

Summary of Stakeholder Meetings on DSRIP Transition

Background:

In September and October 2019, HHSC held work sessions with representatives of the following groups:

- Rural Hospitals and Regional Healthcare Partnership (RHPs)
- Hospitals
- Academic Health Science Centers
- Community Mental Health Centers
- Local Health Departments
- Physician Groups

The purpose of these meetings was to discuss ways to sustain delivery system reforms post-DSRIP and collect feedback on the providers' priorities.

The agenda of each meeting was generally:

- 1) DSRIP Transition Priorities for provider group
- 2) Options to Sustain Delivery System Reforms
 - Directed Payments in Managed Care
 - Targeted Enhancement of Benefits
 - Leveraging Existing Waiver Financing Structures
- 3) Quality Strategies for Transition Proposals that Align with Key Focus Areas
- 4) DSRIP Strategies that Represent Potential Statewide Best Practices
- 5) Stakeholder Engagement
- 6) Action Items & Next Steps

Discussion questions included:

- 1) Have you explored a Medicaid directed payment program to help sustain the types of work DSRIP enabled you to do once DSRIP ends?
- 2) What best practices from DSRIP would you seek to continue and what quality measures do you think would be most beneficial and feasible?

3) Are there key sub-populations that you serve that could receive a targeted benefits enhancement?

4) What alternative suggestions do you have for sustaining delivery system reforms?

5) Do you have data analysis that would be helpful in assessing delivery system reform options or recommendations for specific data analysis?

Cross-meeting summary:

Priorities that came up across multiple groups included:

- Access to care, including for low-income uninsured (LIU) population
- Care coordination and patient navigation (health coaches, community health workers)
- Additional, “non-medical” services (e.g., transportation, food, other services to address social drivers of health)
- Behavioral health (BH)
- Integration of BH and Primary Care services
- Improved data systems and performance reporting
- Collaboration around quality measures (shared regional goal(s))
- Chronic disease prevention and management (e.g., diabetes)
- Telehealth and telemedicine

Other common discussion topics included:

- Interest in directed payment options and targeted eligibility or benefits.
- Requests for more information about potential total funding amounts to be available in the future.
- Concerns about contracting with MCOs.
- Simplifying and aligning performance measures across payors.

The following summaries reflect stakeholder feedback to HHSC. HHSC is providing these summaries of stakeholder feedback to promote information sharing across stakeholder groups. HHSC is also considering this stakeholder feedback in the planning for post-DSRIP.

Summary of DSRIP Transition Stakeholder Workgroup Meeting with Rural Hospitals and RHPs, Sept. 13, 2019

Organizations:

RHP 16, RHP 19, RHP 11, Texas A&M Health Science Center, Texas Organization of Rural and Community Hospitals, HHSC

Key areas of transformation these providers want to sustain:

- Access to care (retaining providers added through DSRIP, same day appointments)
- Care coordination (including health coaches)
- Collaboration around quality measures (shared regional goal(s))
- OB/Gyn
- Telehealth and telemedicine
- BH
- Specialty care
- Transportation

Highlights:

- Supplemental Medicaid funding programs, including DSRIP, have helped sustain rural providers, and the prospect of that funding ending causes concerns about hospital and provider closures.
- DSRIP payment for outcome reporting has supported and driven reforms that have benefitted patients, such as more care coordination. Rural providers would like to continue pay for reporting/performance. They generally do not support payment models where they have risk and prefer incentive payment structures for making modifications. However, rural providers vary in their resources and technology to make significant structural changes and some would need upfront financing and technical assistance to continue modernizing their systems.
- Expanding telehealth, BH, and care coordination are all high priorities. There may also be an option for some hospitals to become step-down units for observation only, in lieu of closing.
- The rural anchors like the RHP structure and would be interested in models that build on that. Even if the RHP structure is no longer the format, regional collaboration will continue to be very important, especially for coordinating

Intergovernmental Transfer (IGT) funding and Local Provider Participation Funds (LPPFs). Some rural providers feel that collaboration and communication has decreased from DSRIP 1.0 to DSRIP 2.0, because they no longer have shared projects or goals. They would be interested in a model that gives them some shared goals to accomplish, perhaps in the form of regional measures (pay for reporting/performance). When selecting measures for a post-DSRIP program, simplification and alignment with Medicare and Medicaid MCOs is important.

- Data is a major challenge, and up-front funds are needed for care transformation (e.g., certain Medicare ACO models).
- One potential model post-DSRIP is a directed payment program, which could be structured to go to rural health clinics, a health care collaborative, or perhaps to rural providers who partner with CMHCs. Any such program will be based on Medicaid MCO utilization to some degree. Given the volume of Medicaid patients served by rural providers, some changes may be necessary to incentivize MCOs to include rural providers in their programs and networks.
- The total amount of federal funding that will be available post-DSRIP is unclear at this point. As for structure of the next waiver, North Carolina's 1115 waiver may be a starting model, as it was the first waiver approved by the current administration. However, discussions are ongoing with the Center for Medicare and Medicaid Services (CMS) about their parameters and priorities.

Next Steps:

- 1) HHSC explores Directed Payment Program option for rural health clinics and rural hospital-owned clinics.
 - a. Identify all applicable clinics.
 - b. Research Medicaid expenditures and utilization for those clinics and share analysis results when available.
- 2) HHSC explores Directed Payment Program option for Healthcare Collaborative.
- 3) HHSC evaluates what data is available for Potentially Preventable Events (PPEs)/DSRIP outcomes by RHP, perhaps by hospital in rural RHPs, and shares results when available.
- 4) HHSC considers what quality measures would be best for rural providers.

- 5) Stakeholders continue to consider preferred quality measures and potential programs.

Summary of DSRIP Transition Stakeholder Workgroup Meeting with Hospitals, Sept. 17, 2019

Organizations:

Adelanto Healthcare Ventures (AHCV), Children's Hospital Association Texas (CHAT), Harris County Hospital District, JPS Health Network, Parkland Health & Hospital System, South Texas Hospital Coalition-DHR Health, Texas Association of Voluntary Hospitals (TAVH), Texas Hospital Association (THA), Teaching Hospitals of Texas (THOT), Texas Organization of Rural & Community Hospitals (TORCH), University Health System, HHSC

Key areas of transformation these providers want to sustain:

- Increased access to care (including for LIU)
- Additional, "non-medical" services (e.g., not billable to Medicaid such as CHWs, other services to address social drivers of health)
- Chronic care (e.g., diabetes, blood pressure management)
- BH (e.g., Licensed Professional Counselors (LPCs) in schools, intensive outpatient programs, must also address physical health co-morbidities, SUD)
- Collaborating to improve care for complex populations (e.g., children with medical complexity, pediatric BH)

Highlights:

- Some stakeholders wanted more analysis of the comparative federal revenue Texas might see under various scenarios (1115 waiver with budget neutrality cap, not using a waiver and using actuarially sound rates with no cap, other types of waivers or other versions of 1115 waivers). These stakeholders felt it was important to first know the structure that maximized federal funding, then design the next program to work within that funding and parameters. However, both federal approval and gathering the non-federal share of any increased funding could be challenging. Providers with IGT that do not have a large portion of Medicaid eligible patients may not feel it is useful to participate, and their IGT may not be available.
- Stakeholders feel that the uncertainty over the total available funding, the likely structure, and the potential allocation of that funding are all contributing to a competitive environment and anxiety among provider organizations and local governments. They want to prioritize quickly getting answers for providers, who need to plan their budgets and resources. They want historical continuity of funding based on a formula. Stakeholders also

had questions and concerns about whether the next phase would count against Hospital Specific Limits (HSL).

- When considering designs for directed payment programs, stakeholders want flexibility on performance measures and regional needs addressed where possible. One potential solution is a standard menu of performance measures from which regions or hospitals could choose.
- Hospital stakeholders are concerned about drops in access at hospitals that serve high proportions of LIU individuals if DSRIP funding is not replaced at similar levels that can also be used for serving that population. For some hospitals, the LIU population is 40-50% of their population. Hospitals are also concerned about transitioning to a model where funding only flows through managed care, because they are concerned about technical denials of care.
- Some stakeholders have prioritized reforming their systems of care for medically complex populations, especially children and people with BH conditions. They are focusing on regional collaboration with MCOs and other community resources. There was support for a targeted benefit package for people with serious mental illness (SMI), but the hospitals think whole person coverage, including for integrated primary care for those people is crucial, as many have co-morbid conditions such as diabetes, and sometimes those conditions are worsened by medication they take for their SMI.
- Addressing social drivers of health is also important to hospitals. One has put professional counselors in schools and provides transportation to intensive outpatient clinics because transportation is such a barrier to treatment. Another has brought in farm food.
- While wanting to continue funding, access, and collaboration, stakeholders and HHSC want to look for ways to administratively simplify programs and performance measure reporting where possible. Stakeholders feel the shift in DSRIP 2.0 to funding outcomes was positive and allows them to adjust their processes while still working toward what matters. They would prefer to use a subset of existing metrics, rather than creating new ones.

Next Steps:

- 1) HHSC explores whether any proposed programs for post-DSRIP funding would count against HSL, and whether costs would count to offset.
- 2) HHSC explores the feasibility and revenue associated with options such as using several smaller 1115 waivers or non-1115 waiver options.
- 3) DHR via AHCV will submit to HHSC their preferred regional metrics.

- 4) HHSC continues conversations with CMS around budget neutrality to arrive at total funding for post-DSRIP as soon as possible.

Summary of DSRIP Transition Stakeholder Workgroup Meeting with Academic Health Science Centers, Sept. 20, 2019

Organizations:

TAMU Health Science Center dba Baylor College of Dentistry, Texas Medical Association, Texas Tech University Health Sciences Center Amarillo, Texas Tech University Health Sciences Center EL Paso, Texas Tech University Health Sciences Center Odessa, Texas Tech University Health Sciences Center Lubbock, The TX A&M University System Health Science Center, UT Health Center at Tyler, UT Health Science Center San Antonio, UT Medical Branch Galveston, UT Rio Grande Valley, UNTHSC at Fort Worth, UT Health Science Center at Houston, UT Health - San Antonio/Houston, UT Health - School of Public Health, UT Southwestern Medical Center at Dallas, UT System, HHSC

Key areas of transformation these providers want to sustain:

- Increased access to care (retaining providers added through DSRIP, including for LIU, improved dental care)
- Additional “non-medical” (non-billable) services that help patients stay out of the emergency department and hospital (e.g., not billable to Medicaid such as CHWs, prevention programs, and other services to address social drivers of health)
- Chronic care (e.g., diabetes, blood pressure management)
- BH
- Improved data systems and performance reporting through DSRIP
- Increased training – including for specialty care, CHWs

Highlights:

- Academic Health Science Centers (AHSCs) feel that with funding, they can fill gaps others may not be able to, such as by providing community health worker (CHW) training programs and social determinants of health (SDOH) services. These services can enhance the capacity of primary care providers and expand their impact by reducing barriers to primary care treatment and prevention activities, which in turn helps keep people out of the hospital.
- They can also help provide more traditional services, such as dentistry to underserved subpopulations, such as low-income seniors and pregnant women, and have co-located these services with other facilities and provided expanded hours to help divert patients from the ER. About 10% of ER visits are for oral health.

- In areas with very few providers, no public hospitals, and high uninsured populations, such as near the border with Mexico, AHSCs have added providers through community clinics and used CHWs to outreach to the poorest patients. There is not another source of funding for this work outside of DSRIP.
- Some providers felt that the transition from DSRIP 1.0 to 2.0 changed their ability to partner with other organizations, because it transitioned to outcome measures based on a “system” definition, and they did not believe they could include affiliates in their system, or did not want to be accountable for the outcomes of their affiliates, and therefore decided to end those affiliations.
- Providers, especially those without large Medicaid utilization, are concerned about losing the progress they have made in transforming their delivery system when DSRIP funding ends. Even for the Medicaid eligible services and populations, they are concerned that MCOs will not administer funding as efficiently or simply as HHSC has, and that processes and systems will vary by MCO, greatly increasing administrative burden for the AHSCs.
- Providers are especially concerned about not getting performance data from MCOs in a timely manner or a standardized format, and that performance measures would not be aligned between all the various MCOs and other payors. They prefer HHSC to continue evaluating performance and directing the MCOs to pay providers, rather than leaving that up to individual MCOs. However, providers do note that in other programs that are just a pass through by the MCOs, such as Network Access Improvement Program (NAIP), the MCOs are not as involved, and were more involved when they had a larger administrative role and some risk.
- Data needs to be useable. AHSCs noted several deficiencies remaining in using Health Information Exchanges (HIEs), such as performance model specific data, demographic data, community-based data, data on SDOH, and data on community resources. Also, the data is not linked to claims, so it is not possible to see a patient’s total utilization across providers. It is also not possible to query the HIE at a population level, which makes reporting on population measures such as hospital readmission data more difficult. AHSCs also recommended looking at Medicare and all-payer approaches to alternative payment models.
- Specific suggestions for directed payment programs, targeted benefits, or targeted populations include:
 - A DPP with a per member per month (PMPM) payment to create or operate clinics in underserved neighborhoods that could be staffed by both physicians and paraprofessionals to assist with SDOH.

- A targeted benefit of dental care for pregnant women in Medicaid.
 - Targeted benefits for chronic disease management and diabetes prevention; nutrition; maternal health; BH embedded in primary care; food insecurity; social isolation; transportation.
 - Mobile services, or services at schools to reduce transportation barriers for children.
- Ways providers record and bill for services affect their likelihood of continuation (i.e., Z codes for directing patients to community services, the lack of ICD 10 codes for SDOH). A PMPM could provide a stable and efficient funding base instead of focusing on billing individual services. However, those services must still be recorded somewhere, even if not a claim. Also, 70% of physicians in Texas are in small practices of 8 or fewer doctors, and they are still not comfortable with any risk-based structure, including PMPM, and are only comfortable and prepared to use fee for service. AHSCs feel they can help lead by testing service models and data systems and processes, then help train and support smaller practices.
 - AHSCs have some clinics with high Medicaid volume currently, mostly OBGYN and pediatric clinics. Some provide specialty care to Medicaid patients that other specialists won't accept because of lower rates in Medicaid. However, those that see Medicaid patients have noted a large drop in volume recently, which will create changes in contracts and other challenges if it continues.
 - Providers asked about total funding available after DSRIP and indicated they would not be able to continue funding many of the current DSRIP programs without that funding being replaced by something. TMA expressed concern about further siloing an already complex program into too many different programs or eligibility groups.

Next Steps:

- 1) HHSC explores directed payment program for clinics in underserved areas operated by or affiliated with AHSCs.
- 2) HHSC explores targeted benefits for:
 - dental care for pregnant women in Medicaid;
 - chronic disease management and diabetes prevention and nutrition;
 - maternal health;
 - BH embedded in primary care;

- SDOH, such as food insecurity, social isolation, transportation; and
 - mobile services, or services at schools to reduce transportation barriers for patients.
- 3) HHSC considers issues remaining with data sharing and HIE for HIE strategic plan.
 - 4) For future programs, HHSC considers the definition of “system” and the implications of performance models on collaboration between providers under quality payment structures.

Summary of DSRIP Transition Stakeholder Workgroup Meeting with Community Mental Health Centers, Sept. 23, 2019

Organizations:

Bluebonnet Trails, Harris Center, Helen Farabee, Integral Care, MHMR Tarrant, StarCare, Texas Council of Community Centers, Tropical, HHSC

Key areas of transformation these providers want to sustain:

- Continued implementation of Certified Community Behavioral Health Clinics (CCBHCs)
- Access to care for the uninsured (60% of their patients), including MH and substance use disorder (SUD) services
- Integrated care between MH, SUD, and primary care
- Telepsychiatry
- Addressing SDOH
- Crisis services, including coordination with law enforcement
- Care coordination (including peer services and for individuals with Intellectual and Developmental Disabilities)

Highlights:

- DSRIP funds have been a substantial portion of funding for community mental health centers (CMHCs) in recent years, and have allowed the CMHCs to expand, enhance, and transform their service delivery. Part of delivery system reform has been moving toward the CCBHC model. There are currently 9 CCBHCs, and the TX Council expects all CMHCs to become CCBHCs by August 2021.
- CMHCs want to continue this momentum and support this model post-DSRIP through a Medicaid DPP for CMHCs as CCBHCs. CCBHCs have been cost reporting to try to estimate the rates that would be needed to sustain the CCBHC model, and to potentially use that information to develop alternative payment models for a DPP for that population. CMHCs have also been testing alternative payment models through grant funding. Texas Council and HHSC IDD BH both have data they can share for analysis.
- The CMHCs are also interested in creating a targeted population for Medicaid eligibility that would be for adults, based on diagnosis, functional impairment, and financial criteria. About 60% of people they see are currently uninsured. Virginia has implemented a targeted Medicaid population

for SMI and did it through an 1115 waiver to target. TX Council would prefer the benefit package be full STAR+PLUS but acknowledge that even a more limited benefit package would be helpful.

- While CCBHCs perform primary health screenings and SUD screenings and referrals, TX Council and centers want to also explore how to maintain and expand integration of primary care with BH and SUD treatment services. This might be considered CCBHC+, and may require general revenue from the legislature, but they may be able to repurpose some funds currently appropriated for inpatient psychiatric care that might be avoided with these services.
- The CMHCs that have been piloting integrated primary care have had difficulty contracting with MCOs to date, even for primary care services for Medicaid eligible patients. Some centers indicated the MCOs already had their primary care networks in place and didn't think it was helpful to add the CMHC. In other instances, MCOs' systems may not be set up to recognize a provider that can do both primary care and BH, so they can't process the provider enrollment or claims properly. Many MCOs have separate BH organizations within them or subcontracted, which has also presented contracting challenges.
- Texas Council would also like to find a way to address more SDOH. They are interested in a potential pilot operating statewide alongside the CCBHCs.
- Individual CMHCs shared examples of DSRIP-funded initiatives that were successful at reforming the delivery system, and which are their priority to continue.

Next Steps:

- 1) HHSC explores a DPP for CCBHCs that would start with CMHCs, then expand to other CCBHC clinics that are not CMHCs.
- 2) HHSC explores a targeted population for Medicaid eligibility and the costs of STAR+PLUS or a limited benefit package (e.g., Virginia).
- 3) Texas Council completes latest round of cost reporting for CCBHCs and provides HHSC with data.
- 4) HHSC works with Texas Council to understand costs of adding primary care integration to CCBHCs.

Summary of DSRIP Transition Stakeholder Workgroup Meeting with Local Health Departments, Sept. 23, 2019

Organizations:

City of Amarillo Public Health, City of Austin, City of El Paso Department of Public Health, City of Houston, Harris County Public Health, TACCHO, Tarrant County Public Health, DSHS, HHSC

Key areas of transformation these providers want to sustain:

- Continued financial support for access to services for Medicaid and the LIU population (including public health core clinical services including Sexually Transmitted Disease (STD) screenings, immunizations, Tuberculosis (TB), and services some LHDs offer such as dental care, family planning, and primary care)
- Continue to reduce access barriers by taking care to the community - mobile units, schools, home-based care
- Patient navigation
- Health promotion and disease prevention, including outreach and education by CHWs
- Chronic disease prevention and management

Highlights:

- Local Health Departments (LHDs) want to maintain at least the same amount of funding they received under DSRIP, which they estimate is about \$140 million. An idea for distributing funding was to have 3 tiers: 1) a baseline, 2) pay for performance, and 3) innovation.
- They are interested in a funding structure like uncompensated care (UC) funding to help reimburse them for services provided to uninsured patients. Some do already get UC funding available for dental services. They point out that they are not a for profit provider, so they just charge the cost of services at most. Also, many of their grant requirements also require that they not turn people away if they cannot pay, much like emergency rooms.
- They also want to maintain the IGT funding structure. LHDs indicate contracting with MCOs has been very difficult for several reasons. They are concerned that being required to go through an MCO would mean they would not be able to continue serving populations as they are currently.
- LHDs are interested in becoming a designated Medicaid provider type. Many LHDs already have Texas provider identifiers and can bill Medicaid, but some

indicate the billing structure is not ideal or that contracting difficulties with MCOs result in bills not being paid or being paid at a lower out-of-network rate.

- LHDs have been talking to MCOs to try to identify administrative barriers to contracting. One issue MCOs have indicated is the contract template. The MCOs also indicate the provisions in the contract are designed for providers such as primary care, not a local health department, and there are some provisions that are incompatible with LHD structures, processes, and legal requirements.
- TACCHO does have a list of services they would consider core public health services. Each LHD may do a different subset of those services. Core services include tuberculosis (TB) services, sexually transmitted disease (STD) services, and immunizations. Some LHDs also provide dental care, family planning, and some primary care.
- In addition to direct service provision, LHDs connect people to care and help them navigate the health care system with health educators and CHWs. While this work may be part of LHD requirements for accreditation, these are generally not billable services in Medicaid. They also provide technical assistance to doctors' offices on improving immunization rates and inform providers on standards and best practices. They would like to do more patient education and service navigation for chronic care self-management, but there has been very little funding for that. They see their role as enhancing access and prevention through linking people to the appropriate care.
- LHDs provide preventative and some primary care, but are safety net providers, not medical homes. They feel that performance measures should account for this, rather than penalize them for people not coming back to them if they successfully connect someone with a medical home. Also, because LHDs see a specific patient less consistently than a medical home, they have less access to patient-level data. To show benefits of their work, they are looking at CMS penalties to hospitals for their readmission rates and looking for opportunities to help hospitals lower those rates and reduce penalties. However, when they have done this in the past, some hospitals did not want to pay them for this work. They also have concerns that their work will not be compensated by MCOs, despite helping to avoid costs for the MCOs.
- LHDs have had challenges with data on Medicaid eligibility and utilization of their clients. DSRIP has improved that data collection through category B measure reporting and funding to participate in their local HIE or health

atlas. Some are continuing to improve their interview processes to better collect and verify Medicaid eligibility. For HHSC to get utilization data, they would likely have to go to individual LHDs and/or get a list of all TPIs used to bill Medicaid in the past, because there is no way to filter for LHDs in the Medicaid provider system.

- LHDs expressed interest in creating targeted populations or benefits for those with TB, chronic disease, and STD.

Next Steps:

- 1) HHSC looks into the MCO contracting template for LHDs.
- 2) HHSC explores targeted populations or benefits for those with TB, chronic disease, and STDs.
- 3) HHSC collects available Medicaid utilization data to make projections.
- 4) HHSC explores a possible UC program for some services provided by public health entities.
- 5) HHSC and TACCHO create workgroup for LHD and MCO representatives to work on contracting issues.

Summary of DSRIP Transition Stakeholder Workgroup Meeting with Physician Groups, October 4, 2019

Organizations:

American College of Obstetricians and Gynecologists, District XI (Texas), American College of Physicians, Texas Chapter, Federation of Texas Psychiatry, Texas Academy of Family Physicians, Texas Association of Obstetricians and Gynecologists, Texas Medical Association, Texas Pediatric Society, HHSC

Key areas of transformation these providers want to sustain:

- Access to care, including for LIU population
- Incentivizing primary care and building outpatient infrastructure and capacity
- Chronic disease management in outpatient setting
- Improved access to specialists for complex conditions
- Improved maternal health services and patient flow
- Improved coordination among community physicians, hospitals, and health plans through community accountability and shared decision-making

Highlights:

- Physicians are very concerned about the proportion of uninsured patients in Texas. Not only does it affect access to care, but it also affects reimbursement. Physicians believe this could also discourage recruitment of future primary care doctors if a significant portion of their patients cannot pay them. Physicians indicate that the lack of an increase in Medicaid payment rates over the last 20 years has led more to work for hospitals, and that this has decreased productivity and increased costs. The smaller number of community physician practices that continue to see a significant proportion of Medicaid and LIU largely rely on patient volume to sustain operations, which diminishes the time they have to manage certain conditions and increases referrals to more costly hospital and sub-specialty care.
- Physicians recognize the many successes from DSRIP and see value in scaling DSRIP innovations across the state. Physicians want to encourage more team-based, ambulatory primary care, reduce the use of hospitals for chronic disease or complex care management, and lower total cost of care. They suggest that focusing on maternal health and providing access to specialty and chronic disease services, especially for pregnant women, would lead to healthier babies and avoid significant costs from newborns ending up in the NICU.

- While the Texas Alliance for Innovation on Maternal Health (AIM) initiative has been positive for maternal health, it is hospital focused, and women still have difficulty accessing needed follow up services outside of the hospital, which reduces access and increases costs. Also, more of the evidence-based protocols used in AIM should be pushed out to outpatient office visits as well. As part of AIM, women with high-risk pregnancies should be directed to higher level hospitals, so those hospitals should not be inappropriately penalized for seeing increased rates of complicated cases or worse outcomes. Performance measures should account for this change in patient flow and not disincentivize these hospitals from taking high-risk patients.
- A way to encourage the availability of outpatient services for women with high-risk pregnancies is to create a simpler process for Medicaid to reimburse subspecialists who would only see a few Medicaid patients a year and therefore may not enroll in Medicaid, thus leaving only hospital-based providers accessible to women. Also, smaller practices don't have the same liability protections as public hospitals and practices, which discourages them from seeing high-risk patients. Allowing liability protections to follow the patient to the doctor's office would increase the likelihood of additional physicians taking on high-risk patients.
- Physicians would like HHSC to more strongly encourage hospitals and health plans to engage with community physicians. Physicians expressed they should have a role in deciding how to spend funds in the health care system. They are in favor of a model, such as a community ACO, that is governed by a local board that includes community physicians among a variety of stakeholders. The board makes allocation, network, and quality monitoring decisions publicly and transparently. Oregon and Chicago use models like this and can serve as examples that CMS has approved. Physicians suggest that this would also benefit hospitals by improving their discharge planning, access to specialists, and readmission rates. Financing for this model would need to be explored.
- Physicians encourage discussions across a broad array of provider types, payers, and state agencies. They suggest it would be beneficial to identify opportunities for alignment of approaches, resources, and incentives with Medicaid, Medicare, the Employees Retirement System (ERS) and the Teachers Retirement System (TRS).

Next Steps:

- HHSC explore concept of Community ACO model:
 - TMA provide information from Oregon and Chicago about Community ACO examples, including shared governance structures.

- HHSC consider meeting with physician practices who have done total cost of care contracts.
- HHSC look at use of Community ACOs in Medicare.