Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 89th Texas Legislature

As Required by
Texas Government Code §531.012, 1 Texas Administrative Code §351.821

December 2024

About This Report

This report was prepared by members of the Value-Based Payment and Quality Improvement Advisory Committee. The opinions and recommendations expressed in this report are the members' own and do not reflect the views of the Texas Health and Human Services Commission Executive Council or the Texas Health and Human Services Commission.

The information contained in this document was discussed and voted upon at regularly scheduled meetings in accordance with the Texas Open Meetings Act. Information about these meetings is available at https://www.hhs.texas.gov/about/leadership/advisory-committees/value-based-payment-quality-improvement-advisory-committee.

Report Date

December 2024

Contact Information

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Letter from the Chair

Dear Members of the Texas Legislature and Health and Human Services Executive Commissioner Cecile Erwin Young:

The Value-Based Payment and Quality Improvement Advisory Committee (Committee) is pleased to submit our biennial report. Our diverse committee includes representatives from Texas health care providers, hospitals, health plans, industry groups, and other expert stakeholders. Our mission is to promote broad-based partnerships and innovations for better care, smarter spending, and healthier communities. Improving health care quality, eliminating health disparities, and achieving desired health outcomes are key to elevating Texans' quality of life and the economic prosperity of our state. Prioritizing the delivery of value-based care is one proven way to accomplish these goals.

The Texas Medicaid program has been actively transitioning to value-based models for more than 25 years. Value-based care operates under a theory that efficient health care delivery models should reward providers for value — that is, better outcomes at lower cost — rather than volume. Payments aligned with value encourage providers to engage in evidence-based practices, collaborate and coordinate with peers and partners, and connect people to appropriate clinical and non-medical services to improve health and reduce disparities. Alternative payment models with the greatest potential to transform the health care system shift more accountability to providers and promote population-wide strategies to improve health outcomes.

Since the Committee's inception, several themes continue to emerge. First, the Committee believes greater awareness and alignment among stakeholders are necessary to advance value-based initiatives. Second, secure access to timely data is critical to the successful achievement of value-based care. Third, reimbursement methods in Medicaid and other state-funded programs must encourage long-term investment in payment and care models to adequately recognize and reward improved health for Texans.

Our Committee reached unanimous consensus on the recommendations in this report. We considered the latest research, heard from experts, and explored value-based care and quality initiatives across the country. This report extends the Committee's prior work and focuses on four key areas for improving health care quality and health through the advancement of value-based care in Texas:

- Advancing the alignment of APM contractual requirements for Medicaid managed care organizations.
- Improving access to care in rural settings.
- Leveraging available mechanisms within the Medicaid program to address non-medical drivers of health.
- Enhancing opportunities for secure and timely data sharing to support value-based care.

I would like to personally thank the members of the Committee and the subcommittee leads for their time, contributions, and dedication to this effort. Our Committee appreciates the Texas Health and Human Services Commission team who helps organize and facilitate our work, and we are honored to support their commitment and efforts to advance many of the initiatives described within this report.

Thank you for considering these recommendations. Our Committee stands ready to collaborate with you and other stakeholders and work together to improve the health of all Texans.

Respectfully,

Carol Huber, DrPH, MBA
Chair, Value-Based Payment and Quality Improvement Advisory Committee
University Health
San Antonio, Texas

About the Committee

This Committee is established in accordance with Texas Government Code §531.012, 1 Texas Administrative Code §351.821, and governed by Texas Government Code Chapter 2110 (State Agency Advisory Committees). The Committee provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment (VBP) initiatives for Medicaid, other publicly funded health services, and the wider health care system.

By December 1st of each even-numbered year, the committee submits a written report to the Texas Health and Human Services (HHS) Executive Commissioner and Texas Legislature to help Texas achieve the highest value for health care in the nation. This report describes current trends, identifies best practices in health care for VBP and quality improvement, and provides recommendations consistent with the purposes of the Committee.

These recommendations, by rule, may cover the following scope:

- VBP and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services.
- Core metrics and a data analytics framework to support VBP and quality improvement in Medicaid and Children's Health Insurance Program (CHIP).
- Texas Health and Human Services Commission (HHSC) and managed care organization (MCO) incentive and disincentive programs based on value.
- The strategic direction for Medicaid and CHIP value-based programs.

Committee Members

The Committee members are appointed by the Texas HHS Executive Commissioner and represent a variety of stakeholders, including:

- Medicaid MCOs;
- Hospitals;
- Physicians;
- Nurses;
- Providers of long-term services and supports;
- Academic systems;
- Pharmacies; and
- Members from other disciplines or organizations with expertise in health care finance, delivery, or quality improvement.

The Texas HHS Executive Commissioner may also appoint non-voting, ex officio representatives.

Voting Members

Carol Huber, DrPH, MBA, Chair
University Health, San Antonio

Paul Aslin
Texas Organization of Rural and Community Hospitals, Beach City

Dana Danaher, DrPH
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Acknowledgements

The Committee would like to thank the Center for Health Care Strategies, Episcopal Health Foundation, St. David's Foundation, Texas A&M Rural and Community Health Institute, Texas Academy of Family Physicians, Texas Collaborative for Healthy Mothers and Babies, Texas Hospital Association, Texas Medical Association, Texas Organization of Rural and Community Hospitals, Texas Pediatric Society, Treaty Oak Strategies, and the UT Health Houston School of Public Health for their expertise and support to develop these recommendations.

The Committee would also like to thank its past members who contributed significantly to these recommendations but whose terms expired prior to the publication of this report: Dr. Janet Hurley, Dr. Andy Keller, Melissa Matlock, Dr. Binita Patel, Dr. Mary Dale Peterson, and Alejandra Posada.

Finally, the Committee would like to thank individuals who helped conduct research and prepare materials and other logistics for this Committee and this report.

Executive Summary

As health care costs in the United States continue to increase, health disparities widen, and too many individuals remain uninsured, there is momentum in Texas and nationwide to change how we pay for and deliver care. Value-based payments (VBP) are an effective strategy to improve health care quality and health outcomes for patients while reducing cost trends. These alternative payment models (APM) incentivize quality and cost-efficiency by linking health care payments to measures of value.

In 2016, the Texas Health and Human Services (HHS) Executive Commissioner established the Value-Based Payment and Quality Improvement Advisory Committee (Committee) to evaluate the evidence on emerging value-based approaches and make recommendations to the Texas Health and Human Services Commission (HHSC) and the Texas Legislature on ways to optimize Texas' health care system.

The Committee released its first biennial report in 2018.[1] These recommendations included implementing a comprehensive informatics strategy, making data more readily available to support value-based initiatives, addressing patients' non-medical health-related needs, prioritizing maternal and child health, sustaining innovative behavioral health models, expanding VBP for substance use disorders, and reducing administrative complexity to promote provider participation in APMs.

The Committee released its second biennial report in 2020.[2] The 2020 recommendations focused on maternal and newborn health, multi-payer data, non-medical drivers of health (NMDOH), advancing APMs in Medicaid, and lessons learned from the COVID-19 federal public health emergency (PHE). Many of these recommendations emphasized information gathering, such as conducting landscape assessments of current programs, barriers, and tools for VBP. Additionally, the

[1] Texas Value-Based Payment and Quality Improvement Advisory Committee. (2018). *Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 86th Texas Legislature.* Texas Health and Human Services Commission.
[2] Texas Value-Based Payment and Quality Improvement Advisory Committee. (2020). *Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 87th Texas Legislature.* Texas Health and Human Services Commission.

recommendations underscored the importance of convening stakeholders to review and identify standardized performance measures and best practice models.

In 2022, the Committee's third biennial report continued these themes and detailed recommendations related to APMs in Medicaid, value-based care in home health and pharmacy, NMDOH, and timely, actionable data.

The recommendations presented in this year's report delve further into opportunities to expand APMs in Texas Medicaid, a specific focus on value-based care to improve rural health care access, integrating NMDOH into medical services and managed care, and improving access to timely, actionable data.

The Committee unanimously adopted these recommendations, which reflect many of the same priorities that have informed its work since 2016. For example, advancing value-based care requires broad stakeholder engagement, timely integrated data, minimal administrative burden, and aligned incentives for MCOs and providers. This year's report builds on recommendations from prior years to include specific actions Texas legislators, policy makers, and other leaders can and should take to achieve efficient high-quality care, reduce health disparities, and improve health outcomes, particularly in Medicaid and the Children's Health Insurance Program (CHIP).

2024 Recommendations

Alternative Payment Models in Texas Medicaid

- HHSC should work to align next steps for its APM program with the Centers for Medicare and Medicaid Services (CMS) Innovation Center's strategy refresh released in October 2021, including working to increase the number of Medicaid beneficiaries in a care relationship with provider accountability for quality and total cost of care by endorsing standardized elements of such models, conveying Texas Medicaid priorities, and rewarding multi-payer collaboration.
- Texas should review financing mechanisms that encourage, evaluate, and sustain Medicaid APMs that effectively address provider workforce shortages (e.g., nurses and behavioral health providers) and address NMDOH.
- HHSC should continue to explore ways to reduce provider administrative burden to enable greater participation in APMs, particularly in more advanced APMs.

- HHSC should consider a more formal structure for dissemination of best practices of VBP models, including emerging trends such as Clinically Integrated Networks (CIN) and a review of MCO APM reporting in 2024 of the "test year" for HHSC's revised APM framework.

Value-Based Care to Improve Rural Health Care Access

- HHSC should develop guidance for MCOs to optimize the use of pharmacists to increase access to high quality care in rural areas. HHSC should:
  - Clarify how pharmacists can be paid for covered services delivered within a pharmacist's scope of practice.
  - Evaluate current services within the pharmacist's scope of practice and expand services covered under Texas Medicaid (e.g., test and treat, childhood immunizations).
  - Establish standards and a working definition for an Accountable Pharmacy Organization (APO) and work to increase engagement with APOs.
- HHSC should develop guidance for rural providers and MCOs related to the use of community health workers (CHW) to address rural workforce shortages and gaps in rural health care access. HHSC should:
  - Establish guidance for alternative methods to achieve CHW certification for health care workers, such as certified pharmacy technicians and medical assistants, serving rural communities.
  - Evaluate APMs that leverage the recent expansion of billable CHW services and promote the dual purposing of rural staff to address gaps in access.

Non-Medical Drivers of Health (NMDOH)

- HHSC should use the various Medicaid authorities and/or regulatory tools to strengthen cross-sector partnerships between MCOs, health care providers, and social services organizations to address beneficiaries' NMDOH. HHSC should focus on the three priorities (food, transportation, and housing) identified in the Medicaid and CHIP Services *NMDOH Action Plan*. Regulatory tools include, but are not limited to, In-Lieu of Services and Settings (ILOS), experience rebates, quality improvement cost, incorporating NMDOH risk-markers in determination of capitation rates, and APMs.

- HHSC should identify strategies to increase enrollment of eligible Medicaid members in federal food benefit programs such as Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to reduce food insecurity. For example, HHSC could provide Medicaid enrollees' SNAP and WIC enrollment status to MCOs to support targeted outreach and case management.
- HHSC should assess the impact of House Bill (HB) 113, 88th Legislature, Regular Session (88R) which allows MCOs in STAR Medicaid to categorize services provided by CHWs as a quality improvement cost, instead of as an administrative expense. HHSC should provide a report to the Legislature by December 31, 2025, on the use of CHWs and quality improvement costs reported by each MCO. The report should describe how CHWs may have impacted each MCO's medical loss ratio, and how these reported costs can be used to develop capitation rates in the future (e.g., as a projected non-benefit cost, or to prepare for potential transition to a state plan benefit).

Timely and Actionable Data

- HHSC or a neutral, third party contractor should perform a landscape assessment of where Texas is in terms of data interoperability, including health information exchange (HIE) and sharing of data on NMDOH. Based on that assessment, HHSC should create a strategic plan with next steps to leverage data to improve care in Medicaid and CHIP.
- Texas should evaluate opportunities to maximize the use of the Texas All-Payor Claims Database (TX-APCD) (along with other state data sets), including identifying and prioritizing needed investments to advance high-value care, particularly for Medicaid and other state-funded health care programs.
- HHSC should analyze and share data on the number of providers who are billing the new Medicaid collaborative care benefit to inform an assessment of what additional steps may be needed to encourage greater use of this benefit.

1. Introduction

Texas invests in its residents through services designed to improve health and support economic growth, including $48.9 million for Medicaid and CHIP in 2021 alone. In fact:

- Medicaid and CHIP cover 4.9 million Texans and 51% of births.
- Fifty-eight percent of nursing home residents are covered by Medicaid.
- Ninety-seven percent of Medicaid beneficiaries access services through MCOs that are paid a fixed amount of premium per member per month.

Texas offers financial and administrative incentives to MCOs that achieve improvements in quality, outcomes, and cost-effectiveness. These value-based initiatives have helped Texas Medicaid and CHIP increase access to preventive care and contain cost growth.[3] Yet opportunities to improve quality and health in Texas still exist. The Urban Institute reports:

> On average, infants, mothers, and adults in Texas live in poorer health and lead shorter lives than peers in most states. Black adults and infants face some of the most pervasive disparities. A Black person at birth can expect to live five fewer years than a white person. Black pregnant women and infants face mortality rates two times higher than white pregnant women and infants—a disparity that has persisted for decades. Other groups also face disparities—Hispanic adults have higher rates of fair or poor health status, obesity, and diabetes, and white adults have among highest rates of any cancer and depression in the state.[4]

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[3] *Texas Medicaid and CHIP Reference Guide*, 14th Edition - https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf

[4] Siddiqui, N.J., Morriss, S., Taylor, K.J., & Smedley, B. (2024). *Moving Upstream to Achieve Better and Equitable Health in Texas*. Urban Institute. https://www.urban.org/research/publication/moving-upstream-achieve-better-and-equitable-health-texas

These and other disparities negatively impact health care spending and economic productivity. In fact, Altarum estimates health disparities cost Texas nearly $8 billion, not counting the value of lives lost to premature death.[5]

Since its creation in August 2016, Texas' Value-Based Payment and Quality Improvement Committee has pursued a mission to identify and promote broad-based partnerships and collaborations for better care, smarter spending, and healthier communities. As part of this charge, the Committee reports its consensus findings and recommendations every two years to the HHS Executive Commissioner and the Texas Legislature.

According to the *New England Journal of Medicine*, value-based care is a "health care delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes."[6] As defined in the Committee's first report, VBPs, also known as Alternative Payment Models (APM), are payment approaches whose goal is to incentivize high-quality and cost-efficient care by linking health care payments to measures of value.[7]

Value-based care operates under a theory that efficient health care delivery models should reward health care providers for value — that is, better outcomes at lower cost — rather than volume. These models can apply to a specific clinical condition, a care episode, or a population, and may incorporate financial risks and rewards, as well as non-financial incentives. Payments aligned with value encourage providers to engage in evidence-based practices, collaborate and coordinate with peers and partners, and connect people to appropriate clinical and non-medical services. APMs have shown great potential to transform the health care system, shift more accountability for quality to providers, and promote population-wide strategies to

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[5] Turner, A., LaVeist, T.A., Richard, P., & Gaskin, D.J. (2021). *Economic Impacts of Health Disparities in Texas 2020 – an Update in the Time of COVID-19*. Altarum. https://dev.altarum.org/publications/economic-impacts-health-disparities-texas-2020-update-time-covid-19#:~:text=Updating%20estimates%20from%20our%202016%20study%2C%20we%20find,to%20premature%20deaths%2C%20conservatively%20valued%20at%20%2422.6%20billion

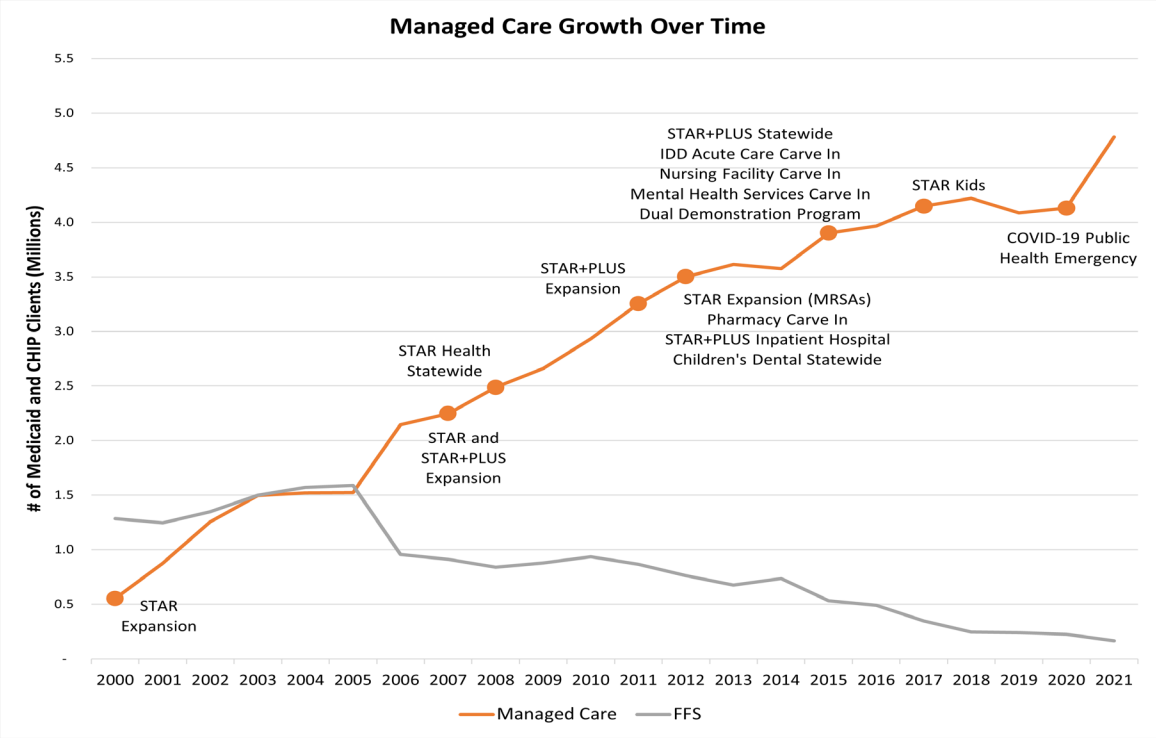
[6] NEJM Catalyst. (2017). *What is Value-Based Healthcare?* https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558

[7] Texas Value-Based Payment and Quality Improvement Advisory Committee. (2018). *Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 86th Texas Legislature.* Texas Health and Human Services Commission.

improve health outcomes. Value-based care, operationalized through effective APMs, benefits patients, providers, payers, suppliers, and society.[8]

The Texas Medicaid program has been transitioning to a value-based model for some time now. For more than 25 years, the state has gradually moved care delivered through Medicaid away from traditional fee-for-service (FFS) reimbursement to a system where MCOs are financially responsible for managing costs and improving quality. Ninety-seven percent of Texans (4.1 million) enrolled in Medicaid and CHIP receive services through managed care as-of 2021. (Figure 1)**.** Increased enrollment and improved access to preventive services within managed care help keep Texas Medicaid costs an estimated 35 percentage points lower than the U.S. national average.[9]

Figure 1: Texas Medicaid and CHIP Managed Care Program Growth, 2000-2021



[8] NEJM Catalyst. (2017). *What is Value-Based Healthcare?* https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558

[9] Texas Medicaid and CHIP Reference Guide, 14th Edition - https://www.hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf

Texas' Healthcare Transformation and Quality Improvement Program included incentive payments to hospitals and other providers for strategies to enhance access to health care. Through this 1115 waiver, the Delivery System Reform Incentive Payment (DSRIP) program "laid a solid foundation of quality improvement, upon which Texas may continue to pursue health care delivery reform and advance value in the Medicaid program."[10] Between 2012 and 2021, DSRIP providers, including hospitals, community mental health centers, local public health departments, and physician practices affiliated with academic medical centers, earned over $24 billion (federal and intergovernmental transfer funds) for their participation in the program, which included developing and testing innovative projects, achieving goals, and tracking and improving performance on process and outcome measures.

In state fiscal year 2022, HHSC implemented four new directed payment programs (DPP) intended to advance Texas' health care quality goals and sustain funding levels earned under DSRIP. Currently, HHSC has approval from CMS for five DPPs: Comprehensive Hospital Increase Reimbursement Program (CHIRP), Directed Payment Program for Behavioral Health Services (DPP BHS), Quality Incentive Payment Program (QIPP), Rural Access to Primary and Preventive Services Program (RAPPS), and Texas Incentives for Physicians and Professional Services (TIPPS).[11]

Other statewide initiatives aimed at increasing value in Medicaid and CHIP include: the Medical and Dental Pay for Quality (P4Q) Programs; Managed Care Report Cards; Performance Improvement Projects (PIPs); Hospital Quality-Based Payment Program; Quality and Cost-Efficiency Benchmarks for MCOs; and Value-Based Enrollment. These programs are described in HHSC's Annual Report on Quality Measures and Value-Based Payments[12] and summarized in Table 1.

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[10] HHSC report: Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8 - https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf

[11] HHSC report: Annual Report on Quality Measures and Value-Based Payments. - https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2023.pdf

[12] Ibid.

Table 1: Summary of Statewide Incentive Programs for Quality Improvement and Value-Based Care[13]

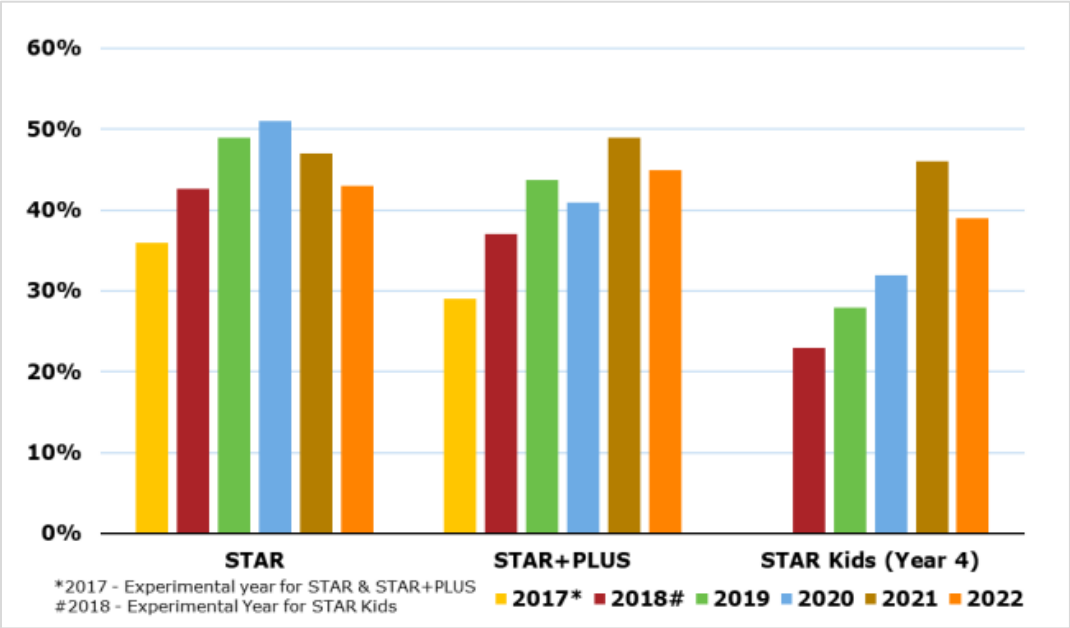
Value-Based Care Initiatives	Priority Population, Provider Type, and/or Payer	Brief Description
Directed Payment Programs	Hospitals, nursing homes, providers, certain physician practices, Rural Health Clinics, and community mental health centers	Payments made to health care providers through MCOs based on performance parameters. Programs include CHIRP, QIPP, TIPPS, RAPPS, and DPP-BHS.
Alternative Payment Model Requirements for MCOs	Managed care organizations	Requires MCOs to shift an increasing share of provider reimbursement into APMs that link a portion of provider payments to measures of value (quality and efficiency). These APMs may involve financial risk for providers and/or reward them for meeting performance standards based on measures of value. MCOs must report annually to HHSC on the volume of APM contracts they implemented with their providers in the prior calendar year.
Benchmarks for Managed Care Organizations	Managed care organizations	HHSC publishes quality of care and cost efficiency benchmarks to complement existing initiatives to monitor and incentivize efficiency and quality of care in Medicaid and CHIP managed care. For each domain, benchmarks categorize performance as exceptional, high, satisfactory, marginal, or low.
Hospital Quality-Based Payment Program	All hospitals participating in Medicaid and CHIP	Incentivizes hospitals to reduce potentially preventable hospital readmissions and complications.
Medical Pay for Quality (P4Q)	Managed care organizations	Incentivizes performance improvement using financial risks and rewards, coupled with performance and improvement targets on quality measures. Up to three percent of each MCO's capitation is at-risk of recoupment.

[13] Ibid.

Value-Based Care Initiatives	Priority Population, Provider Type, and/or Payer	Brief Description
Dental Pay for Quality (P4Q)	Dental maintenance organization (DMO)	Incentivizes performance improvement using financial risks and rewards, coupled with performance and improvement targets on quality measures. One and a half percent of each DMO's total calendar year capitation is at-risk of recoupment.
Managed Care Report Cards	Managed care organizations	Empowers prospective enrollees to make informed choices about Medicaid and CHIP MCOs in their service area.
Performance Improvement Projects (PIP)	Managed care organizations	Encourages MCOs to improve health care delivery and care outcomes by assessing existing processes and identifying areas of improvement.
Medicaid Value-Based Enrollment	Managed care organizations	Adjusts auto-enrollment for Medicaid managed care organizations based on measures of quality and efficiency.

Further, HHSC encourages value-based contracting directly between MCOs and their network providers. Under this initiative, HHSC contractually established targets for MCOs to connect a minimum percentage of provider payments to value using APMs starting in calendar year 2018. The APM percentage targets increased incrementally between 2018 and 2021. HHSC extended the 2021 targets through 2022 due to impacts of the federal PHE. If an MCO fails to meet the APM targets, the MCO must submit a corrective action plan and HHSC may impose contractual remedies, including liquidated damages. High-performing MCOs are allowed certain exceptions. MCOs have made steady progress in this area, with some reductions noted during the COVID-19 PHE (Figure 2).

Figure 2: Overall APM Achievement by Program, Calendar Years (CY) 2017-2022



To provide a collaborative framework for achieving progress toward value-based care, the contractual targets are accompanied by a set of guiding principles, set forth in HHSC's VBP Roadmap, which was published in 2021. These principles call for: 1) continuous engagement of stakeholders; 2) harmonization and coordination of value-based initiatives; 3) administrative simplification; 4) data driven decision-making; 5) movement through a VBP continuum as represented by the Health Care Learning & Action Network (HCP-LAN) APM framework; and 6) rewarding success.

Progress since the Committee's 2022 Report

The Committee's 2022 recommendations addressed APMs in Medicaid, value-based care in home health and pharmacy, NMDOH, and timely, actionable data. Many of these recommendations focused on adopting new APMs and services; prioritizing alignment with other existing and emerging initiatives; clarifying definitions, billing processes, and other rules; and broadening capabilities for secure data sharing.

The Committee's 2022 recommendations helped inform subsequent state initiatives, including legislation proposed and/or passed in 2023, a new APM framework implemented in Medicaid managed care, new DPPs, and the creation of a new *NMDOH Action Plan*.

Legislative Actions in the Texas 88th Legislature, Regular Session, 2023

The Texas Legislature sets the requirements and direction for HHSC. During its regular session, the 88th Legislature enacted several bills and riders that improve access to care, health care quality, and outcomes; reduce disparities; and steer the trajectory of value-based care:

- HB 12 extends Medicaid postpartum coverage from 60 days to 12 months. HHSC also extended this 12-month postpartum coverage to eligible CHIP clients (but not those with coverage under CHIP Perinate). Under state plan amendments, anyone enrolled in Medicaid or CHIP who is pregnant or becomes pregnant will be automatically enrolled for 12 months of postpartum coverage. Services covered by Medicaid and CHIP include prenatal care visits, prenatal vitamins, labor and delivery, and postpartum care visits.
- HB 113 addresses a funding barrier to hiring CHWs by allowing MCOs that contract with the state through the STAR Medicaid managed care program to report expenses incurred through the provision of CHW services as a quality improvement investment rather than an administrative expense.
- HB 1575 standardizes the screening process for pregnant women eligible for public benefits programs offered by Texas' HHS agencies to better identify non-medical health-related needs that could impact birth and health outcomes. The law also increases access to existing supports by allowing CHWs and doulas to be reimbursed for providing services under the Case Management for Children and Pregnant Women (CPW) program with the goal

of improving health outcomes for mothers and babies and self-sufficiency for these families.

- HB 2727 expands the availability of home telemonitoring services under Medicaid to more patients if HHSC determines them to be cost-effective and clinically effective, including those with specific health conditions such as pregnancy, diabetes, heart disease, cancer, and others. It also includes provisions for the sharing of clinical information between home tele-monitoring service providers and the patients' physicians, ensuring continuity of care and effective monitoring.
- HB 3414 clarifies the application process and requirements for qualified research entities to access data submitted to the TX-APCD, which is administered by the Center for Health Care Data (CHCD) at the UT Health Houston School of Public Health and overseen by the Texas Department of Insurance, with specific and appropriate restrictions on access and use of data.

The following bills were considered but failed to become law during the 88th Legislature, Regular Session, 2023:

- HB 1073 proposed an amendment to the Insurance Code to allow preferred and exclusive provider benefit plans to enter into value-based/capitated payment arrangements.
- HB 2171 sought to establish the Texas Center for Rural Health Education at the University of Texas Rio Grande Valley. The Center aims to improve rural health education and health care outcomes by conducting research, developing performance metrics, and creating partnerships between educational institutions and local medical systems to train and retain health care professionals in underserved rural areas.
- HB 2983 sought to create a five-year "food is medicine" pilot program in coordination with community-based organizations and medical providers to demonstrate the cost-effectiveness and improved health outcomes of Medicaid pregnant and postpartum recipients who are provided medical nutrition assistance.

Alternative Payment Models

Specific to APMs, the Committee recommended in 2022 that HHSC should adopt a more comprehensive contractual framework to assess MCO advancement toward value-based care, including:

- Move away from a specific focus on meeting APM percentage targets.
- Provide a menu of approaches to give MCOs credit for a broader range of work promoting value-based care.
- Revise the current APM reporting tool to collect only needed data in as streamlined a format as possible.

HHSC accomplished this strategy, with input from the Committee and other stakeholders, through implementation of the revised APM Performance Framework (APM-PF) included in the Medicaid Managed Care Contract for calendar year 2023.

Directed Payment Programs

With approval from CMS under 42 Code of Federal Regulations § 438.6(c), states may direct MCO expenditures in ways that support health care improvement goals. Texas develops these programs specific to classes of providers and directs MCOs to implement the associated provider payments. In 2018, HHSC launched the Quality Incentive Payment Program (QIPP) for nursing homes, designed to help nursing facilities achieve transformation in care quality through innovation.

In state fiscal year 2022, HHSC implemented four new DPPs:[14]

- Comprehensive Hospital Increase Reimbursement Program (CHIRP) is a DPP for hospitals providing health care services to adults and children enrolled in the STAR and STAR+PLUS Medicaid managed care programs. Eligible hospitals include children's hospitals, rural hospitals, mental health hospitals, state-owned hospitals, and urban hospitals.
- Texas Incentive for Physicians and Professional Services (TIPPS) is a DPP for certain physician groups providing health care services to children and adults enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid managed care

[14] HHSC report: Annual Report on Quality Measures and Value-Based Payments. - https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2023.pdf

programs. Eligible physician groups include health-related institutions, indirect medical education physician groups affiliated with hospitals, and other physician groups.

- Directed Payment Program for Behavioral Health Services (DPP BHS) is a value-based payment program for Community Mental Health Centers to incentivize the continuation of providing services aligned with the Certified Community Behavioral Health Clinic model of care for Medicaid enrollees.
- Rural Access to Primary and Preventive Services (RAPPS) is a DPP for rural health clinics that incentivizes the provision of primary and preventive services to individuals enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs.

CMS requires states to evaluate DPPs annually. Most recently, HHSC reported these findings:

- Participants' abilities to track and report data is improving, including the ability to isolate data for Medicaid Managed Care clients. In the first year, participants were not able to report Medicaid Managed Care data for approximately 30% of the measures.
- Providers participating in the DPPs serve Medicaid clients with higher rates of preventable hospital admissions and emergency department visits.
- Some measures are not a good fit for the DPPs because performance rates are already high during the first year, or the measures have poor alignment with the Medicaid population.
- Hospitals participating in CHIRP reported a 12% increase in the adoption of HIE between the first and second year.
- Challenges continue with evaluating the impact of the payment arrangements. The evaluation results are limited by initial delays in program approval, the impacts of the COVID-19 PHE, and annual changes in program enrollment.

Texas' *Non-Medical Drivers of Health Action Plan*

Non-medical drivers of health (NMDOH) are "the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." – NMDOH Action Plan

In February 2023, HHSC developed its *Non-Medical Drivers of Health (NMDOH) Action Plan* to advance Texas' health care quality goals, pursue cost savings from improved population health management and reduced use of health care services, and respond to requests from MCOs and providers for state guidance. The *NMDOH Action Plan* focuses on three priority drivers: food insecurity, housing, and transportation.

HHSC invites MCOs, health care providers, and community organizations to align their efforts to achieve four main goals:[15]

1. Build Medicaid NMDOH data infrastructure for statewide quality measurement and evaluation.
2. Coordinate services and existing pathways throughout the delivery system to address food insecurity, housing, and transportation for Texas Medicaid beneficiaries.
3. Develop policies and/or programs to incentivize MCOs and providers to identify and address food insecurity, housing, and transportation for Medicaid beneficiaries while demonstrating cost containment.
4. Foster opportunities for collaboration with partners internal and external to Texas HHS.

[15] HHSC - Non-Medical Drivers of Health - https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/non-medical-drivers-health

2. Policy Issues, Recommendations, and Discussion

Throughout 2023 and 2024, the Committee heard invited presentations from diverse health care professionals, subject-matter experts, and stakeholders. For example:

- HHSC leaders and staff presented updates on the new APM-PF, *NMDOH Action Plan*, DPPs, state and national policy and legislative actions, quality initiatives and report findings, emerging quality measurement trends, and HIE progress.
- Episcopal Health Foundation shared its latest research on efforts to understand and address NMDOH.
- St. David's Foundation described how foundations and non-profit community organizations can partner with MCOs and providers to address NMDOH.
- UT Health Houston School of Public Health provided an update on cross-agency coordination on health care strategies, data, and performance measures.
- The executive director of the TX-APCD gave an update on progress, challenges, and next steps for data sharing and research.
- The Texas Collaborative for Healthy Mothers and Babies identified priorities for addressing maternal mortality in Texas.
- The Texas A&M University Rural and Community Health Institute discussed opportunities for improving maternal health in rural communities.
- The Texas Organization for Rural and Community Hospitals shared progress developing its CIN.
- Treaty Oak Strategies presented opportunities for how pharmacy providers and services can improve Texans' health and access to care.

The Committee also reviewed an array of relevant research to develop its recommendations for 2024. The recommendations of this Committee are strongly aligned with those made by other state and national groups and published reports. For example:

- America's Health Rankings recommends "transitioning primary care reimbursement to value-based payment that enables investment in health promotion, disease prevention, and chronic disease management…, investing in social services, … and reducing inequitable administrative burdens affecting patients and providers."[16]
- The Center for Health and Biosciences at Rice University's Baker Institute for Public Policy recommends Texas address the upstream drivers of health and transform health financing in *The Texas 10x10x10: A Road Map for achieving a Healthier Texas*.
- In its *Medicaid Pharmacy in Focus* report, Treaty Oak Strategies identified opportunities to expand APMs and address rural workforce shortages to reduce health disparities and improve outcomes through innovations in pharmacy.
- After interviewing Texas health leaders and experts, the Urban Institute described how MCOs, hospitals, and other providers are working to address NMDOH as a means to improve health. Their report recommends applying a multilevel systems change approach to engaging communities as partners and investing in data-driven strategies to achieve better health, including incentives to address NMDOH and documentation of evidence-based best practices.[17]

In preparing its recommendations, the Committee identified key themes, including the importance of stakeholder engagement, timely data, innovative strategies to meet the unique and diverse needs of Texas, and aligned incentives. The recommendations, all adopted by unanimous vote of the Committee's multi-stakeholder membership, reflect these themes and offer solutions to further

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[16] United Health Foundation, American Public Health Association. (2023). *Executive Brief: 2023 Annual Report*. America's Health Rankings. https://assets.americashealthrankings.org/app/uploads/ahr_2023annual_executivebrief_final-web.pdf

[17] Siddiqui, N.J., Morriss, S., Taylor, K.J., & Smedley, B. (2024). *Moving Upstream to Achieve Better and Equitable Health in Texas*. Urban Institute. https://www.urban.org/sites/default/files/2024-03/Moving%20Upstream%20to%20Achieve%20Better%20and%20Equitable%20Health%20in%20Texas.pdf

advance VBP implementation to achieve improved care and health outcomes for Texas' patients and families.

Above all, the Committee continues to be guided by Texas' health care quality goals. HHSC published an updated version of these goals in early 2024:[18]

1. Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.
2. Keep patients free from harm by building a safer health care system.
3. 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.
4. 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.

Policy Issue: Alternative Payment Models in the Texas Medicaid Program

Since its inception, this Committee has focused on APMs as a key strategy to advance value-based care, reduce health disparities, and improve quality and outcomes in the Texas Medicaid program. Starting in calendar year 2018, Texas HHSC established APM percentage targets for Medicaid MCOs. In the subsequent six years, HHSC reported aggregate data on MCO performance against these targets and shared information on MCO-specific models to promote collaborative learning. In 2022, the Committee recommended that HHSC adopt a more comprehensive contractual APM framework to assess MCO achievement, including:

- Move away from a specific focus on meeting APM percentage targets.
- Provide a menu of approaches to give MCOs credit for a broader range of work promoting value-based care.

[18] HHSC report: Draft Texas Managed Care Quality Strategy. - https://www.hhs.texas.gov/sites/default/files/documents/draft-texas-managed-care-quality-strategy.pdf

- Revise the current APM reporting tool to collect only needed data in as streamlined a format as possible.

Based on their program experience, recommendations from this Committee, and stakeholder input, HHSC overhauled the APM framework. The newly revised performance framework, known as APM-PF, was adopted and instituted in the Uniform Managed Care Manual (UMCM) for calendar year 2023 for the STAR & CHIP, STAR+PLUS, STAR Kids, and STAR Health managed care programs.

The Committee's 2024 recommendations propose next steps to continue to learn and implement best practices for APMs, while staying focused on state priorities, alignment with national initiatives, reduction of administrative burden, and achievement of quality goals that improve the health of Texans.

Recommendation 1

HHSC should work to align next steps for its APM program with the CMS Innovation Center's strategy refresh released in October 2021, including working to increase the number of Medicaid beneficiaries in a care relationship with provider accountability for quality and total cost of care by endorsing standardized elements of such models, conveying Texas Medicaid priorities, and rewarding multi-payer collaboration.

Recommendation 2

Texas should review financing mechanisms that encourage, evaluate, and sustain Medicaid APMs that effectively address provider workforce shortages (e.g., nurses and behavioral health providers) and address NMDOH.

Recommendation 3

HHSC should continue to explore ways to reduce provider administrative burden to enable greater participation in APMs, particularly in more advanced APMs.

Recommendation 4

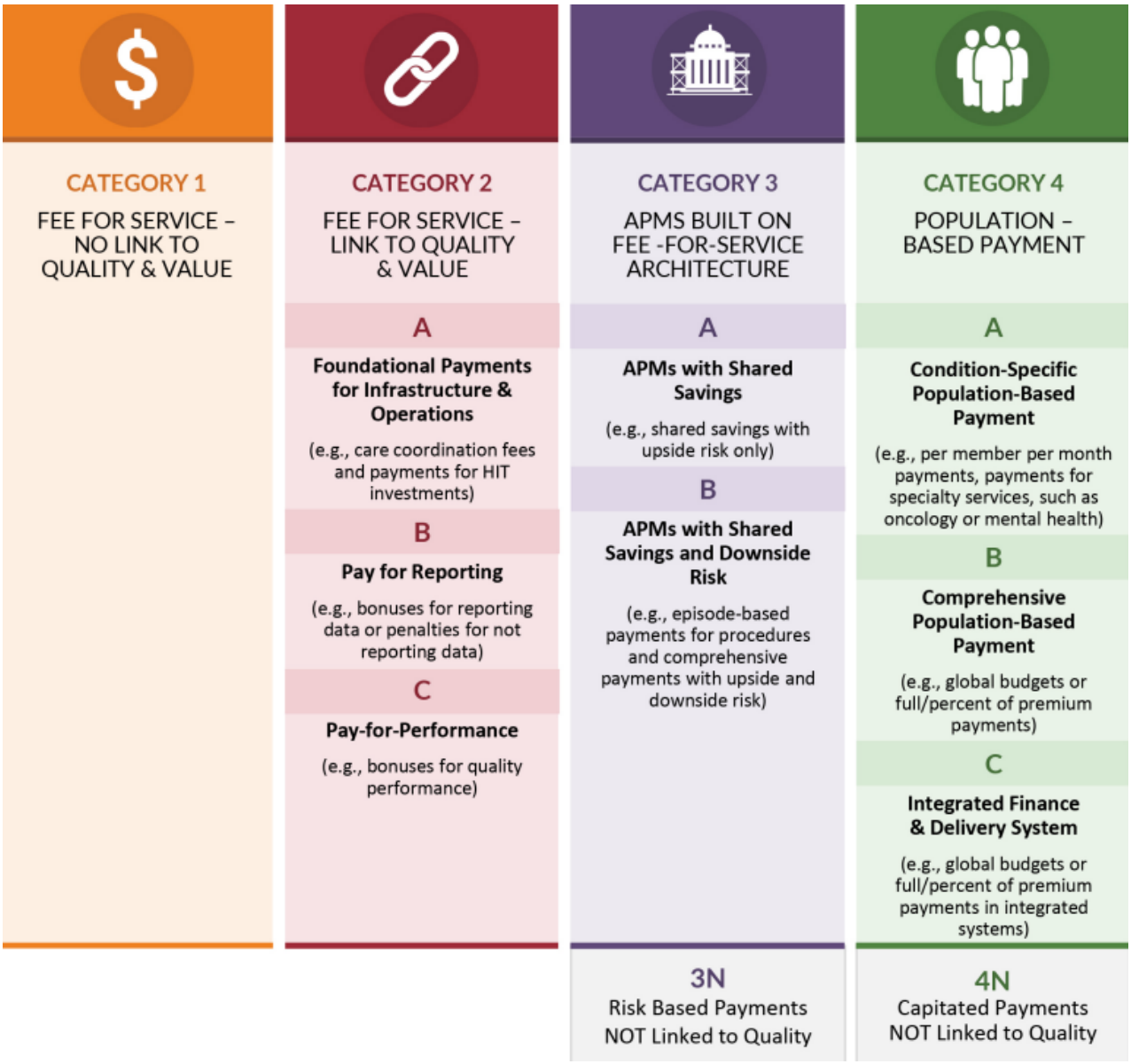
HHSC should consider a more formal structure for dissemination of best practices of VBP models, including emerging trends such as Clinically Integrated Networks (CIN) and a review of MCO APM reporting in 2024 of the "test year" for HHSC's revised APM framework.

Discussion

APM Framework

The Health Care Payment Learning & Action Network (HCP-LAN) framework outlines categories of APMs designed to achieve value-based care (Figure 3). The HCP-LAN seeks to increase overall utilization of APMs and promote implementation of more advanced APMs in Categories 3 and 4, which may include shared savings, shared risk, and population-based payments.

Figure 3: Health Care Payment Learning & Action Network Framework[19]



The Texas Medicaid APM requirements and targets align with the HCP-LAN concepts, including the advancement of risk-based APMs. The original APM framework for Texas MCOs specified targets beginning in calendar year 2018 (Table

[19] Health Care Payment Learning & Action Network. (n.d.). *Figure 1 & 4: The Updated APM Framework* [Infographic]. Retrieved November 15, 2023, from https://hcp-lan.org/workproducts/apm-figure-1-final.pdf

2). HHSC extended calendar year 2021 targets through calendar year 2022 due to the federal PHE brought on by the COVID-19 pandemic.

Table 2: Texas Medicaid MCO Contract Targets for APMs[20]

Period	Minimum Overall APM Ratio	Minimum Risk-Based APM Ratio
Measurement Year 1	≥ 25%	≥ 10%
Measurement Year 2	Year 1 Overall APM Ratio + 25%	Year 1 Risk-Based APM Ratio + 25%
Measurement Year 3	Year 2 Overall APM Ratio + 25%	Year 2 Risk-Based APM Ratio + 25%
Measurement Years 4 and 5	≥ 50%	≥ 25%

Since 2018, HHSC has required MCOs to shift an increasing share of provider reimbursement into APMs that link a portion of provider payments to metrics for quality and efficiency. By calendar year 2022, HHSC required MCOs to make 50% of their provider payments through any form of APM, and with at least 25% through APMs involving financial risk for providers. For the most recent year with complete data, MCOs collectively averaged 47% of payments through APMs in STAR, 49% in STAR+PLUS, and 46% in STAR Kids.

As HHSC transitions to the APM-PF for calendar year 2023, it recognizes MCOs' additional efforts to advance APMs beyond meeting minimum APM targets. Under the APM-PF, MCOs are encouraged to develop and implement innovative models that address specific quality improvement priorities. Some examples include models that encourage ambulance transports to alternative sites instead of emergency departments when appropriate, models that address NMDOH, and models that incentivize the integration of primary and behavioral health care services. Additionally, HHSC recognizes MCOs for evaluating their APMs, sharing lessons

[20] HHSC requires that MCOs increase their total APM and risk-based APM ratios according to the following schedule. A Measurement Year is a 12-month period from January 1 to December 31. Measurement Year 1 is calculated starting January 1 after the respective MCO enters into a new Medicaid or CHIP Program. The percentage targets could be lower for an MCO based on exceptions, such as achieving a higher-than-expected level of performance on both potentially preventable hospital admissions (PPA) and potentially preventable emergency department visits (PPV) as defined in the contract.

learned with peers, and collaborating with other organizations to align quality measures and reduce administrative burden.[21]

APM-PF offers MCOs flexibility to advance value-based strategies and initiatives, while maintaining alignment with the HCP-LAN. MCOs earn points across five APM domains over four years:

1. Achievement Levels
2. Quality Performance
3. APM Priorities
4. APM Pilots and/or Initiatives
5. APM Support

The APM point requirements are guided by the following:

- Achievable point requirements with annual benchmarks.
- First year (2023) is a Test Year.
- Current APM percentage targets will remain (50% overall, 25% risk-based).
- Options for recognizing "year over year" improvement (dollars invested, members served, providers engaged) are built in.
- STAR and CHIP programs will be calculated together.
- MCOs new to a program or with a substantial change in Service Delivery Areas (SDA) will start with a Test Year (or Year Zero).

HHSC will test the updated data submission tool in December 2024 and fully implement the new requirements for calendar year 2024, with associated MCO reporting due in September 2025.

Alignment with National Models

In 2022, the Committee recommended HHSC align next steps for its APM program with the CMS Innovation Center's strategies, including working to increase the

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[21] HHSC report: *Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid* - https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-medicaid-aug-2023.pdf

number of Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care. The CMS Innovation Center leads the development and testing of innovative health care payment and service delivery models for Medicare and Medicaid. The CMS Innovation Center strategy refresh in 2021 included putting patients at the center of care with a strategic objective that, "the vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030." The Committee carries this recommendation forward in this 2024 report.

A focus on primary care continues to be a priority for Texas and nationally, and HHSC designed the APM-PF to promote "accountable care." The APM-PF is an opportunity to incentivize a broader range of providers by recognizing the importance of a health home, relationship-based care, multi-payer initiatives, and the importance of care continuity for patients who may be transitioning between Medicaid and other types of coverage, such as Marketplace and local hospital-district initiatives.

HHSC also has a continued focus on maternal and child health, especially the importance of the initial well-child visits in the first 12 months after birth. With coverage for pregnant women extended from 60 days to 12 months postpartum, maternal and infant health can be an optimal area to establish accountable health homes.

Using APMs to Address Workforce Shortages and NMDOH

Texas' health care system continues to experience the aftermath of the COVID-19 PHE, including a shortage of nurses and behavioral health providers. The APM-PF presents an opportunity to develop and deploy APMs to increase access to providers for which there is a shortage and to reward MCOs for these efforts. There are certain services that are "counted" through the capitation rate-setting process for MCOs, and some that are not. HHSC can study APMs designed to address workforce shortages to identify and implement potential adjustments to the capitation calculations.

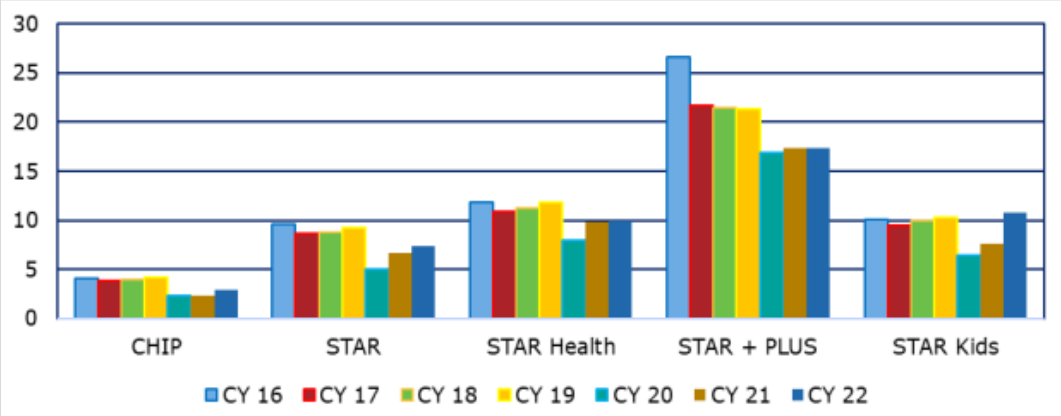
The Committee also notes there are opportunities to use APMs to address NMDOH. The APM-PF framework prioritizes this as an innovative model. This topic is covered more fully in the NMDOH section of this report.

Reducing Administrative Burden

The APM-PF includes a new reporting tool to capture MCO's additional investments in APMs. Although this is an expanded version of the previous reporting tool, HHSC sought to minimize the added burden to MCOs. MCOs will test this tool in the first year of implementation. Their experience with the tool and HHSC's use of the data will inform revisions for subsequent years.

Administrative burden is a provider concern, especially for those who participate in multiple coverage programs and MCO networks. Time spent on paperwork and complex payment arrangements takes away from time caring for patients. One way to minimize administrative burden while improving health and health care is to align quality measures. HHSC has made significant progress in this area with consistent inclusion of certain measures across multiple value-based care initiatives. For example, HHSC has prioritized reducing potentially preventable events, including emergency department visits, readmissions, and complications. These measures are included in four DPPs, the Performance Indicator Dashboard, and P4Q programs. This alignment is helping to achieve positive results. Potentially preventable emergency department visits have decreased across nearly all programs since 2016 (Figure 4).

Figure 4: Seven-Year Trends of Potentially Preventable Emergency Department Visits Weights per 1,000 Member Months – All Programs (lower is better)[22]



[22] HHSC report: Annual Report on Quality Measures and Value-Based Payments - https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2023.pdf

The Committee identified improved access to data as another strategy to reduce administrative burden. This topic is covered more fully in the timely and actionable data section.

Dissemination of Best Practices

The Committee's 2024 report includes a recommendation for a more formal structure for the dissemination of best practices. HHSC prohibits MCOs from sharing proprietary information, and the competitive MCO contract procurement process also poses a barrier to collaboratively sharing and scaling successful initiatives. In its review of enhanced MCO APM-PF reporting in 2024, HHSC will be better equipped to identify and describe successful models, lessons learned, best practices, planning strategies, and implementation challenges across all MCOs in a way that is more standardized and actionable.

Additionally, emerging trends, such as CINs, present new opportunities. The Texas Organization of Rural and Community Hospitals, the Texas Association of Community Health Centers, and the Community Pharmacy Enhanced Services Network have organized CINs to assist their provider members to participate with Medicaid MCOs for APMs. Through CINs, providers can engage in APMs that are more consistent across providers and MCOs, which should help reduce administrative burden.

Alternative Payment Models in the Texas Medicaid Program: Key Reports and Other Resources

STAR Kids Alternative Model Feasibility Report (December 2022)

This report summarizes research and feedback from stakeholders on the Medicaid benefits for children enrolled in the STAR Kids managed care program under an ACO or APMs.

Annual Report on Quality Measures and Value-Based Payments (December 2023)

These reports present data on HHSC's health care quality improvement activities for Texas Medicaid and CHIP. The reports specifically give updates on managed care VBP programs, quality improvement programs, trends in key quality measures, and maternal health care.

Policy Issue: Value-Based Care to Improve Rural Health Care Access

Texas has the largest population of rural residents in the United States. According to the 2020 Census, an estimated 4.7 million Texans reside in rural communities.[23] Rural residents face more barriers to accessing health care and experience poorer health outcomes than their urban counterparts.

Adequate access to health care requires that "services are available and obtainable in a timely manner."[24] As of April 1, 2024, there were 224 Texas counties designated as whole (214) or partial (10) health professional shortage areas. Within those 224 counties, Texas has 368 total primary care shortage areas with only 55% of the primary care needs being met in those areas.[25] Access issues deepened between 2005 and 2021, when Texas led the nation with 24 rural hospital closures.[26]

Health care workforce shortages have long been a barrier, but there are opportunities to increase access to care for rural Texas residents. This Committee recommends the expanded use of community pharmacists and broader utilization of certified CHWs to help achieve this goal.

A national cross-sectional study using 2016 Medicare claims data noted that patients sought chronic disease management and preventive care services nearly twice as often from community pharmacists than from primary care physicians. These findings suggest community pharmacists are accessible health care providers who can collaborate with physicians to deliver preventive care and chronic disease

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[23] United States Census Bureau. (2022, December 29). *Nation's Urban and Rural Populations Shift Following 2020 Census* [Press Release]. https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html

[24] Rural Health Information Hub. (n.d.). *Health Access in Rural Communities*. https://www.ruralhealthinfo.org/topics/healthcare-access

[25] Kaiser Family Foundation. (n.d.). *Primary Care Health Professional Shortage Areas (HPSAs)* [Data set]. https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[26] Liao, K., & Sypher, K. (n.d.). *Rural Health and Hospitals: A Focus on Texas.* APM Research Lab. https://www.apmresearchlab.org/rural-hospital-closures

management.[27] In rural areas, where primary care providers may be in short supply and may require more travel time for the patient to access, pharmacists are often on the front line of care. Pharmacists can help discern when patient issues can be treated over the counter and when they should be referred to a physician or for emergent treatment. "If patients are not regularly seeing physicians, nurse practitioners, or other primary care providers, Texas pharmacists may be the first health care professional to notice that something is wrong."[28]

Further, the Bureau of Labor Statistics projected a 14% growth rate in the number of CHWs between 2022 and 2032; faster than all other occupations.[29] Providing guidance and alternative pathways to CHW certification for residents of rural communities can help improve quality of life and employment options, provide added reimbursable and sustainable service options for rural providers, help reduce workforce shortages, and increase health resources available in rural communities.

The Committee believes its recommendations can offer benefits to rural providers and patients. More in-depth evaluation of these strategies will be necessary to support long-term changes to health policy and expansion of APMs that foster value-based care across rural parts of the state. The recommendations are presented in the context of other states that have had success in implementing similar programs to improve access in their rural communities. The decisions to implement the pharmacy recommendations, in particular, and processes to establish the parameters and design the frameworks, should be a joint collaboration among the relevant stakeholders and industry associations (e.g., Texas Pharmacy Association, Texas Medical Association, Texas Academy of Family Physicians, etc.).

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[27] Berenbrok., L.A., Gabriel, N., Coley, K.C., & Hernandez, I. (2020). Evaluation of Frequency of Encounters With Primary Care Physicians vs Visits to Community Pharmacies Among Medicare Beneficiaries. *JAMA network open, 3*(7), e209132. https://doi.org/10.1001/jamanetworkopen.2020.9132

[28] Jerry H. Hodge School of Pharmacy. (2020, March 21). *Rural Community Pharmacy: A Critical Need in Texas*. Texas Tech University Health Sciences Center Daily Dose. https://dailydose.ttuhsc.edu/2020/march/sop-rural-community-pharmacy-a-critical-need-in-texas.aspx

[29] U.S. Bureau of Labor Statistics, U.S. Department of Labor. (n.d.*). Occupational Outlook Handbook: Community Health Workers*. https://www.bls.gov/ooh/community-and-social-service/community-health-workers.htm

Recommendation 1

HHSC should develop guidance for MCOs to optimize the use of pharmacists to increase access to high quality care in rural areas. HHSC should:

- Clarify how pharmacists can be paid for covered services delivered within a pharmacist's scope of practice.
- Evaluate current services within the pharmacist's scope of practice and expand services covered under Texas Medicaid (e.g., test and treat, childhood immunizations).
- Establish standards and a working definition for an Accountable Pharmacy Organization (APO) and work to increase engagement with APOs.

Recommendation 2

HHSC should develop guidance for rural providers and MCOs related to the use of CHWs to address rural workforce shortages and gaps in rural health care access. HHSC should:

- Establish guidance for alternative methods to achieve CHW certification for health care workers, such as certified pharmacy technicians and medical assistants, serving rural communities.
- Evaluate APMs that leverage the recent expansion of billable CHW services and promote the dual purposing of rural staff to address gaps in access.

Discussion

Payment for Non-Dispensing Pharmacy Services

Independent community pharmacies represent more than three quarters of the pharmacies in rural areas and are often the closest health care provider to rural patients. This makes community pharmacies uniquely positioned to improve access to care.[30] Community pharmacies are also well positioned to support public health initiatives and emergencies, as was demonstrated during the pandemic. A 2022

[30] Evernorth Health Services. (2023). *The Pharmacist Can See You Now: Evolving rural health to improve equitable access to care*. https://www.evernorth.com/sites/default/files/2023-10/Evernorth_Rural_pharmacy_whitepaper.pdf

article in the *Journal of the American Pharmacists Association* noted community pharmacists played a significant role during the pandemic, conducting more than 42 million COVID-19 tests and providing more than 270 million vaccinations between February 2020 and September 2022.[31] Pharmacists helped reduce the burden on primary care clinics and other health care settings, thus allowing those providers to focus on other important health care services.

In addition to providing vaccinations, pharmacists were also granted authority to order and administer treatments like oral antivirals and monoclonal antibodies during the PHE. The ability to provide these services and bill Texas Medicaid MCOs using the traditional medical billing framework demonstrated that the infrastructure needed to reimburse pharmacists for medical services in Texas is already in place.

Additionally, in early 2021, the Texas Medicaid & Healthcare Partnership (TMHP) assumed enrollment processing for the Texas Vendor Drug Program through the TMHP Provider Enrollment and Management System. As a result of the new process, the National Provider Identification (NPI) numbers of both individual pharmacists and pharmacy organizations are directly visible to health plans. Including pharmacy in the same system used for other provider types removed a significant barrier for payment of non-dispensing services.

There is a significant opportunity to maintain and expand access to services beyond those offered during the pandemic, especially in rural areas and medically underserved communities. These services may include payment for other Clinical Laboratory Improvement Amendment (CLIA) waived point-of-care testing, smoking cessation, Diabetes Self-Management Education and Support, transitions of care, comprehensive medication reviews, medication therapy management (MTM), and services performed under collaborative practice agreements.

Despite the passage of HB 1757 and HB 3441 in 2019, which formally recognized pharmacists as providers in the Texas Insurance Code and ensured reimbursement for services provided within the scope of their license, pharmacists continue to be under-utilized for non-dispensing services and face challenges related to payments for covered services.

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[31] Grabenstein, J.D. (2022). Essential services: Quantifying the contributions of America's pharmacists in COVID-19 clinical interventions. *Journal of the American Pharmacists Association, 62*(6), 1929-1945. https://doi.org/10.1016/j.japh.2022.08.010

It would be helpful for HHSC to provide additional clarity and guidance for MCOs to pay pharmacists for services under the medical benefit like other recognized providers. While the mechanism exists for MCOs to pay pharmacists for non-dispensing services today, low utilization may indicate a lack of knowledge about these payment options and how to implement them.

Further, payment for non-dispensing services would complement and enhance a pharmacy's ability to participate in VBP arrangements. For example:

- Pharmacists and MCOs that negotiate VBP arrangements to improve diabetes outcomes may wish to test, bill, and report hemoglobin A1c (HbA1c) results using traditional medical billing pathways.
- An MCO may agree to pay a pharmacy for instances of asthma medication management intervention with traditional medical billing pathways and arrange for additional value-based incentives.

Payers and pharmacists can work together to identify which high-value care services to incentivize by collaborating on and using clinical guidance, checklists and toolkits from reputable organizations including the American Pharmacists Association.[32]

Non-Dispensing Services: Expanding Scope

In 2022, a study published in the *Journal of Managed Care & Specialty Pharmacy* sought to compare pharmacists as "accessible health care providers" with other "qualified health care professionals (QHP)" such as primary care physicians. The study found that patients visit community pharmacies, on average, one-and-a-half to two times more often than another QHP. It was also noted that patients with multiple comorbidities and chronic conditions increased visits to community pharmacies at "an equal or greater rate than visits to health care providers."[33] The study concluded that value-based programs can benefit from using pharmacists to help manage patients, improving outcomes and costs. Community pharmacists can

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[32] Pharmacy Quality Alliance. (n.d.) *Strategies to Expand Value-Based Pharmacist-Provided Care: Action Guide for Community Pharmacists, Healthcare Payers and Other Stakeholders*. https://pqa.memberclicks.net/assets/S2S/Pharmacist-Provided%20Care%20Action%20Guide.pdf

[33] Valliant, S.N., Burbage, S.C., Pathak, S., & Urick, B.Y. (2022). Pharmacists as accessible health care providers: quantifying the opportunity. *Journal of Managed Care & Specialty Pharmacy, 28*(1), 85-90. https://www.jmcp.org/doi/epdf/10.18553/jmcp.2022.28.1.85

act as an "accessible intermediary for point-of-care testing, medication reconciliation, education, and can recommend referrals to providers when patient care requires further intervention." These services help prevent patients from progressing to a multiple comorbidity or "super-utilizer" state, especially those who do not see their primary care providers as recommended. The study noted that these opportunities for using community pharmacists, and their value in increasing access and improving outcomes, can only happen through increased collaborations and the creation of new models with greater incentives.

Another study looked at data over a three-year period (2016-2019) in Washington State to compare care provided by community pharmacists for minor ailments to care provided in more traditional care locations (primary care, urgent care, and emergency departments).[34] While pharmacist-provided care was known to improve access to the communities served, the researchers were specifically interested in whether the care had comparable quality and if the pharmacist-provided care reduced financial strain on the health care system. The research team concluded that there were significant patient and health care system cost savings and the care provided was of comparable quality. Care provided at the traditional sites averaged $278 higher than that of the pharmacies. The pharmacists were also able to obtain CLIA certificates of waiver that allowed them to provide point of care testing and screenings. The CLIA-waived tests used in the community pharmacies included Group A streptococcus, influenza, Hepatitis C, HIV, HbA1c, cholesterol, and Helicobacter pylori. Additionally, the Washington pharmacists were granted authority to treat a defined set of ten conditions which included asthma, urinary tract infection, allergic rhinitis, headache, shingles, and anaphylaxis, among others. The research findings supported a benefit to patients and public health by creating opportunities and removing barriers to access care in community-based settings like pharmacies.

In February 2024, *Medicaid Pharmacy in Focus: Opportunities to Improve Texans' Health and Access to Care*, commissioned by the Episcopal Health Foundation in partnership with Treaty Oak Strategies, described the "landscape of pharmacy" in Texas Medicaid. The report suggested that "community pharmacists are often the most accessible health care professional for many patients and are well-positioned

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[34] Akers, J.M., Miller, J.C., Seignemartin, B., MacLean, L.G., Mandal, B., & Kogan, C. (2024). Expanding Access to Patient Care in Community Pharmacies for Minor Illnesses in Washington State. *ClinicoEconomics and Outcome Research, 2024*(16), 233-246. https://www.dovepress.com/article/download/92385

to provide additional services if reimbursed appropriately" and noted that many states are increasing the types of services pharmacists can provide that can be reimbursed, including the programs noted in the studies above. Within Texas, nearly 90% of the state's community pharmacies participate in the Medicaid, CHIP, and Healthy Texas Women programs and provide good access for those patients. To optimize the benefit for those members, especially beneficiaries living in rural and underserved communities, the scope of reimbursable services pharmacists can provide would need to be updated.

Two areas in which the scope for pharmacists could be expanded to increase access to care and to aid timely treatment are: 1) vaccination authority; and 2) prescribing authority for community pharmacists to test and treat a defined set of conditions.

During the COVID-19 PHE, the Public Readiness and Emergency Preparedness (PREP) Act expanded federal immunization authority and allowed pharmacists, pharmacy technicians, and supervised pharmacy interns to administer vaccines to any patients aged three years and older. Additionally, the PREP Act authorized pharmacists to order the administration of COVID-19, influenza, and any Advisory Committee on Immunization Practices-recommended vaccines for persons aged three to 18 years. Pharmacists were authorized to order and administer any COVID-19 diagnostic tests, including approved serology tests, and to order and administer COVID-19 therapeutics including monoclonal antibody injections and oral antivirals. With the expiration of the PHE and the PREP Act authorizations, Texas pharmacists no longer have the authority to order and administer vaccines for children aged three to 18 years of age, with the exception of influenza and COVID-19 vaccines that expires December 31, 2024. Under the Texas Pharmacy Act and rules, pharmacists can only administer FDA-authorized influenza vaccines to children aged seven years and older and all other vaccines to patients aged 14 years or older.[35]

The pandemic highlighted pharmacists' impact on vaccinations, with an estimated 300 million doses of vaccine provided by community pharmacies between 2021 and 2023. With the majority of the population estimated to live within five miles of a pharmacy, community pharmacists can help increase access to vaccines and other health care services. Overall vaccination rates are low and tend to be lower in rural

[35] Texas State Board of Pharmacy. (n.d.). [Table of authorization status for certain pharmacy providers to administer vaccines, diagnostic tests, and treatments according to the PREP Act & Texas Pharmacy Act/Rules]. Retrieved November 26, 2024, from https://www.pharmacy.texas.gov/files_pdf/coronavirus/PREP-TSBP-comparison.pdf

and underserved communities. This may be due to lack of patient education, mistrust of the health system by some patients, and barriers such as transportation to get to primary care providers. Additional barriers may include reimbursement, regulatory issues, and role-based restrictions that limit pharmacists' participation in vaccination programs like the Vaccines for Children program, despite the positive impact pharmacists have on vaccine access and immunization rates.[36] As front-line health care professionals, and members of the communities they serve, pharmacists are trusted to educate patients about vaccinations and help bridge the trust gap some rural and underserved communities experience. Expanding the scope of Texas pharmacists to include the ability to order recommended vaccinations, as well as to expand the age range to allow administration of vaccines to children, can increase access to immunizations for patients, improve state vaccination rates, and aid MCOs in improving health outcomes and performance on quality measures.

Medicaid Pharmacy in Focus highlighted an example of a test and treat scenario for a patient with the flu. An encounter for this infection would be comprised of simple steps that include:

- Initial patient interview screening;
- Administration of the rapid flu test if determined to be applicable;
- Review of the test results and determination of the treatment course;
- Counseling the patient on results and recommend treatment to gain patient consent;
- Ordering the antiviral drug if appropriate;
- Dispense of the medication; and
- Documentation of the encounter for the patient's primary care physician.

Since antiviral medications must be given within 48 hours of the first onset of symptoms, the ability for pharmacists to test and treat the patient in a single pharmacy visit can aid in patients' access to timely treatment, limiting the severity of the illness if left untreated. Without prescribing authority, a pharmacist cannot currently test and treat patients without some type of formal collaborative practice

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[36] DeMaagd, G., & Pugh, A. (2023). Pharmacists' Expanding Role in Immunization Practices. *U.S. Pharmacist, 48*(10), 34-38. https://www.uspharmacist.com/article/pharmacists-expanding-role-in-immunization-practices

agreement between the pharmacist and the physicians.[15] Additional services provided by pharmacists, as part of or in the scope of test and treat, can include chronic disease management and health screening services for conditions such as diabetes management and smoking cessation.

Multiple studies, like those highlighted above, have suggested expansion of the pharmacist's role and the utilization of community pharmacists serving rural communities are effective means of improving access to care, improving health outcomes, and delivering cost savings to the health care system.

While there are challenges and considerations for reimbursing pharmacists for broader non-dispensing services noted in the pharmacy landscape report, expanding these scope authorities would allow pharmacists to work with MCOs and other providers to pilot interventions and evaluate cost and quality for member populations. They may also be in a better position to partner with non-profit organizations, like the American Heart Association, to implement chronic disease prevention and management programs in rural areas where those organizations are expanding access initiatives. Pharmacists authorized to provide test and treat services can explore opportunities and partnerships that will aid in moving VBP models forward in Medicaid through proofs of concept while work is ongoing to develop reimbursement for non-dispensing services with MCOs and adopt necessary policy and payment changes.

The Committee acknowledges that these ideas are not new, nor are they universally supported. The Texas Pharmacy Association championed bills in the last legislative session specific to expanding both Immunization Authority (HB 1105 /SB 749) and Test and Treat Authorization (HB 2079) for Texas pharmacists, which failed to pass.[37]

The Committee appreciates the input on the recommendations it received from representatives of the Texas Academy of Family Physicians, the Texas Services Chapter of the American College of Physicians, and the Texas Pediatric Society. These industry groups shared their concerns regarding the expansion of pharmacist scope of practice and covered services under Texas Medicaid, particularly in relation to patient safety. Specific concerns included:

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[37] Texas Pharmacy Association. (n.d.). *2023 Texas Legislative Wrap-Up*. https://www.texaspharmacy.org/page/2023Wrapup

- Data and peer-reviewed studies regarding how the expansion of pharmacist scope impacts access, cost, and patient safety are limited, given that only a few states allow pharmacists to independently prescribe medications and treat conditions;
- Pharmacist training on taking patient histories, performing physicals, diagnosing, interpreting test results, and providing primary care services is limited;
- Pharmacists may lack access to full medical records for some patients;
- The need for additional examination and diagnosis for medical issues may not be evident when patients present for certain tests or conditions at the pharmacy;
- The expansion of pharmacist scope for test and treat may encourage patients to bypass recommended physician visits; and
- Integrated, physician-led teams and models are preferred ways to ensure a comprehensive approach to patient needs. For example, physicians and pharmacists already participate in collaborative care models that are consistent with a team-based approach to care.

Despite these concerns, Texas must explore all opportunities and innovative approaches that can help improve access to health care for rural patients. In 2022, the Department of State Health Services (DSHS), in partnership with the Texas Center for Nursing Workforce Studies, found that 28 counties in the state had no primary care physicians or primary care physician assistants.[38] Texas continues to face decades-long challenges in addressing workforce development and retention in rural areas. Moving forward on these recommendations and other best practices requires collaborative dialogue with stakeholders and a deeper understanding of the benefits and associated risks. For example, one potential next step could be to geo-map the counties identified by DSHS as having no primary care providers to evaluate the availability of other health care services in those areas, including community pharmacies.

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[38] Health Professions Resource Center, Texas Center for Nursing Workforce Studies. (2021). *A Glance at the Texas Health Care Workforce: Primary Care Physicians and Physician Assistants in Texas* (25-16605). Texas Department for State Health Services. https://www.dshs.texas.gov/sites/default/files/chs/hprc/publications/PrimaryCarePhysiciansandPAs.pdf

Accountable Pharmacy Organizations

Accountable care organizations (ACO) have emerged as a pay-for-performance and value-based purchasing conduit for medical providers. Similarly, accountable pharmacy organizations (APO) can offer a means by which to supplement the current fee-for-product pharmacy reimbursement with VBP arrangements across pharmacy locations. An APO is "a legal entity that contracts on behalf of pharmacy providers who agree to the provision of enhanced pharmacy services (beyond safe and accurate dispensing) and are willing to take risk on clinical, humanistic, and cost of care outcomes based on performance."[39,40]

APOs can provide enhanced services subject to performance measurements that determine payment. APO-provided services can be designed to improve the quality of care and care coordination while reducing the unnecessary use of resources, leading to lower health care costs. VBP arrangements that reward APOs meeting predetermined goals and measures create competition among pharmacy groups to produce positive results.

APOs can include regional pharmacy chains, national pharmacy chains, or CINs of independent pharmacies. Establishing this standard definition provides clarity for stakeholders as they contract with and increase VBP arrangements with pharmacies.

APOs are distinct in form and function from a pharmacy services administrative organization (PSAO), which negotiates fee-for-product drug dispensing contracts on behalf of pharmacy groups with pharmacy benefit managers. As an example, independent pharmacies may use various PSAOs to negotiate existing drug dispensing contracts but may also join under clinical integration to form a single APO that would contract with MCOs in value-based enhanced services arrangements. These arrangements would be separate and supplemental to their existing PSAO contracts.

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[39] Shafrin, J. (2020, June 1). *Accountable Pharmacy Organizations*? Healthcare Economist. https://www.healthcare-economist.com/2020/06/01/accountable-pharmacy-organizations/

[40] Trygstad, T. (2020). A Sleeping Giant: Community Pharmacy's Potential is Unrivaled. *Journal of Managed Care & Specialty Pharmacy, 26*(6), 705-708. https://doi.org/10.18553/jmcp.2020.26.6.705

APOs are uniquely engaged in contracting for enhanced pharmacy services using value-based arrangements (i.e., "non-dispensing" services like local care management, asthma management, diabetes management, hypertension management, and other chronic care management). APOs are unique in their use of the Pharmacist eCare Plan (PeCP), an interoperable HL7 data standard that allows for pharmacy technology providers to have a common method of exchanging information related to care delivery, including patient goals, health concerns, active medication list, drug therapy problems, laboratory results, vitals, payer information, and billing for services. While PSAOs have not traditionally been composed of CINs or are engaged in enhanced services contracting, it is possible for a PSAO to form an APO.

These new payer concepts should not detract from the possibility that an APO can participate with an ACO but should clarify that if pharmacies are contracting for services directly with MCOs on their own, they are defined as an APO.

Compensation for APO-enhanced services should not be siloed using the traditional pharmacy benefit bucket. APO services are wider in scope than drug dispensing and directly impact medical expenditures. MCOs should be given flexibility to pay for these pharmacy enhanced services using the medical benefit.

Improved care coordination and chronic care management are the cornerstones of the VBP models, and medication management is central to both objectives. Any effort to improve quality and reduce costs over the long term will be difficult to achieve if patients do not take their medications appropriately. Considering the growing evidence that pharmacists are uniquely positioned to improve medication management across the care continuum and provide a range of health services in the community and as part of care teams, HHSC should advocate for the expansion of community pharmacy inclusion in VBP models focused on disease management priorities (Table 3).

Table 3: Disease Management Priorities and Associated Measurement Sets

Priority Area	Measurement Set
Asthma	Asthma Medication Ratio; Completed PeCP; Asthma Control Test; Asthma Action Plan Counseling; Asthma Controller Medication Adherence; Emergency department visit rate
Diabetes	HbA1c Reported; HbA1c <7.0, <8.0, <9.0; HbA1c test completion; Proportion of Days Covered (PDC) >80% (Medication Adherence); Completed PeCP

Priority Area	Measurement Set
Hypertension	Blood Pressure (mmHg) Reported; mmHg <150/90, <140/90; Completed PeCP; PDC >80%
Behavioral Health	Completed Patient Health Questionnaire (PHQ)-2, PHQ-4, PHQ-9, Generalized Anxiety Disorder (GAD)-7; Completed PeCP; Referred to Care Team Member

While VBP models have primarily focused on physicians and hospitals, they are now expanding to include more types of providers. The goal of value-based care is to align performance and health outcomes with compensation by assessing performance using quality and health metrics, and to provide tools and programs to improve patient health outcomes. VBPs have the potential to improve outcomes, enhance care coordination, and create more system efficiencies. The contribution of community pharmacy in helping achieve this goal is promising.

Successful outcomes for a VBP model and other coordinated care programs depend on making sure multiple provider types are able to deliver their services to enrollees. This should include the multitude of services provided by community pharmacies. Pharmacists play a key role in helping patients take their medications as prescribed and offer a variety of pharmacist-delivered services, such as MTM, to improve quality and outcomes. Immediate access to these types of services may not only increase the overall health of patients but can also result in a decrease in overall health care costs.

Alternative Certification and Expanded Use of Community Health Workers

The Texas DSHS oversees the certification of CHWs in the state. To be eligible to apply for CHW certification, an applicant must be a Texas resident, at least 16 years of age, and provide proof of successful completion of an approved 160-hour competency-based training program or, alternatively, document work experience that equals a minimum of 1000 hours within the most recent three years as verified

by supervisors. [41,42] This alternative, experience-based certification option is listed on the DSHS website. Committee discussions with subject matter experts on the deployment of CHWs supported increased advocacy efforts to help raise awareness of this opportunity.

In many rural communities, existing staff are acting in the capacity of a CHW without the benefit of certification. Community pharmacies, for example, often have pharmacy technicians who have taken on the role of CHW. Studies have identified community pharmacies as being uniquely positioned to help mitigate access challenges experienced by people in underserved areas. Training their technicians as CHWs was noted to be an effective way to increase patient contact and improve patient-to-provider and patient-to-pharmacy relationships.[43]

Likewise, rural health clinics and rural hospitals often have medical aides performing the care and coordination services of a CHW. The opportunities for those team members to achieve certification for the work they have already undertaken, without the expense required to complete a formal CHW training course, can help expand the number of CHWs available in rural areas and provide a reimbursement opportunity that may not be currently available or known to the providers for the services they have been offering.

There is an opportunity to expand the rural workforce by establishing and broadly disseminating guidance that highlights the experience track for CHW certification and clarifies that the pathway exists through both work and volunteer efforts. Certification through this route can be achieved at minimum expense to the

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[41] Texas Department of Health and Human Services Commission, Texas Department of State Health Services. (n.d.). *Community Health Worker Initial Certification*. https://www.dshs.texas.gov/community-health-worker-or-promotora-training-certification-program/chw-certification-renewal/chw-initial-certification

[42] Texas Department of Health and Human Services Commission, Texas Department of State Health Services. (2025). *Community Health Worker Online Services Support Guide Application Based on Experience*. https://www.dshs.texas.gov/sites/default/files/chw/Community%20Health%20Worker%20Online%20Services%20Support%20Guide%20Application%20Based%20on%20Experience.pdf

[43] Yoon, H.S., Teshome, B.F., Eisenbeis, A, & Micek, S.T. (2024). Pharmacy technicians trained as community health workers: A prospective multicenter cohort study. *Journal of the American Pharmacists Association, 64*(1), 47-54. https://www.japha.org/article/S1544-3191(23)00293-5/fulltext

applicants and the health care organizations employing them, in a manner that promotes increased sustainability. This may also allow for expansion of services when there is a reimbursement mechanism within Texas Medicaid allowing payment for services provided by certified CHWs as a medical benefit.

Consideration should also be given to the development of other alternative pathways to CHW certification including dual-certification programs in conjunction with state and community partners, as well as courses and dual-credit programs offered in local high schools. The Pharmacy Technician Certification Board recently awarded funds to the Texas Pharmacy Association to advance pharmacy technician training and plans to introduce a CHW training program for a group of pharmacy technicians.[44]

Texas has established allied health programs in multiple high schools across the state through their "Health Science Career Cluster" that include industry-based certifications, such as clinical medical assistant and pharmacy technician, that do stand alone and can be earned outside of high school or achieved as part of a dual-credit program. Texas DSHS and the Texas Education Agency collaborated in 2021 and 2022 to offer CHW certification training as a career pathway in high schools across Texas. The first graduates of this pathway were certified in 2023.

The University of Kentucky's Center of Excellence in Rural Health started a dual-credit pilot project through its long-standing CHW program, Kentucky Homeplace, to address the "lack of opportunity for workforce development and retention of career-ready health care professionals graduating high school." In this pilot, students who attend CHW classes can receive dual credits for high school and college courses, making them eligible for state CHW certification upon program completion and the opportunity for an apprenticeship with Kentucky Homeplace.[45] The program has proven successful in aiding workforce development efforts and

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[44] Pharmacy Technician Certification Board. (2023, December 12). *PCTB Awards Funds for Pharmacy Technician Training and Advancement Across the Country: Recipients Include State Associations in Hawaii, Iowa, New Jersey, Pennsylvania, Tennessee, Texas, and Washington.* https://www.ptcb.org/news/ptcb-awards-funds-for-pharmacy-technician-training-and-advancement-across-the-country

[45] Kentucky Department for Public Health. (2022). *Kentucky Community Health Worker Stories of Success* (Issue no.2, Spring 2022). Kentucky Cabinet for Health and Family Services. https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/CHW%20Program/storiesofsuccess22.pdf

increasing care coordination and monitoring services in rural Appalachia and other underserved communities.

Evaluate Expanded Billing Services and Dual-Purpose Staff

Many rural communities already have staff who are acting in a dual capacity performing a CHW role beyond the duties of their hired positions. Formal CHW certification can provide some realized reimbursement for the portion of services performed that may be billable under Medicaid. Additionally, rural communities and providers can be better positioned to address gaps in access and care as policies and value-based care models adapt to the changing health care landscape.

Beyond the traditional scope of services typically associated with CHWs, the passage of HB 1575 in 2023 provides a significant opportunity to aid rural communities with maternal health care. The bill established a rule that allows licensed social workers, CHWs, and doulas to be recognized as providers in the maternal space when providing case management services to children and pregnant women in Texas Medicaid. Rural health providers may seek to dual-purpose staff who have already been performing in the role of CHWs, particularly in rural clinics and rural hospitals that continue to provide maternal services. Existing community members who have already achieved CHW certification may seek to complete additional training to receive doula certification, further expanding the services local staff may be able to provide to pregnant women in rural communities.

Guidance and assistance should be given to CHWs and doulas to set up individual NPI numbers for billing under Medicaid with collaboration to provide and bill for these services encouraged and fostered between MCOs and rural providers. One MCO, Aetna Better Health of Texas, has developed an internal CHW training program in which they promote/recruit members within their plan to participate in a program to be trained and certified as a CHW. The purpose of the program is to aid selected members to be champions in their communities to improve access to care, further educational pursuits, and enhance their quality of life through career options. As part of this program, participants can opt to attend additional training to become doulas (as well as other specialty certifications available to certified CHWs).

Aetna also helps these CHWs set up NPI numbers so they can bill for allowable services and work with doctors and other medical health care providers.[46,47]

While it should be noted that HB 1575 provides case management services related primarily to non-medical drivers of health, the bill still promotes an expanded opportunity that comes with CHW certification and adds to the care available in rural communities. Any improvements in access and services available to pregnant women and children are significant in rural Texas, where a 2023 study conducted by the March of Dimes found 46.5% of Texas counties are considered maternity care deserts, 20.4% of birthing women received inadequate prenatal care, and women with chronic health conditions experience a 43% increase in likelihood they will have a preterm birth.[48]

Additionally, outside of HB 1575, there is an opportunity for APMs in partnership with local organizations, including community pharmacies, to aid in screening and referrals for maternal depression. Maternal depression and maternal mortality rates may be higher in rural communities and maternal health care deserts that lack postpartum engagement and follow-up to the levels seen in more urban areas.[49]

Texas offers multiple CHW training opportunities and continuing education to further enhance their CHW certification. Texas should continue to evaluate and expand the types of services provided by CHWs that are reimbursable under Texas Medicaid in coordination with MCOs and local provider organizations to better address access to care. Exploring federal and other state models for APMs in rural

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[46] Aetna Better Health of Texas. (n.d.). *Get involved: Member Advisory Group*. https://www.aetnabetterhealth.com/texas/member-advisory-group.html

[47] CVS Health. (2021, July 16). *Aetna Better Health trains Community Health Workers*. https://www.cvshealth.com/news/community/aetna-better-health-trains-community-health-workers.html

[48] Fontenot, J., Lucas, R., Stoneburger, A., Brigance, C., Hubbard, K., Jones, E., & Mishkin, K. (2023*). Where you live matters: Maternity Care Desert and the Crisis of Access and Equity in Texas.* March of Dimes. https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Texas.pdf

[49] Vasquez, A., & Vanhoose, L. (2024). *Medicaid Pharmacy in Focus: Opportunities to Improve Texans' Health and Access to Care*. Episcopal Health Foundation. https://www.episcopalhealth.org/wp-content/uploads/2024/02/2-12-24-Medicaid-Pharmacy-in-Focus-Complete.pdf

communities can aid in expansion of value-based infrastructure and opportunities for rural providers in Texas.

Additionally, recent activity and proposed legislation at the federal level related to the utilization and payment of CHWs may provide additional guidance and opportunities to expand the use of CHWs in Medicaid.

CMS made changes in the 2024 Physician Fee Schedule Final Rule, recently summarized by the Medicare Learning Network as follows:

> Since there isn't a Medicare benefit for paying CHWs and other auxiliary personnel directly, we will pay their services as incidental to the services of the health care practitioner who directly bills Medicare. See 42 CFR 410.26 and 42 CFR 410.27 for more information. The auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as through a community-based organization that employs CHWs or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of Community Health Integration services.

On March 7, 2024, US Senator Bob Casey of Pennsylvania introduced the *Community Health Worker Access Act.* This bill specifically looks to improve reimbursement for CHW services under Medicare and integrate them into Medicaid as well. The Senator cited a randomized controlled trial showing a yield of $2.47 for every dollar invested in CHWs and estimating $4200 a year in savings per Medicaid beneficiary.[50]

Providing guidance for experiential CHW certification and developing joint certification opportunities, in conjunction with dual-purposing existing staff, can help address workforce development and employment opportunities in rural communities. Additionally, rural providers can sustain care coordination and other services, as well as potentially expand services, if they are aware of and more equipped to utilize available options that provide reimbursement.

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[50] Office of U.S. Senator Bob Casey. (n.d.). *The Community Health Worker Access Act* [Press Release]. https://www.casey.senate.gov/imo/media/doc/community_health_worker_access_act_one-pager.pdf

Value-Based Care to Improve Rural Health Care Access: Key Reports and Other Resources

Rural Texas Pediatric Tele-Connectivity Resource Program Report – December 2022

The Pediatric Tele-Connectivity Resource Program awards grants to non-urban health care facilities to implement telemedicine services that connect these facilities to pediatric specialists and pediatric subspecialists who provide telemedicine services. This is the third biennial submission of the program's report. This report gives updates since the last submission in 2020 on: outcome of the 2020-21 biennium grants program projects, response to the 2022-23 biennium grants program request for applications for funding appropriated for this grants program, and program implementation challenges and lessons learned.

All Texas Access Report – December 2023

All Texas Access works to improve rural access to mental health services. For fiscal year 2023, three priority projects were the primary focus: a community engagement pilot project, a peer support learning collaborative, and supporting local mental health authorities (LMHAs) & local behavioral health authorities (LBHAs) in funding and implementing jail diversion strategies.

Rural Hospital Services Strategic Plan Progress Report (Nov 2022)

The Rural Hospital Services Strategic Plan focuses on efforts to maintain access to rural hospitals. Since the November 2022 update, strategies focused on three goals: ensuring Medicaid reimbursements are adequate, increasing access to established revenue opportunities, and identifying challenges experienced in providing services to patients covered by Medicare and other payers. The report outlines specific operational milestones accomplished and describes efforts to strategically improve relations and education for rural hospitals related to the Medicaid program.

Advancing Value-Based Payment Policies Relevant to Rural Health (2023)

This white paper from the Rural Health Value team outlining recommendations to the Centers for Medicare and Medicaid Services (CMS) and the CMS Innovation Center to improve opportunities for rural health organizations to participate in value-based care. The Rural Health Value initiative was created through a

cooperative agreement between the University of Iowa School of Public Health and the Federal Office of Rural Health Policy.

Pharmacy:

Medicaid Pharmacy in Focus: Opportunities to Improve Texan's Health and Access to Care (Feb 2024)

Treaty Oaks Strategies, with support from the Episcopal Health Foundation, conducted a study to outline the pharmacy landscape in the Texas Medicaid program. The report provides an overview of access to prescription drug benefits. Potential opportunities to better utilize pharmacists within Texas Medicaid, including recommendations related to alternative payment models and rural health, are explored.

The Pharmacist Can See You Now: Evolving Rural Health to Improve Equitable Access to Care (Oct 2023)

This report describes common care and access challenges faced by rural communities and explores the role of independent pharmacies and evaluates the potential to address health disparities and affordability through the expanded role of rural community pharmacies. EverNorth Health Services partners with employers, health plans, hospital systems, unions, and the public sector to evaluate health challenges and explore improvements.

Strategies to Expand Value-Based Pharmacist-Provided Care: Action Guide for Community Pharmacists, Health care Payers, and Other Stakeholders (2019)

The Pharmacy Quality Association developed an action guide to help advance conversations and promote collaboration between community pharmacy organizations and payers. The guide outlines 15 recommended actions including five that can be pursued by pharmacists, five for payers, and five for pharmacists and payers to pursue together.

Community Health Workers:

Community Health Worker Access Act (March 2024)

US Senate Bill (SB) 3892, introduced March 7, 2024, and referred to the Senate Committee on Finance, to amend the Social Security Act and increase access to CHWs under Medicare and Medicaid programs.

Medicaid Financing for Community Health Workers (May 2023)

This white paper evaluates opportunities for states to improve health outcomes for beneficiaries via CHW services through Medicaid. Principles outlined can be used by states, like Texas, that already have measures to utilize CHWs in Medicaid as recommendations that can better support the CHW workforce. Partners in Health is a nonprofit organization with a focus on strengthening public health and providing care to underserved populations in partnership with academic and medical institutions, public health agencies, and national governments.

Impact of Community Health Workers on Access to Care for Rural Populations in the United States: A Systematic Review (Nov 2021)

This systematic review evaluates and summarizes peer-reviewed literature, for studies published between 2015 and 2021, to analyze and describe CHW interventions and their outcomes in rural populations in the United States.

Policy Issue: Non-Medical Drivers of Health

NMDOH are the conditions in which people live, work, play, and age that impact health outcomes.[51] In Texas, non-medical factors such as physical infrastructure (e.g., clean air, safe housing) and economic environment (e.g., income level, educational attainment) have a significant impact on health outcomes for children, adolescents, and pregnant women, as measured by standard CHIP and Medicaid quality metrics.[52]

Over the past six years, Texas has made noticeable strides in understanding and addressing NMDOH. Since 2019, HHSC, the Texas Association of Health Plans, and the Texas Association of Community Health Plans convened the MCO NMDOH Learning Collaborative with support from local foundations. The purpose of the learning collaborative is to share evidence-based NMDOH interventions, promote

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[51] Texas Medical Association. (n.d.). *Nonmedical Drivers of Health*. https://www.texmed.org/NonmedicalDriversofHealth/

[52] Texas External Quality Review Organization. (2020). *Texas Medicaid Managed Care Focus Study: Social Determinants of Health and Their Impact on Health Care Quality Measures in the CHIP and STAR/STAR Kids/STAR Health Populations*. Texas Health and Human Services Commission. https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/attachment-1-tx-medicaid-managed-care-focus-study.pdf

effective strategies for addressing the non-medical needs of Medicaid beneficiaries, and support the development, implementation, and expansion of these interventions. Further, the learning collaborative provides critical input to HHSC as it develops NMDOH programs and makes policy decisions.

In 2023, major Medicaid NMDOH policy developments occurred at the state and federal levels. Building on the increased momentum and interest from MCOs, providers and other stakeholder groups, HHSC released the *Non-Medical Drivers of Health Action Plan*, a multi-pronged strategy and set of guiding priorities to drive NMDOH activities in Medicaid. It identified three key NMDOH areas: food insecurity, housing, and transportation. Additionally, Governor Greg Abbott signed HB 1575, which requires HHSC to develop standardized screening questions related to non-medical needs for pregnant women in STAR Medicaid and allows CHWs and doulas to become billable provider types under HHSC's Case Management for CPW program.

At the federal level, CMS provided additional clarity to states on options to cover NMDOH services.[53,54] CMS' informational bulletin details 15 interventions and four pathways for federal approval, including those related to nutrition services and housing. Relevant authorities include: In Lieu of Services and Settings (ILOS); Home- and Community-Based Services programs and, relatedly, Money Follows the Person; Section 1115 demonstrations; and CHIP Health Services Initiatives (HSI).[55]

Recommendation 1

HHSC should use the various Medicaid authorities and/or regulatory tools to strengthen cross-sector partnerships between MCOs, health care providers, and social services organizations to address beneficiaries' NMDOH. HHSC should focus

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[53] Tsai, D. (2023). *Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program*. Centers for Medicare & Medicaid Services. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf

[54] Centers for Medicare & Medicaid Services. (2023). *Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP).* https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf

[55] Crumley, D. (2024, January). *Understanding New Federal Guidance on Medicaid Coverage of Health-Related Social Needs Services*. Center for Health Care Strategies. https://www.chcs.org/resource/understanding-new-federal-guidance-on-medicaid-coverage-of-health-related-social-needs-services/

on the three priorities (food, transportation, and housing) identified in the Medicaid and CHIP Services *NMDOH Action Plan*. Regulatory tools include, but are not limited to, ILOS, experience rebates, quality improvement cost, incorporating NMDOH risk-markers in determination of capitation rates, and APMs.

Recommendation 2

HHSC should identify strategies to increase enrollment of eligible Medicaid members in federal food benefit programs such as Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to reduce food insecurity. For example, HHSC could provide Medicaid enrollees' SNAP and WIC enrollment status to MCOs to support targeted outreach and case management.

Recommendation 3

HHSC should assess the impact of HB 113 88(R), which allows MCOs in STAR Medicaid to categorize services provided by CHWs as a quality improvement cost, instead of as an administrative expense. HHSC should provide a report to the Legislature by December 31, 2025, on the use of CHWs and quality improvement costs reported by each MCO. The report should describe how CHWs may have impacted each MCO's medical loss ratio, and how these reported costs can be used to develop capitation rates in the future (e.g., as a projected non-benefit cost, or to prepare for potential transition to a state plan benefit).

Discussion

Health outcomes are driven by more than health care alone. The environments in which people live and work have an even greater impact on health. The best available evidence indicates that addressing significant non-medical needs can lead to real savings for the health care system, reductions in health disparities, and improvements in health outcomes, particularly for many low-income people. In fact, health care payers and providers in Texas and across the country are increasingly interested in addressing these factors and have introduced numerous pilot programs with notable effects on health care cost, quality, and experience of care.

The *Texas Managed Care Focus Study: Social Determinants of Health and their Impact on Health Care Quality Measures*[56] explored the impact of NMDOH (also called Social Determinants of Health) on Texas Medicaid and CHIP populations. This study found that NMDOH factors have an influence on health outcomes, as measured by standard Medicaid and CHIP quality metrics. Child and adolescent health outcomes are particularly sensitive to NMDOH, and outcomes among pregnant women were also meaningfully associated with some NMDOH. Researchers from Milliman found that women with high-risk pregnancies are about twice as likely to have had a non-medical health need as women with non-high-risk pregnancies in Texas. They estimated that the health care cost of high-risk pregnancies in Texas was $776 million.[57] Both reports recommend that policymakers consider how they can prioritize interventions to address NMDOH for Medicaid and CHIP members.

Implement Regulatory Tools to Achieve the Goals of the Texas Medicaid and CHIP Services *NMDOH Action Plan*

MCOs have the flexibility to provide services that are not formal Medicaid benefits. This flexibility has allowed MCOs to pursue pilot programs that improve the quality and cost-effectiveness of their members' care. However, MCO payment rates do not typically reflect the cost and utilization of these pilot programs, which can discourage MCOs from offering them at a larger scale. States can address this gap by considering various regulatory tools such as ILOS, experience rebates, quality improvement expense, and APMs.

Concrete examples of how other states leverage these regulatory tools can be found in the report Opportunities to Address the Non-Medical Drivers of Health in Texas: A Review of Food, Community Health Worker, and Non-Medical Perinatal

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[56] Texas External Quality Review Organization. (2020). *Texas Managed Care Focus Study: Social Determinants of Health and their Impact on Health Care Quality Measures.* Texas Health and Human Services Commission. https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/attachment-1-tx-medicaid-managed-care-focus-study.pdf

[57] Davenport, S., Caverly, M., & Muse, D. (2023). *Approaches for addressing nonmedical drivers through Medicaid managed care*. Episcopal Health Foundation. https://www.episcopalhealth.org/wp-content/uploads/2023/02/Milliman-Nonmedical-Health-Drivers-2023-02-13.pdf

Interventions, and Alternative Payment Models[58] published by the Center for Health Care Strategies (CHCS) with support from the Episcopal Foundation. As the title suggests, there are specific funding strategies already working successfully across the United States that Texas can adopt to address food insecurity, sustain the ongoing use of CHWs, and provide comprehensive case management services to pregnant women. In its report, Enhancing Health Care Investments by Addressing Patients' Non-Medical Needs, Rice University's Baker Institute for Public Policy raised a call to action for Texas to maximize its investment in advancing services that address NMDOH, highlighting strategies for funding this work and the positive financial and health impacts it can deliver. The 2022 VBPQIAC Legislative Report also detailed examples of other states using ILOS as a tool to incentivize cross sector partnerships between MCOs, health care providers, and social services organizations.[59]

Addressing Food Insecurity with Medicaid Beneficiaries

Food insecurity is one of the major focus areas identified in the Medicaid and CHIP Services *NMDOH Action Plan*. MCOs identify this as the most common NMDOH need experienced by their members.[60] SNAP, which provides low-income families with

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[58] Spencer, A., & Crumley, D. (2024). *Opportunities to Address the Non-Medical Drivers of Health in Texas: A Review of Food, Community Health Worker and Non-Medical Perinatal Interventions, and Alternative Payment Models*. Episcopal Health Foundation. https://www.episcopalhealth.org/wp-content/uploads/2024/08/8-8-24-NMDOH-Full-Text.pdf

[59] With support from Episcopal Health Foundation, the Center for Health Care Strategies (CHCS) provided technical assistance and learning opportunities to the Value-Based Payment & Quality Improvement Advisory Committee on this topic. The Committee thanks Anne Smithey and Diana Crumley, CHCS, for their contributions to this section of the report. For additional information, see In Lieu of Services to Address Nonmedical Drivers of Health: Three Potential Interventions and Related Evidence (Sim, S.-C., Smithey, A., & Crumley, D. (2022). *How Medicaid in Texas Could Use in Lieu of Services to Address Non-Medical Drivers of Health: Three Potential Interventions and Related Evidence*. Episcopal Health Foundation. https://www.episcopalhealth.org/wp-content/uploads/2022/12/Moving-Upstream-Addressing-Non-Medical-Drivers-of-Health-in-Texas-report.pdf).

[60] Vanhoose, L., Mills, S., Sim, S-C., Ghahremani, K., & Lynch, J. (2023). *Non-Medical Drivers of Health (NMDOH) Strategies: Findings from a 2022 Survey of Managed Care Organizations (MCOs) in Texas.* Episcopal Health Foundation. https://www.episcopalhealth.org/wp-content/uploads/2023/02/2022-MCO-NMDOH-Survey-Report-SCS-Clean-Revised2.pdf

assistance to purchase food, significantly reduces food insecurity.[61] The CHCS report provides evidence of Medicaid cost savings and the return on investment of SNAP benefits. For instance, connecting individuals to SNAP, including through application assistance provided by community-based organizations, providers and MCOs, is associated with reduced rates of poverty and health care expenditures, particularly among individuals with diet-sensitive chronic conditions such as diabetes and heart disease. Among older adults, SNAP enrollment is associated with fewer hospital and long-term care admissions and emergency department visits, resulting in an estimated Medicaid cost-savings of $2,360 per person annually.[62]

There is also growing momentum in federal policy to allow state Medicaid agencies to consider various pathways to implement nutrition interventions. In 2023, CMS released guidance on coverage pathways for the nutrition interventions, including case management services for access to food/nutrition, nutrition counseling and instruction, home delivery meals or pantry stocking, nutrition prescription, and grocery prescription.[63]

Improving access to data so MCOs can help increase enrollment of eligible Medicaid members in SNAP and WIC could be key to reducing food insecurity in Texas. For example, HHSC could provide SNAP and WIC enrollment status to MCOs to support targeted outreach and case management for their eligible members.

Assessing the Impact of HB 113 that Allows MCOs to Categorize Services Provided by Community Health Workers as a Quality Improvement Investment

CHWs are professionals who provide a range of services addressing the health and social needs of their clients, including culturally appropriate health promotion and

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[61] Coleman-Jensen, A., Rabbitt, M.P., Gregory, C.A., Singh, A. (2019). *Household Food Security in the United States in 2019* (USDA Publication No. 275). U.S. Department of Agriculture. https://www.ers.usda.gov/webdocs/publications/99282/err-275.pdf

[62] Berkowitz, S.A., Seligman, H.K., Rigdon, J., Meigs, J.B., & Basu, S. (2017). Supplemental Nutrition Assistance Program (SNAP) Participation and Health Care Expenditures Among Low-Income Adults. *JAMA internal medicine, 177*(11), 1642–1649. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653910

[63] Centers for Medicare & Medicaid Services. (2023). *Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)*. https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf

education, assistance in accessing medical and non-medical services, translation services, care coordination, and social support. According to the Texas DSHS, there are an estimated 5,000 certified CHWs in the state.[64]

Increasingly, Medicaid programs are recognizing the value of CHWs in reducing health disparities, improving health outcomes for underserved communities, and potentially reducing health care costs. According to KFF, 29 states recently reported allowing Medicaid payment for services provided by CHWs using coverage approaches such as state plan amendments, and integrating CHWs into Medicaid health homes, Section 1115 demonstration waivers, and managed care.[65] Given the passage of HB 1575 and HB 113 during the 88th Texas legislative session, there will likely be increased demand for CHW services to address the NMDOH for Medicaid members. The implementation of these new laws will require thoughtful planning and stakeholder engagement.

HB 1575 allows the CHW to become a billable provider type under the Texas Medicaid Case Management for CPW program. It requires HHSC to submit a formal assessment of its implementation to the Texas Legislature. HB 113 allows MCOs in STAR Medicaid to categorize services provided by CHWs as a quality improvement investment, instead of as an administrative expense. HB 113 did not include an assessment or reporting requirement. Therefore, this Committee recommends the Legislature should direct HHSC to assess its impact similar to that of HB 1575.

Specifically, HHSC should provide a report to the Legislature by December 31, 2025, on the use of CHWs and the associated quality improvement investment reported by each MCO. The report should describe how CHWs may have impacted each MCO's medical loss ratio and how these reported expenditures can be used to develop capitation rates in the future (e.g., as a projected non-benefit cost, or to prepare for potential transition to a state plan benefit).

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[64] Hernandez, D., & St. John, J. (2024). *Summary Report: 2024 Landscape of the Texas Community Health Worker (CHW) Workforce and Implications for Sustainability*. Episcopal Health Foundation. https://www.episcopalhealth.org/wp-content/uploads/2024/08/8-07-24-CHW-Full-text-edited.pdf

[65] Haldar, S., & Hinton, E. (2023, January 23). *State Policies for Expanding Medicaid Coverage of Community Health Worker (CHW) Services.* Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/

Non-Medical Drivers of Health: Key Reports and Other Resources

CMS Letter to State Medicaid Directors Re: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (January 7, 2021)

This letter describes opportunities under Medicaid and CHIP to better address social determinants of health and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs.

Opportunities to Address the Non-Medical Drivers of Health in Texas: Food Interventions, Community Health Worker Programs, Alternative Payment Models (August 2024)

This report presents state examples of MCO-led interventions to address NMDOH.

Approaches for Addressing Non-Medical Health Drivers through Medicaid Managed Care (February 2023)

This report examines NMDOH efforts underway in a few specific states and provides profiles of these states' initiatives and impact.

Creating Thriving Communities Through Civic Participation (March 2024)

This report highlights the importance of civic infrastructure and spaces to connect and be informed. Evidence shows that participating in our communities, whether through volunteering or joining neighborhood groups, strengthens our social connections and sense of belonging which in turn, benefits our physical and mental health.

2024 Landscape of the Texas Community Health Worker (CHW) Workforce and Implications for Sustainability (August 2024)

This report examines the perceptions and experiences of CHWs to develop strategies that best support the long-term sustainability of the workforce through new funding streams and evolving state policies.

Policy Issue: Timely and Actionable Data

Over the past eight years, the Committee has focused on the importance of timely, actionable data to advance value-based care along the APM continuum. MCOs and providers cannot improve their management of populations to succeed in APMs without necessary information. HHSC, policymakers, and other community partners also need data to make meaningful program improvements. While progress has been achieved through data dashboards, databases, and HIEs, more is needed to standardize and spread best practices. The following recommendations focus on strategies to understand and expand secure and timely data sharing among MCOs, providers, HHSC, and other public agencies.

Recommendation 1

HHSC or a neutral, third party contractor should perform a landscape assessment of where Texas is in terms of data interoperability, including HIEs and sharing of data on non-medical drivers of health. Based on that assessment, HHSC should create a strategic plan with next steps to leverage data to improve care in Medicaid and CHIP.

Recommendation 2

Texas should evaluate opportunities to maximize the use of the TX-APCD (along with other state data sets), including identifying and prioritizing needed investments, to advance high-value care, particularly for Medicaid and other state-funded health care programs.

Recommendation 3

HHSC should analyze and share data on the number of providers who are billing the new Medicaid collaborative care benefit to inform an assessment of what additional steps may be needed to encourage greater use of this benefit.

Discussion

Prior Committee reports have highlighted the importance of equipping HHSC, policymakers, MCOs, and providers with timely and actionable data to advance value-based care and improve health outcomes in Medicaid and other state-funded health care programs.

Texas has made progress in this area over the past several years. The Texas Health Services Authority (THSA) fulfills its state-directed purpose of promoting, implementing, and facilitating the secure electronic exchange of health information in Texas through its state-level health information network HIETexas.[66] The Texas Medicaid HIE Connectivity Project has leveraged federal funds to increase HIE adoption and use by Medicaid providers, build connectivity between the state's local HIEs and HIE Texas, and promote the exchange of administrative and clinical information for use by Medicaid providers, Medicaid MCOs, and the Texas Medicaid program. Through HIETexas, Texas Medicaid receives hospital inpatient and emergency department Admission Discharge Transfer (ADT) data for Medicaid members and some related clinical data in Consolidated Clinical Document Architecture (C-CDA) format.[67] ADT messages transmit administrative patient data related to patient identification and the patient hospital inpatient or emergency department visit. C-CDA-based clinical data contains information such as patient demographics, encounter diagnoses, procedures, medications, lab values, and care plans.

The 87th Legislature formally established the TX-APCD administered by the CHCD at the UT Health Houston School of Public Health.[68] CHCD is certified by CMS as a Qualified Entity for administration of Medicare data. This initiative is intended to increase public transparency of health care information so it can be used to improve the quality of health care and outcomes. Among other provisions, the law required the database to include a means for the public to access and navigate the aggregated information it contains. The TX-APCD now aggregates data for about 16 million Texans. CHCD is working to assess the quality of the data so that more TX-APCD data can be made available to the public and qualified researchers beginning in 2025.

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[66] H.B. 1066, 80th Legislature, Regular Session. (Texas. 2007). https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=80R&Bill=HB1066

[67] The HIE Connectivity Project was implemented through approval of Texas' HIE Implementation Advance Planning Document (HIE IAPD) that has used federal matching funds through the Health Information Technology for Economic and Clinical Health (HITECH) Act and federal funds for the Medicaid Management Information System (MMIS) to fund the Connectivity Project strategies.

[68] UTHealth Houston School of Public Health. (n.d.). *TX-APCD Overview*. https://sph.uth.edu/research/centers/center-for-health-care-data/texas-all-payor-claims-database/

The 88th Legislature passed HB 1575, which includes a standardized assessment of non-medical needs for pregnant women in Medicaid managed care and the Thriving Texas Families Program. MCOs, providers and community-based organizations can use this standard tool to screen patients and help connect patients to services. HHSC will receive and study standardized assessment information from MCOs to inform future policy-making. This legislation aligns with Texas Medicaid's *NMDOH Action Plan* released in early 2023.

In a number of its Medicaid DPPs, HHSC includes reporting measures related to participation in HIEs. The measures for state fiscal year 2025 include:

- Comprehensive Hospital Increase Reimbursement Program (CHIRP) – reporting on status of enrollment in a public HIE, including submission of ADT and CCDA data; and
- Texas Incentives for Physicians and Professional Services (TIPPS) Program, Rural Access to Primary and Preventives Services (RAPPS) Program and Directed Payment Program for Behavioral Health Services (DPP BHS) – reporting on status of connection to an HIE or electronic health record with HIE capabilities, including submission of ADT, CCDA, and Fast Healthcare Interoperability Resources (FHIR®) data.

Most recently, HHSC developed a new quality payment program which it will implement in state fiscal year 2025. The Aligning Technology by Linking Interoperable Systems for Client Health Outcomes (ATLIS) program will include up to $690 million in possible payments the first year. To improve outcomes for Medicaid beneficiaries and advance APMs, HHSC will enter into incentive arrangements with MCOs for achieving milestones related to the electronic exchange of client data with providers in their networks. The first year of the program requires an assessment of current connectivity and interoperability status between hospitals, MCOs, and HIEs to identify and quantify opportunities for improving secure data exchange. If MCOs are successful in achieving milestones and earning incentives, they may share the payments with their in-network hospitals. As the program progresses, HHSC proposes to add additional process and outcome measures related to assessing the impact of improved data exchange on the health care and outcomes for Medicaid beneficiaries.[69]

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[69] Texas Hospital Association. (n.d.*). ATLIS: Resources on New State Medicaid Quality Programs*. https://www.tha.org/issues/medicare-and-medicaid/atlis/

Landscape Assessment of Texas Data Interoperability

Despite recent progress to improve the quality, accessibility, and interoperability of health-related data, Texas can pursue additional data exchange opportunities. Since federal and local funding continues to be invested in HIEs, Texas needs to assess where it is in its current implementation strategies to guide its next steps.

On the federal front, Texas Medicaid and other payers are required to comply with nationwide initiatives. The CMS Interoperability and Patient Access Final Rule (CMS-9115-F),[70] which was finalized in 2020, aims to improve the electronic exchange of health care information and streamline prior authorization for medical items and services. This rule requires payers to comply with FHIR® Application Programming Interface (API) standards for Patient Access, Provider Access, Provider Directory, Payer-to-Payer, and Prior Authorization APIs. Implementation of the Patient Access, Provider Access, and Provider Directory APIs is already required and the *Advancing Interoperability and Improving Prior Authorization Processes* (CMS-0057-F) final rule, which CMS issued on January 17, 2024, requires implementation of the Payer-to-Payer and Prior Authorization APIs by January 1, 2027.[71]

In 2022, CMS launched the *National Quality Strategy* initiative that established an objective to support data standardization and interoperability by developing and expanding requirements for sharing, receipt, and use of digital data, including digital quality measures, across CMS quality and value-based programs. In March 2022, CMS released *the Digital Quality Measurement Strategic Roadmap* with a key priority to make the transition to digital quality measurement.

The National Committee for Quality Assurance (NCQA) similarly has committed to transitioning to fully digital Electronic Clinical Data System (ECDS) measures by 2030. All new measures NCQA releases will be ECDS, and there is a transition plan for moving all existing measures into ECDS. Texas Medicaid is not capable of using many of the new measures, because they require more data than the Medicaid program currently is able to gather.

Historically, quality measurement has been burdensome. There has been limited standardization between measurement expectations across APMs and different payers. Moving towards standardized electronic measures will reduce burden and costs, improve measure alignment and relevance, and lead to higher quality health

[70] 85 FR 25510
[71] 89 FR 8758

care and improved outcomes. However, HHSC will need to assess capacity to meet these new requirements immediately in order to strategically approach timely compliance.

A landscape assessment will help Texas prepare for required federal programs and build on existing state and local programs. As discussed, there are a number of required federal initiatives such as digital quality measures for which Texas is assessing preparedness and thinking about how to strategically address gaps. This assessment should also review the status of existing programs such as HHSC's Emergency Department Event Notification and Admission Discharge Transfer/Consolidated Clinical Document Architecture (ADT/C-CDA) data exchange and how best to use that data to improve care in Medicaid.

A landscape assessment would include (but not be limited to) the following:

- A review of THSA and each of the regional HIEs for their current providers, MCOs, community-based organizations, and other stakeholder participation; the types of data exchanged; completeness of data; available services; and innovative initiatives available through each.
- A review of the current Qualified Health Information Networks™ capable of nationwide health data exchange governed by the Trusted Exchange Framework and Common Agreement℠ and their reach and influence in Texas.
- The current status in Texas of CINs and how they are helping facilitate data exchange and value-based care.
- The quality of the data exchanged and opportunities to improve data quality.
- The capacity and interoperability of NMDOH data.
- How data are being shared under existing arrangements; the initiatives underway by the state, providers, MCOs, community-based organizations, and other stakeholders; and opportunities for each of these entities to better utilize the data to improve patient outcomes.

The findings of the landscape assessment should form the basis of a strategic plan with next steps to leverage data to improve care in Medicaid, CHIP, and other state-funded health care programs:

- Determine if provider participation levels meet the threshold to move the needle on quality initiatives and if not, recommend what can be done to increase provider participation in data exchange.
- Describe the state of data quality and as needed, recommend how to improve it to achieve health care quality and outcome goals.
- Identify steps that must be taken to comply with national initiatives, such as NCQA and digital quality measures, and the strategic direction required to be most effective.
- Discern how to leverage incentive programs like ATLIS and other federal funding opportunities to improve connectivity.

Maximizing Use of the Texas All-Payor Claims Database and Other Data Sets

This Committee has been consistent in making recommendations to expand and leverage available datasets to improve the quality and efficiency of health care delivery in Medicaid and other state-funded health care programs. Previous reports included recommendations promoting cross-agency collaboration in the integration and use of health care data from state and commercial payer sources administered by the CHCD, which laid the foundation for the TX-APCD.

In 2021, the Texas Legislature authorized the Texas Department of Insurance to establish the TX-APCD to increase public transparency of health care information and improve the quality of health care in Texas.[72] The TX-APCD was designed to receive and aggregate claims and encounters, enrollment, and benefit information from medical, dental, pharmaceutical, and other relevant health care insurance or benefits. This includes all health and dental benefit issuers regulated by the Texas Department of Insurance and all health or dental insurance or benefits under state-funded programs. Payers who provide health coverage to more than 60% of covered individuals in Texas are required to submit data to the TX-APCD, and other payers voluntarily may submit data.[73] Claims data offers insight across time on the

[72] H.B. 2090, 87th Legislature, Regular Session. (Texas. 2021). https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=HB2090

[73] Under Supreme Court of the United States caselaw, the Employee Retirement and Income Security Act of 1974 (ERISA) pre-empts application of state law to self-funded employer benefit plans.

cost of care, inpatient and outpatient visits, health outcomes, incidence, and disease prevalence for a large portion of the population.

The first biennial report to the legislature on the TX-APCD in 2022 stated that the TX-APCD was not fully funded. Yet, CHCD did not receive additional funding for the TX-APCD in the 88th Legislature, Regular Session, 2023. The TX-APCD was built on multiple legislative sessions of cross-agency collaboration among five agencies that operate state-provided health benefit programs: the Texas DSHS, Employee Retirement System, Teacher Retirement System, Texas Department of Criminal Justice, and HHSC. The TX-APCD includes data from all of these agencies for publicly-funded health care programs, including State of Texas employee benefits.

A study commissioned by The Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health & Human Services found that as of January 1, 2023, a total of 23 states had either a mandatory or a voluntary All-Payer Claims Database (APCD), and an additional eight states were developing mandatory APCDs.[74] The 23 states include Florida, Georgia, Virginia, Maryland, Delaware, Hawaii, New York, Connecticut, Rhode Island, Massachusetts, New Hampshire, Maine, Vermont, Minnesota, Arkansas, Texas, Kansas, New Mexico, Colorado, Utah, California, Oregon, and Washington.

Georgia has recently made significant strides in health care transparency. In December 2023, it launched public insurance claim databases, offering a clearer picture of health care access statewide. By utilizing de-identified claims data, Georgia is enabling the public to understand the true costs of health care services, from major procedures to basic supplies. This initiative represents the state's most extensive compilation of health care data to date, allowing for nuanced analysis across various demographics and service categories.

California has followed suit, releasing its inaugural APCD report to guide both policymakers and residents through the complex health care landscape. This comprehensive report aims to interpret data on their annual health care

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[74] The Office of the Assistant Secretary for Planning and Evaluation, Kranz, A.M., Dworsky, M., Ryan, J., Heins, S.E., & Bhandarkar, M. (2023). *State All Payer Claims Databases: Identifying Challenges and Opportunities for Conducting Patient-Centered Outcomes Research and Multi-State Studies*. https://aspe.hhs.gov/reports/state-all-payer-claims-databases-pcorf-multi-state-studies

expenditure of over $400 billion. California is also setting its sights on reforming dental care, a pressing issue in the health care sector.

In Massachusetts, the APCD has uncovered a concerning trend: a significant increase in schizophrenia diagnoses among non-elderly adults over two years. This data revealed that individuals with schizophrenia face greater obstacles in health care insurance compared to those with other mental health conditions. In response, Massachusetts is implementing stricter oversight of insurance agencies, particularly Medicaid, to ensure patients receive appropriate coverage.

These examples highlight how APCDs are transforming health care policy and practice across the country, addressing issues from cost transparency to mental health care access. By providing data-driven insights, these databases are enabling states to make more informed decisions and implement targeted health care reforms. Texas can look to these states to gain ideas about the content and to prioritize needed investment in the TX-APCD for quality improvement, cost transparency, care enhancement, and cost savings initiatives.

Researchers from public interest organizations, institutions of higher learning, CHCD, and health care providers may access the TX-APCD to conduct studies, and there is a public portal which gives individuals the opportunity to explore health care costs, quality, utilization, outcomes, access, and disparities data at regional and statewide levels.

Along with the TX-APCD, the Committee continues to encourage meaningful use of other valuable state data assets including as the Texas Healthcare Learning Collaborative (THLC) Portal, which provides data on Medicaid MCO and DMO performance through a dashboard display and the Texas Healthcare Information Data Collection at DSHS, which receives and compiles hospital inpatient, outpatient and emergency department discharge data. Texas should continue to explore how to maximize the use of all of these assets to advance high-value care for Medicaid and other state-funded health care programs to drive quality improvement, especially for high cost and high prevalence conditions such as diabetes and priority populations such as mothers and babies.

Data on Use of the Medicaid Collaborative Care Benefit

The Medicaid Collaborative Care Model (CoCM) integrates the services of behavioral health care managers and consulting psychiatrists with primary care provider oversight to manage behavioral health conditions (mental health and/or substance use) in the primary care setting. Numerous studies have found CoCM is a cost-

efficient way to increase access to behavioral health care and enhance patient outcomes.[75]

Texas implemented the CoCM benefit on June 1, 2022, as a component of delivering high-value primary care.[76] Despite its potential for promoting cost-effective care that enhances patient outcomes, providers and other stakeholders anecdotally have shared that they do not think the CoCM benefit has been used widely. They have also expressed there are specific obstacles to Federally Qualified Health Centers and Rural Health Clinics using the benefit.

HHSC should analyze and share data on the number and types of providers who are billing the new Medicaid CoCM benefit. HHSC can also analyze the patient populations for whom the benefit has been used and the impact on health outcomes. This analysis will help HHSC target conversations with providers to understand the barriers and identify strategies to expand their use.

Timely and Actionable Data: Key Reports and Other Resources

Interoperability for Texas: Powering Health 2022 (December 2022)

This report describes Texas HHS agencies' progress on meeting health data standards, interoperability, and HIE to facilitate care coordination, ensure quality improvement, and realize cost savings.

Texas All-Payor Claims Database Biennial Report to the 88th Legislature (September 2022)

This report provides an update on the TX-APCD as well as a recommendation regarding funding of the TX-APCD to assure it is capable of achieving the goals set by state policymakers.

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[75] Reist, C., Petiwala, I., Latimer, J., Raffaelli, S.B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. *Medicine, 101*(52), e32554. https://doi.org/10.1097/md.0000000000032554

[76] Subsection 9.3, "Collaborative Care Model (CoCM)", Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks), Texas Medicaid Provider Procedures Manual.

3. Summary

The Value-Based Payment and Quality Improvement Advisory Committee is committed to achieving better care, smarter spending, and healthier Texas communities. The Committee unanimously adopted the recommendations presented here, and have included relevant background, context, and supporting resources to help stakeholders learn more about these issues.

This report advances ideas from prior years and includes specific actions Texas legislators, policy makers, and other leaders can and should take to achieve efficient high-quality care and improve health outcomes, particularly in Medicaid and CHIP.

Our recommendations focus on optimizing APMs in Medicaid, leveraging value-based payments to increase access to care in rural Texas, screening for and addressing NMDOH, and improving secure access to timely, actionable data. These strategies can be implemented and integrated across multiple Texas agencies and programs. We encourage adoption of these ideas and best practices to achieve Texas' health care quality goals.

List of Acronyms

Acronym	Full Name
ACO	Accountable Care Organization
ADT	Admit, Discharge, and Transfer
APCD	All-Payer Claims Database
API	Application Programming Interface
APM	Alternative Payment Model
APM-PF	Alternative Payment Model – Performance Framework
APO	Accountable Pharmacy Organization
ATLIS	Aligning Technology by Linking Interoperable Systems
C-CDA	Consolidated Clinical Document Architecture
CHCD	Center for Health Care Data at the UT Health Houston School of Public Health
CHCS	Center for Health Care Strategies
CHIP	Children's Health Insurance Program
CHIRP	Comprehensive Hospital Increase Reimbursement Program
CHW	Community Health Worker
CIN	Clinically Integrated Networks
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
DMO	Dental Maintenance Organization
DPP	Directed Payment Program

Acronym	Full Name
DPP BHS	Directed Payment Program for Behavioral Health Services
DSHS	Texas Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
ECDS	Electronic Clinical Data System
FFS	Fee-For-Service
GAD	Generalized Anxiety Disorder
HB	House Bill
HbA1c	Hemoglobin A1c
HCP-LAN	Health Care Payment Learning & Action Network
HHS	Health and Human Services
HHSC	Texas Health and Human Services Commission
HIE	Health Information Exchange
ILOS	In-Lieu of Services and Settings
LMHA	Local Mental Health Authority
LBHA	Local Behavioral Health Authority
MCO	Managed Care Organization
MTM	Medication Therapy Management
NCQA	National Committee for Quality Assurance
NMDOH	Non-Medical Drivers (or Determinants) of Health
NPI	National Provider Identification
P4Q	Medical and Dental Pay for Quality

Acronym	Full Name
PDC	Proportion of Days Covered
PeCP	Pharmacist eCare Plan
PHE	Public Health Emergency
PHQ	Patient Health Questionnaire
PIP	Performance Improvement Project
PREP Act	Public Readiness and Emergency Preparedness (PREP) Act
PSAO	Pharmacy Services Administrative Organization
QHP	Qualified Health Care Professional
QIPP	Quality Incentive Payment Program
RAPPS	Rural Access to Primary and Preventive Services
SB	Senate Bill
SNAP	Supplemental Nutrition Assistance Program
THLC	Texas Healthcare Learning Collaborative Portal
THSA	Texas Health Services Authority
TIPPS	Texas Incentive for Physicians and Professional Services
TMHP	Texas Medicaid & Healthcare Partnership
TX-APCD	Texas All-Payor Claims Database
VBP	Value-Based Payment
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children