commissioned reports showed that participating clinics deepened their knowledge, commitment, and skills to engage in community prevention, built capacity to engage in multi-sectoral community partnerships, and took action to improve community health. While the formal initiative concluded in 2020, the work continues in the participating clinics because they changed their practices as a result of the initiative.

Further, because clinical care is just one factor that influences health, health policy is more than just healthcare policy. By affecting the social determinants of health, public policies can have a significant health impact by reducing barriers, creating opportunities, or providing incentives that influence the choices that

impact health; yet, a critical gap remains in terms of how best to build support and momentum for community-centered health home-type efforts within the federal and state health policies that can sustain such efforts.

Professor Sara Rosenbaum, J.D., and her colleagues at the Milken Institute School of Public Health based at the George Washington University studied this issue, and identified various state policy levers that can spur broader adoption of community health improvement efforts like the community-centered health home within Medicaid managed care.

As the report shows, current federal managed care guidance offers flexibilities to state Medicaid agencies to incorporate the factors that have made the community-centered health home model a success, into a sustainable, statewide community-oriented managed care strategy. In Texas, there has been increased interest and momentum at the legislative and executive branches during the current legislative session, to develop policies and programs that address the social determinants of health affecting Medicaid beneficiaries, as a critical path to improve the health of this population.

We encourage policy makers, health plans, providers, and other stakeholders to review this report and use its findings to inform policy discussions in strengthening managed care and improving community health in Texas and elsewhere.

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## Executive Summary

The health of a community helps determine the health of its residents, and for this reason, community-wide health improvement efforts have assumed prominence. History has shown that comprehensive, community-based primary health care not only offers a major entry point into better health, but also offers a key launch point for broader community health improvement efforts. As Medicaid managed care has become the dominant means of delivering health care in medically underserved communities, and as comprehensive primary care has emerged as the basic building block of an effective managed care strategy, leaders in health care and managed care have joined forces to support reforms that utilize managed care systems - working in partnership with primary care network providers and communities themselves - as a major tool for improving community health.

As state policymakers consider how to integrate community health improvement into Medicaid managed care, the Episcopal Health Foundation's Texas Community Centered Health Homes (CCHH) initiative offers valuable lessons. The initiative has proven successful in integrating community health improvement into primary care.

Federal managed care flexibilities enable Texas to incorporate the factors that have made the CCHH model a success into a sustainable, statewide community-oriented managed care strategy. Among the most salient factors that emerge from CCHH are deep community roots, primary care leadership, partnership across health and health care sectors, and startup investments that enable primary care providers, working with their partners, to develop and support community health improvement strategies that respond to community need. By incorporating the lessons from CCHH into managed care policy and practice, the state has the opportunity to strengthen managed care while bringing real change to its most vulnerable communities.

## Introduction: Primary Care, Community Health Improvement, and Medicaid Managed Care

A community's overall health has a measurable impact on the health of its residents.<sup>2</sup> Personal choices are important, of course. But extensive research shows that the choices we make are shaped by the social and economic conditions in which we live.<sup>3</sup> The "social determinants of health"<sup>4</sup> mean that as communities grow healthier, so can their residents. For this reason, comprehensive health improvement strategies focus not only on the accessibility and quality of health care, but also on improving health community-wide by strengthening community resources linked to overall health.

On a daily basis, millions of Texans face health risks driven in great part by community conditions, which have grown more serious during the COVID-19 pandemic. Fifteen percent of all state residents, and 21 percent of all Texas children, live in poverty.<sup>5</sup> Nearly one in ten Texas children are growing up in a family living in deep poverty, that is, with family income under 50 percent of the federal poverty level (\$13,248 for a family of four in 2021).<sup>6</sup> Furthermore, poverty tends to be concentrated. As a result, poor Texans are more likely to live in communities that lack important resources and social supports that enable residents to grow, live, work, and play in healthy surroundings: good schools; quality childcare and after-school programs; decent and stable housing; safe playgrounds and neighborhoods; job opportunities; plentiful healthy and affordable food; and opportunities for community and civic engagement.

## Primary Care and Managed Care at the Forefront: Advocating for Community-Wide Health Improvement Efforts

Because of the strong link between individual and community health, health care leaders,<sup>7</sup> leaders of special initiatives to improve primary care,<sup>8</sup> hospitals and hospital systems,<sup>9</sup> and Medicaid managed care plans,<sup>10</sup> all advocate for greater integration of community health improvement efforts into health care itself. In this regard, both Medicaid managed care and community based primary care providers have a long history of involvement in community-wide health.

Early Medicaid managed care pioneers tested models that integrated health care and social services,<sup>11</sup> and these early efforts can be seen today in new approaches to Medicare Advantage<sup>12</sup> and special needs plans for dually-enrolled Medicare and Medicaid beneficiaries.<sup>13</sup> Using special demonstration authority, states are testing Accountable Communities for Health models that combine health care with broader health and social services.<sup>14</sup> The Texas Association of Health Plans (TAHP), in a recent paper, calls for using Medicaid managed care to address social barriers to care during the COVID-19 public health emergency and beyond.<sup>15</sup> Working with the Houston Food Bank, TAHP and the Texas Association of Community Health Plans (TACHP) has called for building a greater commitment to social, health, and health care integration through the use of Medicaid managed care rate-setting tools.<sup>16</sup>

Community health improvement is also embedded in community based primary care, most clearly, as a core element of the community health centers programs. Today, 72 community health centers operate in over 575 locations<sup>17</sup> and are vital to the success of Medicaid and Medicaid managed care; these health centers are descendants of the first community health center demonstrations and continue to carry on the program's original mission of improving both health and health care.

<sup>18</sup>

A commitment to community health also can be seen in other health care sectors. The state's public and private nonprofit hospitals operate with a community benefit framework, and community health improvement activities lie at the heart of federal and state tax exemption policies.

It is not surprising, therefore, that leaders across the health care landscape, including managed care plans, primary care providers, and health systems have come together to support a different, more holistic and integrated approach to health care for poor and vulnerable populations.<sup>19</sup> Leaders support the integration of health care and community health not only because of its documented health impact, but also because of its potential to help bend the health care cost-curve in a state that spends 83 cents of every Medicaid dollar on chronic disease.<sup>20</sup> Public opinion further bolsters this view: nearly 60 percent of Texans agree that good medical care alone does not ensure a healthy life.<sup>21</sup> For these reasons, many primary care providers desire to move in the direction of integrating personal health care with community health, making community health improvement a core element of their operations. Experts such as the Texas Primary Care Association note the importance of the state's decision to begin to move Medicaid managed care in this direction.<sup>22</sup>

Indeed, broader Texas policy is moving in this direction, as can be seen in the aims and goals of the state's Medicaid DSRIP demonstration that emphasizes a new approach to health and health care as a core demonstration feature by promoting medical homes and care integration, and utilizing a "clinic to community" framework that can help connect patients to community health and social resources.<sup>23</sup> This reliance on primary care as an entry point into community health reflects the fact that community-based primary care providers are particularly well situated to undertake such a challenge. They are positioned to identify health conditions among their patients that are indicative of broader community-wide health challenges and then partner with community residents, the

managed care organizations (MCO) of which they are a part, and other stakeholders to implement and help build support for strategies that strengthen the resources needed to meet these challenges.

This overall movement in the direction of community health integration is aided by resources such as the Episcopal Health Foundation's *Healthy Places Toolkit*, which promotes community-wide health impact projects that aim to strengthen the relationship between health care and broader overall health.<sup>24</sup> The Foundation's Community Centered Health Homes (CCHH) initiative, discussed below, provides a strong example of a successful effort to translate concepts into actual practice, and the model offers much to policymakers regarding what works and how to go about operationalizing the concept of community health/health care integration throughout the state, using managed care as a basic tool.<sup>25</sup>

### The Challenge of Sustaining Community Health Improvement as a Core Element of Health Care and Medicaid Managed Care

The ability of the health care system in general and Medicaid managed care in particular to undertake a sustained leadership role in community health improvement presents challenges even where networks include primary care providers with deep community roots. Community health improvement projects are hard work and require investment of time and resources. Evidence drawn from the CCHH initiative and other efforts to use health care as an entry point into community health improvement suggests that such initiatives require:

- Collecting and analyzing the extensive information that is essential to ensuring that any community improvement initiative is grounded in timely and accurate evidence;
- Strategic planning in partnership with multiple stakeholders that not only identifies problems but develops solutions and action plans;
- Initiating and maintaining ongoing

engagement with community residents and local and civic leaders to ensure that the initiative is - and remains - responsive to needs and priorities;

- Developing working collaborations with other health and social services organizations that share the same goals;
- A continual improvement strategy that can monitor and measure the impact of changes and assess whether further adjustments are needed; and
- Constant communication about the community health improvement effort and its impact to ensure community awareness

Community-based primary health care providers are especially well-positioned to spearhead such efforts because they have the closest direct relationships with patients, have deep community roots, and enjoy a strong degree of trust. But empowering these providers to carry out this work requires investments that allow them to scale up and support efforts over time. Furthermore, because Medicaid managed care provides such a powerful health care purchasing mechanism, managed care systems effectively assume a leadership role in shaping the policies that help empower their network providers to create the information about patient need, as well as community health entry point that both are essential to successful and durable community health improvement.

Given the nature and structure of the modern health care system, Medicaid managed care emerges as key to a more durable solution. In its broadest sense, Medicaid managed care represents a tool that states can use to design and administer health care systems that work for vulnerable populations. Given the role of community health improvement in overall health, the reach of Medicaid managed care across the state, and the strong relationship among managed care organizations, primary care provider networks, and the communities they serve, it makes sense to build a community-wide health orientation into managed care itself. Indeed, at

the federal level, Republican and Democratic administrations alike have embraced this type of broader orientation in Medicaid managed care, one that incorporates efforts to address social determinants of health as a key operational feature.<sup>26</sup>

The growing policy interest in using health care and managed care as an entry point into improving community health is reflected in the emphasis placed on this goal by the state's managed care leaders. Support for deepening the relationship between managed care, primary care, and community health can be seen in the results of a recent survey showing that 71 percent of MCOs report investing in community-based organizations that address social determinants, while 60 percent report favoring policies that reward managed care plans that invest in community resources.<sup>27</sup>

To this end, the Texas MCO Social Determinants of Health Learning Collaborative<sup>28</sup> has played a key role in bolstering understanding among Medicaid managed care organizations regarding effective strategies for addressing their plan members' social needs and how to design high-value interventions. The collaborative is a partnership among the Center for Health Care Strategies (CHCS) (a national leader in Medicaid and health system transformation), the Texas Association of Health Plans (TAHP), and the Texas Association for Community Health Plans (TACHP) that underscores the strength of the support that Texas' Medicaid managed care plans have shown for community health improvement as a basic element of Medicaid managed care. Together, CHCS, TAHP, and TACHP are working to educate the collaborative on managed care's role in addressing the social determinants of health, particularly during COVID-19,<sup>29</sup> as well as the tight link between managed care purchasing and community health improvement.<sup>30</sup>

In particular, the Social Determinants Collaborative recognizes the vital role played by community primary care providers tasked with addressing members' health and social needs on a daily basis. To this end, the Collaborative has supported the Foundation's CCHH initiative as well as efforts to

translate the lessons drawn from the initiative into a sustainable aspect of Medicaid managed care.

## The Community-Centered Health Home (CCHH) Initiative: Lessons Learned for a Community-Oriented Medicaid Managed Care System

The Texas Community-Centered Health Home initiative provided multi-year awards to community-based health care providers to enable them to improve the health and lives of their patients by enhancing "the quality of life in the surrounding community."<sup>31</sup> The goal of the initiative was to "complement health care with community action" in order to reach "the root causes of poor health outcomes."

CCHH, originally developed by Prevention Institute,<sup>32</sup> focuses on creating a health care model pioneered by community health centers. It is designed to more effectively serve impoverished, underserved rural and urban communities through an approach that combines high quality clinical practice with a broader focus on the health of the entire community. Within this overall aim, the CCHH model has three essential features:

- **Adopting community health-oriented policies and practices that gather information about health needs and identify actions from evidence.** Clinics following the CCHH model revise their core clinical policies and practices to ensure that the evidence gained from screening and treating patients is aggregated into broader population-level health information that can inform both the clinic and the community about unmet population needs. For example, information showing that one in two adult patients is experiencing symptoms linked to diabetes or pre-diabetes provides important insight into what is likely a widespread community health problem. Similarly, information gleaned by young parents during well-child visits that they frequently must hold back part of their rent payments to be able to afford food or heat informs health care providers about health and

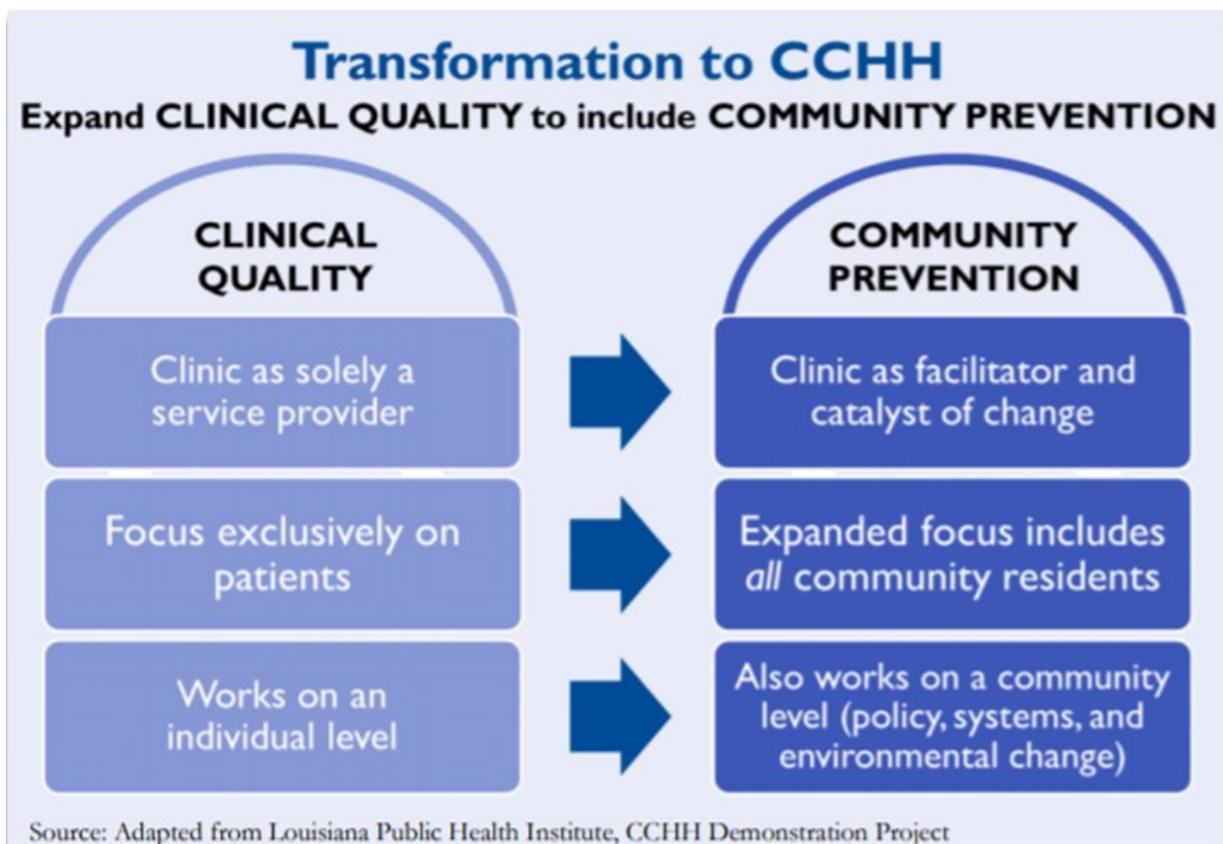
nutrition needs that are serious enough to threaten stable housing. Collecting and analyzing such information across thousands of patient visits provides critical insight into unmet community need.

- **Building and strengthening community partnerships.** With information in hand, clinics operating under the CCHH model are better able to build community partnerships with other programs and service providers engaged in common service to the population, such as food banks, childcare programs, local volunteer organizations, schools, and others.
- **Incorporating community health improvement into overall health strategies.** From the evidence gathered and the partnerships made, CCHH clinics then design projects aimed at addressing identified community needs. These efforts might entail creating farmers' markets, developing parenting support groups, and or engaging in broader reform advocacy to develop new sources of community supports.

The initiative enlisted comprehensive primary care providers with deep community roots, provided them with the resources and technical supports needed to undertake sustained community health improvement efforts, and enabled clinics to position themselves as facilitators and catalysts of change. In this way, the Texas CCHH initiative helped grantees position themselves to move beyond clinical quality improvement alone and extend their reach to the broader social conditions in which residents of their service areas live.

## Five Texas CCHH Initiative Grantee Profiles

We spoke at length with five Texas CCHH grantees that have achieved especially notable results under the initiative. These grantees represent providers across the state, as well as variable approaches to community health improvement. They all share a fundamental commitment to a form of clinical practice that embeds community health improvement at its core.



## The Hope Clinic

*Community roots.* Located in four sites throughout greater Houston, the HOPE clinic has a long history of engaging with the area's underserved and isolated Asian communities. Early in its community-level work, the clinic initiated the "Nail It" program, which specifically sought to decrease workplace environmental hazards among local Vietnamese nail salon workers. Through conversations with their patients, providers had learned that nail salon workers regularly quitting their jobs early in pregnancy to avoid the routine and unhealthy postures their work required, which were known to be associated with a higher risk of miscarriage. Clinicians worked with nail salon owners to identify ergonomic changes to the working environment, which permitted workers to keep their jobs throughout their pregnancy as a stable source of income.

*CCHH goals:* HOPE seeks to **reduce hypertension and diabetes** by combating obesity within the Alief community.

*Community health improvement efforts.* In more recent years, the HOPE Clinic has experienced a great deal of success with their "Bite of Hope" program funded by Novo Nordisk. The program has sought to reduce community obesity by supporting local restaurants to provide residents with healthier eating opportunities. To date, the program has worked with two cohorts of eight restaurants to incorporate healthier cooking techniques, adjust portion sizes, and provide training on digital marketing to promote their business. Under the Texas CCHH initiative, HOPE expanded its focus to Houston's Alief community, home to more than 100,000 residents. Its project has sought to increase opportunities for residents to connect socially, be active, and reduce stress by focusing on greater use of Alief Spark Park and Nature Center for exercise, social interaction, and community engagement. In particular, this has included the construction of new sidewalks, gazebos, and gaming tables, as well as the provision of community events in Alief Spark Park. Of special interest is its "Walk with a Doc" program that allows residents to informally engage with

clinicians through walks in the community.

*Community partners.* HOPE's partners are the Alief Super Neighborhood Council, the Alief Independent School District, VN Teamwork (a Houston-based nonprofit program serving the local Vietnamese population), the Westside Police Station, the Houston Food Bank, and the International Management District.

## The People's Community Clinic

*Community roots.* With two sites in Austin, the People's Community Clinic began 30 years ago in a church basement. Originally run by volunteers, the People's Community Clinic and community health center has a long history of civic engagement and community advocacy. The clinic is also a cutting-edge primary care provider, having been one of the state's first community health centers to integrate behavioral health care into its services.

*CCHH goals.* **The clinic seeks to foster coalitions and engage on broader policy issues** to advance nutrition, reduce obesity, and improve wellbeing in two middle school catchment areas.

*Community health improvement efforts.* With the support of the Texas CCHH initiative, the People's Community Clinic has expanded its efforts to support local community organizations as they develop policy proposals for local government officials. Through capacity expansion, the clinic has been able to act as a co-partner with the local community, offering key evidence-gathering tools such as GIS mapping of social and nutritional needs and survey tools. One key success of this expanded coalition work was a commitment on the part of local leaders to repurpose empty building space into a location that improves community access to affordable, healthy foods and nutrition. CCHH also has helped People's create a "neighborhood champions" program that supports local community resident efforts to more systematically track and tackle the systemic determinants of obesity. The model also offers a medical legal partnership program that provides enhanced advocacy to help residents meet basic human needs.

*Community partners.* Community partners include Austin ISD, Austin Interfaith, Sustainable Food Center, YMCA, Central Texas Food Bank, Texas Legal Services Center, City of Austin, Texas Center for the Prevention and Treatment of Childhood Obesity, Children’s Optimal Health, It’s Time Texas, Texas Pediatric Society, Marathon Kids, and Go!/Vamos! Austin.

## Waco Family Medicine

*Community roots.* Serving patients in 16 sites across Waco, Texas, Waco Family Medicine was established to address the acute problem of medical underservice among the region’s most vulnerable populations. The center has been an essential part of the community’s health system for over 50 years, offering comprehensive primary and preventive care, as well as serving as a key source of health professions training, education, and research for West Texas. Today, the center also has fully integrated behavioral health into its practice and offers a special Centering Pregnancy program for pregnant patients. The center also has a long tradition of services addressing social and public health needs, including a medical-legal partnership, a “reach out and read” program for pediatric patients, and provision of fitness and produce “prescriptions” to a local fitness center and grocery store.

*CCHH goals.* Waco Family Medicine seeks to promote access to healthy eating and active living to reduce **obesity and related diseases** among five communities around Waco.

*Community health improvement efforts.* Through the Texas CCHH initiative, Waco Family Medicine has been able to move beyond its work with its immediate patient population. In partnership with Prosper Waco, the health center’s providers have helped lead and participate in initiatives to create a community gathering space and urban gardens that can promote community connections, expand access to fresh produce, develop civic and public engagement interest among residents, and provide geo-mapping support to measure social determinants at the local level. Its broader health advocacy efforts have also helped strengthen the

accessibility of care for community residents through reforms that expand the prescribing authority of primary care physicians to include prescribing medications for patients with behavioral health conditions.

*Community partners.* With its long history in the community, Waco Family Medicine works with a wide range of partners including the CCHH Clinician Council, Prosper Waco, Baylor University, AgriLife-Better Living for Texans, McLennan County Community College Community Programs, Baylor Continuing Education, World Hunger Relief, and Greater Waco Legal Services.

## St. Paul Children’s Services

*Community roots.* St. Paul Children’s Services is a pediatric-focused clinic located in Tyler, Texas. Rooted in a strong tradition of community-centered care, the clinic was founded 30 years ago as part of a local Methodist Church’s afterschool program for low-income and immigrant children. The clinic’s very origins are an outgrowth of the type of deep understanding of community health needs on which so many community health centers and similar community-based clinics such as St. Paul’s rest. Through service to families, the founders of St. Paul’s Children’s Services learned the full range of the community’s needs and sought to meet those needs by creating a food pantry, ESL classes, and health care services. Indeed, by centering its services in community need, the St. Paul clinic has “intuitively” been applying the CCHH model for decades.

*CCHH goals.* The clinic seeks to reduce obesity by improving local food security, healthy eating, and physical activity in the Tyler community.

*Community health improvement efforts.* Through the Texas CCHH initiative, the clinic has been able to become more systematic in surveying the community for their needs, specifically local Head Start parents. Additionally, the initiative has pushed St. Paul’s to focus more squarely on improving their cross-sector collaborations. A key focus has been on improving nutrition, food security, and healthy eating among the Tyler community. Expanding the scope of their pre-existing food

pantry, the clinic has increased and improved the pantry's supply of fresh produce. Additionally, the clinic provides core support to the Smith County Food Security Coalition - a community initiative seeking to advance a strong, sustainable local food system in the Tyler community through partnerships across local nutrition organizations serving Tyler families, such as local food agencies and WIC.

*Community partners.* St. Paul's key partners for its food program work include Tyler ISD, East Texas Food Bank, UTHealth, Better Living for Texans, Tyler Family Circle of Care, NetHealth, Children's Defense Fund, Christus Health, East Texans Humans Needs Network, Region 7 Head Start, Northeast Texas Public Health District, Tyler Metropolitan Planning Organization, Red Moon Farms, and Micro Family Farms.

## AccessHealth

*Community roots.* For over 45 years, AccessHealth has been a key member of the Western Houston community. An outgrowth of the United Way of Greater Houston, AccessHealth began as a WIC program, added pediatric care and maternity care, and ultimately grew into the multi-site community health center it is today. Across its service area, AccessHealth operates 14 clinics and is actively engaged with the broader community through its health fairs and a community-wide food bank, with food and nutrition still a staple of its activities on the community's behalf.

*CCHH goals.* The center seeks to reduce the prevalence of **obesity, diabetes, and related mental health issues** like anxiety and depression in two neighborhoods in the Richmond area.

*Community health improvement efforts.* Through CCHH, AccessHealth has been able to strengthen its activities, especially its ability to engage in evidence-based community health practice through the routine and ongoing analysis of health information about patients gained from the health center's electronic health records system and clinician interviews. Through this enhanced, in-depth assessment process, AccessHealth identified obesity, diabetes, and related mental health

conditions as crucial community needs that emerged as a focus of its CCHH work. This model of practice also enabled the health center to adjust its approaches to outreach, treatment, and community engagement. For example, as clinicians began reporting higher-than-average rates of road fatalities in the Richmond area, AccessHealth expanded its work to include advocacy for expanded sidewalks as a core component of their work. Services also have been expanded to include improved transportation to clinic care and nutrition and financial education for residents.

*Community partners.* AccessHealth community partners for its CCHH activities include Uber, Houston Food Bank, Fort Bend County Health and Human Services, the YMCA, Lamar Jr High, Attack Poverty, Catholic Charities, and the Fort Bend Regional Council.

## Drawing Lessons from the CCHH Experience

Discussions with CCHH leaders reinforced what decades of experience have shown about the need for and value of bringing a community health improvement dimension to health care. To be successful and sustainable over time, community health improvement activities must be grounded in evidence of need, rest on a solid action plan for moving forward, and ultimately, must reflect the priorities and needs of people who will ultimately use services as well as other community organizations that share the same health improvement focus. Initiatives also must be nimble and resilient, as well as reshape and grow as on-the-ground conditions change.

Successful community health improvement, in other words, takes time, talent, and resources. In particular, resources are needed to:

- Collect and analyze a wide array of community-level evidence;
- Support one entity as a "backbone" to the community engagement effort, providing the support work needed through which a broad coalition can develop a strategy and put it into

action; and

- Measure success and present information on what the effort is achieving.

Conversations with Texas CCHH leaders and preliminary CCHH evaluation findings also point to several key attributes that successful CCHH sites demonstrate. While each CCHH grantee is unique in how it has responded to its community needs, successful grantees share certain attributes that can help guide development of a community-wide health improvement component into Medicaid managed care:

- Previous experience with community-wide improvement efforts, including pre-existing cross-sector partnerships and strong connections to the community
- An ability to leverage cross-sector partnerships as a smooth “on-ramp” to discussions with policymakers and local policy change
- A dedicated CCHH manager who is well-versed in the social determinants of health
- Recognition that this work takes time, and that “learning while doing” is the norm
- Securing the buy-in of key community leaders

**The question thus becomes how managed care might grow community-wide health improvement efforts statewide.** While philanthropy remains absolutely essential, philanthropic undertakings work best in creating pilot efforts that help show the way to broader systemic changes. Indeed, this is the story of community health centers themselves, which began as a pilot program in the mid-1960s and ultimately evolved into a core feature of the American formal health policy landscape as the nation’s largest comprehensive primary care system.

## Making Community Health Improvement a Core Feature of Medicaid Managed Care

In recent years, as interest in addressing the underlying social determinants of health has grown, federal Medicaid policy has evolved in important ways, especially when it comes to identifying ways in which managed care systems can be employed to further this goal.

Except in rare circumstances related to beneficiaries with severe chronic health conditions and limited housing and employment supports for vulnerable people, Medicaid does not directly pay for services such as food, housing, education, and job training. At the same time, however, *federal Medicaid policy offers multiple avenues for supporting development of, and support for, a model of primary care practice that couples high quality care with community health improvement innovation in order to best ensure a “social determinants” approach to care for the most vulnerable state residents.* These innovations can be adopted on a fee-for-service basis of course, but in a state such as Texas, where Medicaid managed care is such an operational staple, federal policy also permits states in collaboration with their health plans to instill a fundamental community health improvement orientation to the managed care enterprise more generally.

**This basic re-orientation of managed care and the primary care networks – in which MCOs partner toward community health improvement - can be achieved over time.** In order to do so, we believe that two steps are needed.

**Step 1: Coverage and payment reform.** The first step is to adopt certain Medicaid coverage, payment, and incentive flexibilities that have been identified in comprehensive federal guidance.<sup>33</sup> As pointed out by managed care plans in collaboration with community health and nutrition providers, these reforms ultimately are captured in the managed care rate-setting process, coupled with the introduction of major purchasing reforms and priorities into the Medicaid managed care

contracting process.

**Step 2: Innovation start-up funding.** The second step is a relatively modest up-front investment in helping community providers achieve and strengthen a community health innovation model. In doing so, this supports managed care plans themselves in achieving true community orientation.

These complementary actions – strengthening the investment in Medicaid managed care and planning for community health improvement reforms – would enable the state to transform Medicaid managed care over time. This approach would enable Texas to become a leader in using Medicaid managed care to improve community health, and as the model matures, complementary investments might flow from other sources such as philanthropies, community benefit spending by nonprofit hospitals, and value-based investment among managed care plans themselves.

Our discussions with CCHH grantees underscored the importance of startup funding at the provider level, and the CCHH experience can help inform the shape of these local investment grants in order to produce managed care networks that, to the maximum degree possible, include providers with:

- i) a history as a comprehensive primary care provider in the community that has earned the trust of community residents and key stakeholders;
- ii) a longstanding focus on social determinants and community collaborations as measured by past and ongoing community health improvement activities; and
- iii) evidence of community partnership and support from health, health care, social service, and civic leaders.

### **Federal Medicaid Flexibilities that Promote Managed Care Strategies to Address the Social Determinants of Health**

Experts point to states' power to use the Medicaid managed care contracting process and the power

of managed care and primary care working together to "catalyze activities" that promote health equity and identify and address social needs at both the population and individual member levels.<sup>34</sup>

These expert recommendations received validation from comprehensive guidance issued by the Trump administration in January 2021 that identifies coverage, payment, and contracting practices that can help transform managed care into a tool for promoting health on a community-wide basis by strengthening services and benefits not payable by Medicaid but recognized as key to the social determinants of health, such as nutritious food, transportation, affordable housing, quality education, and opportunities for meaningful employment.

The 2021 guidance describes<sup>35</sup> state options for using managed care to promote a community-based approach to primary care that responds to patient and community social and health needs. Under this guidance, states can:

- Target initiatives on special populations such as individuals with disabilities, older adults, pregnant and postpartum women and infants, children and youth, individuals with mental and/or substance abuse disorders, individuals living with HIV/AIDS, rural communities, individuals experiencing homelessness, individuals from racial and ethnic minority populations, and individuals with limited English proficiency. Interventions targeting the health of mothers and children have received a recent boost under the American Rescue Plan Act through a new postpartum coverage option (effective March 2022) that enables states to extend full Medicaid benefits to pregnant women throughout pregnancy and a full 12-month postpartum period.
- Target specific conditions such as asthma attributable to home environments, severe diabetes related to food insecurity, falls and injuries arising from physical barriers and safety hazards, frequent use of emergency departments because of homelessness, or

stress related to joblessness and economic insecurity.

- Adopt coverage reforms that enhance services available through community health centers (federally qualified health centers (FQHC)), rural health clinics (RHC), patient-centered health homes, or providers serving mothers and children. For example, states can cover enhanced social risk screening and case management coverage as a FQHC and RHC benefit, thereby enhancing provider resources to screen for need and manage care across health, education, and social sectors. States can enhance Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits for children and use to screen for social and health risks and help families secure needed health, educational and social services for their children.
- Take advantage of Medicaid’s “health homes” option to support comprehensive, community-based primary care practices that focus on “whole person” treatment and coordination across primary, acute, and long-term services and supports. States adopting new health homes programs are entitled to eight quarters of enhanced federal funding and can request two additional enhancement quarters. Currently 21 states and the District of Columbia have exercised this option.
- Enhance Medicaid managed care rates (as suggested by the TAHP, TACHP, and Houston Food Bank coalition)<sup>15</sup> to reflect broader coverage for certain populations and services, and target provider payment incentives aimed at improving health outcomes for members with conditions that pose elevated health risks such as diabetes, hypertension, asthma, depression, and other conditions that reflect a combination of clinical symptoms and broader social health risks.
- Enhance plan rates to reflect quality improvement initiatives aimed at strengthening their community-based primary care providers’ capacity to undertake health and social risk

assessment, more intensive care management, and the creation of primary care teams that use community health workers as part of their care coordination teams. These types of quality improvement strategies can qualify as quality improvement expenditures for purposes of calculating plans’ cost numerators.<sup>36</sup>

- Reward managed care plans that emphasize and support provider networks that couple enhanced primary health care and community-wide health improvement projects aimed at strengthening health and social services. The CCHH model offers examples of exactly this type of provider – that is, community primary care practices with deep roots, active, involved leadership, social risk screening, and use of aggregated data resulting from social risk screening to build coalitions to tackle broader community need. Plan rewards can include financial incentives, star ratings, and auto enrollment preferences that favor such plans when it comes to enrolling individuals who have not selected a health plan. Plans could also be rewarded for using strategies to connect their higher need members with community-based primary care providers practicing in the CCHH model.
- Reward managed care plans that test alternative payment strategies that encourage the use of capitation and bundled payment approaches tied to underlying costs, much in the same way that actuarial soundness in Medicaid managed care contracting is tied to the cost of caring for the enrolled population.<sup>37</sup> Translating the concept of total population costs into payment principles for comprehensive primary care providers that build community health improvement efforts into their practice model can help create a steadier stream of practice income affording greater flexibility to introduce new approaches to patient care. Such models could be tested based on the entire enrolled patient population or for targeted patient groups such as pregnant women and infants, adults with diabetes or elevated diabetes risk, or children

with asthma.

## Building Community-Oriented Managed Care: Putting Federal Flexibilities to Work While Investing in Pilot Funding to Build System Strength

In building community health improvement into Medicaid managed care, there is value and importance in a model that can bring together health plans, network providers, community leaders, and health and social service providers to identify common opportunities and strategies within any community. This does not prevent the type of competition essential to managed care innovation. But such a convening function can help ensure a community-wide embrace of key priorities. This function might be undertaken by one backbone agency such as a local public health agency or county council. It also might be assumed by a coalition of health, health care, educational, and social service providers that offer services to the entire community regardless of health insurance status, thereby affording plans a more panoramic view of on-the-ground social and health needs. This type of cross-stakeholder collaboration offers an opportunity for greater efficiency and collaboration, of great importance in communities experiencing serious medical underservice, where the community and managed care plans depend on a modest number of primary health care providers and social service networks.

A source of guidance for such collaboration efforts that might help collaborators pinpoint especially high-value health interventions might be the Community Guide, published by the Community Preventive Services Task Force.<sup>38</sup> This Guide identifies evidence-based community health improvement strategies and provides a valuable tool for public health planning because its recommendations for investment are grounded in years of evidence.

An effort to integrate community health improvement into Medicaid managed care as a formal policy priority would also benefit from collaboration between Texas Medicaid and the Department of State Health Services, which in

recent years has heightened its focus on public health both statewide and regionally. Chief among DSHS goals are fostering the partnerships and collaborations that in turn enhance the opportunity to achieve public health goals.

To produce the types of collaborative efforts that in turn can help inform Medicaid, its partnering managed care plans, and the community-based primary care providers that are so integral to managed care networks, start-up pilot grants may be key. Foundations have long played a role in this regard through initiatives such as CCHH that produce proof of concept.

For an initiative aimed at transforming the relationship between managed care systems and the communities in which plans operate, start-up investment funding likely would consist of two distinct but highly-related components:

- One component would be grants to help community-based primary care providers strengthen their data analysis, care management, and care team capabilities so that they can serve as effective entry points, not only into individual care but also into the community health systems of which they are a part. In effect, these providers are the connective tissue between managed care systems, community residents, and health and social service providers, and they need to have the capacity to serve in this role. Grants could be targeted to community primary care providers that possess the essential capabilities underscored by the CCHH model:
  - i) Experienced leadership with a track record of community-level health improvement activities;
  - ii) Staff members who can (or can be trained to) undertake analysis of evidence gained from social risk screening and other sources in order to ascertain common health risk patterns across their patients;
  - iii) Staff members who can coordinate and work with community programs and

services aimed at addressing health and social risks community-wide and build partners; and

- iv) Staff members with the ability to convene health and healthcare providers community-wide to analyze and present results and continually assess successes and challenges.
- A second component, established and overseen jointly by the Medicaid agency and DSHS, would provide grants to local health agencies working with the managed care plans that operate in their geographically defined communities, to identify the range of payment and delivery reform strategies that would best align with each community's major health priorities. As a formal public health undertaking, such a grant would enable plans to work together at the community health conceptual level without implicating concerns regarding anticompetitive conduct.

## Conclusion

We have long known that the health of communities plays a pivotal role in individual health. In recent years, the vast web of policies that guide Medicaid and Medicaid managed care increasingly has embraced this recognition. Successive Presidential administrations – Republican and Democratic alike – have advanced policies that give states the option to essentially reinvent Medicaid managed care as a key part of any community health improvement strategy in the very communities that are most dependent on Medicaid managed care because of concentrated poverty, extensive health disparities, and elevated health risks. Most recently, the Trump administration has encouraged states to pursue such efforts, recognizing Medicaid managed care not only as key to a good health care system for beneficiaries but also a means of helping communities improve overall health because of its reach.

**The challenge is how to put such an opportunity into action.** Ultimately, managed care is more than insurance; it is an organized

system of care for the members it serves. This means building at the point of care itself and using health care as the major initial entry point into better health for patients and communities.

The Texas CCHH initiative demonstration underscores the value of this vision, and the results produced by grantees points to the **value of state Medicaid investment strategies that reward MCOs that make quality improvement investments in their community-based provider network and prioritize a focus on populations identified by the state as a public health priority.** Given the pending state option to provide postpartum women with 12 months of continuous enrollment, targeting pregnant women and infants makes special sense, as do investments in school-age children and youth at elevated health risk and adults with serious physical and mental health conditions that carry significant costs if uncontrolled.

With Medicaid enrollment surpassing 4.2 million<sup>39</sup> (and the majority of enrollees in managed care), Texas has an opportunity to lead the nation in a basic reorientation of managed care and managed care provider networks towards substantial and meaningful community health improvement.

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