Directed Payment Program for Behavioral Health Services Requirements State Fiscal Year 2026

Program Overview

The Directed Payment Program for Behavioral Health Services (DPP BHS) is a directed payment program (DPP) that provides for increased Medicaid payments to Community Mental Health Centers (CMHCs) and Local Behavioral Health Authorities (LBHAs) to promote and improve access to behavioral health services, care coordination, and successful care transitions for adults and children enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs.

Quality Goals

DPP BHS aims to advance the goals of the Texas Managed Care Quality Strategy. Participating providers will report quality measures that tie to the following quality strategy goals:

1. Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.
2. Promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs.
3. Use high quality health information for people, families, communities, and the health care system to make data driven decisions to improve quality health care for all Texans.

Program Structure

DPP BHS includes one component for state fiscal year (SFY) 2026. DPP BHS provides a uniform dollar increase in the form of prospective, monthly payments to all qualifying CMHCs and LBHAs.

CMHCs and LBHAs must apply to participate in the program.

Component 1

Component 1 includes structure, process, and outcome measures.

All measures in Component 1 must be reported as a condition of participation. Failure to meet any conditions of participation will result in removal of a CMHC or LBHA from DPP BHS and recoupment of all funds previously paid during the program period.

Reporting Requirements

Annually, providers must submit status updates about the implementation of the structure measures and data for the process and outcome measures.

There are two SFY 2026 reporting periods during which providers submit data on the DPP BHS measures to the Health and Human Services Commission (HHSC):

- Reporting Period 1: In October 2025, providers will report progress on the implementation of the structure measures.
- Reporting Period 2: In March 2026, providers will report data for outcome and process measures for the measurement period of January 1, 2025, to December 31, 2025.

Reporting must follow the detailed specifications for each measure as included in the SFY 2026 Measure Specifications (Excel file).

Providers must submit responses to qualitative reporting questions that summarize their progress toward implementing structure measures. Providers are not required to implement structure measures as a condition of reporting or program participation.

For outcome and process measures, a provider must submit specified numerator and denominator data and respond to qualitative reporting questions from HHSC. Providers must report rates for most measures stratified by Medicaid Managed Care, Other Medicaid, Uninsured, and All-Payer.

Reported qualitative and numeric data will be used to monitor provider-level progress toward state quality objectives.

Component 1 Provider-Reported Measures

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
B1-105	Health Information Exchange (HIE) Participation	Structure	NA	NA	NA
B1-145	Certified Community Behavioral Health Clinic (CCBHC) Certification Status	Structure	NA	NA	NA
B1-147	Provide integrated physical and behavioral health care services (mental health and/or substance use services) to children and adults with serious mental illness and/or substance use conditions	Structure	NA	NA	NA
B1-149	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	2152	Physician Consortium for Performance Improvement	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer

B1-150	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	1365	Mathematica	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer
B1-151	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	0104e	Mathematica	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer
B1-152	Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	Outcome	0576	NCQA	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer
B1-153	Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital)	Outcome	0576	NCQA	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer

B1-161	Food Insecurity Screening and Follow-up Plan	Process	NA	NA	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer
B1-167	Depression Remission at Six Months (DEPREM-6)	Outcome	0711	MN Community Measurement	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer

Attribution Methodology

Providers must follow these steps to identify the specific population that should be included in the numerator and denominator for provider-reported process and outcome measures.

Step 1: Determine the DPP-attributed population.

Step 2: Determine the measure-specific denominator population.

Step 3: Stratify the measure-specific denominator population by required reporting payer type.

Attribution Step	Details
Step 1: Attributed Population Definition	Using a retrospective attribution methodology, the DPP-BHS-attributed population includes the individuals that a participating provider, as indicated in the enrollment application, must include in accordance with the "Attributed Population Inclusion Criteria."
Step 1: Attributed Population Inclusion Criteria	The provider's attributed population includes any individual who has at least one encounter with the provider during the measurement period.
Step 1: Allowable Exclusions	Encounters with an individual incarcerated in a state or federal facility during the measurement period.
Step 2: Measure-Specific Denominator Population Definition	The measure-specific denominator population (Step 2) includes the individuals or encounters from the DPP BHS-attributed population (Step 1) that meet all criteria in the Measure Specifications.
Step 3: Reporting Payer Types	Measures must be stratified by the required reporting payer as outlined below. • Medicaid Managed Care: exclusive to STAR, STAR+PLUS, and STAR Kids • Other Medicaid: STAR Health, and Medicaid Fee-For-Service • Uninsured: includes No insurance; County-based or other public medical assistance • All Payer: includes Medicaid Managed Care, Other Medicaid, Uninsured, and all other payer types such as CHIP, Medicare, Medicare/Medicaid Dual Eligibles, Commercial Insurance, Qualified Medicare Beneficiaries, and Non-Texas Medicaid individuals/encounters

Attribution Step	Details
Step 3: Payer-Type Assignment Methodology	The payer type assignment methodology depends on the unit of measurement for the denominator. The unit of measurement is defined in the Measure Specifications file. 1. Individual: If a person can be counted once in the denominator, then the unit of measurement is an individual. The payer type assignment will be determined by either the most recent payer type on record at the end of the measurement period OR as any individual with a Medicaid Managed Care-enrolled service at any point in the measurement period, even if their most recent payer type of record is not Medicaid Managed Care. The same assignment methodology for determining Medicaid Managed Care must be applied consistently across the measurement period. 2. Encounter: If a person can be counted in the denominator more than once, then the unit of measurement is an encounter. The payer type assignment will be determined by the payer type on record for the qualifying encounter (e.g., visit or admission).

Additional Reporting Information

Data Sources and Data Elements

Depending on the measure steward and the publicly available measure specifications source, the measure specifications may have been written based on electronic health record (E.H.R.) and claims data sources available to health care providers or health plans. For any measures where the measure specifications were originally written based on data sources available to health plans, HHSC has adapted the measure specifications for DPP-participating providers as possible.

For DPP reporting purposes, DPP-participating providers are responsible for complying with measure specifications and should use the most complete data available to ensure that the data reported are representative of the entire population served. In cases where a variance from a designated measure specification is required due to variances in data sources, DPP-participating providers may opt to use local or proprietary data elements (codes or values) mapped to the standard data elements (codes or values) included in the measure specifications.

DPP-participating providers that use local or proprietary data elements must maintain documentation of the relevant clinical concepts, definitions, or other information as applicable that crosswalks to the standard data elements. DPP-participating providers should keep a record of such variances to make note of and ensure consistency when reporting each measurement year.

Data Measurement Periods

The data measurement period required for a given reporting period is identified under the "Data Measurement Period" column in the Measure Specifications file. Additionally, measure-specific denominator specifications may place additional limitations on the measurement period used for denominator inclusion. This may include using only a portion of the measurement period for denominator inclusion or identifying encounters or a diagnosis that occurred before the measurement period for denominator inclusion (a lookback period).

All measures are specified for a 12-month data measurement period, unless otherwise specified under the "Data Measurement Period" column in the Measure Specifications file.

Sampling Methodology Requirements

DPP-participating providers should use the most complete data available to ensure that the rates reported are representative of the entire population served. All cases that meet the eligible population requirements for the measure must be included.

For measures where all required data elements are not available electronically (E.H.R., claims data, or registry) or are of poor quality, providers may conduct a sample to determine rate for a given measurement year. DPP-participating providers should follow the sampling methodology

included in the measure specifications, or if no sampling methodology is specified, providers should follow the HHSC sampling methodology identified below:

HHSC Sampling Methodology

DPP-participating providers should use available administrative data to determine the denominator population. Sampling must be systematic and random to ensure that all eligible individuals have an equal chance of inclusion. The resulting sample must be representative of the entire eligible population for the measure. At the time of reporting, DPP-participating providers will indicate if a sampling methodology is used. DPP-participating providers must maintain records of sampling methodology and random selection.

HHSC Minimum Sample Size for All-Payer

- For a denominator that is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a denominator that is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases.
- For a denominator that is greater than 380, providers must report on a random sample of cases that is not less than 20 percent of all cases; however, providers may cap the total sample size at 411 cases.

It is recommended to select an oversample of 10-15 percent of the sample size for substitution in the event that cases in the original sample are excluded from the measure.

Appendix A: Summary of Program Changes

1. B1-163 Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices was replaced by B1-161 Food Insecurity Screening and Follow-up Plan.
2. Reporting Period 2 was changed from April to March.